APPENDIX G: MODEL CONTRACT (Addendum F)

XXX ##/##-### AGREEMENT

BETWEEN STATE OF

RHODE ISLAND

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

AND

XXXXX

FOR MEDICAID MANAGED CARE SERVICES

Name of Contractor:

Title of Agreement:

Basis for Contract:

Contract Award:

Performance Period:

General Conditions of Purchase https://rules.sos.ri.gov/regulations/part/220-30-00-13

ADDENDA

Attached hereto, incorporated into, and made a part herein of this agreement, are the following addenda, as applicable:

ADDENDUM A — **General Insurance Requirements**

ADDENDUM B — **Information Technology Requirements and/or Management Information System Requirements**
Hereby incorporated by reference into GC Addendum F
(Not Applicable)

ADDENDUM C — **Public Works Project Requirements**
(Not Applicable)

ADDENDUM D — **Agency Specific Federal Funding Requirements**
Provides any requirements imposed by federal partners.
All Federal Requirements are included in Addendum F and are hereby incorporated by reference into the Agreement

ADDENDUM E — **Business Associates Agreement**

ADDENDUM F — **Agency Special Requirements Not Otherwise Addressed in the General Conditions**

ADDENDUM A
General Insurance Requirements

Insurance Requirements

In accordance with this solicitation, or as outlined in Section 13.19 of the General Conditions of Purchase, found at https://rules.sos.ri.gov/regulations/part/220-30- 00-13 **and General Conditions - Addendum A found at** https://www.ridop.ri.gov/documents/general-conditions-addendum-a.pdf, the insurance coverage that shall be required of the awarded vendor(s) is stated in Section 1: Introduction of the RFP.

ADDENDUM B
Information Technology Requirements

(Not Applicable)

ADDENDUM C
Public Works Projects Requirements

(Not Applicable)

ADDENDUM D
Agency Specific
Federal Funding Requirements

Provides Any Requirements Imposed by Federal Partners
(See Addendum F for Applicable Federal Requirements)

FEDERAL FUNDING REQUIREMENTS

COMPLIANCE WITH FEDERAL LAWS AND REGULATIONS

When federal financial assistance rules are applicable to this transaction or any follow-on transactions, the Vendor is at all times acting as a contractor or vendor and not as a sub-recipient or sub-grantee, as those terms are defined in federal financial assistance regulations. It is understood that the Vendor shall be subject to the Vendor's commercial terms, and only to those mandatory provisions in the federal financial assistance regulations specifically relevant to contractors or vendors.

In performing the services contained in the Entire Agreement and subsequent amendments, the Vendor shall comply with all applicable federal laws and regulations. Specifically, the Vendor agrees to comply with the following:

PAR 1. AVAILABILITY OF FUNDS

It is understood and agreed by the Parties hereto that all obligations of the State, including the continuance of payments hereunder, are contingent upon the availability and continued appropriation of State and federal funds, and in no event shall the State be liable for any payments hereunder in excess of such available and appropriated funds. In the event that the amount of any available or appropriated funds provided by the State or federal sources for the purchase of services hereunder shall be reduced, terminated or shall not be continued at an aggregate level sufficient to allow for the purchase of the specified amount of services or products to be purchased hereunder for any reason whatsoever, the State shall notify the Vendor of such reduction of funds and the State shall be entitled to reduce its commitment hereunder as it deems necessary, but shall be obligated for payments due to the Vendor up to the time of such notice.

PAR 2.FEDERAL FUNDING PROVISIONS

Funds made available to the Vendor under the Entire Agreement are derived from federal funds made available to the State. The provisions of **PAR. 5** and **EXHIBIT B** of **ADDENDUM F SUPPLEMENTAL TERMS AND CONDITIONS** notwithstanding, the Vendor agrees to make claims for payment under the Entire Agreement in accordance with applicable federal policies. The Vendor agrees that no payments under the Entire Agreement shall be claimed for reimbursement under any other agreement, grant, or contract that the Vendor may hold that provides funding from the same State or federal sources. The Vendor agrees to be liable for audit exceptions that may arise from examination of claims for payment under the Entire Agreement. The Vendor specifically agrees to abide by all applicable federal requirements for vendors, including laws, regulations and requirements related to services performed or products sold outside the United States by the Vendor or its subcontractors.

PAR 3.NONDISCRIMINATION IN EMPLOYMENT AND SERVICES

By signing the Entire Agreement, the Vendor agrees to comply with the requirements of the following, as amended from time to time: Title VI of the Civil Rights Act of 1964 (42 USC 2000d et seq.); Section 504 of the Rehabilitation Act of 1973 (29 USC 794); the Americans with Disabilities Act of 1990 (42 USC 12101 et seq.); Title IX of the Education Amendments of 1972 (20 USC 1681 et seq.); the Food Stamp Act; the Age Discrimination Act of 1975; the United States Department of Health and Human Services (DHHS) regulations found in 45 CFR Parts 80 and 84; the United States Department of Education implementing regulations (34 CFR Parts 104 and 106); and the United States Department of Agriculture Food and Nutrition Services regulations (7 CFR § 272.6), which prohibit discrimination on the basis of race, color, national origin (limited English proficiency persons), age, sex, disability, religion, or political

beliefs in acceptance for, or provision of, services, employment, or treatment in educational or other programs or activities.

Pursuant to Title VI and Section 504, as listed above and as referenced in **EXHIBITS 2 AND 3**, which are incorporated herein by reference and made part of this Addendum, the Vendor shall have policies and procedures in effect, including, mandatory written compliance plans, which are designed to assure compliance with Title VI and/or Section 504, as referenced above. An electronic copy of the Vendor's written compliance plan, all relevant policies, procedures, workflows, relevant chart of responsible personnel, and/or self-assessments must be available to the State upon request.

The Vendor's written compliance plans and/or self-assessments referenced above and detailed in **EXHIBITS 2 AND 3** of this Addendum must include but are not limited to the requirements detailed in **EXHIBITS 2 AND 3** of this Addendum.

The Vendor must submit, within thirty-five (35) days of the date of a request by DHHS or the State, full and complete information on Title VI and/or Section 504 compliance and/or self-assessments, as referenced above, by the Vendor and/or any subcontractor of the Vendor.

The Vendor acknowledges receipt of **EXHIBIT 2 - RHODE ISLAND EOHHS NOTICE TO VENDORS ON THEIR RESPONSIBILITIES UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964** and **EXHIBIT 3 - RHODE ISLAND EOHHS NOTICE TO VENDORS ON THEIR RESPONSIBILITIES UNDER SECTION 504 OF THE REHABILITATION ACT OF 1973.**

The Vendor further agrees to comply with all other provisions applicable to law, including the Americans with Disabilities Act of 1990 and the Governor's Executive Order No. 05-01, Promotion of Equal Opportunity and the Prevention of Sexual Harassment in State Government.

The Vendor also agrees to comply with EOHHS requirements for safeguarding of confidential information (as such requirements are made known to the Vendor).

Failure to comply with this Paragraph may be the basis for cancellation of the Entire Agreement.

PAR 4. ACCESSIBILITY AND RETENTION OF RECORDS

The Vendor agrees to make accessible and to maintain all records and supporting documentation that directly pertain to the performance of the services or furnishing of the products under the Entire Agreement (whether paper, electronic, or other media) for a minimum of ten (10) years after final payment, unless a longer period of records retention is stipulated (45 CFR § 155.1210). This accessibility requirement shall include the right to review and copy such records upon request. This requirement is also intended to include, but is not limited to, any auditing, monitoring, and evaluation procedures, including on-site visits, performed individually or jointly, by State or federal officials or their agents necessary to verify the accuracy of the Vendor's invoices or compliance with the Entire Agreement (in accordance with 45 CFR § 75.361 and 45 CFR § 155.1210). If such records are maintained outside of the State, such records shall be made accessible by the Vendor at a Rhode Island location. Additionally, if any litigation, claim, or audit commences before the expiration of the ten (10) year period, the records must be retained until all litigation, claims, or audit findings involving the records have been resolved and final action taken in accordance with 45 CFR § 75.386. If audit findings have not been resolved at the end of the ten (10) years, the records shall be retained for an additional three (3) years after the resolution of the audit findings are made or as otherwise required by law.

The Vendor and its subcontractors, if subcontractors are permitted within the scope of the Entire Agreement, shall provide and maintain a quality assurance system acceptable to the State covering

deliverables and services under the Entire Agreement and shall tender to the State only those deliverables that have been inspected and found to conform to the Entire Agreement's requirements. The Vendor shall keep records evidencing inspections and their result and shall make these records available to the State during the term of the Entire Agreement and for ten (10) years after final payment. The Vendor shall permit the State to review procedures, practices, processes, and related documents to determine the acceptability of the Vendor's quality assurance system or other similar business practices related to performance of the Entire Agreement.

Further, the Vendor agrees to include a similar right of the State, federal officials, and their agents to audit records and interview staff in any subcontract related to the services or products under the Entire Agreement.

PAR 5. DRUG-FREE WORKPLACE POLICY

The Vendor agrees to comply with the provisions of the Governor's Executive Order 91-14, the State's Drug Free Workplace Policy, and the Federal Omnibus Drug Abuse Act of 1988. As a condition of contracting with the State of Rhode Island, the Vendor hereby agrees to abide by EXHIBIT 4 - DRUG-FREE WORKPLACE POLICY and, in accordance therewith, has executed EXHIBIT 5 - DRUG-FREE WORKPLACE POLICY VENDOR CERTIFICATE OF COMPLIANCE.

Furthermore, the Vendor agrees to submit to the State any report or forms which may from time-to-time be required to determine the Vendor's compliance with this policy. The Vendor acknowledges that a violation of the Drug-Free Workplace Policy may, at the State's option, result in termination of the Entire Agreement.

PAR 6. PRO-CHILDREN ACT OF 1994

As a condition of contracting with the State of Rhode Island, the Vendor hereby agrees to abide by **EXHIBIT 6 - CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE**, and in accordance has executed **EXHIBIT 6 - CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE.**

PAR 7.DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS

The Vendor agrees to abide by **EXHIBIT 7 – INSTRUCTIONS FOR CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS – PRIMARY COVERED TRANSACTIONS,** and in accordance has executed the required certification included in **EXHIBIT 8 – CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS – PRIMARY COVERED TRANSACTIONS.**

PAR 8.CLEAN AIR ACT AND FEDERAL WATER POLLUTION CONTROL ACT

Contracts and subgrants of amounts in excess of $150,000 must contain a provision that requires the non-Federal award to agree to comply with all applicable standards, orders, or regulations issued pursuant to the Clean Air Act (42 USC §§ 7401-7671q) and the Federal Water Pollution Control Act (33 USC §§ 1251-1387), as either is amended from time to time. Violations must be reported to the Federal awarding agency and the Regional Office of the Environmental Protection Agency (EPA). (45 CFR Part 75.)

PAR 9.FEDERAL TAX INFORMATION

Performance: In performance of this Entire Agreement, the Vendor agrees to comply with, and assume responsibility for, compliance by its employees with the following requirements:

(1) All work will be done under the supervision of the Vendor or the Vendor's employees.

(2) The Vendor and the Vendor's employees with access to, or who use, Federal Tax Information ("FTI") must meet the background check requirements defined in Internal Revenue Service (IRS) Publication 1075.

(3) Any return or return information made available in any format shall be used only for the purpose of carrying out the provisions of this Entire Agreement. Information contained in such material will be treated as confidential and will not be divulged or made known in any manner to any person except as may be necessary in the performance of this Entire Agreement. Disclosure to anyone other than an officer or employee of the Vendor will be prohibited.

(4) All returns and return information will be accounted for upon receipt and properly stored before, during, and after processing. In addition, all related output will be given the same level of protection as required for the source material.

(5) The Vendor certifies that the data processed during the term of this Entire Agreement shall be completely purged from all data storage components of his or her computer facility, and no output shall be retained by the Vendor at the time the work is completed. If immediate purging of all data storage components is not possible, the Vendor certifies that any IRS data remaining in any storage component shall be safeguarded to prevent unauthorized disclosures.

(6) Any spoilage or any intermediate hard copy printout that may result during the processing of IRS data will be given to EOHHS or its designee. When this is not possible, the Vendor shall be responsible for the destruction of the spoilage or any intermediate hard copy printouts, subject to prior approval from EOHHS, and shall provide EOHHS or its designee with a statement containing the date of destruction, description of material destroyed, and the method used.

(7) All computer systems receiving, processing, storing or transmitting FTI must meet the requirements defined in IRS Publication 1075. To meet functional and assurance requirements, the security features of the environment must provide for managerial, operational, and technical controls. All security features must be available and activated to protect against unauthorized use of, and access to, FTI.

(8) No work involving FTI furnished under this Entire Agreement will be subcontracted without prior written approval of the IRS.

(9) The Vendor shall maintain a list of employees with authorized access. Such list shall be provided to EOHHS and, upon request, to the IRS.

(10) EOHHS shall have the right to void the Entire Agreement if the Vendor fails to provide the safeguards described above.

Criminal/Civil Sanctions:

(1) Each officer or employee of any person to whom returns or return information is or may be disclosed will be notified in writing by such person that returns or return information disclosed to such officer or employee can be used only for a purpose and to the extent authorized herein, and that further disclosure of any such returns or return information for a purpose or to an extent unauthorized herein constitutes a felony punishable upon conviction by a fine of as much as $5,000 or imprisonment for as long as 5 years, or both,

together with the costs of prosecution. Such person shall also notify each such officer and employee that any such unauthorized further disclosure of returns or return information may also result in an award of civil damages against the officer or employee in an amount not less than $1,000 with respect to each instance of unauthorized disclosure. These penalties are prescribed by IRCs 7213 and 7431 and set forth at 26 CFR § 301.6103(n)-1.

(2) Each officer or employee of any person to whom returns or return information is or may be disclosed shall be notified in writing by such person that any return or return information made available in any format shall be used only for the purpose of carrying out the provisions of this contract. Information contained in such material shall be treated as confidential and shall not be divulged or made known in any manner to any person except as may be necessary in the performance of the contract. Inspection by or disclosure to anyone without an official need-to know constitutes a criminal misdemeanor punishable upon conviction by a fine of as much as $1,000 or imprisonment for as long as 1 year, or both, together with the costs of prosecution. Such person shall also notify each such officer and employee that any such unauthorized inspection or disclosure of returns or return information may also result in an award of civil damages against the officer or employee in an amount equal to the sum of the greater of $1,000 for each act of unauthorized inspection or disclosure with respect to which such defendant is found liable or the sum of the actual damages sustained by the plaintiff as a result of such unauthorized inspection or disclosure plus in the case of a willful inspection or disclosure which is the result of gross negligence, punitive damages, plus the costs of the action. These penalties are prescribed by IRC 7213A and 7431 and set forth at 26 CFR § 301.6103(n)-1.

(3) Additionally, it is incumbent upon the Subrecipient Entity to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a(i)(1), which is made applicable to Subrecipient Entities by 5 U.S.C. 552a(m)(1), provides that any officer or employee of a Subrecipient Entity, who by virtue of his/her employment or official position, has possession of or access to the State's records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

(4) Granting a Subrecipient Entity access to FTI must be preceded by certifying that each individual understands the State's security policy and procedures for safeguarding IRS information. Subrecipient Entities must maintain their authorization to access FTI through annual recertification. The initial certification and recertification must be documented and placed in the State's files for review. As part of the certification and at least annually afterwards, Subrecipient Entities must be advised of the provisions of IRCs 7431, 7213, and 7213A (see Exhibit 4, Sanctions for Unauthorized Disclosure, and Exhibit 5, Civil Damages for Unauthorized Disclosure to IRS Publication 1075). The training provided before the initial certification and annually thereafter must also cover the Incident response policy and procedure for reporting unauthorized disclosures and data breaches. (See Section 10 of IRS Publication 1075). For both the initial certification and the annual certification, the Subrecipient Entity must sign, either with ink or electronic signature, a

confidentiality statement certifying their understanding of the security requirements.

Inspection: The IRS and the State, with 24-hour notice, shall have the right to send its inspectors into the offices and plants of the Subrecipient Entity to inspect facilities and operations performing any work with FTI under this contract for compliance with requirements defined in IRS Publication 1075. The IRS' right of inspection shall include the use of manual and/or automated scanning tools to perform compliance and vulnerability assessments of information technology ("IT") assets that access, store, process or transmit FTI. On the basis of such inspection, corrective actions may be required in cases where the Subrecipient Entity is found to be noncompliant with contract safeguards.

EXHIBITS

Attached hereto, incorporated into, and made a part herein of this Addendum are the following Exhibits:

EXHIBIT 1 -	**FISCAL ASSURANCES**
EXHIBIT 2 -	**RHODE ISLAND EOHHS NOTICE TO VENDORS OF THEIR RESPONSIBILITIES UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964**
EXHIBIT 3 -	**RHODE ISLAND EOHHS NOTICE TO VENDORS OF THEIR RESPONSIBILITIES UNDER SECTION 504 OF THE REHABILITATION ACT OF 1973**
EXHIBIT 4-	**DRUG-FREE WORKPLACE POLICY**
EXHIBIT 5 -	**DRUG-FREE WORKPLACE POLICY VENDOR CERTIFICATE OF COMPLIANCE**
EXHIBIT 6 -	**CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE**
EXHIBIT 7 -	**INSTRUCTIONS FOR CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS – PRIMARY COVERED TRANSACTIONS**
EXHIBIT 8 -	**CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS – PRIMARY COVERED TRANSACTIONS**
EXHIBIT 9 -	**EQUAL EMPLOYMENT OPPORTUNITY**
EXHIBIT 10 -	**BYRD ANTI-LOBBYING AMENDMENT**

EXHIBIT 1

FISCAL ASSURANCES

1. The Vendor agrees to segregate all receipts and disbursements pertaining to the Entire Agreement from recipients and disbursements from all other sources, whether by separate accounts or by utilizing a fiscal code system.
2. The Vendor assures a system of adequate internal controls shall be implemented to ensure a separation of duties in all cash transactions.
3. The Vendor assures the existence of an audit trail which includes cancelled checks, voucher authorization, invoices, receiving reports, and time distribution reports.
4. The Vendor assures a separate subsidiary ledger of equipment and property shall be maintained.
5. The Vendor agrees any unexpended funds from the Entire Agreement are to be returned to EOHHS at the end of the time of performance unless EOHHS gives written consent for their retention.
6. The Vendor assures insurance coverage is in effect as mutually agreed under the Entire Agreement (**ADDENDUM A – GENERAL CONDITIONS**).
7. The following Federal requirements shall apply pursuant to 45 CFR Part 75, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for DHHS Awards. Where applicable:
   - Subpart A – Acronyms and Definitions (75.1–75.2)
   - Subpart B – General Provisions (75.100 – 75.113)
   - Subpart C – Pre-Federal Award Requirements and Contents of Federal Awards (75.200 – 75.218)
   - Subpart D – Post Federal Award (75.300 – 75.391)
   - Subpart E – Cost Principles (75.400 – 75.477)
   - Subpart F – Audit Requirements (75.500 – 75.521)
   - All Subsequent Addenda
8. If the Vendor expends Federal awards during the Vendor's particular fiscal year of $750,000 or more, then 45 CFR §75.500 et seq., Audits of States, Local Governments and Non-profit Organizations, shall also apply or if applicable, an audit shall be performed in accordance with "Government Auditing Standards" as published by the Comptroller General of the United States.
9. The Entire Agreement may be funded in whole or in part with Federal funds. If so, the CFDA reference number is 93.791. The Vendor must review applicable Federal Statutes, regulations, terms and conditions of the Federal Award in accordance with 45 CFR § 75.752.

EXHIBIT 2

RHODE ISLAND EOHHS NOTICE TO VENDORS ON 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 the Rhode Island Executive Office of Health and Human Services (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 hereinafter as Title VI. EOHHS contracts with vendors include a vendor'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 vendors to assure that they are complying with these requirements. Further, EOHHS reserves its right to at any time require from contractors and sub-contractors that they are also complying with Title VI.

The Vendor 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 Vendor's written compliance plan and all relevant policies, procedures, workflows and relevant chart of responsible personnel must be available to EOHHS upon request.

The Vendor'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 Vendor'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 contractors and sub-contractors of the Vendor execute assurances that said contractors and sub-contractors follow Title VI.

The Vendor must enter into an agreement with each sub-contractor 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 Vendor must submit, within thirty-five (35) days of the date of a request by DHHS or EOHHS, full and complete information on Title VI compliance by the Vendor and/or any sub-contractor or vendor of the Vendor.

It is the responsibility of each vendor 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 EOHHS**.**

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 Application
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	Definitions

EXHIBIT 3

RHODE ISLAND EOHHS NOTICE TO VENDORS ON THEIR RESPONSIBILITIES UNDER SECTION 504 OF THE REHABILITATION ACT OF 1973

Public and private agencies, organizations, institutions, and persons that receive Federal financial assistance through the **Rhode Island Executive Office of Health and Human Services (**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 (hereinafter collectively referred to as Section 504.) EOHHS contracts with vendors include a vendor's assurance that it shall comply with Section 504, which prohibits discrimination against handicapped persons in providing health, welfare, or other social services or benefits.

The Vendor 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 Vendor's written compliance plan and all relevant policies, procedures, workflows and relevant chart of responsible personnel must be available to EOHHS upon request.

The Vendor'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 Vendor'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 contractors and sub-contractors of the Vendor execute assurances that said contractors and sub-contractors are in compliance with Section 504.

The Vendor must enter into an agreement with each sub-contractor under which there is the provision to furnish to the Vendor, DHHS, or EOHHS on request, full and complete information related to Section 504 compliance.

The Vendor must submit, within thirty-five (35) days of the date of a request by DHHS or EOHHS, full and complete information on Section 504 compliance by the Vendor and/or any sub-contractor of the Vendor.

It is the responsibility of each vendor to acquaint itself with all of the provisions of Section 504. A copy of Section 504, 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** EOHHS.

Vendors 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 APPLICATION

84.3 DEFINITIONS

84.4 DISCRIMINATION PROHIBITED

84.5 ASSURANCE REQUIRED

84.6 REMEDIAL ACTION, VOLUNTARY ACTION, AND SELF-EVALUATION

84.7 DESIGNATION OF RESPONSIBLE EMPLOYEE AND ADOPTION OF 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 - ACCESSIBILITY SECTION:

84.21 DISCRIMINATION 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

84.55 PROCEDURES RELATING TO HEALTH CARE FOR HANDICAPPED INFANTS

84.56 – 84.60 (RESERVED)

EXHIBIT 4

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 and 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 shall be subject to discipline up to and including termination. An employee may also be discharged or otherwise disciplined for a conviction involving illicit drug use, regardless of whether the employee's 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 shall be subject to discipline up to and including termination.

2. The term "controlled substance" means any drugs listed in 21 USC § 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) shall 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 shall 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 Personnel Officer has more information on RIEAP.

7. The law requires all employees to abide by this policy.

EXHIBIT 5

DRUG-FREE WORKPLACE POLICY VENDOR CERTIFICATE OF COMPLIANCE

I, _____, (Name) _____(Title) of _____ _____(Vendor Name), a vendor 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 (to include but not limited to such drugs as marijuana, heroin, cocaine, PCP, and crack, 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 Entire Agreement.

_____

SIGNATURE:

_____

TITLE:

_____

DATE:

EXHIBIT 6

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part c - Environmental Tobacco Smoke (20 USCA §§ 6081-6084), also known as the Pro-Children Act of 1994 (the "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 Act 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.

Any failure to comply with a prohibition in this section shall be a violation of this section and any person subject to such prohibition who commits such violation may be liable to the United States for a civil penalty in an amount not to exceed $1,000 for each violation, or may be subject to an administrative compliance order, or both, as determined by the Director. Each day a violation continues shall constitute a separate violation. In the case of any civil penalty under this section, the total amount shall not exceed the amount of Federal funds received by such person for the fiscal year in which the continuing violations occurred.

By signing and submitting this application, the Vendor certifies that it shall comply with the requirements of the Act. The Vendor further agrees that it shall require the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-contractors shall certify accordingly.

_____

SIGNATURE:

_____

TITLE:

_____

DATE:

EXHIBIT 7

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

By signing and submitting this proposal, the prospective primary participant is providing the certification set out below.

1. 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 State'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.

2. The certification in this clause is a material representation of fact upon which reliance was placed when the State determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the State. The State may terminate this transaction for cause or default.

3. The prospective primary participant shall provide immediate written notice to the State 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.

4. 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 and 12689.

5. A contract award will not be made to parties listed on the government-wide exclusions in the System for Award Management (SAM), in accordance with the OMB guidelines at 2 CFR § 180 that implement Executive Orders 12549 (3 CFR Part 1986 Comp., p. 189) and 12689 (3 CFR Part 1989 Comp., p. 235), "Debarment and Suspension."

6. The prospective primary participant agrees by submitting this proposal 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 State.

7. The prospective primary participant further agrees by submitting this proposal that it shall include the clause titled certification regarding debarment, suspension, ineligibility and voluntary exclusion - lower tier covered transactions, provided by the State, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. 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 non- procurement list (of excluded parties).

9. 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 as prudent person in the ordinary course of business dealings.

10. 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 State may terminate this transaction for cause of default.

EXHIBIT 8

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS – PRIMARY COVERED TRANSACTIONS

The Vendor, as the primary participant, certifies to the best of the Vendor's knowledge and belief that the Vendor and its principals:

1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal, State, or local agency;

2. Have not within a three (3) year period preceding this application/proposal 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; or 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 2 of this certification; and

4. Have not within a three (3) year period preceding this application/proposal 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 participant shall attach an explanation to this application/proposal.

_____

SIGNATURE:

_____

TITLE:

_____

DATE:

EXHIBIT 9

EQUAL EMPLOYMENT OPPORTUNITY

During the term of the Entire Agreement, the Vendor agrees as follows:

1. The Vendor shall not discriminate against any employee or applicant for employment relating to the Entire 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 Vendor 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 Vendor agrees to post in conspicuous places available to employees and applicants for employment notices setting forth the provisions of this nondiscrimination clause.

2. The Vendor shall, in all solicitations or advertising for employees placed by or on behalf of the Vendor relating to the Entire 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 Vendor shall inform the contracting State's equal employment opportunity coordinator of any discrimination complaints brought to an external regulatory body (e.g., RI Ethics Commission, RI Department of Administration, or DHHS Office of Civil Rights) against it by any individual as well as any lawsuit regarding alleged discriminatory practice.

4. The Vendor shall comply with all aspects of the Americans with Disabilities Act (ADA) in employment and in the provision of services or products to include accessibility and reasonable accommodations for employees and clients.

5. Vendors and subcontractors with agreements in excess of $50,000 shall also pursue in good faith affirmative action programs.

6. The Vendor shall cause the foregoing provisions to be inserted in any subcontract for any work covered by the Entire Agreement so that such provisions shall be binding upon each subcontractor, provided that the foregoing provisions shall not apply to contracts or subcontracts for standard commercial supplies or raw materials.

EXHIBIT 10

BYRD ANTI-LOBBYING AMENDMENT

No Federal or State appropriated funds shall be expended by the Vendor for influencing or attempting to influence an officer or employee of any agency, a member of congress or State Legislature, an officer or employee of congress or State legislature, or an employee of a member of congress or State legislature in connection with any of the following covered actions: the awarding of any agreement; the making of any grant; the entering into of any cooperative agreement; and the extension, continuation, renewal, amendment, or modification of any agreement, grant, or cooperative agreement. Signing this Addendum fulfills the requirement that vendors receiving over $100,000 in Federal or State funds file with the State on this provision.

If any Non-Federal or State Funds have been or shall be paid to any person in connection with any of the covered actions in this provision, the Vendor shall complete and submit a "Disclosure of Lobbying Activities" form.

The Vendor must certify compliance with all terms of the Byrd Anti-Lobbying Amendment (31 1352) as published in the Federal Register May 27, 2003, Volume 68, Number 101.

The Vendor hereby certifies that it shall comply with Byrd Anti-Lobbying Amendment provisions as defined in 45 CFR Part 93 and as amended from time to time.

_____

SIGNATURE:

_____

TITLE:

_____

DATE:

ADDENDUM E

Business Associates Agreement

BUSINESS ASSOCIATES AGREEMENT

Except as defined or otherwise provided in this Business Associate Agreement Addendum (this "Addendum"), the Executive Office of Health and Human Services (EOHHS, "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, (INSERT AGENCY) ("Covered Entity"), as specified herein and in the Contract, which this Addendum supplements and is made part of, provided such use, access, or disclosure does not violate

(A) the Health Insurance Portability and Accountability Act, 42 U.S.C. § 1320d *et. seq.*, and its implementing regulations including, but not limited to, 45 C.F.R. Parts 160, 162 and 164 (respectively, the "Privacy Rule," the "Security Rule," and patient confidentiality regulations, and collectively, "HIPAA"),

(B) the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated into the American Recovery and Reinvestment Act of 2009, Public Law 111-5, and any regulations adopted or to be adopted pursuant to the HITECH Act that relate to the obligations of business associates (the "HITECH Act"),

(C) the Rhode Island Mental Health Law (R.I. Gen. Laws § 40.1-5 *et. seq.*), and

(D) the Confidentiality of Health Care Communications and Information Act, (R.I. Gen. Laws § 5-37.3 *et seq.*). Business Associate recognizes and agrees it is obligated by law to meet the applicable provisions of the HITECH Act.

1. Definitions.

   A. Generally:

      i. Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in 45 C.F.R. §§ 160.103, 164.103, and 164.304, 164.402, 164.410, 164.501, and 164.502.

      ii. The following terms used in this Addendum shall have the same meanings as they have in HIPAA, the Privacy Rule, the Security Rule and the HITECH Act: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information or Unsecured PHI, and Use.

   B. Specific:

      i. "Addendum" means this Business Associate Agreement Addendum.

      ii. "Business Associate" generally has the same meaning as the term "business associate" at 45 C.F.R. § 160.103, and in reference to the party to this Addendum, shall mean EOHHS.

      iii. "Contract" means the underlying contractual agreement by and between Covered Entity and Business Associate, awarded pursuant to State of Rhode Island's

Purchasing Law (R.I. Gen. Laws § 37-2 *et seq.*) and Rhode Island Department of Administration, Division of Purchases, Purchasing Rules, Regulations, and General Conditions of Purchasing.

iv. "Covered Entity" generally has the same meaning as the term "covered entity" at 45 C.F.R. § 160.103, and in reference to the party to this Addendum, shall mean the **(**INSERT AGENCY).

v. "Electronic Protected Health Information" means PHI that is transmitted by or maintained in electronic media as defined in the Security Rule.

vi. "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 45 C.F.R. Part 160 and Part 164 (Subparts A and E).

vii. "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.

viii. "Security Rule" means the Standards for the security of Electronic Protected Health Information found at 45 C.F.R. Parts 160 and 164 (Subparts A and C). The application of 45 C.F.R. §§ 164.308, 164.310, 164.312, and 164.316 shall apply to Business Associate in the same manner that such sections apply to Covered Entity.

ix. "Suspected breach" is a suspected acquisition, access, use, or disclosure of Protected Health Information (or "PHI") in violation of the Privacy Rule.

2. Obligations and Activities of Business Associate.

A. Business Associate agrees to not use or further disclose PHI other than as permitted or required by this Addendum or as Required By Law, provided such use or disclosure would also be permissible by law by Covered Entity.

B. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Addendum. Business Associate agrees to implement Administrative Safeguards, Physical Safeguards and Technical Safeguards ("Safeguards") that reasonably and appropriately protect the confidentiality, integrity and availability of PHI as required by the Security Rule.

C. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate from a use or disclosure of PHI by Business Associate in violation of the requirements of this Addendum.

D. Business Associate agrees to report to Covered Entity the discovery of any use or disclosure of PHI not provided for by this Addendum, including breaches of Unsecured PHI as required by 45 C.F.R. § 164.410, and any Security Incident of which it becomes aware, within twenty-four (24) hours of the breach and/or Security Incident.

E. Business Associate agrees to perform any required breach notifications to individuals, federal agencies, and potentially the media, on behalf of Covered Entity, if requested by Covered Entity.

F. Business Associate agrees to ensure that any agent, including a subcontractor or vendor, to whom it provides PHI received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Addendum to Business Associate with respect to such information through a contractual arrangement that complies with 45 C.F.R. § 164.314.

G. Business Associate agrees to provide paper or electronic access, at the request of Covered Entity and in the time and manner designated by Covered Entity, to PHI 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 C.F.R. § 164.524. If the Individual requests an electronic copy of the information, Business Associate must provide Covered Entity with the information requested in the electronic form and format requested by the Individual and/or Covered Entity if it is readily producible in such form and format; or, if not, in a readable electronic form and format as requested by Covered Entity.

H. Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 C.F.R. § 164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity. If Business Associate receives a request for amendment to PHI directly from an Individual, Business Associate shall notify Covered Entity upon receipt of such request.

I. Business Associate agrees to maintain reasonable written security procedures and practices, and shall make its internal written procedures, practices, books, and records relating to the use and disclosure of PHI received from, created or received by Business Associate on behalf of Covered Entity available to Covered Entity, or at the request of Covered Entity to the Secretary, in a time and manner designated by Covered Entity or the Secretary, for the purposes of the Secretary determining compliance with the Privacy Rule and Security Rule.

J. Business Associate agrees to document such disclosures of PHI 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 PHI in accordance with 45 C.F.R. § 164.528.

K. Business Associate agrees to provide to Covered Entity or an Individual, in a time and manner designated by Covered Entity, information collected in accordance with this Addendum, to permit Covered Entity to respond to a request by an individual for an accounting of disclosures for PHI in accordance with 45 C.F.R. § 164.528. If Business Associate accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses Unsecured Protected Health Information for Covered Entity, it shall, following the discovery of a breach of such information, notify Covered Entity by telephone call plus e-mail, web form, or fax upon the discovery of any breach of within twenty-four (24) hours after discovery of the breach and/or Security Incident. Such notice shall include: (i) the identification of each individual whose Unsecured Protected Health

Information has been, or is reasonably believed by Business Associate to have been accessed, acquired or disclosed during such breach; (ii) a brief description of what happened, including the date of the breach and discovery of the breach; (iii) a description of the type of Unsecured PHI that was involved in the breach; (iv) a description of the investigation into the breach, mitigation of harm to the individuals and protection against further breaches; (v) the results of any and all investigation performed by Business Associate related to the breach; and (vi) contact information of the most knowledgeable individual for Covered Entity to contact relating to the breach and its investigation into the breach. Upon learning new or additional information regarding the breach or Security Incident, Business Associate shall provide corrected supplemental information to Covered Entity.

L. To the extent Business Associate is carrying out an obligation of Covered Entity's under the Privacy Rule, Business Associate must comply with the requirements of the Privacy Rule that apply to Covered Entity in the performance of such obligation.

M. Business Associate agrees that it will not receive remuneration directly or indirectly in exchange for PHI without authorization unless an exception under 45 C.F.R. § 164.502(a)(5)(ii)(B)(2) applies.

N. Business Associate agrees that it will not receive remuneration for certain communications that fall within the exceptions to the definition of Marketing under 45 C.F.R. § 164.501, unless permitted by 45 C.F.R. § 164.508(a)(3)(A)-(B).

O. If applicable, Business Associate agrees that it will not use or disclose genetic information for underwriting purposes, as that term is defined in 45 C.F.R. § 164.502.

P. Business Associate hereby agrees to comply with state laws and rules and regulations applicable to PHI and personal information of individuals' information it receives from Covered Entity during the term of the Addendum.

i. Business Associate agrees to: (a) implement and maintain appropriate physical, technical and administrative security measures for the protection of personal information as required by any state law and rules and regulations; including, but not limited to (i) encrypting all transmitted records and files containing personal information that will travel across public networks, and encryption of all data containing personal information to be transmitted wirelessly, (ii) prohibiting the transfer of personal information to any portable device unless such transfer has been approved in advance, and (iii) encrypting any personal information to be transferred to a portable device; and (b) implement and maintain written security procedures as required by any state law as applicable.

ii. The Safeguards set forth in this Addendum shall apply equally to PHI, confidential and "personal information." Personal information means an individual's first name and last name or first initial and last name in combination with any one or more of the following data elements that relate to such resident: (a) Social Security number; (b) driver's license number or state-issued identification card number; or (c) financial account number, or credit or debit card number, with or without any

required security code, access code, personal identification number or password, that would permit access to a resident's financial account; provided, however, that "personal information" shall not include information that is lawfully obtained from publicly available information, or from federal, state or local government records lawfully made available to the general public.

3. Permitted Uses and Disclosures by Business Associate.

A. Except as otherwise limited to this Addendum, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the Minimum Necessary policies and procedures of Covered Entity required by 45 C.F.R. § 164.514(d).

B. Except as otherwise limited in this Addendum, Business Associate may use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

C. Except as otherwise limited in this Addendum, Business Associate may disclose PHI for the proper management and administration of Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

D. Except as otherwise limited in this Addendum, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504 (e)(2)(i)(B).

E. Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. § 164.502(j)(1).

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 C.F.R. § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

B. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI to the extent that such changes may affect Business Associate's use or disclosure of PHI.

C. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

5. Permissible Requests by Covered Entity.

Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity, provided that, to the extent permitted by the Contract, Business Associate may use or disclose PHI for Business Associate's Data Aggregation activities or proper management and administrative activities.

6. Term and Termination.

A. The term of this Addendum shall begin as of the effective date of the Contract and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions of this Section.

B. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

i. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Addendum and the Contract if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity; or

ii. Immediately terminate this Addendum and the Contract if Business Associate has breached a material term of this Addendum and cure is not possible.

C. Except as provided in Paragraph (D) of this Section, upon any termination or expiration of this Addendum, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI. Business Associate shall ensure that its subcontractors or vendors return or destroy any of Covered Entity's PHI received from Business Associate.

D. In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity written notification of the conditions that make return or destruction infeasible. Such written notice must be provided to Covered Entity no later than sixty (60) days prior to the expiration of this Addendum. Upon Covered Entity's written agreement that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Addendum to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI. This provision regarding written notification shall also apply to PHI that is in the possession of subcontractors or agents of Business Associate.

7. Miscellaneous.

A. A reference in this Addendum to a section in the Privacy Rule or Security Rule means the section as in effect or as amended.

B. The Parties agree to take such action as is necessary to amend this Addendum from time to time as is necessary for Covered Entity to comply with the requirements of HIPAA, the Privacy Rule, the Security Rule, and the HITECH Act.

C. The respective rights and obligations of Business Associate under Sections 6(C) and 6(D) of this Addendum shall survive the termination of this Addendum.

D. Any ambiguity in this Addendum shall be resolved to permit Covered Entity to comply with HIPAA and the HITECH Act.

E. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

F. 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 and assigns, any rights, remedies, obligations or liabilities whatsoever.

G. Modification of the terms of this Addendum shall not be effective or binding upon the parties unless and until such modification is committed to writing and executed by the parties hereto.

H. This Addendum shall be binding upon the parties hereto, and their respective legal representatives, trustees, receivers, successors and permitted assigns.

I. Should any provision of this Addendum be found unenforceable, it shall be deemed severable and the balance of the Addendum shall continue in full force and effect as if the unenforceable provision had never been made a part hereof.

J. This Addendum and the rights and obligations of the parties hereunder shall in all respects be governed by, and construed in accordance with, the laws of the State of Rhode Island, including all matters of construction, validity and performance.

K. All notices and communications required or permitted to be given hereunder shall be sent by certified or regular mail, addressed to the other part as its respective address as shown on the signature page, or at such other address as such party shall from time to time designate in writing to the other party, and shall be effective from the date of mailing.

L. This Addendum, including such portions as are incorporated by reference herein, constitutes the entire agreement by, between and among the parties with respect to the subject matter herein, and such parties acknowledge by their signature hereto that they do not rely upon any representations or undertakings by any person or party, past or future, not expressly set forth in writing herein.

M. Business Associate shall maintain or cause to be maintained sufficient insurance coverage as shall be necessary to insure Business Associate and its employees, agents, representatives or subcontractors against any and all claims or claims for damages arising under this Addendum and such insurance coverage shall apply to all services provided by Business Associate or its agents or subcontractors pursuant to this Addendum. Business

Associate shall indemnify, hold harmless and defend Covered Entity from and against any and all claims, losses, liabilities, costs and other expenses (including but not limited to, reasonable attorneys' fees and costs, administrative penalties and fines, costs expended to notify individuals and/or to prevent or remedy possible identity theft, financial harm, reputational harm, or any other claims of harm related to a breach) incurred as a result of, or arising directly or indirectly out of or in connection with any acts or omissions of Business Associate, its employees, agents, representatives or subcontractors, under this Addendum, including, but not limited to, negligent or intentional acts or omissions. This provision shall survive termination of this Addendum.

8. Acknowledgment.

The undersigned affirms that he/she is a duly authorized representative of Business Associate for which he/she is signing and has the authority to execute this Addendum on behalf of Business Associate.

[SIGNATURES ON NEXT PAGE]

Acknowledged and agreed to by:

STATE OF RHODE ISLAND **EXECUTIVE OFFICE OF** **HEALTH AND HUMAN SERVICES**	**[VENDOR]**
_____	_____
AUTHORIZED AGENT	AUTHORIZED AGENT
_____	_____
TITLE	TITLE
_____	_____
Printed Name	Printed Name
_____	_____
Date	Date

ADDENDUM F

Agency Special Requirements

Not Otherwise Addressed in the General Conditions of Purchase

ADDENDUM F

Agency Special Requirements
Not Otherwise Addressed in the General Conditions of Purchase

Attached hereto, incorporated into, and made a part herein of Addendum F, are the following attachments, as applicable:

ATTACHMENT F-1	**Definitions and Acronyms**
ATTACHMENT F-2	**EOHHS General Terms and Conditions**
ATTACHMENT F-3	**Scope of Work**
ATTACHMENT F-4.1	**Schedule of In-Plan Benefits**
ATTACHMENT F-4.2	**Schedule of Out-of-Plan Benefits**
ATTACHMENT F-4.3	**Schedule of Non-Covered Benefits**
ATTACHMENT F-4.4	**Schedule of In Lieu of Services**
ATTACHMENT F-5	**Capitation Rates and Fiscal Assurances**
ATTACHMENT F-6	**Liquidated Damages Matrix**
ATTACHMENT F-7	**Request for Proposals**
ATTACHMENT F-8	**Contractor's Proposal**
ATTACHMENT F-9	**Rhode Island Medicaid Managed Care Manual**
ATTACHMENT F-10	**Contractor's Key Personnel Tables**
ATTACHMENT F-11	**Contractor's Executive Management Function Resumes**

ATTACHMENT F-1

Definitions and Acronyms

1. Definitions

The words and phrases in this section shall have the following meaning for purposes of this Agreement. In addition, any subcontracts and in any other documents that relate to this Agreement, the Contractor shall use the following definitions and any other definitions that appear in this Agreement:

1.1. 1115 Waiver

The State of Rhode Island's Medicaid demonstration project, authorized by the Center for Medicare and Medicaid Services (CMS) pursuant to Section 1115(a) of the Social Security Act that enables a state flexibility in designing and improving their Medicaid program.

1.2. 340B Drug Pricing Program

The program administered by Health Service Resource Administration (HRSA) that requires drug manufacturers to provide covered outpatient drugs to eligible health care organizations at significantly reduced rates. Eligible organizations must register and be enrolled with the 340B Program and comply with all 340B Program requirements, including requirement contained within this Agreement.

1.3. Abandoned Call

A call in which the caller selects a valid option, and either is not permitted access to that option or disconnects from the system.

1.4. Abuse

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 Member practices that result in unnecessary cost to the Medicaid program. [42 C.F.R. § 455.2]

1.5. Acceptance Rate

The percentage of encounter data that are accepted by the MMIS vendor from the Contractor, and any Subcontractors, upon initial submission for each month.

1.6. Access

When used in the context of external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by the Contractor's successful demonstration and reporting on outcome information for the availability and timeliness elements defined in the Network Adequacy Standards and Availability of Services described under this contract [42 C.F.R. §§ 438.14(b), 438.68, 438.206, and 438.320]

1.7. Accountable Entity (AE)

A Medicaid provider that meets EOHHS Accountability Entity Certification Standards, is subcontracted with the Contractor to coordinate a portion of or the full continuum of Health Care Services (as detailed in its subcontract with Contractor) to the Contractor's Members who are attributed to that AE and has agreed to participate in the Accountable Entity Program.

1.8. Accountable Entity Incentive Pool (AEIP)

The total incentive dollars, as established by EOHHS, that may be earned during the

performance year by a qualified AE that is participating in the Medicaid Infrastructure Incentive Program (MIIP).

1.9. Accountable Entity Program

The program intended to promote health care delivery system reform and substantially support the transition away from fee-for-service toward models that pay for and promote quality, not volume.

1.10. Accreditation

The process of evaluating an organization against a set number of measures of performance, quality, and outcomes by an industry recognized accrediting agency, such as NCQA or URAC. The accrediting agency certified compliance with the criteria, assures quality and integrity, and offers EOHHS and members a standard of comparison in evaluating health care organizations.

1.11. Accrediting Entity

An entity recognized by CMS under 45 C.F.R. § 156.275. To the extent CMS recognizes Accrediting Entities, EOHHS will also permit the Contractor to achieve accreditation from such entity to meet requirements of this Contract.

1.12. Act or The Act

Refers to the Social Security Act.

1.13. Active Contract Management (ACM)

Is a set of strategies that applies high-frequency use of data and purposeful management of agency-service provider interactions to improve contracted services. ACM consists of the following elements:

1. Contractor to detect and rapidly respond to problems;
2. Make consistent improvements to performance; and
3. Identify opportunities for reengineering service delivery systems.

1.14. Activities of Daily Living (ADL)

Daily self-care activities, with or without the use of assistive devices, that enables an individual to meet basic life needs including bathing, dressing, feeding, toileting, grooming, and transferring (walking, transferring from bed to wheelchair or wheelchair to toilet, etc.) and continence.

1.15. Acute Care

Preventative, primary care, and other medical care provided under the direction of a provider for a condition having a relatively short stay.

1.16. Acute Care Hospital

A hospital that provides inpatient medical care and other related services surgery, acute medical conditions, or injuries (usually for short-term illness or condition). For purposes of determining network adequacy, Acute Care hospitals must include an emergency department, which may be off-site.

1.17. Actuarial Sound Capitation Rates

Capitation rates that have been developed in accordance with generally accepted actuarial

principles and practices; are appropriate for the populations to be covered and the services to be furnished under this Agreement; and, have been certified as meeting the requirements of 42 C.F.R. § 438.6(c) by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

1.18. Actuary

An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. In this Agreement, the term refers to an individual acting on behalf of EOHHS to develop and certify Capitation Rates. [42 C.F.R. § 438.2]

1.19. Addiction and Recovery Treatment Services (ARTs)

A comprehensive continuum of addiction and recovery treatment services based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. This will include:

1. Inpatient withdrawal management services,
2. Residential treatment services;
3. Partial hospitalization;
4. Intensive outpatient treatment
5. Outpatient treatment including Medication Assisted Treatment;
6. Case management; and,
7. Peer recovery supports.

Providers must be credentialed and trained to deliver these services consistent with ASAM's published criteria and using evidence-based practices, including Screening, Brief Intervention and Referral to Treatment (SBRIT) and Medication Assisted Treatment.

1.20. Adjudicate

To review, process, and deny or pay a claim.

1.21. Administrative Services

The performance of services or functions necessary for the management of, and the delivery of, and payment for Covered Services, as well as care management, and the coordination of Non-Covered Services, including but not limited to network management, utilization management, clinical and/or quality management, service authorizations, claims processing, encounter data submissions, management information systems (MIS) operation and reporting.

1.22. Administratively Necessary Days (AND)

A day of Acute Inpatient Hospitalization in which an Enrollee's care needs can be provided in a setting other than an Acute Inpatient Hospital and on which an Enrollee is clinically ready for discharge, but for whom an appropriate setting is not available.

1.23. Adult Protective Services

A program within the Rhode Island Office of Healthy Aging (OHA) that provides vulnerable adults with protection from abuse, neglect, or exploitation.

1.24. Advance Directive

A written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) that relates to the provision of health care when an individual is incapacitated. [42 C.F.R. §§ 438.3, 438.10, 422.128, and 489.100]

1.25. Advanced Practice Practitioners

Inclusive of physician assistants, certified nurse practitioners, and certified nurse midwives. These individuals are subject to the laws and regulations of Rhode Island and may not exceed the authority of such laws.[R.I. Gen. Laws § 5-34-3]

1.26. Adverse Benefit Determination

The following actions by the Contractor or its Representatives [42 C.F.R. § 438.400(b)]:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because a claim does not meet the definition of a "clean claim" at 42 C.F.R. § 447.45(b) is not an Adverse Benefit Determination.
4. The failure to provide services in a timely manner, as defined by the EOHHS.
5. The failure of a Health Plan to act within the timeframes provided in 42 C.F.R. § 438.408(b)(1) and (2) regarding the standard resolution of Grievances and Appeals.
6. The denial of a Member's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities, as applicable. [42 C.F.R. § 438.400(b)]

1.27. Adverse Childhood Experiences (ACEs)

Are stressful or traumatic events, including abuse and neglect. They also may include household dysfunction which as witnessing domestic violence or growing up with family members who have substance use disorder. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those with substance use disorders. The ten (10) categories of ACEs are:

1. Physical abuse;
2. Sexual abuse;
3. Emotional abuse;
4. Physical neglect;
5. Emotional neglect;
6. Family member with substance use disorder;
7. Mental ill, depressed, or suicidal person in the home;
8. Witnessing domestic violence against a parent or guardian;

9. Incarceration of any family member; and,
10. Loss of a parent or death, abandonment, or divorce.

1.28. Affiliate

Any individual or entity that meets any of the following criteria:

1. Owns or holds more than five percent (5%) interest in the MCO (either directly, or through one (1) or more intermediaries;
2. Is an entity in which the MCO owns or holds more than a five percent (5%) interest, either directly or through one (1) or more intermediaries;
3. Is a parent entity or subsidiary entity of the MCO regardless of the organizational structure of the entity;
4. Has a common parent with the MCO, either directly or through one (1) or more intermediaries;
5. Directly, or indirectly through one (1) or more intermediaries, controls, or is controlled by, or is under common control with, the MCO; or,
6. Would be considered an affiliate by the Securities and Exchange Commission (SEC) or Internal Revenue Service (IRS) regulation, Federal Acquisition Regulation (FAR), or by another applicable regulatory body.

1.29. Affiliate Pharmacy

A pharmacy in which the Contractor, PBM, or Subcontractors have an ownership interest.

1.30. Affordable Care Act (ACA)

The Patient Protection and Affordable Care Act [Public Law 111-148] and The Health Care and Education Reconciliation Act of 2010 [Public Law 111-152]. ACA is intended to improve the healthcare system and provide affordable quality of care to all Americans, lowering the uninsured rate by expanding public and private insurance coverage, and reduce the cost of care for individuals and government through a variety of measures. ACA requires businesses with more than fifty employees to provide health insurance to full-time employees and requires individuals to purchase health insurance. Subsidies are available to those who cannot afford health insurance. ACA establishes Affordable Insurance Exchanges to enable employers and individuals to purchase health insurance through a competitive marketplace. ACA prevents insurance companies from denying coverage to those with pre-existing conditions, eliminating life-time limits on benefits, and allow young adults up to twenty-six (26) years old to remain on their parent's insurance policy.

1.31. Affordable Care Act Eligibles or Expansion Population

The optional Medicaid coverage group, consisting of low-income adults ages nineteen (19) or older and under sixty-five (65) years, that Rhode Island has elected to cover under the ACA.

1.32. Agent

Any person or entity who has been delegated the authority to obligate or act on behalf of another.

1.33. Aging and Disability Resource Center (ADRC)

An organization that serves as a single point of entry into the long-term services and supports

system for older adults, people with disabilities, caregivers, veterans, and families.

1.34. Agreement or Contract

Has the meaning assigned in the General Conditions of Purchase.

1.35. Aligned Enrollment

Refers to the enrollment in a dual eligible special needs plan of full-benefit dual eligible individuals whose Medicaid benefits are covered under a Medicaid Health Plan contract between the State and the dual eligible special needs plan's (D-SNP's) Medicare Advantage organization, the D-SNP's parent organization, or another entity that is owned and controlled by the D-SNP's parent organization. Exclusively aligned enrollment is the condition in which the State's policy limits a D-SNPs membership to individuals with aligned enrollment. [42 C.F.R. § 422.2].

1.36. All Payer Claims (APC) Database

A large-scale database, maintained by EOHHS with support from the State's selected vendor that systematically collects healthcare claims data from a variety of payer sources, including Medicare, Medicaid, and Rhode Island's commercial payers.

1.37. Allegation of Fraud

An unproved assertation; an assertation, especially relating to wrongdoing or misconduct on the party of the individual, entity or provider. An allegation of Fraud is an allegation, from any source, including, but not limited to the following:

1. Fraud hotline complaints;
2. Claims data mining;
3. Referral of potential fraud received from the Contractor; and,
4. Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

1.38. Alternative Formats

The provision of Member information in a format that takes into consideration the special needs of those who, for example, are visually impaired or having limited reading proficiency. Examples of Alternative Formats shall include, but not be limited to, braille, large font, audio tape, video tape, and information read aloud for a Member.

1.39. Alternative Payment Method (APM)

A payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to specific clinical conditions, care episodes, or populations.

1.40. Alternative Payment Model Implementation Plan or Value-Based Purchasing Plan

The Contractor's plan for meeting the APM requirements described in this Agreement.

1.41. Ameliorate

Means necessary to improve or to prevent the condition from getting worse, with regarding to EPSDT services.

1.42. American Indian/Alaskan Native (AI/AN)

An individual that:

1. Is a member of a Federally recognized Indian tribe;
2. Resides in an urban center and meets one (1) or more of the four (4) criteria:
    a. Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree of any such member;
    b. Is an Eskimo or Aleut or other Alaska Native;
    c. Is considered by the Secretary of the Interior to be an Indian for any purpose; or
    d. Is determined to be an Indian under regulations issued by the Secretary;
3. Is considered by the Secretary of the Interior to be an Indian for any purpose; or,
4. Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian Health Care Services, including as a California Indian, Eskimo, Aleut, or other Alaska Native. [42 C.F.R. § 438.14(a)]

1.43. American Society of Addiction (ASAM) Criteria

The comprehensive set of guidelines for determining placement, continued stay and transfer or discharge of Members with SUD and co-occurring disorders.

1.44. American Society of Addiction Medicine (ASAM)

A professional society dedicated to increasing access and improving the of addiction treatment.

1.45. Americans with Disabilities Act (ADA)

The civil rights law that prohibits discrimination against Members with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the public. This Contract ensures that the ADA principles, such as non-discrimination, equal opportunity, and reasonable accommodations, are strictly adhered to in the delivery of health care services. It emphasizes the commitment of Contractor and Medicaid to offer accessible, high-quality, and appropriate medical care to people with disabilities, while preserving their rights and dignity.

1.46. Ancillary Services

The additional services ordered by the provider to support the core treatment provided to the Member. These services may include, but are not limited to, laboratory services, radiology services, drugs, physical therapy, occupational therapy, and speech therapy.

1.47. Anticompetitive Business Practices

The activities conducted by the Contractor, subcontractor, affiliates or subsidiaries that impede fair competition and increase and/or potentially increase the cost of and/or prices to the Medicaid Program. Examples of such activities include, but are not limited to, activities that reduce competition, increase prices, and undermine or diminish the pressure to improve quality and practices deemed unfair and uncompetitive under R.I. Gen. Laws § 27-29-1. Specific contract terms used by Contractors that can be considered anticompetitive include, but are not limited to, contract terms that protect their market share and position and hinder efforts to curb

healthcare costs. Federal and state antitrust agencies, including the Federal Trade Commission and Department of Justice, and state attorneys general have the authority to challenge such practices to promote competitive markets and protect consumers.

1.48. Any Willing Provider or Willing Provider

A provider credentialed as a qualified provider according to the requirements of EOHHS and the Contractor, and agrees to render Covered Services as authorized by the Contractor and in compliance with the terms of the Contractor's Provider Agreement, including reimbursement rates and policy manual. [R.I. Gen. Laws § 40-8.13-7]

1.49. Appeal (Member)

The Contractor's review of an Adverse Benefit Determination. [42 C.F.R. § 438.400(b)]

1.50. Appeal (Provider)

The requests made by the Contractor's providers (in-network or out-of-network) to review the Contractor's reconsideration decision.

1.51. Appeals Process

The procedure for handing, processing, collecting and tracking Member requests for a review of an adverse benefit determination which is in compliance with 42 C.F.R. § 438 Subpart F and this Agreement. The Appeals Process shall be governed by Federal and State laws, regulations, rules, policies, procedures, and manuals, and all applicable court orders and consent decrees, including the Rhode Island Administrative Procedures Act [RI Gen. Laws § 42-35-1, et seq.] and the Appeals Process and Procedures for EOHHS Agencies and Programs [210 RICR-10-05-2].

1.52. Applicant

An individual who is seeking Medicaid coverage.

1.53. Application Program Interface (API)

A set of functions and procedures allowing the creation of technology applications that access the features or data of an operating system, application, or other service. [45 C.F.R. § 170.404]

1.54. Artificial Intelligence (AI)

Refers to the utilization of machine learning and other sophisticated technologies to analyze data, automate labor-intensive processes, and find operational efficiencies. AI is leveraged to support decision-making, interact with Enrollees, make predictions, and provide business insights. When responsibly adopted, AI can address cost escalation, enhance access to healthcare services, reduce health disparities, and improve clinical outcomes. It can help advance health equity, expand coverage, and provide cost savings. The decision to adopt AI is influenced by factors like reimbursement amounts for coverage and the value and cost of each unique AI service by the Contractor.

1.55. Assertive Community Treatment (ACT)

The evidence-based practice of delivering comprehensive and effective services to members with SMI by a multidisciplinary team primarily in member homes, communities, and other natural environments.

1.56. Assess

To evaluate an individual's condition, including social supports, health status, functional status, psychological history, and environment. Information is collected from the individual, family, significant others, and medical professionals, as well as the assessor's observation of the individual.

1.57. Attribution

The method used in a Value-Based Payment model to determine which provider group is responsible for a Member's care and costs. Attribution is a mechanism for creating accountability and aligning incentives within a provider group to coordinate a Member's overall care needs.

1.58. Audit

A formal review of compliance with a particular set of internal (e.g., policies and procedures) or external (e.g., laws and regulations) standards used as base measure.

1.59. Authorized Representative or Member Representative

An individual the Member designates or who is authorized by law to act on his or her behalf in assisting with the application, renewal of eligibility, Complaints, Appeals, or other communications with EOHHS or the Contractor. The power to act as a Member Representative is valid until the Member or Member Representative modifies the authorization or notifies EOHHS or the Contractor that the Member Representative is no longer authorized to act on the Member's behalf. [42 C.F.R. § 435.923].

1.60. Automatic Assignment or Auto-Assignment

The process utilized by EOHHS to enroll an eligible Member using a predetermined algorithm for whom enrollment is mandatory in a Contractor chosen by EOHHS in accordance with 42 C.F.R. § 438.54.

1.61. Automatic Refill

Any prescription refill the pharmacy initiates without the Member requesting the prescription to be filled at that time.

1.62. Auxiliary Aids and Services

The services or devices that enable Members with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in the benefits, programs or activities conducted by the Contractor in accordance 45 C.F.R. § 92.102. Services include:

1. Qualified interpreters onsite or through video remote interpreting (VRI), note takers, real-time computer-aided transcription services, written materials, telephone handset amplifiers, assistive listening devices, assistive listening systems, telephones compatible with heading aids, closed captions decoders, open and closed captioning, telecommunications devices for deaf persons, videotext displays, or other effective methods of making aurally delivered materials available to individuals with hearing impairments;
2. Qualified readers, taped texts, audio recordings, Brailed materials, large print materials, or other effective methods of making visually delivered materials available to individuals with visual impairments;

3. Acquisition or modification of equipment or devices; and,
4. Other similar services and actions.

1.63. Benefit Coordination or Coordination of Benefits (COB)

The activities involved in determining Rhode Island Medicaid benefits when a Member has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.

1.64. Behavioral Health

Mental health, substance use disorders, co-occurring disorders and/or conditions and related benefits.

1.65. Behavioral Health Benefits or Behavioral Health Services

A wide range of diagnostic, therapeutic and rehabilitate services used in the treatment of mental illness, substance use disorder and co-occurring disorders described in this Agreement.

1.66. Behavioral Health Emergency

A situation in which a Member presents as being at imminent risk of behaving in a way that could result in serious harm or death to self or others.

1.67. Behavioral Health Parity or Mental Health Parity

Refers to the requirement for health insurers to provide coverage for mental health and SUD services on equal terms with physical health services. The Contractor cannot impose greater financial requirements or more restrictive treatment limitations on mental health and SUD services than on physical health services. Contractor is required to analyze limits on a quarterly basis placed on behavioral health treatment benefits to ensure parity.

1.68. Benchmarking

The process through which standards and thresholds are developed through comparisons with others, standards, and best practices. In terms of quality benchmarking, the goal of a performance improvement system is to develop an assessment process that incorporates four (4) basic comparisons: with self, with others, with standards, and with best practices.

1.69. Benefit Coordination or Coordination of Benefits (COB)

The activities involved in determining Rhode Island Medicaid benefits when a Member has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.

1.70. Bid or Proposal

An offer a Respondent submits to an invitation to Bid or Request for Proposals for the Rhode Island Medicaid Program under the conditions set forth in the solicitation process.

1.71. Board of Directors (BOD)

A group of individuals who are designated to govern the activities and policies of the Contractor related to any scope of the work included in this Agreement. They are responsible for overseeing the organization's operations, ensuring compliance with regulations, and making strategic decisions. The Board usually includes professionals from diverse backgrounds, such as healthcare, business, and law, who bring a range of expertise to the organization. It's essential for the Board of Directors to act in the best interests of the Medicaid

program and its beneficiaries, including the financial management of Contractor and avoid any potential conflicts of interest in their capacity to serve on the BOD.

1.72. Border Community

A city or town in another state in which providers are considered to be In-State Providers for the purpose of the Rhode Island Medicaid program, per 210-RICR-20-00-3.

1.73. Breach

As defined in accordance with Health Insurance Portability and Accountability Act ("HIPAA") and Health Information Technology for Economic and Clinical Health Act ("HITECH") guidelines, means an acquisition, access, use or disclosure or suspected acquisition, access, use or disclosure of Protected Health Information ("PHI") in violation of HIPAA privacy rules that compromise Personally Identifiable Information ("PII") security or privacy.

Additionally, a Breach or suspected Breach means an acquisition, access, use or disclosure or suspected acquisition, access, use or disclosure of PII or Sensitive Information ("SI").

1.74. Budget Neutral

A standard for any risk sharing mechanism that recognizes both the higher and lower expected costs among contracted MCOs under a managed care program and does not create a net aggregate gain or loss across all payments under the managed care program.

1.75. Business Associates Agreement (BAA)

An agreement under the federal Health Insurance Portability and Accountability Act of 1996, as amended (HIPPA), between a HIPPA covered entity and a HIPPA business associate. The agreement protects Protected Health Information (PHI) in accordance with HIPPA guidelines.

1.76. Business Continuity Plan (BCP)

A plan that provides for a quick and smooth restoration of all Contractor functions after a disruptive event. BCP includes business impact analysis, development, testing, awareness, training, and maintenance. This is a day-to-day plan.

1.77. Business Day(s)

Any day other than a Saturday, Sunday, or state or federal holiday on which EOHHS' offices are closed, unless the context of this Contract clearly indicates otherwise.

1.78. Business Hour(s)

Hours for the Contractor's RI business office that are 7 a.m. to 6 p.m. Monday through Friday EST, except for State observed holidays that are posted on the Rhode Island Secretary of State's website.

1.79. Business Owner

An individual who is accountable for and is the primary point of contact for a specified business area.

1.80. Calendar Day

Each day shown on the calendar beginning at 12:00 a.m., which includes weekends and holidays, unless otherwise specified.

1.81. Can or May or Should

In this Agreement, denotes a desirable action, but not a mandatory requirement.

1.82. Capacity Threshold

The maximum number or percentage of Members that may be enrolled in the Contractor's program as determined by EOHHS in its sole discretion and the terms and conditions set forth in this Agreement.

1.83. Capitation Payment

A payment EOHHS makes periodically to the Contractor on behalf of each enrolled Member, which is based on the actuarially sound Capitation Rate, for the provision of services under the Agreement. EOHHS makes the Capitation Payment regardless of whether the Member receives services during the period covered by the payment. [42 C.F.R. § 438.2]

1.84. Capitation Rate

A fixed predetermined fee paid by EOHHS to the Contractor each month for each enrolled Member in a defined Rate Cell, in exchange for the Contractor arranging for or providing a defined set of Covered Services, regardless of the amount of Covered Services used by enrolled Members. As known as the Per Member Per Month (PMPM).

1.85. Care Coordination

The deliberate organization of Member care activities between two (2) or more participants (including the Member or Member's representative) involved in a Member's care to facilitate the appropriate delivery of health care services and supports. Care Coordination services should include connection with resources to address Social Determinants of Health (SDOH), specialty referrals, assistance with Ancillary Services, and referrals to and coordination with community services. Coordinating care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of the Member's care.

1.86. Care Management (CM)

Care management means a set of person-centered, goal-oriented, culturally relevant and logical steps to assure that a member receives needed services in a supportive, effective, efficient, timely and cost-effective manner. Care management emphasizes prevention, continuity of care and coordination of care, which advocates for, and links members to services as necessary across providers and settings. Care Management is provided to high risk populations such as but not limited to, individuals with HIV/AIDS, mental illness, addiction issues or those recently discharged from correctional institutions.

At a minimum, care management functions must include, but are not limited to:

1. Health Risk Assessment for all members;
2. Short term care coordination, where appropriate; and,
3. Intensive Care Management, when appropriate.

Care Management is provided by a Program Coordinator or Care Manager who is properly licensed by the State.

1.87. Care Program

The Contractor's comprehensive approach to providing the full continuum of care coordination and management activities, including Health Promotion and Wellness, Health Risk Assessments, Care Coordination, Care Management, and Complex Case Management.

1.88. Care Team

A team of professionals serving Members identified as requiring Conflict Free Case Management (CFCM), Care Management (CM), or Complex Case Management (CCM) that collaborate, in person and/or through other means, with Members to develop and implement an Individualized Care Plan (ICP) that meets Members' medical, behavioral, Long-Term Services and Supports (LTSS), and social needs.

1.89. Care Transformation Collaborative of Rhode Island (CTC-RI)

Collaborative that promotes the patient-centered medical home model of care throughout the State of Rhode Island. CTC-RI coordinates this work with all major health care stakeholders through the Patient-Centered Medical Home (PCMH) model to improve care, lower costs and promote better health outcomes for Rhode Islanders.

1.90. Caregiver Activation Measure (CAM)

An assessment that gauges the knowledge, skills and confidence essential to providing care for a person with chronic conditions.

1.91. Caregiver Assessment

Defined and refers to a systematic process of gathering information about a caregiving situation to identify the specific problems, needs, strengths, and resources of the family caregiver, as well as the caregiver's ability to contribute to the needs of the care recipient. [R.I. Gen. Laws §§ 40-8.11.2 (a), 40-8.11-3]

1.92. Case Management

In accordance with 42 C.F.R § 440.169, case management services are services furnished to assist individuals, eligible under the State Plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services, in accordance with 42 C.F.R § 441.18.

Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual member's health-related needs through communication and available resources to promote quality and cost-effective outcomes. Case management implicitly enhances care coordination through a designation of a case manager whose specific responsibility is to oversee and coordinate access and delivery targeting to high-risk patients with diverse combinations of health, functional, and social needs.

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

1.93. Case Management Delegation

The oversight and delegation procedures of the Contractor to a subcontracted entity, such as

an AE, to provide case management to the Contractor's members.

1.94. Case Manager

A licensed registered nurse (RN), licensed behavioral health professional, or other trained individual who is employed or subcontracted by the Contractor or an member's PCP or AE. The case manager is accountable for providing intensive monitoring, clinical management of high-risk members, and care coordination activities, which include the development of the Plan of Care, ensuring appropriate referrals and timely two-way transmission of useful member information; obtaining reliable and timely information about services other than those provided by the PCP; supporting the member in addressing SDOH; and supporting safe transitions in care for members moving between institutional and community-based settings. The case manager may serve on one or more multi-disciplinary care teams and is responsible for coordinating and facilitating meetings and other activities of those care teams.

1.95. Certified Community Behavioral Health Clinic (CCBHC)

An EOHHS certified entity providing a comprehensive array of behavioral health services. The Excellence in Mental Health and Addiction Act demonstration established a federal definition and criteria for CCBHCs. CCBHCs are non-profit organizations or units of a local government behavioral health authority. They must directly provide (or contract with partner organizations to provide) nine (9) types of services, with an emphasis on the provision of twenty-four (24) hour crisis care, evidence-based practices, care coordination with local primary care and hospital partners, and integration with physical health care.

1.96. Certified Community Behavioral Health Clinic Designated Collaborating Organization (CCBHC DCO)

A provider with whom a CCBHC has a formal written agreement establishing a relationship to provide certain allowable services on behalf of the CCBHC.

1.97. Certified Electronic Health Record

An EHR certified under the Office of the National Coordinator's (ONC's) Health IT Certification Program. ONC updates the certification criteria approximately every two (2) years. ONC certification criteria and the edition to which they have been certified are listed on the Certified Health IT Products List (CHPL).

1.98. Certified Electronic Health Record Technology (CEHRT)

Systems that meet the technological capabilities, functionality, and security requirements adopted by the U.S. Department of Health and Human Services and are certified by the Office of the National Coordinator for Health Information Technology (ONC) as meeting health IT standards, implementation specifications and certification criteria adopted by the Secretary. The Electronic Health Record (EHR) Certification Program is a voluntary program established by the ONC to provide for the certification of health IT standard, implementation specifications and certification criteria adopted by the Secretary.

1.99. Children with Special Health Care Needs

Members under age twenty-one (21) who have or are an increased risk of having a serious or chronic physical, developmental, behavioral, or emotional condition and who require health and related services of a type or amount beyond that usually expected for the child's age. This includes, but is not limited to, children or infants: in foster care; requiring care in the Neonatal Intensive Care Units; with Neonatal Abstinence Syndrome (NAS); in high stress social

environments/caregiver stress; receiving CEDAR Family Services.

1.100. Children's Health Insurance Program (CHIP)

The joint state and federal program providing health coverage to eligible children through both Medicaid and separate CHIP programs. CHIP is administered by states, according to federal requirements under Title XXI of the Social Security Act.

1.101. Choice Counseling

The provision of information and services in an unbiased manner designed to assist Members in making enrollment decisions; it includes answering questions and identifying factors to consider when choosing among Health Plans and Primary Care Providers. The term does not include making recommendations for or against enrollment into a specific Health Plan. [42 C.F.R. § 438.2]

1.102. Chronic Condition

A physical or mental impairment or ailment of indefinite duration or frequent recurrence such as cardiovascular disease, stroke, cancer, diabetes, obesity, arthritis, mental illness or substance use disorder.

1.103. Chronic Disease Self-Management Education (CDSME) @

Programs that enable individuals with multiple chronic conditions to learn how to manage their overall health, symptoms, and risk factors.

1.104. Civil Monetary Penalty (CMP)

A penalty imposed by EOHHS which the Contractor must pay for acting or failing to act in accordance with 42 C.F.R. § 438.700.

1.105. Claim

A bill for services, a line item of service, or all services for one (1) Member within a bill.

1.106. Clean Claim

A Claim that can be processed without additional information from the provider or a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

1.107. Clinical Data Repository (CDR)

The tool EOHHS is using the advance Rhode Island's capabilities to collect, share and use integrated physical and behavioral health information from provider EHR systems. The CDR is a real-time database that consolidates data from a variety of clinical sources to present a unified view of a single patient. It allows clinicians to retrieve data for a single patient rather than a population of patients with common characteristics.

1.108. Clinical Practice Guidelines

The systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. The Contractor shall adopt Clinical Practice Guidelines in accordance with 42 C.F.R. § 438.236, ensuring that they are based on valid and reliable evidence or a consensus of Providers in the particular field; consider the needs of the Member; are adopted in consultation with Participating Providers; and are reviewed and updated periodically as appropriate.

1.109. Clinically Appropriate

Care that is delivered in the appropriate medical setting. [RI Gen. Laws § 27-81-3]

1.110. Center for Medicare and Medicaid Services (CMS)

The Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services, the federal agency responsible for administering Medicare and overseeing state administration of Medicaid.

1.111. Co-branding

A relationship between two (2) or more separate legal entities, one (1) of which is the Contractor.

1.112. Code of Federal Regulation (C.F.R.)

The codification of the general and permanent rules and regulations, sometimes called administrative law, published in the Federal Register by the executive departments and agencies of the federal government of the United States.

1.113. Cold-Call Marketing or Direct Marketing

Any unsolicited personal contact by the Health Plan with a Potential Member for the purpose of Marketing. [42 C.F.R. § 438.104(a)]

1.114. Community Health Team (CHT)

A health care program for Members to assist in obtaining care and services needed. Services include primary care, Member advocacy, health education, and peer navigation.

1.115. Community Health Worker (CHW)

A trained public health worker who serves as a bridge between communities, health care systems, and state government entities.

1.116. Community Transition Plan

A comprehensive plan that is created for Members who have been identified as able to safely transition from a nursing facility to a community setting.

1.117. Complex Case Management (CCM)

Refers to care management services delivered to Members with multiple or complex conditions to obtain access to care and services and coordination of their care. CCM is provided to highest risk Members with complex conditions and to high-risk populations such as but not limited to children with complex medical needs and/or multiple adverse childhood experiences (ACEs), individuals with HIV/AIDS, mental illness, addiction issues or those recently discharged from correctional institutions.

1.118. Comprehensive Medication Review (CMR)

A systematic process of collecting patient-specific information, assessing medication therapies to identify medication-related problems, developing a prioritized list of medication-related problems, and creating a plan to resolve them with the patient, caregiver and/or prescriber. The related CMR counseling is an interactive person-to-person., telephonic, or telehealth consultation conducted in real-time between the patient and/or other qualified individual, such as a prescriber or caregiver, and the pharmacist or other qualified provider and is designated to improve a patient's knowledge of their prescriptions, over-the-counter medications, herbal

therapies and dietary supplements; identify, and address problems or concerns the patient may have, and empower them to self-manage their medications and health conditions.

1.119. Comprehensive Risk Contract

A Risk Contract between EOHHS and the Contractor that covers comprehensive services, including inpatient hospital and other services described in 42 C.F.R. § 438.2.

1.120. Concurrent Review

The Contractor's review of care and services at the time of the event being reviewed is occurring. Concurrent review includes an assessment of the member's progress towards recovery and readiness for discharge while the member is hospitalized or in a nursing facility; and may involve an assessment of the medical necessity of tests or procedures while the member is hospitalized or in a nursing facility.

1.121. Confidential Information

Information that the Contractor receives or has access to under this Agreement, including but not limited to; PII; SI; PHI; Return Information; other information (including electronically stored information) or 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; any other records, reports, opinions, information, and statements required to be kept confidential by state or federal law or regulation, or rule of court; any statistical, personal, technical and other data and information relating to the State's data; or other such data protected by state and federal laws, regulations**.**

1.122. Conflict Free Case Management (CFCM)

Conflict-free case management, as per the stipulations of the Centers for Medicare and Medicaid Services (CMS) 42 C.F.R. § 441.301(c)(1)(vi), denotes the provision of case management services to members who are beneficiaries of Home and Community-Based Services (HCBS) by an independent entity distinct from the one administering the direct HCBS. This segregation is crucial to mitigate any potential conflict of interest that could arise if one entity holds dual roles. Its importance lies in ensuring a fair, impartial assessment of a member's needs, the creation of a personalized care plan, and the ongoing evaluation of the efficacy of provided services, thereby safeguarding the integrity and objectivity of the care process.

1.123. Conflict Free Case Management Entities (CMEs)

Entities that are certified by EOHHS and assist Members who receive Home and Community Based Services (HCBS) in gaining access to services by conducting a comprehensive review of Members' goals, needs, and preferences; assist in developing the Member's person-centered plan that articulates the member's care needs, wants, and supports, ; connect the Member to needed services and supports; and maintain regular contact to review goal progress and effectiveness of services.

1.124. Conflict Free Case Managers

Case managers who have met minimum education and experience requirements and demonstrated knowledge, competencies, and skills as described in the EOHHS CFCM strategic plan and CFCM Certification Standards. Conflict free case managers are required to complete case management training, includes competency in standards of person-centered planning and the role of the conflict free case management in the overall person-centered planning process

as delineated and required by EOHHS.

1.125. Conflict of Interest

When the Contractor or any of its associates are in a position where their judgment and actions regarding the best interests of the Medicaid Program could be influenced by secondary interests, such as personal gain or advantage. This could include situations where the Contractor contracts for services but does not operate or own the services directly. It is deemed a conflict of interest if the Contractor's other activities, associations, or relationships potentially obstruct their ability to provide impartial and optimal care to the Medicaid beneficiaries or increase costs to the Medicaid Program.

1.126. Consumer Assessment of Health Care Providers and Systems (CAHPS®)

A family of standardized survey instruments, including a Medicaid survey, used to measure Member experience of care.

1.127. Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS® Survey)

A standardized survey of members' experiences with ambulatory and facility-level care established by the Agency for Healthcare Research and Quality (AHRQ).

1.128. Continuity of Care

The provision of continuous care for chronic or acute medical and behavioral health conditions to maintain care that has started or been authorized in one setting as the member transitions between: facility to home, facility to facility; providers; managed care contractors; and Medicaid fee-for-service (FFS) and other health care delivery systems. Continuity of care occurs in a manner that prevents secondary illness, health care complications or re-hospitalizations and promotes optimum health recovery. Transitions of significant importance include but are not limited to: from acute care settings, such as an inpatient physical health or behavioral health care settings or emergency departments, to home or other health care settings such as outpatient settings; from hospital to skilled nursing facility; from skilled nursing to home or community-based settings; from one primary care practice to another; and from substance use care to primary and/or mental health care.

1.129. Continuity of Care Document (CCD)

An electronic document exchange standard for sharing patient care summary information. Summaries include the most pertinent information about current and past health status in a form that can be shared by all computer applications, including web browsers, electronic medical records (EMR) and Electronic Health Record (EHR) software systems.

1.130. Continuity of Care Period

The ninety (90) day period immediately following a Member's enrollment with the Contractor whereby established Member and Provider relationships, current services, and existing PAs and Care Plans shall remain in place in accordance with the requirements of this Agreement.

1.131. Contract Execution Date

The date upon which the Rhode Island Division of Purchasing approves this Agreement and Amendments and issues a Purchase Order.

1.132. Contract Officer

A designated employee of the Contractor authorized and empowered to represent the

Contractor with respect to all matters within such area of authority related to the implementation and oversight of the Contract.

1.133. Contract Readiness or Contract Readiness Review or Readiness Review

The on-site and desk review process required in accordance with 42 C.F.R. § 438.66. The Contractor is required to meet Readiness Review requirements to the satisfaction of EOHHS prior to receiving Member Enrollment.

1.134. Contract Services

All of the services and benefits to be delivered by the Contractor, which are so designated in this Agreement.

1.135. Contract Year

The period of time beginning on July 1st each year and ending on June 30th the following year.

1.136. Contractor

The MCO that has executed this Agreement with EOHHS to serve Members under the conditions specified in this Agreement. The term Contractor is used interchangeably with the terms "Health Plan," "MCO," and "Contractor" in this Agreement.

1.137. Contractor's Representatives or Representatives

The Contractor's officers, employees, Subcontractors, consultants, or agents acting by or on behalf of the Contractor with respect to this Agreement.

1.138. Continuous Quality Improvement

The process of identifying problems, implementing and monitoring corrective action and studying its effectiveness to improve health care.

1.139. Convicted

A formal declaration that someone was guilty of a criminal offense, made by the verdict of a jury or the decision of a judge in a court of law.

1.140. Co-Occurring Disorder or Dual Diagnosis

The situation in which the same person is diagnosed with one (1) mental health condition, such as psychiatric disorders, neurodevelopmental disorders and one (1) substance-related or addictive disorders.

1.141. Copayment

A fixed amount per medical service for which the member is responsible for. This is a type of cost sharing arrangement and must be in accordance with 42 C.F.R. § 438.108 and Section 5006 of the American Recovery and Reinvestment Act of 2009 (ARRA) for Native American enrollees.

1.142. Co-Responder

Term consisting of law enforcement official(s) and behavioral health professional(s) to engage with individuals experiencing behavioral health crises that does not rise to the level of need for incarceration.

1.143. Corrective Action Plan (CAP)

A plan developed by the Contractor that is designed to ameliorate and identified deficiency and prevent re-occurrence of that deficiency. The CAP outlines all steps/actions and timeframes necessary to address and resolve the deficiency.

1.144. Cost Avoidance

The application of a range of tools to identify and prevent inappropriate or medically necessary charges before they are actually paid by the Contractor. This may include service authorizations, second surgical opinions, medical necessity review and other pre-and-post payment/service reviews.

1.145. Cost Sharing

Any copayment, coinsurance, deductible, or other similar charge. [42 C.F.R. § 447.51]

1.146. Covered Drug List

A list maintained by the Contractor giving the details of generic and name brand medications payable by the Contractor. The Covered Drug list shall include all outpatient drugs for which the manufacturer has entered into the Federal Rebate agreement with CMS that meets the standards in Section 1927 of the Social Security Act.

1.147. Covered Services or In-Plan Benefits

The Medicaid-covered services and benefits included within the scope of this Agreement, as described in Attachment F-4.1, "Schedule of In-Plan Benefits." The term also includes any Value-Added Services and In Lieu of Services offered by the Contractor.

1.148. Credentialing

The process of collecting, assessing, and validating qualifications and other relevant information pertaining to a health care provider to determine eligibility to deliver covered services.

1.149. Credentialing Verification Organization (CVO)

A Credentialing Verification Organization (CVO) is a third-party entity that specializes in verifying the credentials of providers. Such organizations are responsible for confirming the accuracy of qualifications, licenses, and certifications of healthcare providers. Their role ensures that only qualified and certified healthcare providers are delivering services to Medicaid beneficiaries, thereby ensuring the quality and safety of care. This process may include verifying education, training, experience, competency, and other relevant credentials of the healthcare provider.

1.150. Credibility Adjustment

An adjustment to the MLR for Partially Credible Contractor to account for a difference between the actual and target MLR that may be due to random statistical variation in accordance with 42 C.F.R. § 438.8.

1.151. Credible Allegation of Fraud

Allegations of fraud are considered credible when they have indicia of reliability and EOHHS has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. [42 C.F.R. § 455.2]

1.152. Crisis Mitigation Services

A provider's assistance to member's during a crisis that provides twenty-four (24) hours on call telephone to prevent relapse or harm to self or others, to provide referral to other services, and to provide support during related crisis. Referral to 911 or a hospital's emergency department alone does not constitute Crisis Mitigation Services.

1.153. Crisis Services

Evaluation and treatment of behavioral health crisis to all Medicaid-enrolled individuals experiencing a crisis. A behavioral health crisis is defined as a turning point in a course of anything decisive or critical, a time, a stage, or an event or a time great danger or trouble, whose outcome describes whether possible bad consequences will follow. Crisis Services shall be available twenty-four (24) hours a day. Crisis services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis Services may be provided prior to completion of an Intake Evaluation. Crisis Services have been expanded to include evaluation and treatment for clients experiencing a crisis, related to SUD.

1.154. Critical Incident (CI)

Any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of a Member, including falls, unplanned hospitalizations, financial exploitation, police-involved incidents, and disasters.

1.155. Critical Provider

The health care provider types without which the Contractor cannot provide a viable program for enrollees. For purposes of this Agreement, Critical Providers are: Hospitals, PCPS, Pediatric PCPs, SUD, mental health, outpatient behavioral health agencies, pharmacy and obstetrical providers.

1.156. Culturally Appropriate Care

Health care services provided with cultural humility and understand of the patient's culture and community and informed by Historical Trauma and the resulting cycle of ACEs.

1.157. Cultural Competency

A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with members. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse Member needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.

1.158. Cultural Humility

The continuous application in professional practice of self-reflection and self-critique, learning from patients, and partnership-building, with an awareness of the limited ability to understand the patient's worldview, culture(s), and communities.

1.159. Current Procedural Terminology (CPT®)

A listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. EOHHS has designated the CPT code set as the national coding standard for physicians and other health care professional services and procedures under HIPPA.

1.160. Data

Records, files, forms, electronic information and other documents or information, in either electronic or paper form, that will be used/converted by the Contractor during the contract term.

1.161. Data Certification

Encounter data or other contractually required reports submitted to EOHHS, which must be certified by one of the following: Contractor's CEO, CFO, or an individual who has delegated authority to sign for, and who reports directly to, the Contractor's CEO or CFO pursuant to 42 C.F.R. §§ 438.604; 606(a).

1.162. Day

In this Agreement, this means calendar day, which includes weekends and state and federal holidays, unless otherwise specified.

1.163. Day Support

An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional, money management, maintaining living arrangements, symptom management) for Medicaid members to promote improved function or restoration to a previous higher level of functioning.

1.164. Debarment

An action taken by a federal official to exclude a person or business entity from participating in transactions involving certain federal funds.

1.165. Deemed Newborn Eligibility

Applies to newborn babies born to Medicaid-eligible pregnant individuals who are residents of Rhode Island in accordance with 42 C.F.R. § 435.117. These newborns are deemed eligible for Medicaid from the date of birth. Once deemed eligible as a newborn, the infant remains eligible for one (1) year and, as such, is a non-MAGI eligibility pathway. Accordingly, retroactive coverage is available for periods prior to the application date if the newborn was otherwise deemed eligible.

1.166. Default Enrollment

A process that allows a Medicare Advantage organization to enroll a Member of an affiliated Medicaid managed care organization into its D-SNP when that Member becomes newly eligible for Medicare.

1.167. Deliverable

Any document, manual, file, plan or report submitted to EOHHS by the Contractor to fulfill the requirements of this contract.

1.168. Denied Claim

A claim for which no payment is made to a provider by the Contractor for any of several reasons, including but not limited to, the Claim is for non-MCO Covered Services, an ineligible provider or Member, is a duplicate of another transaction, or has failed to pass significant requirement in the Claims processing systems.

1.169. Disenrollment

The removal of a Member from participation in the Contractor's plan, but not necessarily the Rhode Island Medicaid Program.

1.170. Dispensing Fee

The fee which:

1. Is incurred at the point of sale (POS or service and pays for the costs in excess of the ingredient cost of a covered outpatient drug each time a covered outpatient drug is dispensed;
2. Includes only pharmacy costs associated with ensuring that possession of appropriate covered outpatient drug is transferred to a Member. Pharmacy costs include, but are not limited to, reasonable costs associated with a pharmacist's time in checking the computer for information about the Member's coverage, performing drug utilization review and preferred drug list review activities, measurement or mixing of the covered outpatient drug, filing the container, Member counseling, physically providing the completed prescription to the Member, delivery, special packaging, and overhead associated with maintaining the facility and equipment necessary to operate the pharmacy; and,
3. Does not include administrative costs incurred by the State in the operation of the covered outpatient drug benefit including system costs for interfacing with pharmacies.

1.171. Disproportionate Share Hospitals

Hospitals that serve a disproportionate share of low-income patients in accordance with 42 C.F.R. § 412.320(a) and 42 C.F.R. § 412.106(c).

1.172. Distant Site

A site at which a Healthcare Provider is located while providing Healthcare Services by means of telemedicine [R.I. Gen. Laws § 27-81-3].

1.173. Doula

A trained professional providing continuous physical, emotional and informational support to a pregnant individual, from antepartum, intrapartum, and up to the first twelve (12) months of the postpartum period. Doulas also provide assistance by referring childbearing individuals to community-based organizations and certified and licensed perinatal professionals in multiple disciplines. [R.I. Gen. Laws §27-41-92(a)] .

1.174. Downstream Entity

Any party that enters a written arrangement with the Contractor or a related entity to provide services for Rhode Island Medicaid-eligible Members that is related to the Contractor or a Related Entity by common ownership or control. These arrangements continue down to the level of the ultimate provider of any administrative or health care related services.

1.175. Drug Efficacy Study Implementation (DESI)

The designation indicating drugs for which EOHHS will not provide reimbursement because the drugs have been determined by the Food and Drug Administration (FDA) to lack substantial evidence of effectiveness.

1.176. Dual Eligible or Dually Eligible

An individual that is entitled to Medicare Part A (hospital insurance) and/or Part B (supplemental medical insurance) and is also enrolled in full-benefit Medicaid and/or the Medicare Savings Programs (MSPs). An individual may be considered a partial dual eligible if they qualify for MSP but are not otherwise eligible to receive full Medicaid medical benefits.

1.177. Dual Eligible Special Needs Plan (D-SNP)

A specialized Medicare Advantage Prescription Drug Plan for special needs individuals to provide specialized care and wrap-around services for individuals who are eligible for Medicare and Medicaid under the Rhode Island State Plan pursuant to Title XIX of the Act as defined under [42 C.F.R. § 422.2]. D-SNPs must have a State Medicaid Agency Contract (SMAC) with the State of Rhode Island.

1.178. Duplicate Claim

A claim that is either a total or partial duplicate of services previously paid.

1.179. Duplicate Coverage

A member covered by the Contractor on a third-party basis at the same time the member is covered by the Contractor under this Agreement.

1.180. Durable Medical Equipment (DME) and Appliances

Are items that are primarily and customarily used to serve medical purpose; generally, are not useful to an individual in the absence of a disability, illness, or injury; can withstand repeated use; and can be reusable or removable.

1.181. Early Intervention (EI)

Services provided through Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.), as amended, and in accordance with 42 C.F.R. § 440.130(d). EI services are designed to meet the developmental needs of children and families and to enhance the development of children from birth to the day before the third (3rd) birthday who have:

1. A twenty-five percent (25%) developmental delay in one or more areas of development;
2. Atypical development; or,
3. A diagnosed physical or behavioral condition that has a high probability of resulting in a developmental delay. EI services provided in the child's natural environment to the maximum extent appropriate.

1.182. Early Intervention Assistive Technology

Any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device.

1.183. Early Intervention Individual Family Service Plan (ISFP)

A plan developed by the Member's interdisciplinary team for providing early intervention supports and services to eligible children and families that:

1. Is based on evaluation for eligibility determination and assessment for service planning;
2. Includes information based on the child's evaluation and assessments, family information, results or outcomes, and supports and services based on peer-reviewed research (to the extent practicable) that are necessary to meet the unique needs of the child and family and to achieve the results or outcomes; and
3. Is implemented as soon as possible once parental consent is obtained.

1.184. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

A Federal law (42 C.F.R. § 441.50 et. seq.) which requires state Medicaid programs to assure that health problems for individuals under the age of twenty-one (21) are diagnosed and treated as early as possible, before the problem worsens and treatment becomes more complex and costly. EPSDT requires a broad range of outreach, coordination and health services that are distinct from the general state Medicaid requirements, and is composed of two (2) Parts:

1. EPSDT promotes the early and universal assessments of children's healthcare needs through periodic screenings, and diagnostic and treatment services for vision, dental, and hearing. These services must be provided by Medicaid at no cost to the member.
2. EPSDT also compels state Medicaid agencies to cover other services, products, or procedures for children, if those items are determined to be medically necessary to ameliorate a defect, physical or mental illness, or condition identified through routine medical screenings or examinations, regardless of whether coverage for the same service/support an optimal or limited service for adults under the state plan. All medically services require service authorizations.

1.185. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefits

Benefits defined in Section 1905(r) of the Social Security Act for Medicaid Members under age twenty-one (21), including: screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan. [Section 1905(r) of the Social Security Act]

1.186. Effective Date of Eligibility

EOHHS' administrative and regulatory determination of the date a recipient becomes eligible for RI Medicaid programs, including eligibility to enroll in Contractor's Health Plan.

1.187. Electronic Health Record (EHR)

A real-time patient health record with access to evidence-based decision support tools that can be used to aid clinicians in decision-making. The EHR can automate and streamline a clinician's workflow, ensuring that all clinical information is communicated. It can also prevent delays in response that result in gaps in care. The EHR can also support the collection of data for uses other than clinical care, such as billing, quality management, outcome reporting, and public

health disease surveillance and reporting.

1.188. Electronic Visit Verification (EVV)

To a computer or telephone-based system that electronically verifies and documents service delivery information. This includes details such as the date, time, type of service, and location of service delivery. It's mandated by Section 12006(a) of the 21st Century Cures Act [P.L. 114-255 § 12006(a)] for all Medicaid personal care services and home health services. EVV aims to improve the quality and efficiency of care by ensuring that intended services are indeed being provided to Medicaid beneficiaries at the right time and location.

1.189. Emergency Ambulance Trip

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

1. Hospital emergency room;
2. General hospital or psychiatric facility where a nonscheduled admission results;
3. General hospital or psychiatric facility where an emergency admission results after qualified transportation recipients were seen at a hospital emergency room; or,
4. Second facility because an emergency medical service was not available at the original emergency room.

1.190. Emergency Dental Condition

A dental condition requiring immediate treatment to control hemorrhage, relieve acute pain, and eliminate acute infection, pulpal death, or loss of teeth.

1.191. Emergency Medical Condition

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or, for a pregnant individual, the health of the woman or her unborn child) in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part. [42 C.F.R. § 438.114(a)]

1.192. Emergency Medical Services

Also known as ambulance services or paramedic services, are a type of emergency service dedicated to providing out-of-hospital acute medical care, transport to definitive care, and other medical transport to patients.

1.193. Emergency Medical Transportation

Ambulance services for an Emergency Medical Condition.

1.194. Emergency Room Care

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

1.195. Emergency Services

Covered inpatient and outpatient services that are:

1. Furnished by a provider that is qualified to furnish emergency services under Medicaid; and
2. Needed to evaluate or stabilize an Emergency Medical Condition. [42 C.F.R. § 438.114(a)]

1.196. Emerging High-Risk Member

A member who has limited or no current medical, or behavioral health needs, but may have needs in the future.

1.197. Encounter

A distinct set of health care services provided to an Enrollee on the dates that the services were delivered.

1.198. Encounter Data or Member Encounter Data

The information relating to the receipt of any items or services by a Member under this Agreement. [42 C.F.R. § 438.2]

1.199. Encounter Data Adjustment

Adjustments to Encounter Data that are allowable under the Medicaid Management Information Systems (MMIS) and as specified in the MCO Manual.

1.200. Encounter Data Reporting Guide or Encounter Data Companion Guide or 837 Companion Guide

The published guide to assist contracted entities in the standard electronic encounter data reporting process required by EOHHS. This is contained the MCO Manual.

1.201. Encryption or Encrypt

To encipher or encode electronic data using software that generates a minimum key length of one-hundred twenty-eight (128) bits.

1.202. Enrollee or Member

A Medicaid beneficiary who is currently enrolled in the Contractor's Health Plan, either by choice or by automatic assignment by EOHHS. [42 C.F.R. § 438.2]

1.203. Enrollment Period

The time that a member is enrolled in a MCO during which they may not disenroll or change MCOs unless disenrolled under one of the conditions described in this Agreement and pursuant to Section 1932 (a)(4)(A) of Title XIX. This period may not exceed twelve (12) months.

1.204. Essential Community Provider (ECP)

A provider that serves predominantly low-income, medically underserved individuals.[45 C.F.R. § 156.235]

CMS has identified eight (8) ECP categories:

1. Federally Qualified Health Centers (FQHCs) and FQHC "Look-Alike" Clinics;

2. Ryan White HIV/AIDS Program Providers;
3. Family Planning Providers;
4. Indian Health Care Providers;
5. Inpatient Hospitals;
6. Mental Health Facilities;
7. Substance Use Disorder Treatment Centers; and
8. Other ECP Providers including Rural Health Clinics, Sexually Transmitted Disease Clinics, Tuberculosis Clinics, Hemophilia Treatment Centers, Black Lung Clinics and other entities that serve predominately low-income, medically underserved individuals.

1.205. Essential Health Administrative Functions

Utilization management, grievances and appeals, network development, provider relations, quality management, data management and reporting, and claims and financial management.

1.206. Every Reasonable Effort

Contractor initiated action to promote EPSDT related screenings, laboratory tests, immunizations, follow-up treatment or other services. Every reasonable effort shall include at a minimum a telephone call or mailed reminder either prior to the due date of each visit or upon learning that a visit has been missed and scheduling appointments for members. In the case of being notified of missed appointment, a telephone call or mailed reminder for the missed appointment is required. If there is no response, a personal visit to urge the parent or guardian to take the child to his or her EPSDT appointment is required.

1.207. Evidence-Based Supported Employment (EBSE)

The provision of vocational supports to members to promote successful competitive employment in the community.

1.208. Exception to the Rule (ETR)

A request by a member or a requesting provider to receive a non-covered health care service.

1.209. Excluded Services or Non-Covered Services

Health Care Services that are not benefits of Rhode Island Medicaid and are not covered by the Contractor as a Value-Added Service or In Lieu of Service.

1.210. Exclusion from Managed Care or Excluded Populations

The removal of a member or population from the Rhode Island Medicaid Managed Care Program.

1.211. Exclusion Lists

The HHS Office of the Inspector General (OIG) List of Excluded Individuals/Entities; the System of Award Management (SAM); the Social Security Administration Death Master File; the list maintained by the Office of Foreign Assets Controls; and to the extent applicable, National Plan and Provider Enumeration System (NPPES).

1.212. Executive Capacity

The ability to serve as the Chief Executive Officer, Chief Operating Officer, Medical Director,

or a Behavioral Health Medical Director.

1.213. Executive Compensation

The remuneration awarded to the top executives of the Contractor. Executive Compensation includes various forms of payment, such as salary, bonuses, stock awards, option awards, sign-on payments, and severance payments. This Executive Compensation is subject to scrutiny, review and possible action and audit by EOHHS if it is funded in part by revenues attributable to the premiums under this Agreement. Additional benefits like contributions to retirement plans and insurance premiums are not included in this definition.

1.214. Executive Office of Health and Human Services (EOHHS)

The Single State Agency for purposes of administering the Medicaid program as specified in 42 C.F.R. § 438.10.

1.215. Expedited Appeal

The process by which the Contractor must respond to an appeal by a member if a denial of care decision by the Contractor may jeopardize the life, physical or mental health, or ability to attain, maintain, or regain maximum function. The Contractor must respond as expeditiously as the member's health condition requires, not to exceed the latter of three (3) Business Days from the initial receipt of an appeal, or three (3) business days from receipt of written certification from the Contractor or treating medical professional that the member's health condition requires expediting handling of the appeal.

1.216. Experimental Treatment or Investigational Treatment

Reliable evidence shows that the consensus of opinion among experts regarding the healthcare service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or reliable evidence shows that the dental service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) does not improve net health outcome, is not as beneficial as any established alternatives, or does not produce improvement outside

1.217. Exploitation

An unjust or improper use of the resources of a member for the profit or advantage, pecuniary and otherwise, of a person other than the vulnerable member through the use undue influence, coercion, harassment, duress, deception, false representation, or false pretense.

1.218. External Appeal

An appeal, subsequent to the Contractor's appeal decision, to the State Fair Hearing process for Medicaid-based adverse decisions.

1.219. External Quality Review (EQR)

The analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that an MCO or their contractors furnish to Medicaid members, as defined in 42 C.R.F. § 438.320.

1.220. External Quality Review Organization (EQRO)

An organization that meets the competence and independence requirements set forth in 42 C.F.R. § 438.354, and performs external quality review, other EQR-related activities as set

forth in 42 C.F.R. § 438.358 , or both. [42 C.F.R. § 438.320]

1.221. External Quality Review Report (EQRR)

A detailed technical report that describes the manner in which the data from all activities described in a ERRO provisions and conclusions in accordance with 42 C.F.R. § 438.358 were aggregated and analyzed and conclusions were drawn as to the quality, timeliness, and access to care furnished by the Contractor.

1.222. Fair Business Practices

Business activities conducted by the Contractor in a fair, ethical, and legal manner. This includes, but is not limited to, providing accurate information about Contractor products or services, treating Members and competitors with respect, avoiding deceptive or fraudulent practices, and complying with all relevant local, national, and international laws and regulations to promote the integrity and goals of the Rhode Island Medicaid Program.

1.223. Family

The adult head of household, their spouse, and all minors in the household for whom the adult has parent or guardian status.

1.224. Family Caregiver

Defined and refers to any relative, partner, friend, or neighbor who has a significant relationship with, and who provides a broad range of assistance for, an older adult or an adult or child with chronic or disabling conditions.[RIGL 40-8.11-2 (b)]

1.225. Family Planning Services and Supplies

The supplies described in Section 1905(a)(4)(c) of The Act, including contraceptives and pharmaceuticals for which EOHHS claims or could claim federal match at the enhanced rate under Section 1905(a)(5) of the Act.

1.226. Federal Financial Participation (FFP) or Federal Match

The Federal share of a State's expenditures under the Medicaid Program.

1.227. Federal Poverty Level (FPL)

The poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).

1.228. Federally Qualified Health Center (FQHC)

An entity that receives a grant under Section 330 of the Public Health Services Act (also see 42 U.S.C. § 1396(I)(2)(B) of the Social Security Act) to provide primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services.

1.229. Fee for Service (FFS) Medicaid Program

The state Medicaid program which pays for services furnished to the Medicaid Member not enrolled in a Medicaid managed care plan, in accordance with the Medicaid State Plan's fee-for-service methodology.

1.230. Fee for Service (FFS) Rate or Medicaid Rate

The reimbursement rate published on EOHHS website or on a monthly procedure file sent to

the Contractor by the Fiscal Intermediary (FI), or its equivalent, whichever is most current on the date of service.

1.231. Fidelity

The accuracy and consistency of an intervention to ensure it is implemented as planned and that each component is delivered in a comparable manner to all members over time.

1.232. Financial Relationship

A financial relationship, in accordance with 42 C.F.R. § 438.320, is relationship that is:

1. A direct or indirect ownership or investment interest (including an option or nonvested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means, and includes indirect ownership or investment interest no matter how many levels are removed from a direct interest; or,
2. A compensation arrangement with an entity.

1.233. Fiscal Intermediary (FI)

Financial management services delivered to self-directed participants by an EOHHS' certified Fiscal Intermediary. These services are designed to assist participants in allocating funds as outlined in the individuals service and spending plan and to facility employment of personal assistance staff by the participant. Self-directed financial matters are maintained by the fiscal agency and a portion of the participant's monthly budget is set aside for the services it provides.

1.234. First Responders

Includes a firefighter, law enforcement officer, paramedic, emergency medical technician, or other individual (including an employee of a legally organized and recognized volunteer organization, whether compensated or not), who, in the course of his or her professional duties, responds to fire, medical, hazardous material, or other similar emergencies.[34 USC § 10705(1)]

1.235. Flesch Readability Formula

The formula by which readability of documents is tested as set forth in Rudolf Flesh, *The Art of Readable Writing* (1949, as revised 1974).

1.236. For Cause

Means for legitimate, specific reason; with justification.

1.237. Former Foster Care Children

Individuals under age twenty-six (26) determined eligible in accordance with 42 C.F.R. § 435.150 who were in Foster Care under the responsibility of the State and enrolled in the Medicaid Program on the date of attaining age eighteen (18) or aging out of Foster Care.

1.238. Formulary

The list of drugs that the Contractor has approved. Prescribing some of the drugs may require service authorizations.

1.239. Foster Care

Planned, goal-directed service that provides twenty-four (24) hours-a-day substitute temporary care and supportive services in a home environment for Children birth to twenty-one (21) years

of age in DCYF custody.

1.240. Fraud

An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law. [42 C.F.R.§ 438.2 and 42 C.F.R. § 455.2]

1.241. Full Credibility

As defined in 42 C.F.R. § 438.8, a standard for which the experience of an MCO is determined to be sufficient for the calculation of the Medical Loss Ratio (MLR) with a minimal chance that the difference between the actual and target medical loss ratio is not statically significant. An MCO that is assigned full credibility (or is fully credible) will not receive a credibility adjustment to its MLR.

1.242. Full Medicaid Pricing (FMP)

A program to ensure consistent pricing in the Managed Care Program for hospital services, including inpatient hospital, outpatient, hospital-based physician, ambulance services, and to maintain and increase access to those services for enrolled Medicaid populations.

1.243. Full-Benefit Dual Eligible (FBDE)

An individual who is entitled to Medicare Part A, Medicare Part B, and full Medicaid benefits. FBDEs are eligible for Medicaid payment of Medicare premiums, deductibles, coinsurance, and co-payments (except for Medicare Part D) as well as full Medicaid benefits.

1.244. Full-Time Equivalent Position (FTE)

The equivalent of one (1) individual full-time employee who works forty (40) hours per week or a full-time primary care provider delivering outpatient preventative (routine, urgent and acute) clinical care for twenty-four (24) hours or more per week (exclusive of travel time).

1.245. Fully Integrated Dual Eligible Special Needs Plan or Aligned Integrated D-SNP

A dual eligible special needs plan that provides dual eligible individuals access to Medicare and Medicaid benefits under a single entity that holds both a Medicare Advantage contract with CMS and a Medicaid Health Plan contract with the State Medicaid agency. Aligned integrated D-SNPs must fully integrate care for FBDE individuals through exclusively aligned enrollment and provide coverage of primary, acute, behavioral health, durable medical equipment, and long-term services and supports benefits.

1.246. Generally Accepted Accounting Principles (GAPP)

The uniform standards of and guidelines to financial accounting and reporting as established by the Financial Accounting Standards Board and the Governmental Accounting Standards Board.

1.247. Geo-Coding

The process involving the use of tools and software to convert location addresses into coordinates for analysis. Geocoded locations of patients, populations, providers, and other services can be potentially coupled with other data sources to inform and enhance clinical and administrative decision-making.

1.248. Go-Live Date or Operational Start Date or Operational Go-Live Date

In this Agreement, this is July 1, 2025, the first Day on which the Contractor is responsible for providing Covered Services to Managed Care Program Members and all related Contract functions. This Agreement will have three (3) operational state dates related to the required date the Contractor must offer services under this Agreement.

1.249. Governing Requirements

All state and federal laws, rules, regulations, codes, ordinances, federal waivers, and policies, and court orders that govern the performance of this Agreement.

1.250. Grievance

An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and failure to respect the Member's rights regardless of whether remedial action is requested. Grievance includes a Member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. [42 C.F.R. § 438.400(b)]

1.251. Grievance and Appeal System

The processes the Contractor implements to handle Appeals of Adverse Benefit Determinations and Grievances, and the processes to collect and track information about them. [42 C.F.R. § 438.400(b)]

1.252. Grievance Process

The procedure for addressing Member grievances. [42 C.F.R. § 438.400(b)]

1.253. Guardian

An adult who is legally responsible for the care and management of a minor child or another adult.

1.254. Guideline

A set of statements by which to determine a course of action. A Guideline streamlines utilization management decision-making processes according to a set routine or sound evidence-based clinical practice.

1.255. Habilitation Services

Health Care Services that help a Member keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology, and other services provided in a variety of inpatient and/or outpatient settings.

1.256. Home-Based Therapeutic Services /Applied Behavior Analysis Therapy (HBTS/ABA)

Refers to home-based therapeutic services and/or applied behavior analysis therapy as described in the Rhode Island Certification Standards for Providers of Home- Based Therapeutic Services.

1.257. Health Care Acquired Conditions (HAC) or Provider Preventable Condition or Never Events

A condition occurring in any inpatient hospital setting, identified as a HAC in the Rhode Island Medicaid State Plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Social Security

Act; other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients. Also includes a condition occurring in any health care setting that is identified in the State Plan, has been found by EOHHS, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; has a negative consequence for the Member or Eligible; is auditable, and includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or invasive procedure performed on the wrong body part; and any surgical or other invasive procedure performed on the wrong patient.

1.258. Health Care Provider or Provider

Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services. [42 C.F.R. § 438.2]

In accordance with 29 C.F.R. § 825.125, this includes:

1. A Doctor of Medicine or osteopathy who is authorized to practice medicine or surgery (as appropriate) by the state in which the doctor practices; or
2. Any other person determined by the Secretary of the Department of Health and Human Services to be capable of providing Health Care Services.

When the term is capitalized in this Agreement ("Provider"), it refers to a Network Provider.

1.259. Health Care Service

Any Medicaid service provided pursuant to this Agreement by the Contractor, in any setting**.** [42 C.F.R. § 438.320]

1.260. Health Disparities

Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations. Populations can be defined by factors such as race or ethnicity, gender, education or income, disability, geographic location (e.g., rural or urban), or sexual orientation. Health disparities are inequitable and are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources.

1.261. Health Equity

The absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically, or geographically.

1.262. Health Equity Plan

The Contractor's strategic initiatives and approaches to activate practices, protocols, and resources that equitably and effectively support the wellness and well-being of the people, populations, and communities EOHHS serves under this Agreement.

1.263. Health Equity Zones (HEZ)

Geographic areas where existing opportunities emerge and investments are made to address differences in health outcomes. Through a collaborative, community-led process, each Health Equity Zone conducts a needs assessment and implements a data-driven plan of action to address the unique social, economic, and environmental factors that are preventing people from

being as healthy as possible. Rhode Island's Health Equity Zone initiative is a health equity-centered approach to prevention work that leverages place-based, community-led solutions to address the social determinants of health. Health Equity Zones are collaboratives of residents, educators, business leaders, health professionals, transportation experts, and people in many other fields who are coming together to address the most pressing health concerns in their neighborhoods. https://health.ri.gov/publications/guides/HEZLeads.pdf

1.264. Health Home

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

1.265. Health Information Technology (HIT)

The application of information processing involving processing both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data and knowledge for communication and decision making. Certified HIT (including certified HER technology (CEHRT)) are systems that that meet the technology capability, functionality, and security requirements adopted by the U.S. Department of Health and Human Services.

1.266. Health Information Technology for Economic and Clinical Health (HITECH) Act

The law enacted as part of the American Recovery and Reinvestment Act of 2009 to promote the adoption and meaningful use of health information technology. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules.

1.267. Health Insurance

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

1.268. Health Insurance Portability and Accountability Act of 1996 (HIPPA)

The federal law, as amended, created to protect the privacy and security of health information and gives patients rights to their own health information. HIPPA established standards for covered entities and their business associates to safeguard protected health information (PHI). HIPPA rules are located at 45 C.F.R. Part 160 and Part 164.

1.269. Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule

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

1.270. Health Insurance Portability and Accountability Act (HIPAA) Security Rule

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

1.271. Health Plan

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 Managed Care Program services.

1.272. Health Promotion and Wellness

Includes innovative and evidence-based educational resources, self-management tools, and information for Members in formats that meet Members' needs, promotes self-care, and empowers Members.

1.273. Health Related Social Needs (HRSN)

The wide range of factors known to have an impact on healthcare, ranging from socioeconomic status, education and employment, to one's physical environment and access to healthcare.

1.274. Health Risk Assessment (HRA)

A person-centered assessment of a Member's care needs, functional needs, social determinants of health needs, accessibility needs and goals that the Contractor or its designee shall complete for all Members through direct contact with the Member, guardian, or adult caregiver.

1.275. Healthcare Effectiveness Data and Information Set (HEDIS®)

A set of standardized performance measures designed to ensure that health care purchasers and members have the information they need to reliably compare the performance of managed care health plans. HEDIS® also includes a standardized survey of Enrollees' experiences that evaluates plan performance in areas such as customer service, access to care and claims processing. HEDIS® is sponsored, supported, and maintained by the National Committee for Quality Assurance (NCQA).

1.276. Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Audit

The set of standards and audit methods used by an NCQA certified auditor to evaluate information systems (IS) capabilities assessments (IS standards) and a Contractor's ability to comply with HEDIS® specifications (HS standards).

1.277. Healthcare Facility

An institution providing Healthcare Services or a healthcare setting, including, but not limited to hospitals and other licensed, inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory and imaging centers; and rehabilitation and other therapeutic-health settings as further defined in RI Gen. Laws § 23-17-2.9.

1.278. Healthcare Professional

A physician or other healthcare practitioner licensed, accredited, or certified to perform specified Healthcare Services consistent with Rhode Island law. [RI Gen. Laws § 27-81-3]

1.279. Historical Trauma

Situations where a community experienced traumatic events, the events generated high levels of collective distress, and the events were perpetuated by outsiders with a destructive or genocidal intent.

1.280. Hold Time

The duration of time spent on hold in a call center following interaction with the interactive voice response, touch tone response system, or recorded greeting but before reaching a call

center employee.

1.281. Home and Community Based Services (HCBS)

In-home or community-based support services that assist Medicaid individuals with long term care needs as authorized under Rhode Island's Section 1115 Waiver. HCBS provide opportunities for eligible individuals to remain and reside in home and integrated community settings as an alternative to long term care institutional placement.

1.282. Home Care Services

Supportive care provided in the home. Care may be provided by licensed healthcare professionals who provide medical treatment needs or by professional caregivers who provide daily assistance to ensure the ADLs are met. Home care services include personal care services, such as assisting the Member with personal hygiene, dressing, feeding, transfer, and ambulatory needs. Home care services also include homemaking services that are incidental to the Member's health needs such as making the Member's bed, cleaning the client's living area, such as bedroom and bathroom, and doing the client's laundry and shopping. Homemaking services are only covered when the Member also needs personal care services. Home care services do not include respite care, relief care, or day care.

1.283. Home Health Services

Services that comply with the requirements of 42 C.F.R. § 440.70, and meet the following conditions:

1. Nursing; home health aide; medical equipment and supplies; physical, occupational, and speech language therapies; and other services described in 42 C.F.R. § 440.70(b) that are covered benefits under the Rhode Island Medicaid State Plan;
2. Provided to Members at their place of residence;
3. On orders written by a physician, nurse practitioner, clinical nurse specialist, or physician assistant, acting within the scope of practice under Rhode Island law, as part of a written plan of care; and
4. On the Member's physician's orders, or orders of a licensed practitioner of the healing arts acting within the scope of practice under Rhode Island law, as part of a written plan of care. [42 C.F.R. § 440.70(a)]

1.284. Homeless

As defined in 42 U.S.C. § 254b(h)(5), means, an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised or public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transition housing. A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or any other unstable or non-permanent situation. A person may be considered to be homeless if that person is "doubled up," a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members. In addition, previously homeless individuals who are to be released from a prison or hospital may be considered homeless if they do not have a stable housing situation to which they can return. A recognition of the instability of an individual's living arrangements is critical to the definition of homelessness (HRSA/Bureau of Primary Health

Care, Program Assistance Letter 99-12).

1.285. Hospice Services

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

1.286. Hospitalization

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

1.287. Hospital Outpatient Care

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

1.288. Hour

Refers to clock Hours, unless otherwise noted.

1.289. Housing Stabilization Program

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

1.290. ICD-10-CM Codes

The International Classification of Diseases, 10th Revision, Clinical Modification codes represent a uniform, international classification system of coding diseases and injury diagnosis. This coding system arranges diseases and injuries into code categories according to established criteria. Contractor shall transition to newer version as they become effective at the direction of EOHHS.

1.291. Immediate

Without delay and with urgency. No less than fifteen (15) minutes upon notification.

1.292. Implementation Start-Up

The period prior to the contract start date during which the Contractor will begin to provide operations and administration necessary for the Contractor to provide services for the go-live date.

1.293. Improper Payment

Any payment made to a provider, contractor or subcontractor that was more or less than the sum to which the payee was legally entitled, including amounts in dispute.

1.294. In Lieu of Service (ILOS)

A service or setting offered by the Contractor, and approved by EOHHS, in lieu of a Medicaid-covered service or setting in accordance with 42 C.F.R. § 438.3(e)(2).

1.295. Incentive Arrangement

Any payment mechanism under which the Contractor may receive additional funds over and

above the Capitation Payments it was paid for meeting targets specified in this Agreement. [42 C.F.R. § 438.6(a)]

1.296. Incident

As defined by OMB Memorandum M-17-12, "Preparing for and Responding to a Breach of Personally Identifiable Information" (January 3, 2017), as an occurrence that actually or imminently jeopardizes, without lawful authority, the integrity, confidentiality, or availability of information or an information system; or constitutes a violation or imminent threat of violation of law, security policies, security procedures, or acceptable use policies.

1.297. Incomplete Claim

A claim that is denied for the purpose of obtaining additional information from the Provider.

1.298. Incurred but Not Reported (IBNR)

Liability for services rendered for which Claims have not been received.

1.299. Indian Health Care Provider (ICHP)

A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603). [42 C.F.R. § 438.14(a)]

1.300. Indian Health Programs

As defined by 25 U.S.C. § 1603(12):

1. Any health program administered directly by the Indian Health Service (HIS);
2. Any Tribal health program; and
3. Any Indian Tribe or Tribal organization to which the Secretary provides funding pursuant to 25 U.S.C. § 47.

1.301. Indian Tribe

As defined in 25 U.S.C. § 1603.

1.302. Indirect Ownership Interest

Pursuant to 42 C.F.R. § 455.101 means an ownership interest in an entity that has an ownership Interest in the Disclosing Entity.

1.303. Individualized Care Plan (ICP)

A written plan developed for members receiving Care Management (CM) or Complex Case Management (CCM).

1.304. Individual Service Plan (ISP)

A written agreement between the member and his or her healthcare team to help guide and manage the delivery of diagnostic and therapeutic services and the Member's engagement in self-management of his or her health (may also be called a treatment plan).

1.305. Individuals with Intellectual or Developmental Disabilities (I/DD)

Adult individuals who have been determined by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals to have a developmental disability as defined in R.I.

Gen. Laws § 40.1-21-4.3(5).

1.306. Information System (IS)

A combination of computing hardware and software that is used in:

1. The capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e., structured data (which may include digitalized audio and video) and documents; or,
2. The processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.

1.307. Informed Choice

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

1.308. Initial Program Implementation

The ninety (90) day period following EOHHS initially enrolling all Eligibles who meet criteria for the Rhode Island Medicaid Managed Care Program in a Health Plan.

1.309. In-Network Provider or Participating Provider or Network Provider

A person, healthcare Provider, practitioner, facility, or entity, acting within the scope of practice and licensure, and who is under a written contract with the Contractor to provide services to Members under the terms of this Agreement. [42 C.F.R. § 438.2]

1.310. Inpatient/Residential Substance Use Treatment Services

Rehabilitative services, including diagnostic evaluation and face-to-face individual or group counseling using therapeutic techniques directed towards Enrollees who are harmfully affected by the use of mood-altering chemicals or have been diagnosed with a SUD. Techniques have a goal of assisting Enrollees in their recovery for individuals with SUDs. Provided in a certified residential treatment facility with sixteen (16) beds or less. Excludes room and board.

1.311. Insolvency

A financial condition that exists when an entity is unbale to pay its debts as they become due in the usual course of business, or when liabilities of the entity exceed its assets.

1.312. In-State Provider

A Provider physically located in the State of Rhode Island or located in a Border Community that is engaged in the delivery of Covered Services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services.

1.313. Institute of Mental Disease (IMD)

Per P.L. 100-360, an institution for mental disease as a hospital, nursing Facility, or other institution of more than sixteen (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. An institution is an IMD if its overall character is that of a Facility established and maintained primarily for the care and treatment of individuals with mental diseases.

1.314. Intake Evaluation

An evaluation that is culturally and age relevant initiated prior to the provisions of any other behavioral health services, except Crisis Services, Stabilization Services and Freestanding Evaluation and Treatment. The intake evaluation is initiated within ten (10) Business Days of the request for services, is used to determine the best course of treatment and shall be completed within thirty (30) Business Days. Routine services, such as rehabilitation case management may begin before the completion of the intake once medical necessity is established. This service is provided by a behavioral health professional.

1.315. Intensive Care Management Plan

A written plan developed in collaboration with the Member, the Member's family (with written consent), guardian or adult caretaker, PCP and other providers involved with the Member to delineate the intensive care activities to be undertaken to address key issues of risk for the Member that were identified in the course of the Member's enrollment with the Contractor.

1.316. Integrated Care

The systematic coordination of behavioral health and primary care services to effectively care for people with multiple health care needs.

1.317. Integrated Eligibility System (IES)

The comprehensive database of the EOHHS' recipient eligibility information.

1.318. Intensive Inpatient Residential Services

A concentrated program of SUD treatment, education, and related activities for individuals diagnosed with a SUD excluding room and board in a twenty-four (24) hour a day supervised facility. The service as described satisfies the level of intensity in ASAM Level 3.5.

1.319. Intensive Outpatient Treatment

Services provided in a non-residential intensive patient centered outpatient program for treatment of SUD. The services as described satisfies the level of intensity in ASAM Level 2.1.

1.320. Interdisciplinary Care Conferences (ICCs)

Structured and documented communication between the Enrollee and Health Care Providers to establish priorities and achieve Enrollee-centric health care and social service treatment goals.

1.321. Intermediate Sanction

The sanctions described in 42 C.F.R. § 438.702 which EOHHS may impose for the Contractor's non-compliance for any of the conditions in 42 C.F.R. § 438.700.

1.322. Interoperable Health IT

Technology that enables the secure exchange of electronic health information with, and use of electronic health information from, other health IT without special effort on the part of the user. It allows for complete access, exchange, and use of all electronically accessible

information for authorized use under applicable state or federal law and precent information blocking.

1.323. Juvenile Justice Involved

All persons in DCYF custody or under its supervision for whom DCYF is required to provide services by law or court order.

1.324. Katie Beckett

An eligibility category in the Rhode Island Medical Assistance (Medicaid) Program that provides medical assistance coverage for certain children under age nineteen (19) who have long-term disabilities or complex medical needs and who live at home. Children eligible for Katie Beckett services may receive those services at home instead o f in an institution.

1.325. Key Personnel or Key Position

The managerial or supervisory position with the Contractor that are assigned to the Rhode Island Medicaid Managed Care Program whose primary focus is the work performed under this Contract.

1.326. Kick Payment

The method of reimbursing the Contractor in the form of a separate one (1) time payment for specific services in addition to the Capitation Payment.

1.327. Lead Case Manager

An appropriately qualified professional who is the Contractor's designated accountable point of contact for each Member receiving Case Management (CM) or Complex Case Management (CCM).

1.328. Least Restrictive Environment

The environment in which the provision of services and interventions in the lives of Medicaid Members can be provided with a minimum of limitation, intrusion, disruption, and departure from commonly accepted patterns of living. Medicaid Members should be treated in those settings that least interfere with their civil rights and freedom to participate in society.

1.329. Level of Care (LOC)

The measure of a Member's care requirements that may be used to determine the setting in which an individual requires medical, behavioral health or long-term care services.

1.330. Licensed

A facility, equipment, or an individual that has formally met State and local requirements, and has been granted a licensed by a local, State, or federal governmental entity.

1.331. Limited English Proficiency (LEP)

Potential Members and Members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English. [42 C.F.R. § 438.10]

1.332. List of Excluded Individuals and Entities (LEIE)

A database maintained by the Department of Health and Human Services, Office of the Inspector General. The LEIE provides information to the public, medical health care providers, patients, and other relating to parties excluded from participation in Medicare, Medicaid, and

all other federal medical health care programs.

1.333. Local Community

The location in or nearest to the member's city, town, or residence.

1.334. Long Term Care Ombudsman

An independent advocacy organization that supports residents of nursing facilities and assisting living facilities, and individuals who receive licensed home care or hospice services. The Long Term Care Ombudsman provides services and information to individuals and their caregiver or representatives: protects the rights and wellbeing of people in nursing and assisted living facilities, represents the interest of the person before governmental agencies, seeks administrative, legal, and other remediation to protect the health, safety, well-being and coordinate with licensing, enforcement and other agencies to assure investigation of abuse and neglect and expedite complaints and follow up with corrective actions.

1.335. Long Term Services and Supports (LTSS)

A spectrum of services and supports, provided to Members, of all ages, with clinical and functional impairments and/or chronic illness or disease, that require the level of care typically provided in a health care institution, that have the primary purpose of supporting the ability of the Member to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting. Medicaid LTSS includes skilled or custodial nursing facility care, therapeutic day services, and personal care as well as various home and community-based services. Medicaid beneficiaries eligible for LTSS are also provided with primary care essential benefits. The scope of these services and supports and the choice of settings is determined by a comprehensive assessment of each person's unique care needs. [42 C.F.R. § 438.2 and 210-RICR-50-00-1]

1.336. Mainstreaming or Mainstreaming Clause

Pursuant to 210-RICR-30-05-2.13, the Contractor shall ensure that all its network providers accept all Medicaid Members for treatment, including all eligible Medicaid populations contained in this Agreement. The MCO also shall accept responsibility for ensuring that network providers do not intentionally segregate Medicaid members in any way from other persons receiving services. If the Contractor has another line of business, including but not limited to, Commercial or Medicare contracts, the Contractor shall ensure that there is parity between those contracts and this Agreement and equal access to services under those lines of business for the Medicaid Members served under this Contract. Managed Care Manual (MCM)

The manual published by EOHHS that contains policies and procedures required for all Health Plans participating in the Managed Care Program. The MCM, as amended or modified, is incorporated by reference into this Agreement.

1.337. Managed Care Information System (MCIS)

A comprehensive, automated and integrated system that:

1. Collects, analyzes, integrates, and reports data [42 C.F.R. 438.242(a)];
2. Provides information on areas, including but not limited to utilization, claims, grievances and appeals, and disenrollment for reasons other than loss of Medicaid

eligibility [42 C.F.R. 438.242 (a)];

3. Collects and maintains data on Members and Providers, as specified in this Agreement and on all services furnished to Members, through an encounter data system [42 C.F.R. 438.242(b)(2)];
4. Meets all the requirements listed throughout this Agreement; and
5. Provides all the data and information necessary for EOHHS to meet State and Federal Medicaid reporting and information regulations.

1.338. Managed Care Organization (MCO)

An entity that has, or is seeking to qualify for, a Comprehensive Risk Contract and that is:

1. A Federally qualified HMO that meets the advance directives requirements of 42 C.F.R. Part 489, Subpart I ; or
2. Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:
3. Makes the services it provides to its Medicaid Members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid Members within the area served by the entity.
4. Meets the solvency standards of 42 C.F.R. § 438.116.
5. The terms "Health Plan" and "MCO" are used interchangeably with the term "Contractor" in this Agreement. [42 C.F.R. § 438.2]

1.339. Managed Care Program or Rhode Island Medicaid Managed Care Program

The Rhode Island managed care program that is the subject matter of this Agreement.

1.340. Managed Long Term Services and Supports (MLTSS)

The delivery of long-term services and supports through capitated Medicaid managed care programs.

1.341. Marketing

Any communication, from a Health Plan to a Medicaid Member who is not enrolled in that entity, which can reasonably be interpreted as intended to influence the Member to enroll in that particular Health Plan's Medicaid product, or either to not enroll in or to disenroll from another Health Plan's Medicaid product. Marketing does not include communication to a Medicaid Member from the issuer of a qualified health plan, as defined in 45 C.F.R. § 155.20 about the qualified health plan. [42 C.F.R. § 438.104(a)]

1.342. Marketing Materials

Materials that:

1. Are produced in any medium, by or on behalf of a Health Plan; and,
2. Can reasonably be interpreted as intended to market the Health Plan to Potential Members. [42 C.F.R. § 438.104(a)]

1.343. Marketing Representative

The Contractor's Representative who is engaged in a Marketing activity.

1.344. Mass Media

A method of public advertising that can create Contractor name recognition among many Enrollees and can assist in educating them about potential health care choices. Examples of mass media are radio spots, television advertisements, newspaper advertisements, roadside billboards, materials in public spaces and/or areas, newsletters, and video in a provider's office waiting room.

1.345. Material Adjustment

An adjustment that, using reasonable actuarial judgment, has a significant impact on the development of the Capitation Payment such that its omission or misstatement could impact a determination whether the development of the Capitation Rate is consistent with generally accepted actuarial principles and practices. [42 C.F.R. § 438.2]

1.346. Material Changes

Changes affecting the delivery of care or services provided under this Contract. Material changes include, but are not limited to, changes in composition of the provider network, Subcontractor, or Subcontractor's network; the Contractor's complaint and grievance procedures; health care delivery systems; services; changes to proposed value-added benefits or services; Enrollment of a new population; procedures for obtaining access to or approval for health care services; any and all policies and procedures that require EOHHS approval prior to implementation. EOHHS shall make the final determination as to whether a change is material.

1.347. Material Provider

A Participating Provider whose loss would negatively affect access to care in the service area in such a way that more than fifty (50) Members would have to change their Primary Care Office/clinic or Behavioral Health provider, receive services from a Non-Participating Provider, or consistently receive services outside the service area.

1.348. Material Subcontract

Any contract or agreement by which the Contractor procures, re-procures, or proposes to subcontract with, for the provision of all, or part, of any program area or function that directly relates to the delivery or payment of Covered Services including, but not limited to, behavioral health, claims processing, care management, utilization management, transportation, or pharmacy benefits, including specialty pharmacy providers. This shall include master service agreements or memorandums of understanding between the Contractor and its parent company, and any amendments thereto. Contracts for administrative services estimated with an annual value of greater than $500,000 shall be considered material under this Agreement.

1.349. Material Subcontractor

Any entity with a Material Subcontract with the Contractor. For the purposes of this Contract, Material Subcontractors do not include providers in the Contractor's provider network. Material Subcontractors may include, without limitation, Affiliates, subsidiaries, and affiliated and unaffiliated third parties.

1.350. Measurable

Applies to the Contractor objective and means the ability to determine definitively whether the objective has been met, or whether progress has bene made toward a positive outcome.

1.351. Measurement Year

With regard to health care quality measure reporting the year during which health care services are provided. For example, for most HEDIS® measures, the previous calendar year is the standard Measurement Year. The health care quality measure steward defines the Measurement Year (or period) in the technical specifications for each measure.

1.352. Medicaid Annual Plan Change Opportunity (MAPCO) or Open Enrollment Period

The annual period, as defined by EOHHS, when Members and Eligibles can enroll in healthcare coverage or choose a different Health Plan.

1.353. Medicaid Director

The State Medicaid Director who is responsible for ensuring of the delivery of healthcare services to Medicaid beneficiaries as the Single State Authority (SSA) under this Agreement.

1.354. Medicaid State Plan

The binding written agreement between EOHHS and CMS that describes how the Rhode Island Medicaid Program is administered and determines the Covered Services for which the State can receive federal financial participation (FFP).

1.355. Medicaid Fraud Control Unit (MFCU)

The Rhode Island Attorney General's Office (AG) Medicaid Fraud Control Unit that investigates and prosecutes abuse of Enrollees of fraud committed by any entity, facility, agency, health care professional, health care provider, primary care provider, provider or individual.

1.356. Medicaid ID Number or Medicaid Member ID Number

The ten (10) digit identification number assigned to an Enrollee by EOHHS.

1.357. Medicaid Infrastructure Incentive Program (MIIP)

A program that allows qualified Accountable Entities (AEs) to earn payments from the Accountable Entity Incentive Pool (AEIP) by meeting metrics defined by EOHHS and its managed care partners and approved by CMS. The funding shall be used to support tangible projects that advance health system transformation. Earned AEIP funds are intended to advance AE program success through capacity building based on identified gaps and needs. Capacity building efforts include implementation of project-specific interventions, business models, and data requirements necessary for AEs to manage the total cost of care and quality of an attributed population.

1.358. Medicaid Management Information System (MMIS)

The system defined by the CMS.gov glossary as: A CMS approved system that supports the operation of the Medicaid Program. The MMIS includes the following types of sub-systems or files: Enrollee eligibility, Medicaid provider data, claims processing, pricing, Surveillance and Utilization Review Subsystem (SURS), Management and Administrative Reporting System (MARS) and potentially encounter processing.

1.359. Medicaid Rate or Fee for Service (FFS) Rate

The reimbursement rate published on EOHHS website or on a monthly procedure file sent to the Contractor by the Fiscal Intermediary (FI), or its equivalent, whichever is most current on

the date of service.

1.360. Medical Loss Ratio (MLR)

An adjusted metric for measuring the ratio of (i) incurred claims plus expenditures for activities that improve health care quality plus expenditures on activities to comply with certain program integrity requirements divided by (ii) adjusted premium revenue, as defined in [42 C.F.R. § 438.8].

1.361. Medical Loss Ratio (MLR) Reporting Year

A period of twelve (12) months that is consistent with the period for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS. The contract period and Rating Period are selected by EOHHS. [42 C.F.R. § 438.8(b)]

1.362. Medical Record

A single complete record kept at the site of the Enrollee's treatment(s), which documents medical or allied goods and services, including but not limited to, outpatient and emergency services whether provided by the Contractor, its Subcontractor, or any out-of-Network providers. The records may be electronic, paper, magnetic material, film, or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media, and meet the requirements of 42 C.F.R. §§ 456.111 and 456.211.

1.363. Medical/Surgical Benefits

Benefits for items or services for medical conditions or surgical procedures, as defined by EOHHS and in accordance with applicable federal and state law, but do not include mental health or substance use disorder benefits. Medical/surgical benefits include long-term care services. [42 C.F.R. § 438.900]

1.364. Medically Necessary or Medical Necessity or Medically Necessary Service(s)

Medical, surgical, or other services required for the prevention, diagnosis, cure, or treatment of an injury, health related condition, disease or its symptoms. For members under the age of twenty-one (21), the term also includes the EPSDT services described in Section 1905(r) of the Social Security Act, including services necessary to correct or ameliorate a defect or physical or mental illness or condition discovered through EPSDT screenings. A service is considered Medically Necessary if it is rendered for any of the following situations:

1. Is provided in response to a life-threatening condition or pain;
2. To treat an injury, illness or infection;
3. To achieve a level of physical or mental function consistent with prevailing community standards for the diagnosis or condition;
4. To provide care for a mother and child through the maternity period;
5. To prevent the onset of a serious disease or illness;
6. To treat a condition that could result in physical or behavioral health impairment; or,
7. To achieve age-appropriate growth and development or to attain, maintain, or regain functional capacity.

1.365. Medicare

Program that is administered by CMS and is a federally financed medical assistance program defined in 42 U.S.C. Subchapter XVIII. Medicare is available for certain individuals who are age 65 or older, people with disabilities, and people with end-stage renal disease, as defined by law.

1.366. Medicare Advantage Prescription Drug (MAPD) Plan

The CMS approved Medicare Advantage plan sponsored, issued, or administered by the MAO as defined at 42 C.F.R. § 423.4 and includes, but is not limited to, Dual-Eligible Special Needs Plans as defined in the Medicare Advantage Regulations.

1.367. Medicare Savings Program

The CMS program that provides assistance to Eligibles in paying the Medicare Premium and Cost Sharing.

1.368. Member Advisory Committee

A group of Members that represents the Member population, established and facilitated by the Contractor. The Member Advisory Committee shall adhere to the requirements set forth in this Agreement.

1.369. Member Materials

All written materials produced or authorized by the Contractor and distributed to Enrollees or Potential Enrollees containing information concerning the Contractor, including but not limited to, Member ID Cards, Member Handbooks, Provider Directories, and Marketing Materials.

1.370. Member Month(s)

A month(s) of coverage for an Enrollee.

1.371. Member No-Show

An occurrence where a member does not keep an appointment for services and fails to the cancel the appointment within a specified time. Member no-shows can also occur when the member fails to attend their scheduled appointment or does not properly utilize their NEMT benefit.

1.372. Member with Special Healthcare Needs

An individual has or is at risk for chronic physical, developmental, behavioral, or emotional conditions and also requires health and related services of a type or amount beyond that required by another similarly aged individual.

1.373. Mental Health Benefits

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

1.374. Mental Health Parity and Addiction Equity Act (MHPAEA)

Requires managed care plans that cover Mental Health Benefits or Substance Use Disorders Benefits to offer coverage for those services that is no more restrictive than the coverage for

Medical/Surgical Benefits. [MHPAEA Final Rule]

1.375. Money Follows the Person (MFP)

A federal demonstration established under the Deficit Reduction Act and extended under the Affordable Care Act, the Medicaid Extenders Act of 2019 (P.L. 116-3), the Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16), the Sustaining Excellence in Medicaid Act of 2019 (P.L 116-39), Sec 205: Further Consolidated Appropriations Act, 2020 (P.L. 116-94), Sec 3811: Coronavirus Aid, Relief, and Economic Security Act, 2020 (P.L. 116-136), and Consolidated Appropriations Act, 2021 (P.L. 116-260). The demonstration is designed to support and better enable individuals who are in qualified long term care settings for sixty (60) calendar days or more to community-based settings.

1.376. Must or Shall or Will

In this Agreement, denotes a mandatory requirement. Failure of a Contractor to perform a duty required as a condition of the Contract will be considered breach of Contract.

1.377. National Correct Coding Initiative (NCCI)

CMS-developed coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits.

1.378. National Practitioner Data Bank

A web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, Providers, and suppliers. Established by Congress in 1986, it is a workforce tool that prevents practitioners from moving state-to-state without disclosure or discovery of previous damaging performance.

1.379. National Provider Identifier (NPI)

The unique identification number for covered health care Providers. Covered health care providers and all MCOs and health care clearing houses must use an NPI in the administrative and financial transactions adopted under HIPPA. The NPI is a ten (10)-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about health care Providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of Provider legacy identifiers in the HIPPA standards transactions.

1.380. Natural Supports

Personal associations and relationships developed in the community to that enhance quality and security of life.

1.381. National Committee for Quality Assurance (NCQA)

The organization responsible for developing and managing health care measures that assesses the quality of care and services that Members receive.

1.382. NCQA Health Plan Accreditation

MCO accreditation, including the Medicaid module obtained from the NCQA, based on an assessment of clinical performance and consumer experience.

1.383. Neonatal Abstinence Syndrome (NAS)

A constellation of symptoms in newborn infants exposed to any of a variety of substances in

utero, including opioids.

1.384. Network

The network of health care providers that a Health Plan or its Subcontractor has credentialed and entered into a network provider agreement with to provide medical care to its Members.

1.385. New Entrant

A Contractor under this Agreement that was not contracted with EOHHS as a MCO as of July 1, 2025.

1.386. Newborn

A live infant born to an Enrollee.

1.387. No Credibility or Non-Credible

A standard for which the experience of the Contractor is determined to be insufficient for the calculation of an MLR. A Contractor that is assigned No Credibility (or is Non-Credible) will not be measured against any MLR requirements.

1.388. Non-Claims Costs

Those expenses for administrative services that are not: Incurred (as defined in 42 C.F.R. § 438.8(e)(2)); expenditures on activities that improve health care quality (as defined in 42 C.F.R. § 438.8(e)(3)); licensing or regulatory fees, or federal and State taxes (as defined in 42 C.F.R. § 438.8(f)(3)).

1.389. Non-Compliance Remedy

An action taken by EOHHS in response to the Contractor's failure to comply with a Contract requirement or a performance standard. Remedies include but are not limited: action, consequential, and liquidated damages; Capitation Payment suspension; auto-assignment suspension; Contract termination.

1.390. Noncompliant Member

An act in which a member does any of the following: Misuses or abuses program rules and requirements, such as fraud, waste and abuse; Fails to follow the rules, procedures, and/or policies of Contractor, health care service providers, facility rules; poses a direct threat to the health and/or safety of self or others; or engages in violent, serious disruptive, or illegal conduct.

1.391. Non-Emergency Medical Transportation (NEMT) Program or Rhode Island NEMT Program or Transportation Broker or NEMT Broker or Single State Transportation Broker

The entity that contracts with EOHHS to deliver Non-Emergency Medical Transportation Brokerage Services to eligible Medicaid, ETP and TANF recipients. [42 C.F.R. §440.170]

1.392. Non-Participating Physician or Out-of-Network Physician

A provider who does not sign a network provider agreement to participate in the Contractor's or its Subcontractor's provider network.

1.393. Non-Participating Provider

A person, health care provider, practitioner, facility or entity acting within their scope of

practice or licensure, that does not have a written Agreement with the Contractor to participate in the Contractor's Provider network but provides health care services to Members under appropriate scenarios (e.g., emergency services, single-case agreements (SCAs), or a referral approved by the Contractor).

1.394. Non-Risk Payment

In accordance with 42 C.F.R. § 438.2, a non-risk payment is a type of risk mitigation strategy used to address uncertainty in rate development, a non-risk payment is a payment made to a managed care plan for specific, identifiable costs reimbursed outside of the capitation rate. This arrangement cedes complete risk for paying for certain services back to the state.

1.395. Non-Symptomatic Office Visits

Office visits from the Member's PCP or another Provider within forty-five (45) calendar days of a request for the visit. Non-Symptomatic Office Visits may include, but are not limited to, well/preventative care such as a physical examinations, annual gynecological examinations, or child or adult immunizations.

1.396. Non-Urgent Sick Care or Non-Urgent, Symptomatic Office Visits

Routine care office visits available from the Member's PCP or another Provider within ten (10) calendar days of a request for the visit. Non-Urgent, Symptomatic Office Visits are associated with the presentation of medical signs or symptoms not requiring immediate attention, but that require monitoring.

1.397. Nursing Facility

A facility which primarily provides nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

1.398. Nursing Home Transition Program (NHTP)

A program offered under Rhode Island Medicaid that offers support to Rhode Islanders who are interested in returning to the community from a nursing home. A transition team provides information and support to help a Member evaluate their needs, develop a plan of care, and facilitate the transition, and provide post transition support.

1.399. Ongoing Special Condition

In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm; in the case of a chronic illness or condition, a disease or condition that is life threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time; in the case of pregnancy, pregnancy from the start of the second trimester; in the case of a terminal illness, a Member has a medical prognosis that the Member's life expectancy is less than six (6) months or less.

1.400. Open Panel

PCPs who are accepting new patients for the Contractor.

1.401. Originating Site

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

Clinically Appropriate [RI Gen. Laws § 27-81-3].

1.402. Other Disclosing Entity

Any other Medicaid Disclosing Entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVII, or XX of the Act pursuant to 42 C.F.R. § 455.101. This includes:

1. Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, Rural Health Clinic, or health maintenance organization that participates in Medicare;
2. Any Medicare intermediary or carrier; and,
3. Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

1.403. Other Provider-Preventable Condition

A condition occurring in any health care setting that meets the following criteria:

1. Is identified in the Rhode Island Medicaid State Plan;
2. Has been found by EOHHS, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
3. Has a negative consequence for the Member;
4. Is auditable; and,
5. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient. [42 C.F.R § 447.26(b)]

1.404. Out-of-Plan Benefits or Out-of-Plan Services

Services that are not a part of the Covered Services under this Agreement but are available to Members through the Rhode Island Fee for Service (FFS) Program.

1.405. Out-of-State Medical Appointment

A medical service originating and/or ending outside Rhode Island or a Border Community. The medical service may also involve the transport of a patient to or from the health care provider, as medically necessary and not covered under the NEMT benefit.

1.406. Overpayment

Any payment made:

1. To a Network Provider by a Health Plan or its Representative to which the Network Provider is not entitled to under Title XIX of the Social Security Act; or
2. To a Health Plan by EOHHS to which the Health Plan is not entitled to under Title XIX of the Social Security Act. [42 C.F.R. § 438.2]

1.407. Ownership Interest

The possession of stock, equity, or any interest in the profits of the Contractor as specified in 42 C.F.R. § 455.101.

1.408. Parent Patient Activation Measure (PPAM)

An assessment that gauges the knowledge, skills, and confidence of the parent's management of their child's health.

1.409. Participating Rebate Eligible Manufacturer

Any manufacturer participating in the Medicaid Drug Rebate Program and who has a signed National Drug Rebate Agreement with the Secretary of Health and Human Services.

1.410. Party

In this Agreement, either EOHHS or the Contractor unless the context clearly indicates otherwise.

1.411. Patient Activation Measure (PAM)

An assessment that gauges the knowledge, skills and confidence essential

1.412. Patient-Centered Medical Home (PCMH)

Provides and coordinates the provision of comprehensive and continuous medical care and required support services to patients with the goals of improving access to needed care and maximizing outcomes. To be recognized as a PCMH, a practice must meet the three-part definition established by the Office of the Health Insurance Commissioner (OHIC), which requires demonstration of practice transformation, implementation of cost management initiatives, and clinical improvement. Updated definitions, standards, quality measures, and an updated list of recognized practices can be found at the following link: http://www.ohic.ri.gov/ohic-reformandpolicy-pcmhinfo.php.

1.413. Patient Share

A Member's contribution toward the cost of their Long Term Services and Supports (LTSS) when their income exceeds an allowable amount.

1.414. Pay and Chase

Recovery of claims paid in which the Standard Medicare, Medicare Advantage plan or private insurance was not known at the time the claim was adjudicated.

1.415. Peer Navigator

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

1.416. Pended Claim

A claim for which additional information is being requested in order for the Claim to be Adjudicated.

1.417. Performance Improvement Projects (PIP)

Projects designed to achieve, through ongoing measurements and interventions, significant

improvement, sustained over time, in clinical care and non-clinical care areas that have a favorable effect on health outcomes and member satisfaction. [42 C.F.R. 438.330]

1.418. Performance Measures

The tools that quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high quality health care and/or that relate to one or more quality goals for health care.

1.419. Permanent Supportive Housing (PSH)

Consists of deeply affordable, community-integrated rental housing combined with supportive services that are designed to assist households in gaining and maintaining access to safe and quality housing. In PSH, the service beneficiary is the tenant and lessee. Tenancy is not contingent upon continued receipt of services.

1.420. Person with Ownership or Control Interest

A person or corporation pursuant to 42 C.F.R. § 455.101 that:

1. Has a Direct Ownership Interest totaling five percent (5%) or more in a Disclosing Entity;
2. Has a Direct Ownership Interest equal to five percent (5%) or more in a Disclosing Entity;
3. Has a combination of Direct and Indirect Ownership Interests equal to five percent (5%) or more in a Disclosing Entity;
4. Owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by the Disclosing Entity that interests equals at least five percent (5%) of the value of the property or assets of the Disclosing Entity.
5. Is an officer or director of the Disclosing Entity that is organized as a corporation; or,
6. Is a partner in a Disclosing Entity that is organized as a partnership.

1.421. Person-Centered

A care planning process driven by the Enrollee that identifies supports and services that are necessary to meet the Enrollee's needs fin the most integrated setting. The Enrollee directs the process to the maximum extent possible and is provided sufficient information and support to make informed choices and decisions. The process is Timely and occurs at times and locations convenient to the Enrollee, reflects the cultural and linguistic considerations of the Enrollee, provides information in plain language and in a manner that is accessible to Enrollees, and includes strategies for resolving conflict or disagreement that arises in the planning process.

1.422. Person-Centered Options Counseling

The decision-support process whereby HCBS participants, with support from family members, caregivers, and/or others, are supported in their deliberations to make informed long-term services and support choices in the context of the HCBS participant's preferences, strengths, needs, values, and personal circumstance.

1.423. Person-Centered Plan

A written document that articulates a HCBS participant's care needs, wants, and services and supports (paid and unpaid) that will assist a HCBS participant to achieve their goals.

1.424. Person-Centered Planning

A process, for selecting and organizing the services and supports that an older adult or person with a disability may need to live in a home or community-based setting. Most important, it is a process that is directed by the HCBS participant who receives the support. This process is more of a conversation and includes a review of any functional needs assessments that have been completed as well as a discussion of what is important to the HCBS participant.

1.425. Personally Identifiable Information (PII)

Any information about an individual maintained by an entity, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information that can be used to distinguish or trace an individual's identity, either alone or when combined with other personal or identifying information that is linked or linkable to a specific individual, such as their name, social security number, date and place of birth, mother's maiden name, biometric records, etc. (as defined in 45 C.F.R. § 75.2 and OMB Memorandum M-06-19, "Reporting Incidents Involving Personally Identifiable Information and Incorporating the Cost for Security in Agency Information Technology Investments" (July 12, 2006)). PII also includes an individual's first name or first initial and last name in combination with any one (1) or more of types of information, including, but not limited to, social security number, passport number, credit card numbers, clearances, bank numbers, biometrics, date and place of birth, mother's maiden name, criminal, medical and financial records, educational transcripts (as defined in 45 C.F.R. § 75.2, "Protected Personally Identifiable Information").

1.426. Pharmacy Benefits Manager (PBM)

A person, corporation, partnership, or other legal entity that contracts with pharmacies on behalf of an insurer, a third-party payor or a prescription drug purchasing consortium. A PBM may fulfill any of the following duties:

1. Process claims for prescription drugs or medical supplies or provide retail network management for pharmacies or pharmacists;
2. Pay pharmacies or pharmacists for prescription drugs or medical supplies; or,
3. Negotiate rebates with manufacturer for drugs paid for or procured.

PBM does not include a health care service contractor.

1.427. Physician Services

Health Care Services a licensed medical physician (Medical Doctor or Doctor of Osteopathic Medicine) provides or coordinates.

1.428. Plan of Care

A written plan developed by the Member's Primary Care Provider, Care Manager, Case Manager, Primary Care Case Manager, or other interdisciplinary team on which the developer documents the proposed Medicaid State Plan services, In Lieu of Services, Medicaid waiver services, and other medical or social services that are needed to promote the health and welfare of the Member.

1.429. Population Health

The health status and health outcomes within a group of people rather than considering the health of one (1) person at a time. For public health practitioners, improving population health

involves understanding and optimizing the health of a population broadly defined by community.

1.430. Population Health Management

A coordinated, data-informed approach to implementing strategies and interventions designed to address the drivers of poor health outcomes in specific populations and communities with the goal of improving physical and psychosocial well-being.

1.431. Population Health Management Systems (PHMS)

Health information technology (HIT) and health information exchange (HIE) technologies that are used at the point-of-care, and to support

1.432. Post-Stabilization Care Services

Covered services related to an Emergency Medical Condition that are provided after a Member is Stabilized to maintain the Stabilized condition, or, under the circumstances described 42 C.F.R. § 438.114I, to improve or resolve the Member's condition. [42 C.F.R. § 438.114(a)]

1.433. Potential Member or Potential Enrollee

A Medicaid beneficiary who is not yet enrolled in a Health Plan. [42 C.F.R. § 438.2]

1.434. Practice Guidelines

Evidence-based clinical guidelines adopted by the Contract that are in compliance with 42 C.F.R. 438.236 and with NCQA's requirements for health plan accreditation. The Practice Guidelines shall be based on valid and reasonable clinical evidence or a consensus of Providers in the particular field, shall consider the needs of Members, be adopted in consultation with Participating Providers, and be reviewed and updated periodically as appropriate.

1.435. Pre-Admission Screening and Resident Review (PASRR)

A Federal requirement (Section 1919 (e)(7) of Social Security Act and 42 C.F.R. Part 483, Subpart C) to help ensure that individuals are not inappropriately placed in nursing homes for long-term care. PASRR requires all applicants to Medicaid certified nursing facility be evaluated for mental illness and/or intellectual disability, offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings), and receive the services they need in those settings.

1.436. Pre-Authorization or Prior Authorization (PA) or Precertification

The process through which provisional affirmation of coverage is submitted to a Health Plan for its review before the service or item is furnished to the Member and before the claim is submitted for processing. [42 C.F.R. § 414.234(a)]

1.437. Pregnancy-Related Services

Services that are necessary for the health of the pregnant person and fetus, or that have become necessary as the result of the person having become pregnant pursuant to 42 C.F.R. § 440.210. EOHHS considers all services received by an Enrollee or Eligible that is pregnant to be a Pregnancy-Related Service.

1.438. Premium

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

copayments, and coinsurance.

1.439. Prepaid Benefit Package

The set of health care related services for which Health Plans shall be responsible to provide and for which the Health Plan shall receive reimbursement through a per member per month predetermined capitation rate.

1.440. Prepaid Inpatient Health Plan (PIHP)

In accordance with 42 C.F.R. § 438.2, a PIHP is an entity that:

1. Provides services to enrollees under contract with the State and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates.
2. Provides, arranged for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and
3. Does not have a comprehensive risk contract.

1.441. Pre-Payment Review

Any action by the Contractor requiring a Network Provider or an Out-of-Network Provider to provide medical record documentation in conjunction with or after the submission of a Claim for payment for medical services rendered, but before the Claim has been Adjudicated by the Contractor.

1.442. Prescription Drug

A drug which can be dispensed only upon prescription by a health care professional authorized by their licensing authority and which is approved for safety and effectiveness as a prescription drug under Section 505 or 507 of the Federal Food, Drug and Cosmetic Act (52 Stat. 1040 (1938), 21 USC 9-301).

1.443. Prescription Drug Coverage

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

1.444. Prevalent Language

Is a non-English language determined to be spoken by a significantnumber or percentage of Potential Enrollees and Members that have Limited English Proficiency. [42 C.F.R. § 438.10]

1.445. Presumptive Eligibility

A period of temporary eligibility provided to individuals determined by a qualified entity, on the basis of Applicant self-attested income information, to meet the eligibility requirements for a Modified Adjusted Gross Income (MAGI) eligibility group.

1.446. Primary Care

All Health Care Services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the Rhode Island Medicaid program, to the extent the furnishing of such services is legally authorized in the state in which the practitioner furnishes them. [42 C.F.R. § 438.2]

1.447. Primary Care Assignment Algorithm

The algorithm the Contractor uses to assign a member who has not affirmatively selected PCP that is a participating provider.

1.448. Primary Care Capitation Model

Primary Care Capitation Model refers to a payment arrangement where primary care providers (PCPs) are paid a fixed amount per member per month (PMPM) for the provision of primary care services to enrolled Medicaid beneficiaries, regardless of the number of services provided.

1.449. Primary Care Case Management

Care Management services led by the Member's Primary Care Provider under the Connect Care Choice program.

1.450. Primary Care Provider (PCP)

The individual Network Provider selected by or assigned to the Member to provide overall clinical direction and serve as the central point for the integration and coordination of all of the Member's health care needs and to initiate and monitor referrals for specialized services when required. Practitioners eligible to serve as Primary Care Providers include licensed, board certified or board-eligible physicians and licensed Advance Practice Registered Nurses (APRN). Licensed eligible physicians include Medical Doctors or Doctors of Osteopathy in the following specialties: family and general practice, pediatrics, gynecology and obstetrics, internal medicine, geriatrics, or other medical specialists who have a demonstrated clinical relationship as the principal coordinator of care for children or adults and who are prepared to undertake the responsibilities of serving as a PCP as stipulated in the Contractor's primary care agreements. A Primary Care Provider may practice as part of a multi- disciplinary team or in a National Committee for Quality Assurance (NCQA) certified Patient Centered Medical Homes. The Primary Care Provider may designate other participating plan clinicians who can provide or authorize a Member's care.

1.451. Primary Care Provider Automatic Assignment or PCP Auto-Assignment

The process by which an enrolled Member will have a Primary Care Provider chosen by the Contractor if the Member does not request an available PCP prior to the thirtieth (30^{th}) day following the Member's enrollment effective date.

1.452. Primary Care Services

Health care services and laboratory services customarily furnished by or through a PCP for diagnosis and treatment of acute and chronic illnesses, disease prevention and screening, health maintenance, and health promotion either through direct service to the Enrollee when possible or through appropriate referral to specialists and/or ancillary services.

1.453. Prior Authorization or Service Authorization Request

A managed care Member's request for the provision of a service, or a request made by a provider on the Member's request. [42 C.F.R. § 431.201]

1.454. Private Duty Nursing

Per 42 C.F.R. § 440.80, nursing services for Members who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided:

1. By a registered nurse or a licensed practical nurse;
2. Under the direction of the Member's physician; and
3. To a Member in one (1) or more of the following locations at the option of EOHHS
   a) His or her own home;
   b) A hospital; or
   c) A skilled nursing facility.

1.455. Promptly

Without unreasonable delay, but no later than two (2) Business Days, unless otherwise required by EOHHS.

1.456. Protected Health Information (PHI)

Individually identifiable information relating to the past, present, or future health status of an individual that is created, collected, or transmitted, or maintained by a HIPAA-covered entity in relation to the provision of healthcare, payment for healthcare services, or use in healthcare operations. Health information such as diagnoses, treatment information, medical test results, and prescription information are considered protected health information under HIPAA, as are national identification numbers and demographic information such as birth dates, gender, ethnicity, and contact and emergency contact information. PHI relates to physical records, while ePHI is any PHI that is created, stored, transmitted, or received electronically. PHI does not include information contained in educational and employment records that includes health information maintained by a HIPAA covered entity in its capacity as an employer.

1.457. Provider-Beneficiary Relationship

A relationship that is defined as one in which the provider has been the main source of Covered Services for the Beneficiary during the past twelve (12) months based on Claims data sorted by the most frequently visited PCP.

1.458. Provider Complaint

A verbal or written expression by a Provider which indicates dissatisfaction or dispute with the Contractor's policy, procedure, claims processing and/or payment, or any aspect of the Contractor's functions.

1.459. Provider Directory

A listing of health care service providers with the Contractor's provider network that is prepared by the Contractor as a reference tool to assist Enrollees in locating provider that are available to provide services.

1.460. Provider-Led Entity

An organization or entity that meets the criteria of at least one (1) of the following two subparagraphs:

1. A majority of the entity's ownership is held by Medicaid Providers in Rhode Island or is held by an entity that directly or indirectly owns or is under common ownership with Medicaid Providers in Rhode Island; or,
2. A majority of the entity's Governing Body is composed of individuals who:

a) Have experience serving Medicaid member; and,

b) Are licensed in Rhode Island as physicians, physician assistants, nurse practitioners, certified nurse-midwives, or certified registered nurse anesthetists,

c) At least one (1) member is licensed behavioral health Provider; or,

d) Are employed by a hospital or other medical facility licensed by and operating in Rhode Island; or an impatient or outpatient mental health or substance use disorder treatment facility licensed or certified by and operating in Rhode Island,

e) Represent the Providers or facilities described above including, but not limited to, individuals who are employed by Statewide Provider associations, or,

f) Are nonclinical administrators of clinical practices serving Medicaid members.

1.461. Prudent Layperson

A person who possesses an average knowledge of health and medicine.

1.462. Qualified Bilingual/Multilingual Staff

An employee of the Contractor who is designated by the Contractor to provide oral language assistance as part of the individual's current, assigned job responsibilities and who has demonstrated to the Contract that they are proficient in speaking and understanding spoken English and at least one (1) other spoken language, including any necessary specialized vocabulary, terminology and phraseology; and is able to effectively, accurately, and impartially communicate directly with Members with LEP in their primary languages.

1.463. Qualified Interpreter for a Member with a Disability

Is an interpreter who, via a remote interpreting service or on-site appearance, adheres to generally accepted interpreter ethics principles, including Member confidentiality; and is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology.

Qualified interpreters can include, for example, sign language interpreters, oral transliterators (employees who represent or spell in the characters of another alphabet), and cued language transliterators (employees who represent or spell by using a small number of handshapes).

1.464. Qualified Interpreter for a Member with LEP

Is an interpreter who, via a remote interpreting service or an on-site appearance adheres to generally accepted interpreter ethics principles, including Member confidentiality; has demonstrated proficiency in speaking and understanding spoken English and at least one (1) other spoken language; and is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

1.465. Qualified Mental Health Professional (QMHP)

A QMHP is a mental health professional who has a minimum of a Master's Degree in a clinical practice a license as a Registered Nurse, or a license as an Advanced Practice Registered Nurse; and who has a minimum of thirty (30) hours of supervised face-to-face emergency services contact experience as a psychiatric emergency service worker in Rhode Island. Such experience may be gained through employment with a CMHC or a licensed hospital conducting emergency psychiatric assessment for individuals under consideration for

admission to a department designated an inpatient mental health facility. [212-RICR-10-10-01]

1.466. Qualified Translator

A translator who adheres to generally accepted translator ethics principles, including Member confidentiality; has demonstrated proficiency in writing and understanding written English and at least one (1) other written language; and is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology, and phraseology. [45 C.F.R.§§ 92.4 and 92.101]

1.467. Qualifying Alternative Payment Model (APM)

An APM approved by EOHHS as consistent with the standards specified in this Agreement and in any subsequent guidance, including EOHHS' Medicaid APM Strategy.

1.468. Quality

As it pertains to external quality review, means the degree to which a Health Plan increases the likelihood of desired outcomes of its Members through:

1. Its structural and operational characteristics.
2. The provision of services that are consistent with current professional, evidenced-based- knowledge.
3. Interventions for performance improvement. [42 C.F.R. § 438.320]

1.469. Quality Assessment and Performance Improvement (QAPI)

A process designed to address and continuously improve Contractor quality metrics. QAPI activities will provide the Contractor with data which it shall use, in conjunction with input from Members and other stakeholders, to improve the delivery of care and care outcomes. The program shall evaluate all populations, care settings, and types of services, including physical health services, behavioral health services, long-term services and supports services, and pharmacy benefits. The Contractor's QAPI program shall comply with all aspects of State and Federal law, including 42 C.F.R. § 438.330.

1.470. Quality Improvement (QI)

The process for monitoring that the delivery of health care services is available, accessible, timely, and medically necessary. The Contract must have quality improvement program (QI program) that includes standards of excellence. It also must have a written quality improvement plan (QI Plan) that draws on its quality monitoring to improve health care outcomes for Members.

1.471. Quality Improvement Committee

A committee within the Contractor's organizational structure that oversees the QAPI functions. The Contractor's Chief Medical Officer shall chair the Committee.

1.472. Rate Cell

A set of mutually exclusive categories of Members that is defined by one (1) or more characteristics for the purpose of determining the Capitation Rate and making a Capitation Payment; such characteristics may include age, gender, eligibility category, and region or geographic area. [42 C.F.R. § 438.2]

1.473. Rating Period

A period of 12 months selected by EOHHS for which the actuarially sound Capitation Rates are developed and documented in the rate certification submitted to CMS. [42 C.F.R. § 438.2]

1.474. Readily Accessible

Electronic information and services that comply with modern accessibility standards, such as Section 508 guidelines, Section 504 of the Rehabilitation Act, and '3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions. [42 C.F.R. § 438.10(a)]

1.475. Readmission

Subsequent admissions of a patient to a hospital or other health care institution for treatment.

1.476. Recovery

A process of change through which Members improve their health and wellness, live self-directed lives, an strive to reach their full potential. Recovery is built on access to evidence-based clinical treatment and Recovery supports for all populations.

1.477. Referral Services

Healthcare services provided to Enrollees in both Participating Providers and Non-Participating Providers when ordered and approved by the Contractor, including, but not limited to specialty care and out-of-network services that are covered under the State Plan.

1.478. Regulatory Compliance Committee

A committee within the Contractor's Governing Body and at the senior management level that oversees the Contractor and its Subcontractor's compliance program and its compliance with requirements under this Agreement. The Contractor's Compliance Officer shall be responsible for the development and oversight of the Regulatory Compliance Committee.

1.479. Rehabilitative Services

Except as otherwise provided under 42 C.F.R. Part 440, Subpart A, Rehabilitative Services includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under Rhode Island law, for maximum reduction of physical or mental disability and restoration of a Member to his best possible functional level. [42 C.F.R. § 440.130(d)]

1.480. Related Entity

Any party related to the Contractor by common ownership or control, and,

1. Performs some of the Contractor's management functions under Contractor delegation;
2. Furnishes services to Members under a written agreement; or
3. Leases real property or sells materials to the Contractor at a cost during any year of this Agreement.

1.481. Related Groups

Those groups the Contractor shall make coverage available to, although they are outside of the actual program.

1.482. Remittance

A payment that the Contractor may be required to make to the state for failure to meet the minimum Medical Loss Ratio (MLR) standard identified in this Contract. The State must also return to CMS the federal government's share of any Remittance. EOHHS will determine the methodology for calculating and collecting the Remittance.

1.483. Remittance Advice

An electronic listing of transactions for which payment is calculated.

1.484. Reprocessing (Claims)

Upon determination of the need to correct the outcome of one (1) or more claims processing transactions, the subsequent attempt to process a single claim or batch of claims.

1.485. Return Information

Defined under 26 U.S.C. § 6103(b)(2) and has the same meaning as "Federal Tax Information" or "FTI" as used in IRS Publication 1075.

1.486. Rhode Island Medicaid Managed Care Program or Managed Care Program

The Rhode Island managed care program that is the subject matter of this Agreement.

1.487. Rhody Health Partners (RHP)

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

1.488. Risk

The chance or possibility of loss associated with provision of care for a given population.

1.489. Risk Adjustment

A method of determining adjustments to the Capitation Rate that account for variation in health risk when determining payment among participating Contractors under this Agreement.

1.490. Risk Contract

An agreement which the Contractor:

1. Assumes risk for the cost of the services covered under the agreement; and
2. Incurs loss if the cost of furnishing the services exceeds the payments under the contract. [42 C.F.R. § 438.2]

1.491. Risk Corridor

A risk sharing mechanism in which the State and the Contractor may share in profits and losses under the contract outside the threshold amount. [42 C.F.R. § 438.6]

1.492. Risk Stratification Level Framework

The EOHHS-approved Contractor methodology for determining the intensity and frequency of Care Management and population health interventions received by Members in accordance with the requirements of this Agreement.

1.493. RIte Care

The health care delivery program through which the State of Rhode Island serves the RI Works and RI Works-related portions of its Medicaid population, uninsured pregnant individuals, and children under age nineteen (19) living in households that meet specified eligibility criteria, and other specific eligible populations as designated by the State.

1.494. RIte Share

The premium assistance program created and operated under R.I. Gen. Laws § 40-8.4-12 *et. seq.* and the Rhode Island Medicaid State Plan, pursuant to which EOHHS will purchase employer-sponsored health insurance for RIte Care Eligible low- income working individuals and their families who are eligible for employer-sponsored insurance but could not otherwise afford such insurance.

1.495. Routine Care

Treatment of a condition which would have no adverse effects if not treated within twenty-four (24) hours or that could be treated in a less acute setting (e.g., physician's office) or by the patient.

1.496. Routine Primary Care

Routine primary care services including the diagnosis and treatment of conditions to prevent deterioration to a more severe level or minimize/reduce risk of development of chronic illness or the need for more complex treatment. Examples include psoriasis, chronic low back pain; requires a face-to-face visit within four (4) weeks of Enrollee request.

1.497. Rural Health Clinic (RHC)

A clinic located in an area designated by EOHHS as rural, located in a federally designated medically underserved area, or has an insufficient number of physicians, which meets the requirements of 42 C.F.R. Part 491 Subpart A.

1.498. Scope of Work

Services and deliverables specified in this Agreement, including all attachments and documents incorporated by reference into the Agreement, and all amendments thereto.

1.499. Second Opinion

The opinion of a qualified health care professional within the Provider network, or the opinion of a Non-Participating Provider with whom the Contractor has permitted the Member to consult, at no cost to the Member. [42 C.F.R. § 438.206(b)(3)]

1.500. Secretary

In this Agreement, refers to the Secretary of the U.S. Department of Health and Human Services (HHS), unless otherwise noted.

1.501. Secure File Transfer Protocol (SFTP)

Software for transferring data files from one (1) computer to another with added encryption.

1.502. Self-Directed Home and Community Based (HCBS) Employee

An individual who has been hired by a member participating in self-directed HCBS or their employer representative to provide self-directed HCVS to the member in an integrated community setting. Self-Directed employee does not include an employee of a provider that is

being paid by the Contractor provide attendance care, respite, or homemaker services.

1.503. Self-Directed Home and Community Based Services (HCBS)

Services that are provided by self-directed employees to members residing in integrated community settings who have opted to self-direct their HCBS.

1.504. Self-Direction

A participant-controlled method of selecting and providing services and supports that allows the individual maximum control of their home and community-based services and supports, with the individual acting as the employer of record with necessary supports to perform that function, or the individual having a significant and meaningful role in the management of a provider of service when the agency-provider model is utilized. Individuals exercise as much control as desired to select, train, supervise, schedule, determine duties, and dismiss their personal care attendant.

1.505. Sensitive Information (SI)

Information that could be expected to have a serious, severe, or catastrophic adverse effect on organizational operations, organizational assets, or individuals if the confidentiality, integrity, or availability is lost. Further, the loss of Sensitive Information confidentiality, integrity, or availability might:

1. Cause a significant or severe degradation in mission capability to an extent and duration that the organization is unable to perform its primary functions;
2. Result in significant or major damage to organizational assets;
3. Result in significant or major financial loss; or
4. Result in significant, severe, or catastrophic harm to individuals that may involve loss of life or serious life-threatening injuries.

1.506. Service Advisory Agency

An agency certified by EOHHS that assesses service needs, assists with planning what services are needed, how to receive them, performs check-ins and evaluations, and is an additional resource to the participant, representative, and/or family to promote safety and quality of care. The SA guides and supports, rather than directs and manages, the participant through the service planning and delivery process. A portion of the participant's monthly budget is set aside to pay the agency for the services it provides.

1.507. Service Coordinator

An appropriately qualified professional who is responsible for facilitating and coordinating the provision of a Member's LTSS in accordance with their LTSS Person-Centered Service Plan.

1.508. Short-Term Care Management

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

1.509. Sibling

Includes sisters, brothers, half-sisters, half-brothers, adoptive sisters, adoptive brothers, stepsisters, and stepbrothers living in the same household.

1.510. Significant

As utilized in this Agreement, except where specifically defined, shall mean important in effect or meaning.

1.511. Single Pharmacy Benefits Manager (PBM)

The single entity designated by EOHHS to be the third-party administrator of outpatient retail prescription drug programs.

1.512. Skilled Care Services

Services provided by technicians and therapists in a Member's home or in a nursing home.

1.513. Skilled Nursing Care

Services from licensed nurses provided in a Member's home or in a nursing home.

1.514. Social Determinants of Health (SDOH)

The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

1.515. Social Risk Factors

Adverse social conditions (i.e., homelessness, social isolation, low education level, etc.) specific to individuals that increase their likelihood of poor health.

1.516. Software

All custom, open source, laaS, SaaS and/or COTS Software and/or applications provided by the Contractor under this Agreement.

1.517. Solvency

The minimum standard of financial health for the Contractor where assets exceed liabilities and timely payment requirements can be met.

1.518. Span of Control

Information systems (IS) and telecommunications capabilities that the Contractor operates or for which it is otherwise legally responsible according to the terms and conditions with EOHHS. The Span of Control also includes systems and telecommunications capabilities outsourced by the Contractor.

1.519. Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

The Federal program administered by the Rhode Island Department of Human Services (DHS) that provides nutritional counseling; nutritional education; breast-feeding promotion; and nutritious foods to pregnant, postpartum and breast-feeding women and infants and children up to the age of five (5) who are determined to be at nutritional risk and who have a low to moderate income.

1.520. Specialist or Subspecialist

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

1.521. Spread Pricing

Spread pricing is a PBM practice of charging the Contractor more than they pay the pharmacy for a medication and then keeping the difference as profit. It refers to the difference between what the PBM charges a patient or patient's health insurance and what the PBM pays the pharmacy for dispensing the medication. This practice and other practices that are similar to spread pricing by PBMs are prohibited under this Agreement.

1.522. Stabilized

Along with 42 C.F.R. §438.114 (citing 42 C.F.R. §489.24) an "emergency medical condition" means that that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the Transfer of the individual from a facility or an emergency medical condition in the context of child birth that the woman has delivered the child and the placenta.

1.523. Standing Order

Reoccurring appointments, usually on the same day and time, at the same location, and with the same Provider.

1.524. State

The State of Rhode Island, acting by and through EOHHS or its designee.

1.525. State Fair Hearing

The process set forth in 42 C.F.R. Part 431, Subpart E, and further clarified at Title 210, Chapter 10, Subchapter 05, Part 2 of the Rhode Island Code of Regulations (210-RICR-10-05-2), regarding fair hearings for Medicaid applicants and Members. [42 C.F.R. § 438.400(b)]

1.526. State Plan

The agreement between a state and the federal government describing how that state administers its Medicaid and CHIP programs.

1.527. Sterilization

Any medical treatment or procedure that renders an individual permanently incapable of reproducing.

1.528. Store-and-Forward Technology

The technology used to enable the transmission of a patient's medical information from an Originating Site to the Healthcare Provider at the Distant Site without the patient being present [RI Gen. Laws § 27-81-3].

1.529. Stratification

The process of partitioning data into distinct or non-overlapping groups.

1.530. Subcontract

Any separate contract or written agreement between the Contractor and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations that the Contractor is obligated to perform pursuant to this Agreement.

1.531. Subcontractor

An individual or entity that has a contract with the Contractor that relates directly or indirectly

to the performance of the Contractor's obligations under this Agreement. A Subcontractor does not include a Participating Provider. [42 C.F.R. § 438.2]

1.532. Subrogation

Personal injury, liability insurance, automobile/home insurance, or accident indemnity insurance where a third party may be liable.

1.533. Subsidiary

An affiliate that is owned or controlled by the Contractor, either directly or indirectly through one (1) or more intermediaries.

1.534. Substance Use Disorder (SUD)

A condition where the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.

1.535. Substance Use Disorder Benefits

Benefits for items or services for substance use disorders, as defined by EOHHS and in accordance with applicable Federal and State law. For purposes of this Agreement, substance use disorder benefits include the long-term care services described in Attachment F-1, Section 3.4, "Behavioral Health." [42 C.F.R. § 438.900]

1.536. Substantial Contractual Relationship

Any direct or indirect business transaction that amount within a twelve (12) month period to more than twenty-five thousand dollars ($25,000) or five percent (5%) of the Contractor's total operating expenses, whichever is less.

1.537. Supplemental Security Income (SSI)

A federal income supplement program funded by general tax revenues (not Social Security taxes) designed to help aged, blind, and disabled people with little or no income by providing cash to meet basic needs for food, clothing, and shelter, in accordance with 42 U.S.C. § 1383c.

1.538. Suspension

Items or services furnished by a specified provider who has been convicted of a program-related offense in a federal, state, or local court that will not be reimbursed under Medicaid.

1.539. System Function Response Time

Based on the specific subfunctions being performed with the Contractor's IS that include the minimum following elements:

1. Record Search Time: The time elapsed after the search command is entered until the list of matching records beings to appear on the monitor.
2. Record Retrieval Time: The time elapsed after the retrieve command is entered until he record data begin to appear on the monitor.
3. Print Initiation Time: The elapsed time from the command to print a screen or report until it appears in the appropriate queue.
4. On-Line Claims Adjudication Response Time: The elapsed time from the receipt of the transaction by the Contractor from the Provider and/or switch vendor until the Contract

hands-off a response to the provider and/or switch vendor.

1.540. System Unavailability

Within the Contractor's IS Span of Control. A system is considered not available when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the "enter" or other function key.

1.541. Targeted Case Management

Services for targeted population groups and certain 1115 waiver populations in accordance with applicable Federal and State laws, regulations, rules, policies, procedures, manuals, and State Plan.

1.542. Telecommunication Relay Service (TRS)

A telephone transmission services that provides the ability for an individual who is deaf, hard of hearing, deaf-blind, or who has a speech disability to engage in communication by wire or radio with one (1) or more individuals, in a manner that is functionally equivalent to the ability of a hearing individual who does not have a speech disability to communicate using voice communication services by wire or radio. [47 C.F.R. § 64.601(a)(43)]

1.543. Telehealth

As defined by the Health Resources Services Administration (HRSA) the use of electronic information and telecommunications technologies to support remote clinical health care, patient and professional health-related education, public health and health administration.

1.544. Telemedicine

The delivery of clinical Healthcare Services by use of real time, two-way (2) synchronous audio, video, telephone-audio-only communications or electronic media or other telecommunications technology including, but not limited to: online adaptive interviews, remote patient monitoring devices, audiovisual communications, including the application of secure video conferencing and store-and-forward technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, counseling and prescribing treatment, and care management of a patient's health care while such patient is at an Originating Site and the Healthcare Provider is at a Distant Site, consistent with applicable federal laws and regulations. "Telemedicine" does not include an email message or facsimile transmission between a Provider and patient, or an automated computer program used to diagnose and/or treat ocular or refractive conditions [RI Gen. Laws § 27-81-3].

1.545. Tenancy Supports

Consists of activities such as helping Enrollees complete apartment applications, seek reasonable accommodations, negotiate and enter into leases, understand the role of a tenant, understand tenant rights, develop budgets, make Timely rent payments, comply with terms of lease, adjust to new home and neighborhood (including how to get to and access essential services), apply for income benefits such as SSI, comply with medication and other treatment regimes, and develop/implement crisis plans to avoid eviction.

1.546. Term

The duration of this Agreement.

1.547. Tertiary Care

Highly specialized medical care, usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities.

1.548. Third Party Liability (TPL)

The legal obligation of third parties, i.e., certain individuals, entities or programs, to pay all or part of the expenditures for medical assistance furnished under the State Plan. [42 C.F.R. § 433.136]

1.549. Timely

Existing or taking place within the designated time period; within the time required by statue, or rules or regulations, contract terms, or policy requirements.

1.550. Tip

A piece of information regarding an act of Fraud, Waste or Abuse or other activity of interest to the EOHHS Office of Program Integrity. A tip, by itself, generally does not provide sufficient information to establish that Fraud, Waste or Abuse has occurred, but it might provide investigators with a direction to pursue in an investigation.

1.551. Total Cost of Care (TCOC)

An alternative payment methodology that includes a historical baseline cost of care projected forward to the end of a performance period. Actual costs during the performance period are then compared to the baseline to identify a potential shared savings or risk pool. The methodology for calculating the Total Cost of Care for the Accountable Entity Program is set forth in the Accountable Entity Total Cost of Care Requirements and Total Cost of Care Technical Guidance.

1.552. Transfer

Transfer means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who has been declared dead, or (ii) leaves the facility without the permission of any such person. [42 CFR § 489.24]

1.553. Transition Phase

Includes all activities the Contractor is required to perform between the date the Agreement is signed by all parties and the Operational Start Date.

1.554. Transitional Case Management

The responsibility of the Contractor to manage Covered Services care transitions for all Members moving from one clinical setting to another or form a clinical setting to home, to prevent unplanned or unnecessary ED visits or adverse health outcomes. The MCO shall maintain and operate a formalized hospital and/or institutional discharge planning program that includes effective post-discharge Transitional Case Management, including appropriate discharge planning for short-term and long-term hospital and institutional stays. [42 C.F.R. § 438.208(b)(2)(i)]

1.555. Transitional Health Care

Care that is available from a primary or specialty provider for clinical assessments and care planning within two (2) Business Days of discharge from inpatient or institutional care for physical and behavioral health disorders or discharge from a SUD treatment program.

1.556. Transitional Home Care

Care that is available with a home care nurse, a licensed counselor, and/or therapists (physical therapist or occupational therapist) within two (2) calendar days of discharge from inpatient or in care for institutional care for physical and behavioral health disorders or as part of the discharge plan.

1.557. Trauma Informed Care

A program, organization, or system that realizes the widespread impact of trauma and understand potential paths for Recovery; recognizes the signs and symptoms of trauma in Members, families, staff, and others involved within the system; responds by full integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resists re-traumatization.

1.558. Travel Time

The time spent by member from that member's pick-up to their destination including stops, delays, to their covered service location.

1.559. Trip

Transportation one-way from the pick-up point to the drop off point by a TP.

1.560. Treatment Limitations

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

1.561. TTY/TDD

Telephone Typewriter and Telecommunication Device for the Deaf, which allow for interpreter capability for deaf or hard of hearing callers.

1.562. Turnover Phase

All activities the Contractor is required to perform in conjunction with the end of the Contract.

1.563. Turnover Plan

The written plan developed the Contractor, approved by EOHHS, to be employed during the turnover phase.

1.564. Uninsured

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

1.565. Urgent Care

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

1.566. Urgent Medical Condition

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

a) Placing the patients health in serious jeopardy;

b) Serious impairment to bodily function; or

c) Serious dysfunction of any bodily organ or part.

1.567. Utilization

The rate patterns of service usage or types of service occurring within a specified time.

1.568. Utilization Management (UM)

The process to evaluate the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. UM is inclusive of Utilization Review and service authorizations.

1.569. Utilization Review (UR)

The evaluation of the clinical necessity, appropriateness, efficacy, or the efficiency of core health care benefits and services, procedures or settings, and ambulatory review, prospective review, and concurrent review, second opinions, care management, discharge planning, or retrospective review.

1.570. Validation

The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis. [42 C.F.R. § 438.320]

1.571. Value-Added Services (VAS) or Value-Added Benefits

Additional services the Contractor offers to Members beyond the Covered Services specified in Attachment F-3.1, "Schedule of In-Plan Benefits." Value-Added Services must be approved by EOHHS, and may be actual Health Care Services, benefits, or positive incentives that EOHHS determines will promote healthy lifestyles, address social determinants of health, or improve health outcomes among Members.

1.572. Value-Based Payment (VBP)

The broad set of performance-based payment strategies that link financial incentives to providers' performance on a set of defined measures of quality and/or cost or resource use.

1.573. Vendor

The meaning assigned in the General Conditions of Purchase. The term is used interchangeably with "Contractor" and "Health Plan."

1.574. Waste

The inappropriate utilization of services or misuse of resources. Waste is not a criminal or intentional act but results in unnecessary expenditures to the Medicaid program that might be prevented.

1.575. Week

The entire seven (7) day week, Monday through Sunday.

1.576. Wellness Visit

A PCP visit the includes health risk and social determinants of health needs assessments, evaluation of the Member's physical and behavioral, including screening for depression, mood disorders, suicidality, and substance use disorder.

1.577. Withhold or Withhold Arrangement

Any payment mechanism under which a portion of a Capitation Rate is withheld from a Health Plan and a portion of, or all of the withheld amounts will be paid to the Health Plan for meeting targets specified in the contract. The targets for a withhold arrangement are distinct from general operational requirements under the contract. Arrangements that withhold a portion of a Capitation Rate for noncompliance with general operational requirements are liquidated damages and not a withhold arrangement. [42 C.F.R. § 438.6(a)]

1.578. Work Plan

Documentation that details the activities for Readiness Activities created in accordance with this Agreement. The Work Plan must include a delineation of tasks, activities and events to be performed and Deliverables to be produced under the Readiness Activities, inclusive of Schedule tasks/activities, Deliverables, critical events, task dependencies, and the resources that would lead and/or participate on each task.

2. Acronyms

2.1. **AE –** Accountable Entity

2.2. **ACA –** Affordable Care Act

2.3. **ACE –** Adverse Childhood Experience

2.4. **ACM –** Active Contract Management

2.5. **ADL –** Activities of Daily Living

2.6. **ADRC –** Aging and Disability Resource Center

2.7. **AEIP –** Accountable Entity Incentive Pool

2.8. **APM –** Alternative Payment Method

2.9. **BAA –** Business Associate Agreement

2.10. **BHDDH –** Department of Behavioral Healthcare, Developmental Disabilities & Hospitals

2.11. **CAHPS –** Consumer Assessment of Healthcare Providers and Systems

2.12. **CAP –** Corrective Action Plan

2.13. **CCBHC –** Certified Community Behavioral Health Clinic

2.14. **CCBHC DCO –** Certified Community Behavioral Health Clinic Designated Collaborative Organization

2.15. **CCM –** Complex Case Management

2.16. **CFCM –** Conflict Free Case Management

2.17. **CFR –** Code of Federal Regulations

2.18. **CHIP –** Children's Health Insurance Program

2.19. **CHW –** Community Health Worker

2.20. **CM –** Care Management

2.21. **CME –** Conflict Free Case Management Entities

2.22. **CMS –** Centers for Medicare and Medicaid Services

2.23. **CPT –** Current Procedural Terminology

2.24. **CTC-RI –** Care Transformation Collaborative Rhode Island

2.25. **DME –** Durable Medical Equipment

2.26. **DOA –** Department of Administration

2.27. **D-SNP –** Dual Eligible Special Needs Plan

2.28. **ECP –** Essential Community Provider

2.29. **EOHHS –** Executive Office of Health and Human Services

2.30. **EPSDT –** Early and Periodic Screening, Diagnostic, and Treatment

2.31. **EQRO –** External Quality Review Organization

2.32. EVV – Electronic Visit Verification

2.33. FBDE – Full Benefit Dual Eligible

2.34. FFS – Fee For Service

2.35. FIDE SNP – Fully Integrated Dual Eligible Special Needs Plan

2.36. FQHC – Federally Qualified Health Centers

2.37. HAC – Healthcare Acquired Conditions

2.38. HCBS– Home and Community- Based Services

2.39. HIPAA – Health Insurance Portability and Accountability Act of 1996

2.40. HITECH – Health Information Technology for Economic and Clinical Health

2.41. HIV/AIDS – Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome

2.42. HMO – Health Maintenance Organization

2.43. IBNR – Incurred But Not Reported

2.44. ICF/IID – Intermediate Care Facility for Intellectual or Developmental Disabilities

2.45. IHCP – Indian Health Care Provider

2.46. ILOS – In Lieu of Services

2.47. IMD – Institution for Mental Diseases

2.48. LEP – Limited English Proficiency

2.49. LOC – Level of Care

2.50. LTSS – Long- Term Services and Supports

2.51. MCM – Managed Care Manual

2.52. MCO – Managed Care Organization or Health Plan

2.53. MHPAEA – Mental Health Parity and Addiction Equity Act

2.54. MIIP – Medicaid Infrastructure Incentive Program

2.55. MLR – Medical Loss Ratio

2.56. MLTSS – Managed Long-Term Services and Supports

2.57. MMIS – Medicaid Management Information System

2.58. NCQA – National Committee for Quality Assurance

2.59. NEMT – Non-Emergency Medical Transportation

2.60. NHTP – Nursing Home Transition Program

2.61. NWIC – National Wraparound Implementation Center

2.62. OB/GYN – Obstetrician and Gynecologist

2.63. OHIC – Office of the Health Insurance Commissioner

2.64. OIG – Office of Inspector General

2.65. PCMH – Patient-Centered Medical Home

2.66. PCP – Primary Care Provider

2.67. PHI – Protected Health Information

2.68. PII – Personally Identifiable Information

2.69. PIP – Performance Improvement Project

2.70. PMPM – Per Member Per Month

2.71. PASRR – Pre-Admission Screening and Resident Review

2.72. QMHP – Qualified Mental Health Professional

2.73. RHC – Rural Health Centers

2.74. RHP – Rhody Health Partners

2.75. RI – Rhode Island

2.76. SAMHSA – Substance Abuse and Mental Health Services

2.77. SDOH – Social Determinants of Health

2.78. SI – Sensitive Information

2.79. SSI – Supplemental Security Income

2.80. SSN – Social Security Number

2.81. TCOC – Total Cost of Care

2.82. TPL – Third-Party Liability

2.83. TRS – Telecommunication Relay Services

2.84. USC – United States Code

2.85. VAS – Value-Added Services

2.86. WIC – Women, Infant, and Children

ATTACHMENT F-2

EOHHS General Terms and Conditions

Table of Contents

Article 1. General Provisions

1.1. Purpose and Scope

1.1.1. This Agreement sets forth the terms and conditions governing the Contractor's participation in the Rhode Island Medicaid Managed Care Program.

1.1.2. Under the terms and conditions of this Agreement, the Contractor shall provide comprehensive health care services through a managed care delivery system across the State of Rhode Island, strictly adhering to the requirements and guidelines outlined in 42 C.F.R. 438 Managed Care.

1.1.3. This Agreement is a comprehensive prepaid capitated Agreement pursuant to 42 C.F.R. § 438.806(a). The Contractor acknowledges and accepts that The Rhode Island Executive Office of Health and Human Services (EOHHS) intends to transition to a full-risk contract model during the second (2nd) base year of this Agreement.

1.1.3.1. The Contractor agrees to make all necessary adjustments under the direction and guidance of EOHHS to facilitate this transition, including but not limited to, required income-based risk capital requirements for full-risk contracts under the purview of the Rhode Island Office of the Health Insurance Commissioners' (OHIC) as required in R.I. Gen. Laws § 27-4.6-2.

1.1.4. Modifications to the terms and conditions of this Agreement may be necessitated by changes in applicable Federal and State Laws and Regulations and as determined by EOHHS.

1.1.5. The Rhode Island Medicaid Managed Care Program places an emphasis on delivering quality services to Medicaid beneficiaries throughout the term of this Agreement. The Contractor's performance will be evaluated against program and contract requirements, including performance standards and potential remedies for non-compliance.

1.1.6. The Contractor is required to comply with:

1.1.6.1. The terms and conditions contained in this Agreement;

1.1.6.2. All applicable State and Federal Laws, Rules, Regulations, Policies, Procedures, the State Plan, and Waivers related to the Rhode Island Medicaid Managed Care Program; and,

1.1.6.3. The Managed Care Manual (MCM).

1.1.7. EOHHS reserves the right to provide written explanations for non-material changes in Contract requirements at any time during the term of this Agreement to ensure the efficient administration of the Rhode Island Medicaid Managed Care Program. The Contractor shall implement these clarifications timely without necessitating an amendment to this Agreement.

1.1.8. EOHHS may notify the Contractor of changes in Rhode Island Medicaid Program policies and procedures that could impact this Agreement. Unless otherwise specified in the correspondence or within this Agreement, the Contractor shall have a period of thirty (30) Days to implement the stated changes.

1.2. General Responsibilities of the Contractor's Under this Agreement

1.2.1. The Contractor shall provide comprehensive health care services to all Members enrolled in the Rhode Island Medicaid Managed Care Program and assigned to the Contractor's care.

1.2.2. The Contractor shall assume responsibility for the administration and management of all program requirements, adhering to all service delivery timelines, milestones, duties, and obligations specified in this Agreement. This includes compliance with relevant laws or regulations, whether explicitly included herein, in the Rhode Island State Plan Amendment, or Rhode Island's 1115 Waiver Demonstration.

1.2.3. Pursuant to 42 C.F.R. § 438.608, the Contractor shall be responsible for remunerating services rendered through Service Agreements with Providers.

1.2.4. The Contractor shall enforce the requirement for Providers to possess all necessary licensure, certification, permits, and credentials mandated by law, regulation, or guidance for activities under this Agreement, including but not limited to those specified in:

1.2.4.1. Federal regulations under 42 C.F.R. § 438.206 which require Providers to meet specific qualifications and standards as a Medicaid Provider;

1.2.4.2. Applicable State regulations and laws governing Provider licensure, certification, and credentialing, including R.I. Gen. Laws § 27-18.4;

1.2.4.3. Any other relevant regulations or requirements as determined by the EOHHS or the Centers for Medicare & Medicaid Services (CMS).

1.2.5. The Contractor shall develop and maintain an adequate Provider Network, and shall credential and contract all Participating Providers in compliance with the following:

1.2.5.1. The 21st Century Cures Act (PL 114-255);

1.2.5.2. The terms and requirements outlined in this Agreement, including but not limited to the obligations set forth in Addendum F-3, Article 18, "Provider Network and Requirements, Access to Care", of this Agreement; and,

1.2.5.3. Guidelines and procedures specified in the Managed Care Manual (MCM) issued by EOHHS.

1.2.6. The Contractor shall secure or arrange for the necessary personnel, facilities, equipment, supplies, and other resources required for, or incidental to, the delivery of services and execution of requirements within this Agreement.

1.2.7. The Contractor's contracted payments to Providers shall be sufficient to support the efficiency, economy, and quality of care, ensuring adequate and active participation of Providers and uninterrupted member access to covered services throughout the term of this Agreement, as required by Federal law [42 C.F.R. § 438.206(c)].

1.2.7.1. Resources shall align with Network Adequacy Standards pursuant to Attachment F-3, Section 18.31, "Network Adequacy and Access to Care", in accordance with federal regulations [42 C.F.R. § 438.68].

1.2.7.2. The Contractor shall ensure that medically necessary services are available twenty-four (24) hours per day, seven (7) days per week, three hundred and

sixty-five (365) days a year, for all Members enrolled in the Contractor's Health Plan [42 C.F.R. § 438.206(b)].

1.2.8. The Contractor shall implement processes to prevent, identify, and address fraud, waste, and abuse in the Rhode Island Medicaid Managed Care Program, in accordance with federal regulations [42 C.F.R. § 438.608].

1.2.8.1. Any suspected Member or Provider fraud, waste, and abuse shall be promptly reported to EOHHS within the specified timeframes contained in this Agreement, as required by federal regulations [42 C.F.R. § 455.21].

1.2.8.2. The Contractor shall adhere strictly to all Federal, State Laws and Regulations pertinent to mitigating fraud, waste, and abuse under this Agreement, including Rhode Island Rules for Managed Care under R.I. Gen. Laws § 40-8.13-1.

1.2.9. The Contractor shall not deny services to any covered services to a Member based on moral or religious objections unless previously approved by EOHHS. The Contractor has explicitly affirmed denial of covered service provision in Contractor's assurances in the Solicitation process. [42 C.F.R. § 438.10]

1.3. General Responsibilities of the Rhode Island Executive Office of Health and Human Services' Under this Agreement

1.3.1. EOHHS is obligated, in accordance with Federal Medicaid managed care regulations, to conduct coordinated oversight and monitoring of the Contractor to ensure adherence to program standards and contract performance requirements. This includes, but is not limited to, EOHHS' assessments of the Contractor's compliance with performance standards, liquidated damages, and quality assurance standards established under this Agreement. EOHHS shall retain the sole authority to oversee the Contractor and assess the Contractor's performance. EOHHS shall take all enforcement actions allowable under this Agreement and federal rules and regulations.

1.3.2. EOHHS commits to procure services outlined explicitly in this Agreement, and the Contractor is legally bound to fulfill all duties and obligations for the delivery and coordination of these services.

1.3.3. EOHHS shall exert rigorous oversight and monitoring of all the Contractor's duties and responsibilities stipulated herein to ensure full compliance with all Contractor requirements. The Contractor shall not object to EOHHS' discovery, review and enforcement of EOHHS' oversight duties and responsibilities as the SSA for the Rhode Island Medicaid Managed Care Program.

1.3.4. The Contractor unequivocally agrees to comply with all requests associated with EOHHS' oversight duties and responsibilities under this Agreement. Failure to comply may result in consequences as stipulated in the Agreement, which EOHHS may unilaterally implement against the Contractor.

1.4. Term of the Agreement

1.4.1. This Agreement will commence on the day both Parties sign it (the "Effective Date") and will end on June 30, 2030 (the "Expiration Date"), unless extended or renewed for up to five (5) additional one-year (1) periods, ending on June 30, 2035, through mutual

agreement and negotiation in good faith.

1.4.2. Agreement extensions beyond the Expiration Date are subject to negotiation.

1.4.3. The Operational Go-Live Date of this Agreement shall occur in three (3) distinct phases:

1.4.3.1. Phase I: Enrollment of core populations and bringing LTSS services in-plan for Medicaid Managed Care Plans for Medicaid only beneficiaries on July 1, 2025.

1.4.3.2. Phase II: Enrollment of current fully dual eligible (FDBE) members into Medicaid Managed Care Plans on January 1, 2026.

1.4.3.3. Phase III: Begin implementation of default enrollment for new dual eligible Members who become newly eligible for Medicare on January 1, 2027, or another date later established by EOHHS.

1.4.4. EOHHS retains the sole and unequivocal authority and discretion to alter or postpone the Operational Go-Live Date in this Agreement.

1.4.4.1. If the Contractor does not meet the Readiness Review Requirements to EOHHS' and CMS' satisfaction, EOHHS shall delay the Contractor's Go-Live Date and cease member enrollment into the Contractor's Health Plan as described in Attachment F-3, Article 30 "Contract Transition and Readiness Review".

1.4.4.2. Should EOHHS decide that any Contractor is unprepared or unable to begin providing services on the Operational Go-Live Date, EOHHS reserves the right to withhold enrollment, impose corrective, or terminate the Agreement immediately, with no additional obligation or liability to the Contractor [42 CFR § 438.56].

1.4.5. The Contractor bears the exclusive responsibility for all costs and risks associated with the Readiness Review Requirements. The Contractor is required to provide sufficient capital to cover start-up costs related to the implementation of this Agreement.

1.4.5.1. EOHHS will not provide any start-up funding to assist the Contractor in initiating operations in Rhode Island, including, but not limited to, securing a business location in Rhode Island, sufficient staffing or other capital or logistical resources necessary for a successful implementation.

1.4.6. The obligations under this Agreement, including any purchase orders issued by Rhode Island Division of Purchasing (RIDOP), depend on sufficient appropriations by the Federal government, the Rhode Island General Assembly, or another governing body. EOHHS expressly reserves the right to terminate its obligations under this Agreement if sufficient funding is not provided by the State legislature or another appropriating governing body. The Contractor shall accept without dispute EOHHS' final and binding decision regarding the adequacy of appropriations.

1.4.7. The Contractor shall have certain obligations that survive Contract termination or expiration. The Contractor shall be obligated to fulfill certain responsibilities that extend beyond the expiration of the Agreement, including but not limited to, records retention, payment of debts owed to Providers or subcontractors, and continuity of care services for formerly enrolled Members within the specified timeframes of this

Agreement.

1.5. Eligibility and Minimum Qualifications of the Contractor

1.5.1. By accepting the terms of the Solicitation and the General Conditions of Purchase, the Contractor assured EOHHS that it met the following eligibility requirements to enter into this Agreement:

1.5.1.1. The Contractor assured EOHHS that it is a private organization, defined as non-state entities that are either nonprofit, proprietary corporations, or partnerships that have a Rhode Island location or a proposed Rhode Island location for its central business operations established within three (3) months of this Agreement and is within a twenty-five (25) mile radius from the Virks Building, 3 West Road, Cranston, Rhode Island, were eligible to submit proposals in response to the Solicitation.

1.5.1.2. Individuals who are not duly formed business entities were ineligible to participate in the Solicitation.

1.5.2. By accepting the terms of the Solicitation and the General Conditions of Purchase, the Contractor assured EOHHS that it met the following minimum qualifications to enter into this Agreement:

1.5.2.1. The Contractor meets the federal definition of a managed care organization (MCO), as defined in 42 C.F.R. § 438.2;

1.5.2.2. The Contractor had a minimum of three (3) consecutive years of experience managing an array of medical, behavioral or long-terms services and supports (LTSS) health services covered by Medicaid and/or Medicare, serving a minimum combined total of fifty thousand (50,000) Medicaid, Medicare, or Medicaid-like covered lives in one (1) or more U.S. states or territories;

1.5.2.3. The Contractor is not an excluded individual or entity as described in 42 C.F.R. § 438.808(b);

1.5.2.4. The Contractor agrees and has the capacity and willingness to perform all functions outlined in the Solicitation, including the terms stipulated in the Model Contract, consistent with Federal Medicaid managed care requirements [42 C.F.R. § 438.206];

1.5.2.5. The Contractor's principal place of business is located within the United States;

1.5.2.6. The Contractor is accredited by a nationally recognized agency such as the National Committee for Quality Assurance (NCQA) and/or the Utilization Review Accreditation Commission (URAC), as defined in federal regulations [42 C.F.R. § 438.224]; and,

1.5.2.7. The Contractor, its corporate parent, or subsidiary of its corporate parent performing managed care services in another state has not been sanctioned, as defined in 42. C.F.R. § 438.702, by a state or Federal government within the last ten (10) years.

1.6. Preconditions and Inducements to Program Rules and Requirements

1.6.1. The Contractor, by accepting the terms of the Solicitation and the General Conditions of Purchase, affirms the following inducements and commitments, which were contingent on the awarding of this Agreement:

1.6.1.1. The Contractor possesses a thorough understanding of the Rhode Island Medicaid Managed Care Program and the Rhode Island healthcare environment, consistent with the requirements under 42 C.F.R. § 438.604;

1.6.1.2. The Contractor reviewed and comprehended the solicitation objectives and affirms its capability to perform in accordance with the Agreement terms and conditions, including meeting and exceeding EOHHS' performance standards and/or performance metrics;

1.6.1.3. The Contractor acknowledged and understood the risks involved in the EOHHS managed care program, as described in the Solicitation, including the risk of non-appropriation of funds;

1.6.1.4. The Contractor assured EOHHS that it has met all the Minimum Contractor Qualifications to enter into this agreement as described in Addendum F-2, Section 1.5, "Eligibility and Minimum Qualifications of the Contractor";

1.6.1.5. The Contractor is committed to the principle of equal service provision under this Agreement. The Contractor shall not engage in any form of selective service provision for any eligible population under this Agreement, commonly referred to as 'cherry-picking';

1.6.1.6. The Contractor read, understood, and accepted the conditions and limitations of the "Model Contract," and the "Draft Medicaid Managed Care Manual";

1.6.1.7. The Contractor, in compliance with 42 C.F.R. § 438.230(b)(2), disclosed any proposed major subcontractor(s) (Excluding health care providers) arrangements in the Proposal. This disclosure includes the nature of the services to be provided by the major subcontractor, the terms of the agreement, and any other relevant information as required by federal and state laws and regulations. The Contractor understands that it is responsible for ensuring that any subcontractors comply with all applicable Medicaid Managed Care regulations, including but not limited to, those pertaining to disclosure requirements, quality of care, and beneficiary protections;

1.6.1.8. The Contractor attested to the accuracy and truthfulness of all information contained in the Bidder's responses to the Solicitation;

1.6.1.9. The Contractor accepted the State's Fiscal and Performance Requirements as set forth in Addendum F-3, Scope of Work, and the actuarial rate development and rate-setting process outlined in "Managed Care Organization Request for Proposal: Financial Bidder Packet," found in Appendix D of the Solicitation;

1.6.1.10. The Contractor agreed to operate as a licensed Health Maintenance Organization (HMO), regulated by the Rhode Island Department of Business Regulation (DBR), or will secure such licensure or approval

within sixty (60) days post-execution of this Agreement;

1.6.1.11. The Contractor assured EOHHS that it is in good standing with and has not been debarred from participation in any Federal or Federal/State health care programs, including Medicare, CHIP, or any other state or territory's Medicaid program, in accordance with the provisions of 2 C.F.R. Part 376 pertaining to nonprocurement debarment and suspension, and 42 C.F.R. § 438.610 pertaining to prohibited affiliations;

1.6.1.12. The Contractor attested to or will obtain NCQA distinction in Multicultural Health Care and LTSS Distinction for Rhode Island Medicaid within twenty-four (24) months of execution of the award under this Solicitation;

1.6.1.13. The Contractor agreed to enter into a Medicare Advantage agreement with the Centers for Medicaid and Medicaid Services (CMS) to provide a Medicare Advantage Prescription Drug (MAPD) Plan under Title XVIII and XIX of the Social Security Act, including Medicare Advantage Special Needs Plan (SNP) that arranges for the provision of Medicare services for individuals who are dually eligible. The Contractor shall execute a statewide Medicaid managed care plan agreement to be eligible to obtain State authorization to operate a FIDE-SNP. The Contractor shall maintain this contract with CMS during the term of this Agreement;

1.6.1.14. The Contractor assured EOHHS that the Contractor and its Subcontractors possess the requisite skills, qualifications, financial capability, and experience to deliver the services outlined in the Solicitation, the Contractor's Proposal, and this Agreement in a cost-effective, efficient, and high-quality manner, consistent with federal requirements;

1.6.1.15. The Contractor understood the Solicitation and has not raised objections to the terms and conditions set forth in Appendix G, Model Contract, or has promptly raised any concerns to EOHHS prior to contract execution in its Letter of Transmittal during the Solicitation process. Such requests were taken into consideration by EOHHS during award contract negotiations; however, the Contractor cannot dispute any material changes requested as they were presented to all interested Bidders during the solicitation process. Contract modifications during contract negotiations are at the sole discretion and authority of EOHHS to make a final determination and subject to the terms and conditions as described in Article 3, "Amendments and Modifications";

1.6.1.16. The Contractor attested to abide by Affirmative Action Policies and Procedures and that the Contractor shall not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, sexual orientation, political affiliation, national origin, or handicap and complies with the Americans with Disabilities Act;

1.6.1.17. The Contractor attested that it has no moral or religious objections to providing any of the Covered Benefits described in this Agreement, including any new covered services added to this Agreement;

1.6.1.18. The Contractor attested that it did not participate in any part of the

Solicitation development process and had no knowledge of the specific contents of the Solicitation prior to its issuance. The Contractor further represents and warrants that no agent, representative, or employee of the State of Rhode Island participated directly in the preparation of the Contractor's proposal. The Bidder also represents and warrants that the submitted proposal is in all respects fair and is made without collusion or fraud;

1.6.1.19. The Contractor attested that no elected or appointed official or employee of the State of Rhode Island has or will benefit financially or materially from this Agreement. EOHHS may terminate a resulting contract if it is determined that gratuities of any kind were either offered or received by any of the aforementioned officials or employees from the Contractor or its agents or employees;

1.6.1.20. The Contractor assured EOHHS that the submitted proposal was not made in connection with any competing organization or competitor submitted a separate proposal in response to the Solicitation. No attempt was made by the Contractor to induce any organization or competitor to submit, or not submit, a proposal for the purposes of restricting competition;

1.6.1.21. The Contractor agrees to obtain prior written consent and approval from RIDOP and EOHHS related to award announcements for this Agreement, including any publicity related to the subsequent award or contract renewals for option years;

1.6.1.22. The Contractor agrees to become a Qualified Health Plan (QHP) on Rhode Island's Health Insurance Exchange, through Health Source Rhode Island (HSRI), within two (2) years of the operational start date of an awarded Contract, unless otherwise agreed to and approved by EOHHS;

1.6.1.23. The Contractor affirms to EOHHS that its operations are not based outside of the United States that it will not include any claims paid to any Provider located outside of the United States in its encounter data reporting to EOHHS, or to EOHHS' fiscal intermediary or Actuary [42 C.F.R. § 438.602(i)].

1.7. Time of the Essence

1.7.1. In consideration of the need to ensure uninterrupted and continuous services under the Rhode Island Medicaid Managed Care Program, time is of the essence in the performance of the Contractor's obligations under the Agreement.

Article 2. Governing Laws and Regulations

2.1. Agreement Interpretation Overview

2.1.1. The introductory sections of the Agreement merely provide a general framework and do not extend or restrict the Parties' duties beyond the specific terms and conditions elucidated within the entire Agreement.

2.1.2. References to the "State" within the Agreement pertain to the State of Rhode Island, unless explicitly stated otherwise. Such references should be construed, when suitable, to denote or encompass EOHHS and other Rhode Island state agencies involved in administering the Rhode Island Medicaid Managed Care Program. However, the interpretation of any provision of this Agreement should not incorporate any entity other than EOHHS as the contracting agency or the Single-State Authority (SSA) for the Medicaid Program.

2.1.3. Regardless of the cause, termination, or expiration of this Agreement, shall not absolve either Party from any liabilities or obligations established in this Agreement that:

2.1.3.1. Are explicitly agreed upon by the Parties to continue post-termination or expiration; or,

2.1.3.2. Originated before the effective date of the termination and are yet to be executed, or by their inherent nature, would be expected to be applicable after termination or expiration of the Agreement.

2.2. Agreement Order Precedence Hierarchy

2.2.1. The terms of the General Conditions of Purchase and Addendum A through F shall apply to this Agreement. In the event of a conflict between the items stated in 220-RICR-30-00- 13.4(B)(3) (State Procurement Regulations, General Conditions of Purchase, and the GC Addendums), the following hierarchy of precedence, ranked from highest to lowest, will prevail:

2.2.1.1. GC Addendum F, Attachments F-1 through F-9;

2.2.1.2. The General Conditions of Purchase;

2.2.1.3. GC Addenda A, B, and D; and,

2.2.1.4. GC Addendum F, Attachment F-8, "Contractor's Proposal", except if the proposal encompasses services or performance levels surpassing the requirements stated in the above-referenced documents. Under these circumstances, the Contractor's Proposal shall hold precedence.

2.2.2. If a discrepancy or contradiction appears between GC Addendum F, "EOHHS Special Requirements," Attachments F-1 to F-9, the EOHHS Managed Care Manual, the Solicitation, and the Contractor's Proposal, the following hierarchy of precedence, listed from highest to lowest, shall be applied:

2.2.2.1. GC Addendum F, Attachments F-1 thorough F-6, and all amendments thereto. EOHHS Managed Care Manual, and all amendments thereto.

2.2.2.2. Attachment F-7, EOHHS Request for Proposals.

2.2.2.3. Attachment F-8, "Contractor's Proposal", except if the Contractor's Proposal contains services or performance levels that exceed the

requirements of the other Agreement attachments. In these circumstances, the Contractor's Proposal shall take precedence.

2.2.3. In addition to the documents identified in Section 13.4 of the General Conditions of Purchase, "Entire Agreement," the EOHHS Managed Care Manual (MCM) is incorporated by reference into this Agreement. The EOHHS Managed Care Manual is published on the agency's website.

2.3. State Purchasing Laws

2.3.1. The terms and conditions of this Agreement are governed and construed in accordance with the State's Purchasing Law (R.I. Gen. Laws § 37-2), the Rhode Island Department of Administration, Division of Purchases, State Procurements Regulations (220-RICR-30), and General Conditions of Purchase [220-RICR-30-00-13].

2.3.2. This Agreement is also subject to any relevant Federal laws, regulations, and procedures regarding the application of federal funds.

2.4. References and Compliance to Laws, Rules, or Regulations

2.4.1. All references in this Agreement to any law, rule, or regulation shall be deemed to refer to the law, rule, or regulation in effect at the time of the issuance of this Agreement or as they may be hereafter amended.

2.4.2. Throughout the term of this Agreement, including any extension(s), the Contractor shall comply with the laws, rules, and regulation in effect at that time.

2.4.3. In accordance with Section 13.24 of the General Conditions of Purchase, "Compliance with Law," the Contractor, its Subcontractors, and other Representatives shall comply, to the satisfaction of EOHHS, with all provisions set forth in this Agreement, all provisions of State and Federal Laws, Rules, Regulations, Codes, Federal Waivers, and Policies, and any Court Orders that govern the performance of the Scope of Work (collectively "Governing Requirements") including all applicable provisions of the following:

2.4.3.1. Constitutional provisions regarding due process and equal protection.

2.4.3.2. Code of Federal Regulations C.F.R., Title 42, Chapter IV, Subchapter C (Medical Assistance Programs) [42 C.F.R. § 430].

2.4.3.3. Provisions related to managed care in 42 U.S.C. § 1396u-2.

2.4.3.4. All applicable standards, orders, or regulations issued pursuant to the Clean Air Act, as amended (42 U.S.C. § 7401, *et. seq.*, regulations issued pursuant thereto; the Clean Water Act, as amended, 33 U.S.C. § 1251, *et seq.*), and regulations issued pursuant thereto; and the Pro-Children Act of 1994 (20 U.S.C. § 6081, *et seq.*) and regulations pursuant thereto.

2.4.3.5. The Balanced Budget Act of 1997, as amended (P.L. 105-33), and regulations issued pursuant thereto; and the Balanced Budget Refinement Act of 1999, as amended (P.L. 106-113), and regulations issued pursuant thereto.

2.4.3.6. Section 1128 of the Social Security Act (42 U.S.C. § 1320a-7) and regulations issued pursuant thereto, relating to the exclusion of certain individuals and entities from participation in Medicare and the Rhode

Island Medicaid Program.

2.4.3.7. The Drug Free Workplace Act of 1988, as amended (41 U.S.C. § 8101, *et seq.*), and regulations issued pursuant thereto.

2.4.3.8. The Byrd Anti-Lobbying Amendments (31 U.S.C. § 1352) and regulations issued pursuant thereto, which provide that the Contractor and its Subcontractor(s) shall file the required certification. Each tier certifies to the tier above, that it will not and has not used Federal appropriated funds to pay for any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 U.S.C. §1352. Each tier must also disclose any lobbying with non-Federal funds that takes place in connection with obtaining any Federal award. Such disclosures are forwarded from tier-to-tier up to the non-Federal award.

2.4.3.9. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008 (P.L. 110-343) and regulations issued pursuant thereto, which require coverage for mental health and substance use disorders to be no more restrictive than the coverage that generally is available for medical/surgical conditions.

2.4.3.10. Title XIX of the Social Security Act.

2.4.3.11. Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et. seq.*). The Age Discrimination Act of 1975 (42 U.S.C. § 6101 *et. seq.*).

2.4.3.12. The Rehabilitation Act of 1973 (Pub. L. 93-112).

2.4.3.13. Title IX of the Education Amendments of 1972 (regarding education programs and activities) (20 U.S.C. § 1681 *et. seq.*).

2.4.3.14. Section 1557 of the Patient Protection and Affordable Care Act (ACA) (42 U.S.C. § 18116).

2.4.3.15. 42 C.F.R. §§ 438.3(f)(1) and 438.100(d).

2.4.3.16. 42 C.F.R. Parts 417, 438, and 455.

2.4.3.17. 45 C.F.R. Part 92.

2.4.3.18. 48 C.F.R. Part 31.

2.4.3.19. 2 C.F.R. Part 200.

2.4.3.20. The Patient Protection and Affordable Care Act ("PPACA;" Pub. L. 111-148).

2.4.3.21. The Health Care and Education Reconciliation Act of 2010 ("HCERA;" Pub. L. 111-152).

2.4.3.22. Clinical Laboratory Improvement Amendments of 1988 (Pub. L. 100-578, 42 C.F.R. Part 493) (for purposes of the Agreement, the Contractor shall require its Providers to agree that the Contractor and EOHHS are

"authorized persons").

2.4.3.23. The Immigration and Nationality Act (8 U.S.C §§ 1101 *et. seq.*) and all subsequent immigration laws and amendments.

2.4.3.24. Laws regarding the use of Electronic Visit Verification (EVV), including section 12006 of the 21st Century Cures Act (Public Law 114-255). Resources regarding EVV are available on the EOHHS website.

2.4.3.25. Laws regarding medication synchronization, including R.I. Gen. Laws §§ 27-18- 50.1, 27-19-26.1, 27-20-23.1, and 27-41-38.1.

2.4.3.26. Laws regarding off label uses for prescription drugs, including R.I. Gen. Laws §§ 27-55-1 and 27-55-2

2.4.3.27. R.I. Gen. Laws § 27-18.9-8, regarding procedural requirements for external appeals.

2.4.3.28. R.I. Gen. Laws § 27-18-84, regarding continuous coverage for contraception.

2.4.3.29. R.I. Gen. Laws § 42-12.3-3 regarding postpartum coverage and Rite Start programs.

2.4.3.30. R.I. Gen. Laws § 42-12.3-4 regarding comprehensive coverage for children under age 19, known as the "RIte track" program.

2.4.4. The Parties acknowledge that Governing Requirements affecting the performance of this Agreement may be added, judicially interpreted, or amended by competent authority. Contractor acknowledges and agrees that the Rhode Island Medicaid Managed Care Program will be subject to continuous change during the term of the Agreement and, except as provided in Article 3, "Amendments and Modifications," Contractor shall provide for adequate resources, at no additional charge to EOHHS, to reasonably accommodate such changes.

2.4.5. The Parties further acknowledge the Contractor was selected, in part, because of its expertise, experience, and knowledge concerning the Governing Requirements. In keeping with EOHHS' reliance on this knowledge and expertise, Contractor is responsible for identifying the impact of changes in Governing Requirements that affect the performance of the Scope of Work. The Contractor shall timely notify EOHHS of such changes and shall work with EOHHS to identify the impact of such changes.

2.4.6. The Contractor is responsible for compliance with changes in Governing Requirements that occur during the term of the Agreement. If there are any conflicts between rules promulgated by CMS and this Agreement, the Federal rules take precedence over the Agreement and the Contractor shall comply with the Federal rules unless CMS has waived applicability of the provision to Rhode Island Medicaid via a waiver.

2.4.7. The Contractor is responsible for any fines, penalties, or disallowances imposed on the State or Contractor arising from noncompliance with the Governing Requirements by the Contractor or its Representatives.

2.4.8. The Contractor is responsible for ensuring all Subcontractors and Representatives who provide Services under the Agreement are properly licensed, certified, and/or has

proper permits to perform any activity related to the Services.

2.4.9. The Contractor warrants that the Services and Deliverables shall comply with all Governing Requirements. Contractor shall indemnify EOHHS from and against any losses, liability, claims, damages, penalties, costs, fees, or expenses arising from or in connection with Contractor's failure to comply with or violation of any such Governing Requirement.

2.5. Agreement Composition

2.5.1. Headings

2.5.1.1. Section headings are included for ease of reference only and will not affect the interpretation or construction of any provision in the Agreement.

2.5.2. Drafting Conventions

2.5.2.1. The terms "include," "includes," and "including" are understood to imply inclusion and should be interpreted as if followed by the phrase "without limitation."

2.5.2.2. References to "sections," "appendices," "exhibits," "attachments," or "addenda" are understood to refer to those of this Agreement.

2.5.2.3. References to laws, rules, regulations, and manuals in this Agreement are understood to refer to the current versions of these documents, inclusive of any amendments, modifications, or supplements throughout the term of this Agreement.

2.5.2.4. All definitions contained in Attachment F-1, "Definitions and Acronyms", adhere to State-developed or State-approved definitions. The Contractor and their Subcontractors are required to use these definitions in the fulfillment of this Agreement.

2.5.3. Signatures and Authority

2.5.3.1. All Parties must sign and date the Agreement.

2.5.3.2. EOHHS possesses the authority to enter this Agreement as per R.I. Gen. Laws § 42-7.2-1 *et. seq.*

2.5.3.3. The Contractor has received authorization from its governing board or controlling owner or officer to enter into this Agreement.

2.5.3.4. The individual(s) signing this Agreement on behalf of the Parties affirm that they have the proper authorization to execute this Agreement and to legally bind the Parties to its terms and conditions.

2.6. Execution in Counterparts

2.6.1. Parties may execute this Agreement in multiple counterparts. Each counterpart shall be considered an original, and all counterparts together will constitute a single Agreement.

2.7. Assignment

2.7.1. In accordance with Section 13.25(B) of the General Conditions of Purchase, "Assignment," the Contractor shall not sell, transfer, assign, or otherwise dispose of all or any portion of its rights under or interests in the Agreement without prior written

consent of the State Purchasing Agent. The Contractor's written request for assignment shall be accompanied by written acceptance by the assignee. Except when otherwise agreed to in writing by the State, assignment shall not release the Contractor from its obligations under the Agreement. The State may withhold its consent at its sole discretion.

2.7.2. For purposes of this Section, any change in ownership of the Contractor shall constitute an assignment of this Agreement.

2.7.3. EOHHS may in one (1) or more transactions assign, pledge, or transfer the Agreement to another State agency.

2.7.4. An assignee shall assume all assigned interests in and responsibilities under the Agreement and any documents executed with respect to the Agreement.

2.8. Mergers and Acquisitions

2.8.1. In the event of any planned participation in an asset acquisition or merger with another MCO or HMO operating or not yet operating within the State of Rhode Island, the Contractor is obliged to furnish EOHHS promptly with a written notification outlining its intentions.

2.8.2. Notwithstanding the above, should the Contractor engage in an asset acquisition or merger with another EOHHS Contractor after the commencement date of this Agreement, EOHHS may exercise its discretion within the confines of the law, to require that each Party involved maintain its individual business lines for the remaining duration of this Agreement.

2.8.3. The Contractor does not have an automatic right to a continuation of the Agreement after any such transaction.

2.9. Fulfillment of Contractual Obligations

2.9.1. The Contractor shall comply with all Agreement stipulations. EOHHS is under no obligation to enroll Enrollees into the Contractor's comprehensive health care plan until the Contractor has fulfilled these requirements.

2.10. Federal Approval of Agreement and Amendments

2.10.1. The delivery of contracted services under this Agreement is contingent upon the approval of the Centers for Medicare & Medicaid Services (CMS), which includes approval of the fully executed contract, rates, network adequacy assurances, parity requirements and readiness in compliance with 42 C.F.R. §§ 438.3(a), 438.8, and 438.66(d)(2)(iii).

2.10.2. In the event that CMS disapproves any necessary pre-implementation document or activity, EOHHS reserves the right to either rectify the identified defects or terminate this Agreement without incurring any penalties or liabilities.

2.10.3. CMS must give final approval to the Capitation Rates and all terms and conditions of this Agreement, including any amendments.

2.10.4. This Agreement is contingent upon CMS approval and concurrence of award. The Contractor acknowledges and agrees that EOHHS will submit the Agreement and all attachments to CMS for review and approval. EOHHS will also submit all documents incorporated by reference as CMS requires to demonstrate compliance with Federal

regulations and the CMS contract review tool.

2.10.5. The Agreement adheres to all applicable Federal authorities approved by CMS, including the State's approved 1115 Waiver and State Plan Amendment.

2.10.6. Any delivery system and provider payment initiatives under 42 C.F.R. § 438.6(c) must be approved by CMS before implementation and shall fully comply with the requirements contained in the above referenced Regulation.

2.10.7. If CMS does not approve the Agreement or any initiatives under 42 C.F.R. § 438.6(c), such Agreement or initiatives shall be deemed null and void.

2.11. Loss of Federal Financial Participation

2.11.1. The Contractor accepts responsibility and liability for any loss of Federal Financial Participation (FFP) suffered by EOHHS, because of the Contractor's Providers' or its Subcontractors' conduct, acts or omissions, including but not limited to, their failure to execute the services stipulated under this Agreement.

2.11.2. Payments allocated under this Agreement to new Enrollees shall be withheld if, and for as long as, payment for these Enrollees is not acknowledged by CMS, in compliance with the prerequisites stipulated in 42. C.F.R. § 438.730.

2.11.3. CMS may deny payment to the State for new Enrollees if its determination is not Timely contested by the Contractor.

2.12. Notices

2.12.1. Any notice, approval, or consent under this Agreement shall be in writing and delivered via email, certified mail with return receipt, or a reliable overnight delivery service. Notices shall be sent to the respective addresses provided below or to any other address that either Party may specify in a notice given in accordance with this Section. A notice will be deemed delivered upon sending.

2.12.2. Notices shall be addressed as follows:

2.12.2.1. For the Contractor:

<<Chief Executive Officer>>

<<Organization_Name>>

<<Mailing_AddressSt_Address>>

<<City>>,<<State>> <<Zip_Code>>

OR

<<email_address>>

2.12.2.2. For EOHHS:

EOHHS Contract Officer

3 West Road, Virks Building, Cranston, RI 02920

OR

<<email_address>>

2.12.3. Notices sent through the United States Postal Service are considered effective on the delivery date, as confirmed by the return receipt. Email notices are deemed received upon acknowledgment of receipt by the recipient through an email reply.

2.12.4. Either Party can change its notification mailing or email address by providing a notice in accordance with this Section, stating the change, and setting forth the new address. Such changes will become effective on the tenth (10th) Business Day following the notice's effective date unless a later date is specified.

2.13. Notification of Legal and Other Proceedings and Significant Events

2.13.1. Each Party to this Agreement must promptly notify the other Party about any substantial legal actions or allegations that may result in a claim for indemnification.

2.13.2. Both Parties must cooperate fully in the defense of any action related to this Contract, providing all reasonably available information and necessary testimony without additional fees.

2.13.3. The Contractor shall inform the EOHHS Contract Officer of all proceedings, reports, documents, actions, and events as specified in the Managed Care Manual.

2.14. No Federal or State Endorsement

2.14.1. The award of this Contract shall not indicate an endorsement of the Contractor by the Center for Medicare and Medicaid Services (CMS), the Federal Government, or the State of Rhode Island.

2.14.2. No Federal funds have been or shall be used for lobbying purposes in connection with this Agreement or the Rhode Island Medicaid Managed Care Program.

2.15. Publicity

2.15.1. Any publicity related to the Rhode Island Medicaid Managed Care Program or services provided under this Agreement, including but not limited to notices, press releases, research, reports, and signage, shall acknowledge and include reference to the State of Rhode Island, EOHHS, the Rhode Island Medicaid or the Rhode Island Medicaid Managed Care Program cannot be released without prior written approval from EOHHS.

2.15.2. EOHHS reserves the right for the Contractor to not engage or rescind publicity related appearances or materials of the Contractor.

2.16. Debarment/Suspension/Exclusion

2.16.1. The Contractor agrees to comply with all applicable provisions of 2 C.F.R. Part 376, pertaining to nonprocurement debarment and/or suspension, and 42 C.F.R. §438.610, pertaining to prohibited affiliations.

2.16.2. The Contractor shall screen all directors, officers, partners, persons with beneficial ownership of five percent (5%) or more, Subcontractors, Network Providers, and persons with an employment, consulting, or other arrangement with the Contractor to determine whether they have been excluded from participation in Medicare, Medicaid, CHIP, and/or any other Federal health care programs.

2.16.3. The Contractor shall conduct such screenings monthly to capture exclusions and reinstatements that have occurred since the last search, and any exclusion information

discovered should be immediately reported to EOHHS.

2.16.4. Any individual or entity that employs or subcontracts with an excluded provider cannot claim reimbursement from the Rhode Island Medicaid Program for any item or services furnished, authorized, or prescribed by the excluded provider. This prohibition applies even when the Rhode Island Medicaid Program payment itself is made to another provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded physician for a Member cannot claim reimbursement from the Rhode Island Medicaid Program. Civil monetary penalties may be imposed against Providers who employ or enter into Provider Agreements with excluded individuals or entities that provide items or services to Members. See 42 U.S.C. §§ 1320a-7 and 1320a-7a and 42 C.F.R. § 1003.140(a)(2).

2.17. Free to Contract

2.17.1. The Contractor retains full freedom throughout the Agreement term to engage with any other state Medicaid agency in procurement activities up to and including the delivery of Medicaid managed care services.

2.17.2. The Contractor shall provide notice of material changes, if any, related to the required terms of this Agreement.

2.17.3. Engagement with any other state Medicaid agency has no impact on EOHHS' or the Contractor's rights and obligations under the terms of this Agreement.

2.18. Collaboration with Other Contractors

2.18.1. In the event EOHHS establishes contracts with additional parties for work related to this Agreement's services, the Contractor shall fully cooperate with such contractors under the direction of EOHHS.

2.18.2. This is not an exclusive Agreement and EOHHS may award simultaneous and/or supplemental contracts for work related to the Agreement, or any portion thereof. The Contractor shall reasonably cooperate with such other vendors and shall not knowingly or negligently commit or permit any act that may interfere with the performance of work by any other vendor, or act in any way that may place Members at risk.

2.18.3. The Contractor is strictly prohibited from any action or lack thereof that may negatively impact the contractual performance of any other EOHHS contractor. This includes, but is not limited to, engaging in anti-competitive business practices against other EOHHS contractors. Examples of such negative behavior by the Contractor are limiting new market entrants in a future solicitation, actions that limit Member choice and healthcare service access, or other activities that EOHHS deems unacceptable to ensure the solvency and efficiency of the Medicaid Program.

2.18.4. Repeated violations of this Section shall result in termination with cause.

2.19. Related Agreement Awards

2.19.1. EOHHS reserves the right to enter into additional agreements related to this Agreement, including agreements with other comprehensive health care plans for Medicaid managed care services and agreements with management firms for aid in this Agreement's administration.

2.19.2. The Contractor shall fully cooperate with other contractors as directed by EOHHS and

to ensure all Subcontractors adhere to this requirement.

2.20. Protection of Enrollees

2.20.1. Notwithstanding State Plan approved cost sharing, the Contractor hereby agrees to not bill, charge, collect a deposit from, seek cost sharing or other forms of compensation, remuneration or reimbursement from, or have recourse against, Enrollees, or persons acting on their behalf, for Covered Services that are rendered to such Enrollees by the Contractor or its Subcontractors.

2.20.2. The Contractor shall ensure that an Enrollee will not be held accountable for payment exceeding the amount they would owe if the Contractor directly provided the service. This clause applies under all circumstances, including Contractor non-payment and insolvency.

2.20.3. The Contractor shall protect Enrollees from costs related to services not covered by the Contractor or without Timely approval or prior authorization.

2.20.4. The Contractor agrees that this provision shall be construed to be for the benefit of the Enrollees, and that this provision supersedes an oral or written contrary agreement now existing or hereafter entered between the Contractor and its Enrollees, or persons acting on their behalf.

2.21. Administrative Simplification of Current Databases and Software

2.21.1. To maximize understanding, communication, and administrative economy among all Managed Care Contractors, their Subcontractors, governmental entities, and Members, the Contractor Shall use and follow the most recent updated versions of:

2.21.1.1. Current Procedural Terminology (CPT);

2.21.1.2. Internal Classification of Diseases (ICD);

2.21.1.3. Healthcare Common Procedure Coding System (HCPS);

2.21.1.4. CMS Relative Value Units (RVUs);

2.21.1.5. CMS billing instructions and rules;

2.21.1.6. The Diagnostic and Statistical Manual of Mental Disorders;

2.21.1.7. The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5TM);

2.21.1.8. NCPDC Telecommunication Standard D.0; and,

2.21.1.9. Medi-Span® Master Drug Data Base or other nationally recognized drug database with approval from EOHHS.

2.21.2. In lieu of the most recent versions, Contractor may request an exception. EOHHS' consent thereto will not be unreasonably withheld.

2.21.3. Drug database requirements are specific to values used as reference file in adjudication of pharmacy claims and storage of pharmacy claim data. Drug databases used for other purposes are not subject to this requirement and do not require approval.

2.21.4. Contractor may set its own conversion factor(s), including special code-specific or

group-specific conversion factors, as it deems appropriate.

2.22. Nondiscrimination in Employment and Services

2.22.1. As stipulated in Attachment F-3, Section 1.18, "Employment Practices," the Contractor shall ensure compliance with all relevant State and Federal fair employment laws and extend this compliance requirement to its Subcontractors.

2.22.2. The Contractor shall adhere to the requirements contained in 42 C.F.R. § 438.100(a)(2). The Contractor shall comply with all applicable Federal and State Laws regarding Member rights and ensure that Member rights are respected and protected by its employees, Subcontractors, and Network Providers.

2.22.3. Non-compliance with any part of this Section may lead to termination of this Agreement pursuant to Article 8, "Termination and Turnover Requirements".

2.23. Civil Rights Compliance

2.23.1. The Contractor agrees to abide by the following requirements, as applicable:

2.23.1.1. Section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. § 18116) and regulations issued pursuant thereto; Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. § 2000d, *et seq.*), and regulations issued pursuant thereto; Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. § 2000e, *et. seq.*), and regulations issued pursuant thereto; Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681, *et seq.*), and regulations issued pursuant thereto; the Age Discrimination Act of 1975; as amended (42 U.S.C. § 6101, *et. seq*.), and regulations issued pursuant thereto; Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), and regulations issued pursuant thereto; Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. § 794d) and regulations issued pursuant thereto; the Americans with Disabilities Act (ADA) of 1990, as amended (42 U.S.C. § 12101, *et seq.*), and regulations issued pursuant thereto; the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. § 4212) and regulations issued pursuant thereto; the Fair Housing Act of 1968 (42 U.S.C. § 3601, *et seq.*) and regulations issued pursuant to thereto; and Federal Executive Order 111246.

2.23.1.2. The Contractor agrees not to discriminate in its employments and practices and shall render services under this Agreement without regard to race, color, religion, sex, sexual orientation, national origin, gender identity, veteran status, political affiliation, disability, or age in any matter relating to employment.

2.23.1.3. The Contractor agrees that no person, on the grounds of these factors, shall be excluded from participation in, or not be denied benefits of the Contractor's program, or be otherwise subject to discrimination and the performance of this contract period. The Contractor shall not use any policy or practice, including its employment practices, that has the effect of discriminating on these factors period. Any act of discrimination committed by the Contractor, or failure to comply with the statutory obligations, when applicable, as determined by EOHHS in its sole

discretion, shall be grounds for termination of this Agreement.

2.23.1.4. In all hiring of employment made possible as a result of this Agreement, the Contractor shall take affirmative action to ensure that applicants are employed and that employees are treated during their employment in accordance with all applicable State and Federal laws regarding employment of personnel.

2.23.1.5. This requirement shall apply to, but is not limited to, the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff, termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship. The Contractor further agrees to give public notice in conspicuous places available to employees and applicants for employment setting forth the provision of this Section. All solicitations or advertisements for employees shall state that all qualified applications will receive consideration or employment without regard to disability, age, race, color, religion, sex, national origin, gender identity, veteran status, political affiliation, or sexual orientation. All responses to inquiries made to the Contractor concerning employment made possible as a result of this Contract shall conform to Federal, State, and local regulations.

2.23.1.6. The Contractor shall post notices of non-discrimination in conspicuous places, available to all employees and applicants. This provision shall be included in all Network Provider Agreements and subcontracts.

2.24. Corporation Requirements

2.24.1. If the Contractor is a corporation, the following requirements shall be met prior to the execution of the Agreement:

2.24.1.1. If the Contractor is a for profit corporation whose stock is not publicly traded, the Contractor shall file a Disclosure of Ownership from the Rhode Island Secretary of State.

2.24.1.2. If the Contractor is a corporation not incorporated under the laws of the State of Rhode Island, the Contractor shall obtain a Certificate of Authority from the Rhode Island Secretary of State.

2.24.1.3. The Contractor's legal counsel shall provide written assurances to EOHHS that the Contractor is not prohibited by its articles of incorporation, bylaws, or the laws under which it is incorporated from performing the services required under this Agreement.

2.24.1.4. Secure and attach to this Agreement a formal Board Resolution indicating the signatory to the Contract is a corporate representative and authorized to sign said Agreement.

2.25. Renegotiation and Procurement Rights

2.25.1. EOHHS reserves the right to initiate renegotiation of certain Agreement terms at any point. Upon receipt of such notice, the Contractor and EOHHS shall engage in good faith negotiations and may amend the Agreement as per Article 3, "Amendments and

Modifications."

2.25.2. Regardless of any clauses in the Agreement, EOHHS reserves the right to issue a Request for Proposals (RFP) for all or part of the Scope of Work outlined in this Agreement, or for services or deliverables comparable to those under this Agreement. If EOHHS decides to procure the Scope of Work or any part thereof from another vendor, EOHHS may subsequently enforce any of its termination rights as described in Article 9, "Termination and Turnover Requirements."

2.26. Agreement Errors or Omissions

2.26.1. The Contractor shall perform in a commercially reasonable manner, refrain from exploiting any errors or omissions in the Solicitation or the resulting Agreement, and promptly notify the EOHHS Contract Officer of any such errors or omissions discovered.

2.27. Interpretation of Contract Language and Policy Decisions

2.27.1. If the Parties disagree about the interpretation of the Contract language, it is understood that EOHHS' interpretation shall control and prevail in any such dispute.

2.27.2. The Contractor may seek from EOHHS, policy decisions or issuance of operating guidelines required for the proper execution of the Agreement. EOHHS shall respond timely. The Contractor can rely on, and act according to EOHHS' policy decisions and guidelines without incurring liability, unless the Contractor acts negligently, maliciously, fraudulently or in bad faith.

2.27.3. Only determinations issued by the EOHHS' Contract Officer, or their designated representative, shall be considered valid.

2.28. Disputes

2.28.1. Before initiating arbitration or litigation regarding any dispute arising from this Agreement, the Purchasing Agent is empowered to resolve any disputes according to 220-RICR-30-00-1.5, with further appeal possible to the Chief Purchasing Officer as per 220-RICR-30-00-1.6.

2.28.2. The terms of this section do not apply to disputes between Providers and the Contractor, and the State shall not be entitled to arbitrate such disputes or controversies.

2.28.3. Fraudulent activity may be subject to criminal prosecution.

2.28.4. When a dispute arises between EOHHS and the Contractor on issues related to this Contract, the Parties agree to follow the dispute process in F-2, Section 2.28.

2.28.5. The Contractor shall submit a written request for a dispute resolution conference with the EOHHS Contract Officer. The written request shall clearly state:

2.28.5.1. The issue(s) in dispute;

2.28.5.2. A summary of the positions of the Parties; and,

2.28.5.3. Any additional facts necessary for a complete and accurate understanding of the dispute.

2.28.6. The EOHHS Contract Officer shall, at his or her discretion, set a time for the parties to

present their views on the disputed issue(s).

2.28.7. The Parties agree that this dispute process shall precede any judicial or quasi-judicial proceedings, the dispute resolution process described in Section 2.28 is the exclusive administrative remedy under this Agreement.

2.28.8. The right to dispute an interpretation does not apply to Contract language based on Federal or State laws, Regulations, Policies, Procedures, or Manuals, the State Plan, or Waivers.

2.28.9. The Contractor cannot dispute language that was previously agreed upon based on the Model Contract from this Solicitation or in a previously executed Amendment.

2.28.10. Disputes regarding Overpayments are not governed by this Section. Disputes regarding other recoveries sought by the EOHHS Program Integrity and Compliance Unit or the Office of the Rhode Island Attorney General's Medicaid Control Fraud Unit (MFCU) are governed by the authorities, laws, and regulations under which the MCFU operates.

2.29. Interpretation Dispute Resolution Procedure

2.29.1. The Contractor may request in writing that EOHHS to provide a written determination concerning the application of any provision of this Agreement necessary for the proper performance of the services. This request should be submitted in writing to the EOHHS Contract Officer.

2.29.2. If the Contractor disagrees with the EOHHS Contract Officer's interpretation, they may request reconsideration. This request shall be in writing, addressed to the Deputy Medicaid Program Director, and shall include an explanation of the disagreement. The deadline for this request is twenty-one (21) days after receiving the Deputy Medicaid Program Director's response.

2.29.3. The Deputy Medicaid Program Director shall make their final decision based on a complete written submission from the Contractor.

2.29.4. EOHHS in its sole discretion may allow the Contractor to make oral presentations, to be considered in the final decision. This presentation, if allowed, is informal and is not governed by the Administrative Procedures Act and the Contractor waives any right of appeal through other Federal or State appeals processes.

2.29.5. The Deputy Medicaid Director may provide his or her affirmed or revised decision in writing to the Contractor. This written decision shall be EOHHS' final decision.

2.29.6. While waiting for the final decision on any dispute of an EOHHS decision, the Contractor shall continue diligently with the performance of the Agreement in accordance with EOHHS' direction.

Article 3. Amendments, Modifications and Implementation Timeframes

3.1. Amendment Overview

3.1.1. Any amendment to this Agreement shall be in written form and signed by both parties: the Contractor's authorized officer and an authorized representative of EOHHS. This supersedes any other forms of agreement, oral or otherwise, related to the subject matter of this Agreement.

3.1.2. Changes necessitated by legislative, regulatory, or CMS programmatic changes shall require alterations to the terms and conditions of this Agreement. The Contractor agrees to accept such revisions without dispute.

3.1.3. EOHHS retains the right to issue unilateral amendments for purposes of corrective action or to provide clarifying information.

3.2. Amendment by Mutual Agreement

3.2.1. Both Parties can mutually agree to amend this Agreement at any time.

3.2.2. Except as provided in Section 3.9, "Modifications to the Managed Care Manual," amendments shall be in writing and signed by individuals authorized to bind the Parties.

3.3. Changes in Law or the Agreement

3.3.1. If changes in Governing Requirements impact either Party's ability to fulfill their obligations under this Agreement, both Parties will negotiate in good faith to adjust the Agreement's terms and conditions equitably. .

3.4. Additions or Removal of Populations or Services

3.4.1. EOHHS retains the right to amend the Agreement to include or exclude populations, services, or programs, including but not limited to, the RIte Smiles program, the Rhode Island Non-Emergency Medical Transportation Program or Pharmacy Benefit Management Services.

3.5. Changes to Capitation Payments

3.5.1. EOHHS and Contractor shall use amendments to reduce or increase Capitation Payments. Annual adjustments in Capitation Payments will be actuarially sound, as required by 42 C.F.R. § 438.6(c).

3.6. Modification as a Remedy

3.6.1. This Agreement may be modified under the terms of Article 7, "Performance Standards and Remedies."

3.7. Distinct Contracts

3.7.1. EOHHS shall prohibit distinct Agreements among Contractor's participating in the Rhode Island Medicaid Managed Care Program.

3.7.2. EOHHS reserves the right to make distinct Agreements if it is in the best interest of the State and the Rhode Island Medicaid Managed Care Program.

3.8. Amendment Procedure

3.8.1. If EOHHS proposes an amendment, it will provide a written notice to the Contractor outlining the proposed modifications to the General Terms and Conditions, Scope of

Work, or other terms and conditions.

3.8.2. EOHHS, in its sole discretion, may pursue an amendment to the Contract at any time. Prior to submission of the amendment for the requisite approval(s), EOHHS may solicit feedback from the Contractor on the proposed amendment language. However, EOHHS retains final decision-making authority on the language that will ultimately be submitted to CMS for review and approval.

3.8.3. If the Contractor objects to the proposed modifications, the Contractor shall provide a written response within the timeframe specified in the notice, but no later than ten (10) Business Days of receipt. Following receipt of the Contractor's objections, the Parties will enter negotiations to arrive at a mutually agreeable amendment, including mediation. If EOHHS determines the Parties will not be able to reach agreement, it will provide written notice to the Contractor of its intent to terminate all or part of the Agreement.

3.8.4. The Contractor shall provide a signed amendment no later than fifteen (15) Days after receiving the final amendment from EOHHS. EOHHS may impose contractual remedies, as described in Article 7, "Performance Standards and Remedies" if the Contractor fails to return a signed amendment within fifteen (15) Days of receipt.

3.9. Modifications to the Managed Care Manual

3.9.1. The Managed Care Manual, and all modifications thereto made during the term of the Agreement, are incorporated by reference into this Agreement.

3.9.2. EOHHS will give the Contractor a minimum of ten (10) Business Days advance written notice before initiating a significant and substantive alteration to the Managed Care Manual. EOHHS will allow the Contractor a reasonable period, typically not less than five (5) Business Days, to comment on proposed changes. Advance written notice is not obligatory for changes that are not significant or substantive, such as rectification of clerical inaccuracies.

3.9.3. The Parties will work in good faith to resolve disagreements concerning modifications to the Managed Care Manual. If the Parties are unable to resolve such issues, either Party may terminate the agreement in accordance with Article 7, "Performance Standards and Remedies."

3.9.4. Modifications to the Managed Care Manual will be effective on the date specified in EOHHS' notice.

3.10. Compliance with Modifications and Amendment Procedures

3.10.1. No extra or different services, work, or products shall be authorized or executed except as permitted by this Article. The Contractor shall not be eligible for payment for any services, work, or products not authorized by a properly executed written amendment to this Agreement.

3.11. Waivers

3.11.1. No provision, condition, duty, obligation, or commitment in this Agreement shall be waived without the written agreement of the Parties and approval of CMS.

3.11.2. Patience or leniency in any form or manner by either Party shall not be construed as a waiver of the provision, condition, duty, obligation, or commitment to be maintained, performed, or discharged by the concerned Party. Even with any such patience or

leniency, the other Party shall retain the right to invoke any remedy available under the law or equity until complete performance or satisfaction of all duties, obligations, and commitments are achieved.

3.11.3. Unless otherwise provided, no waiver of any term, provision, or condition of this Agreement shall be valid unless executed in writing, and in accordance with this Article. Waiving any breach of this Agreement shall not be considered as waiving any prior or subsequent breach.

3.11.4. The EOHHS Contract Officer has the authority to waive one (1) or more of the specific remedies outlined in Article 10 for minor breaches of this Agreement. Such waiver shall be in writing, signed by the EOHHS Contract Officer, and filed with the Division of Purchase.

3.12. Division of Purchases Modification Procedure

3.12.1. All modifications to the Agreement are subject to 220-RICR-30-00-13.4(C)(1)(c).

3.13. Amendment Implementation Timeframes by Contractor

3.13.1. The Contractor shall implement amendments within the following tiers and contractual timeframes after the execution of an amendment by the Parties:

3.13.2. Tier 1: Urgent Amendments—Promptly to fifteen (15) Days.

3.13.2.1. Amendments that address critical regulatory requirements, urgent patient care needs, or immediate risks to patient safety.

3.13.2.2. These amendments are high priority and often require swift action by the Contractor.

3.13.3. Tier 2: High Priority Amendments—Sixteen (16) to forty-five (45) Days.

3.13.3.1. Amendments that are important for compliance or significantly enhance service quality but are not immediately critical. They require prompt attention but allow for a short planning and implementation phase.

3.13.3.2. Updates following new state or federal health guidelines, significant policy changes impacting patient care or data security, or provider rate modifications passed in a legislative budget shall be considered a Tier 2.

3.13.4. Tier 3: Standard Amendments–Forty-six (46) to ninety (90) Days.

3.13.4.1. Regular amendments that are part of ongoing improvements and optimizations. These changes are necessary but not urgent and allow for adequate planning and implementation.

3.13.4.2. Routine updates to administrative processes, standard policy revisions, updates to service offerings that do not require immediate action.

3.13.5. Tier 4: Long-Term Strategic Amendments –Ninety-one (91) Days and beyond.

3.13.5.1. Amendments that involve long-term strategic changes. These often include comprehensive overhauls of systems, processes, or policies that require extensive planning, stakeholder engagement, and phased implementation.

3.13.5.2. Overhauling IT systems, major policy restructuring, implementing new

care models or services on a large scale.

3.13.6. EOHHS reserves the right and discretion to set the tiers and timeframes for implementation by the Contractor. The Contractor shall provide in writing to the EOHHS Contract Officer if there is a disagreement regarding the interpretation for the tier required for implementation.

3.13.7. EOHHS' has the sole authority to determine the tier and its determination shall be final and controlling.

3.13.8. EOHHS shall take the following factors into consideration when assessing a Contractor's amendment implementation timeframes:

3.13.8.1. Flexibility

a) The timeframes may have some flexibility to accommodate unforeseen complexities or delays.

3.13.8.2. Stakeholder Input

a) Engaging stakeholders (including healthcare providers, patients, and regulators) in the amendment process, especially for higher-tier amendments.

3.13.8.3. Monitoring and Evaluation

a) Regular monitoring of the amendment process to ensure timely implementation and to evaluate the impact of the changes.

3.13.8.4. Communication

a) Clear and consistent communication with all stakeholders throughout the amendment process, particularly for higher-tier changes.

3.13.9. The tiered approach to amendment implementation timeframes shall allow the Contractor to prioritize amendments efficiently, ensuring that the most critical changes are implemented swiftly while also managing less urgent, but equally important, long-term improvements.

3.13.10. EOHHS reserves the right to breakout amendment implementation deliverables into tiers to better accommodate timeframes or grant extensions at the sole discretion of EOHHS.

3.13.11. Failure to comply with tiered implementation timeframes shall result in liquidated damages in accordance with Attachment F-6, "Liquidated Damages Matrix."

Article 4. Terms and Conditions of Payment

4.1. Capitation Payment

4.1.1. EOHHS will make Capitation Payments in the manner described herein.

4.1.2. The Capitation Payments made pursuant to this Agreement shall only be made by EOHHS and retained by the Contractor for Medicaid-eligible Members. Adjustments to Capitation Payments due to Member reconciliations shall be made in the month following their discovery.

4.1.3. All payments shall be subject to the availability of funds.

4.1.4. EOHHS in its sole discretion may make Capitation Payments on a lump sum basis when administratively necessary.

4.2. Rate Setting Methodology

4.2.1. Attachment F-5, "Capitation Rates and Fiscal Assurances," includes the rate setting methodology used to develop actuarially sound Capitation Rates.

4.3. Rate Adjustments

4.3.1. The Capitation Rates identified in this Agreement shall in effect during the periods identified in the rate certifications posted on EOHHS website.

4.3.2. Capitation Rates may be adjusted during the term of the Agreement based on EOHHS and actuarial analysis, subject to CMS review and approval.

4.3.3. Adjustments to the Capitation Rate(s) shall be implemented through a written amendment to the Agreement.

4.4. Risk Adjustments

4.4.1. EOHHS will risk-adjust Capitated Payments. As described in Attachment F-5, "Capitation Rates and Fiscal Assurances," EOHHS will analyze the risk profile of Members enrolled with each Contractor using a risk adjustment model selected by EOHHS.

4.4.2. EOHHS will assign each Member a risk category based on their age, sex, classified disease conditions, or other criteria as established by EOHHS. This information and the relative cost associated with each risk category reflects the anticipated utilization of Covered Services relative to the overall population.

4.4.2.1. The relevant portions of the Contractor's proposed base Capitation Rates shall be risk adjusted based on the Contractor's risk score that reflects the expected health care expenditures associated with its Enrollees relative to the applicable total Rhode Island Medicaid Managed Care Program population.

4.4.3. When practical, EOHHS shall notify the Contractor in advance of any major revision to the risk adjustment methodology that differs from the methodology used for the prior risk adjustment update. The Contractor shall be given fourteen (14) Calendar Days from the date of the notice to provide input on the proposed changes. LDH shall consider the feedback received from the Contractor when implementing changes to the risk adjustment methodology but has final decision-making authority.

4.4.4. Certain Capitation Payments may not be risk-adjusted based on considerations of how

such payments were developed and the availability of risk adjustment data.

4.5. Payments to and from Plans

4.5.1. The Contractor shall receive a Capitation Payment covering all In-plan Benefits, as described in Attachment F-3, Article 4, "Covered Benefits, Service Requirements, and Limitations," and Attachment F-4.1, "Schedule of In-Plan Benefits."

4.5.2. EOHHS will make Capitation Payments in the amount specified in Attachment F-5, "Capitation Rates and Fiscal Assurances" for the Rating Period covered thein. Reimbursement will be subject to all conditions specified in this Agreement.

4.5.3. Attachment F-5 describes the rate-setting process used to establish the Capitation Rates. EOHHS reserves the right to adjust rates during the Rate Period based on actuarial analysis. Adjustments shall be made by written amendment to the Agreement, as specified in Article 3, "Amendments and Modifications."

4.5.4. The Capitation Rates and all amendments thereto are subject to CMS review and approval.

4.5.5. EOHHS will make Capitation Payments monthly via electronic funds transfer in the following manner:

4.5.5.1. All Capitation Payments shall receive enrollment files for all eligible populations under this Agreement and must provide services within eight (8) days of when the enrollment is received.

4.5.5.2. These Capitation Payments will reimburse the Contractor for services rendered to these individuals during the present month. If the Contractor is assigned a new Member or a new Member chooses the Contractor, the Member shall be enrolled on the next Day so that projected memberships will not be required for capitation payment calculations.

4.5.5.3. Adjustment will be made for Members for whom an enrollment or disenrollment transaction was made after the fifth (5^{th}) Business Day of the previous month but before the close of the month in question. The adjustment will be based on a daily rate equal to one-thirtieth ($l/30^{th}$) of the month rate for each Rate Cell (rounded to one-tenth ($l/10^{th}$) of a cent, e.g., $3.873). A remittance advice will accompany all payments identifying every Member, their Medicaid ID number, the number of Days paid and total payment and/or adjustments.

4.5.5.4. For Members, whose enrollment lapses for any portion of a month in which a Capitation Payment was made, due to loss of eligibility, death, or other circumstance, EOHHS shall adjust its next monthly Capitation Payment to recoup the portion of the Capitation Payment to which it is due to a refund.

4.5.5.5. For Rite Care Members who are pregnant and whose pregnancy results in a live birth or still birth (still birth defined as spontaneous fetal death at greater than or equal to twenty (20) weeks gestation), EOHHS shall make a supplemental (SOBRA) payment for delivery as part of its monthly capitation payment cycle on the basis of a valid claim by the Contractor. EOHHS will not pay a SOBRA payment for miscarriages (defined as spontaneous fetal death less than twenty (20) weeks), nor will EOHHS

make a SOBRA payment for a pregnancy resulting in induced termination regardless of gestational age.

4.5.5.6. For Members with a cost-sharing requirement to the Contractor, the amount of the Capitation Payment will be reduced by the portion of the premium or copayment that is the responsibility of the Member.

4.5.6. The Contractor agrees to accept enrollment information and Capitation Payments in the manner described above and shall have written policies and procedures for receiving and processing Capitation Payments.

4.6. Incentive and Withhold Arrangements

4.6.1. Attachment F-3, Article 16, "Quality Assurance" describes the EOHHS quality incentive program for Health Plans. In accordance with 42 C.F.R. § 438.6(b)(2) the quality incentive program and corresponding withhold arrangement will comply with the following requirements:

4.6.1.1. All incentive and withhold arrangements will be for a fixed period, which will generally coincide with a Rating Period.

4.6.1.2. Performance will be measured during the Rating Period under the Agreement for which the incentive arrangement is applied.

4.6.1.3. Incentive and withhold arrangements will not renew automatically, will be made available to all Contractors under the same terms of performance, and will not be conditioned on Contractors entering or adhering to intergovernmental transfer agreements.

4.6.1.4. Incentive and withhold arrangements will align with the EOHHS Medicaid Managed Care Quality Strategy, and the activities, targets, performance measures, and quality-based outcomes included in the arrangements will support the quality strategy.

4.6.2. If the Contractor is eligible for incentive payments under the quality incentive program, such payments will not exceed one hundred and five percent (105%) of the approved Capitation Payments.

4.7. Risk Sharing

4.7.1. This Agreement does not include stop-loss limits, non-risk payments or other risk sharing mechanisms, with the exception of:

4.7.1.1. Attachment F-3, Section 27.7 "Reinsurance."

4.7.1.2. Attachment F-3, Section 27.17 "Calculating the Medical Loss Ratio."

4.7.1.3. Attachment F-3, Section 27.18 "Certified Community Behavioral Health Clinics (CCBHCs) Risk Mitigation."

4.7.2. EOHHS expressly reserves the right to modify the risk sharing terms and conditions at any point during the term of this Agreement. Such modifications may include, but are not limited to, the addition or removal of risk corridors or alteration of payment terms and conditions. EOHHS shall provide no less than ninety (90) days written notice to all Parties involved prior to implementing any such modifications, except in cases of

regulatory or legal changes demanding immediate adaptation.

4.7.3. All modifications shall be in alignment with Federal and State laws and regulations, and subject to the conditions stipulated within the Agreement.

4.7.4. Contractor agrees to cooperatively work with EOHHS to make any required or requested changes to risk sharing during the term of the Agreement.

4.8. Payments to Subcontractors and Providers

4.8.1. EOHHS shall bear no liability (other than liability for making payments required by this Agreement) for paying the valid claims of Contractor's suppliers or Representatives, including Subcontractors and Providers.

4.8.2. The Contractor must ensure that the rate of reimbursement for any covered service provided is not less than what would have been paid if the same service was rendered under the Medicaid Rate.

4.9. Liability for Payment for Insolvency

4.9.1. In accordance with Section 1932(b)(6) of the Social Security Act and 42 C.F.R. §§ 438.3, 438.106, and 438.230, the Contractor and its Representatives shall not hold Members and the State or Rhode Island liable for:

4.9.1.1. The Contractor's debts, in the event of the Contractor's insolvency.

4.9.1.2. Covered Services provided to the Member, for which the EOHHS does not pay the Contractor, or for which the EOHHS or the Contractor does not pay the individual or the health care provider that furnishes the services under a contractual, referral, or other arrangement.

4.9.1.3. Payments for Covered Services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the Member would owe if the Contractor provided the services directly.

4.9.2. Should any part of the scope of work under this Agreement relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn Federal authority, or which is the subject of a legislative repeal), Contractor shall do no work on that part after the effective date of the loss of program authority. EOHHS will adjust Capitation Rates to remove costs that are specific to any program or activity that is no longer authorized by law. If Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If EOHHS paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Agreement the work was to be performed after the date the legal authority ended, the payment for that work should be returned to EOHHS. However, if Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and EOHHS included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

4.9.3. If the Contractor becomes insolvent during the term of the Agreement, the Contractor shall cover the continuation of services to Enrollees for the duration of period for which

payment has been made, as well as for inpatient admissions up until discharge.

4.10. Payments for the Health System Transformation and Other Incentives

4.10.1. EOHHC shall make Health System Transformation Project (HSTP) related payments to the Contractor as described in the "HSTP and the Medicaid Infrastructure Incentive Program" document. All payments will be subject to the availability of funds.

4.10.2. All delivery system and payment initiatives, as described in 42 C.F.R. § 438.6(c) shall be approved by CMS prior to implementation and shall comply with the terms of such approval.

4.11. Payments for Institutions for Mental Diseases

4.11.1. In accordance with 42 C.F.R. § 438.6(e), EOHHS will only make Capitation Payments for Members twenty-one (21) to sixty-four (64) years old receiving inpatient psychiatric treatment in an Institution for Mental Diseases (IMD), as defined in 42 C.F.R. § 435.1010, when the length of stay in the IMD is for a short term stay of no more than fifteen (15) Days during the period of the monthly Capitation Payment.

4.11.2. For Members who are twenty-one (21) to sixty-four (64) years old receiving inpatient opioid use disorder or other substance use disorder services in an IMD, EOHHS will only make Capitation Payments for services provided in accordance with the requirements of the Rhode Island Comprehensive Demonstration 1115 waiver.

4.12. Payments for Federally Qualified Health Centers and Rural Health Centers

4.12.1. The Contractor shall reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) either on a capitated basis considering adverse selection factors or on a cost related basis.

4.12.2. In accordance with Section 1903(m)(2)(A)(ix) of the Social Security Act, the Contractor shall reimburse FQHCs/RHCs at a rate not less than that paid for comparable services provided by non-FQHC/RHC based providers.

4.12.3. The Contractor shall ensure the total revenue it provides to each FQHC/RHC is equal to the number of eligible encounters as outlined in EOHHS' "Principles of Reimbursement for Federally Qualified Health Centers" multiplied by that FQHCs/RHCs rate for the fiscal year, as shared by EOHHS. This funding is provided for in the Capitation Rates paid to the Contractor.

4.13. Payments to Indian Health Care Providers

4.13.1. The Contractor shall ensure that payments to Indian Health Care Providers (ICHPs) comply with the requirements of 42 C.F.R. § 438.14(b), as described in Attachment F-3, Section 18.25, "Networks Related to Native Americans."

4.14. Solvency

4.14.1. The Contractor agrees that EOHHS may at any time access any information related to the Contractor's financial condition, or compliance with the Rhode Island Office of the Health Insurance Commissioner (OHIC) requirements, from OHIC and consult with OHIC regarding such information.

4.14.2. The Contractor shall deliver to EOHHS copies of any financial reports prepared at the request of the OHIC or National Association of Insurance Commissioners (NAIC). The Contractor's routine quarterly and annual statements submitted to OHIC and NAIC are

exempt from this request. The Contractor shall also deliver copies of related documents, reports and correspondence (including, but not limited to, Risk-Based Capital (RBC) calculations and Management's Discussion and Analysis), at the same time the Contractor submits them to OHIC or NAIC.

4.14.3. The Contractor shall notify EOHHS within ten (10) Business Days after the end of any month in which the Contractor's net worth (capital and/or surplus) reaches a level representing two (2) or fewer months of expected claims and other operating expenses, or other change which may jeopardize its ability to perform under this Agreement or which may otherwise materially affect the relationship of the parties under this Agreement.

4.14.4. The Contractor shall notify EOHHS within one (1) Business Day after any action by OHIC or the NAIC that may affect the relationship of the parties under this Agreement.

4.14.5. The Contractor shall notify EOHHS if OHIC required enhanced reporting requirements within ten (10) Business Days after the Contractor's notification by OHIC. The Contractor agrees that EOHHS may, at any time, access any financial reports submitted to OHIC in accordance with any enhanced reporting requirements and consult with OHIC staff concerning information contained therein.

4.15. Return of Funds

4.15.1. All amounts owed by the Contractor to EOHHS, as identified through routine or investigative reviews of records or audits conducted by EOHHS or other State or Federal agency, as well as Monetary Penalties levied against the Contractor for Contract non-compliance, may be deducted from the monthly Capitation Payment upon notification by EOHHS.

4.15.2. Amounts that exceed or cannot otherwise be collected through the Capitation Payment deduction shall be due and payable to EOHHS no later than thirty (30) Calendar Days following notification to the Contractor by LDH, unless otherwise authorized in writing by EOHHS. EOHHS reserves the right to accrue and collect interest on unpaid balances beginning thirty (30) Calendar Days from the date of initial notification. Any unpaid balances that remain after the refund is due shall be subject to interest at the current Federal funds rate plus three percent (3%) or ten percent (10%) annually, whichever is higher.

4.15.3. The Contractor shall reimburse EOHHS for any Federal disallowances or sanctions imposed on EOHHS as a result of the Contractor's failure to abide by the terms of the Contract. The Contractor shall be subject to any additional conditions or restrictions placed on EOHHS by HHS as a result of the disallowance. Instructions for returning of funds shall be provided by written notice.

4.16. Other Payment Terms

4.16.1. The Contractor shall make payments to its providers as stipulated in the Agreement.

4.16.2. The Contractor shall not assign its right to receive payment to any other entity without written consent of EOHHS.

4.16.3. Payment for items or services provided under this Agreement will not be made to any entity located outside of the United States.

4.16.4. The Contractor shall agree to accept payments as specified in this Section and have

written policies and procedures for receiving and processing payments and adjustments. Any charges or expenses imposed by financial institutions for transfers or related actions shall be borne by the Contractor.

4.17. Cost Sharing

4.17.1. The Contractor and its subcontractors are not required to impose any Copayments or Cost Sharing requirements on Members.

4.17.2. The Contractor and its subcontractors may impose Cost Sharing on members in accordance with 42 C.F.R. §§ 447.50 through 447.90 provided that it does not exceed Cost Sharing amounts in the State Plan. The Copayment tiers in the State Plan shall be based on the total amount reimbursed to the pharmacy for the claim.

4.17.3. The Contractor shall ensure Cost Sharing incurred by all individuals in the Rhode Island Medicaid Program household does not exceed an aggregate limit of five percent (5%) of the household's income applied on a quarterly or monthly basis as instructed by LDH.

4.17.4. EOHHS reserves the right to amend Cost Sharing requirements.

4.17.5. The Contractor and its subcontractors may not:

4.17.5.1. Deny services to an Enrollee who is eligible for services because of the Enrollee's inability to pay the Cost Sharing.

4.17.5.2. Restrict Enrollees' access to needed drugs and related pharmaceutical products by requiring Enrollees to use mail-order pharmacy providers.

4.17.5.3. Impose Copayments for services specified in the Managed Care Manual.

Article 5. Assurances, Certifications, Guarantees and Warranties

5.1. Ability to Perform

5.1.1. The Contractor warrants and asserts that it has the financial resources to fund the capital expenditures required under the Agreement without advances by EOHHS or assignment of any payments by EOHHS to a financing source.

5.2. Proposal Certifications

5.2.1. The Contractor acknowledges its continuing obligation to comply with the requirements of its Proposal certifications and shall immediately notify EOHHS of any changes in circumstances affecting the certifications.

5.3. Certification of Truthfulness

5.3.1. The Contractor certifies that the information contained and provided in its Proposal and this Agreement is true, accurate, correct, and complete to the best of the Contractor's knowledge and belief. EOHHS may terminate the Agreement at any time in accordance with Article 8, "Termination and Turnover Requirements," if an investigation discloses a material misrepresentation or falsification by the Contractor.

5.4. Certification of Legality

5.4.1. The Contractor represents, to the best of its knowledge, that it has complied with and is complying with all Governing Requirements relating to its property and the conduct of operations; and, to the best of its knowledge, there are no existing or threated violations of any Governing Requirements.

5.5. Certification of Licensure and Accreditation

5.5.1. The Contractor has obtained and shall maintain all licenses, certifications, permits, and authorizations necessary to perform its obligations under this Agreement and is in good standing with all regulatory agencies.

5.5.2. The Contractor certifies that it is licensed by the Rhode Island Department of Business Regulation ("DBR") as an:

5.5.2.1. HMO under R.I Gen. Laws § 27-41 (the "HMO Act");

5.5.2.2. Nonprofit hospital service corporation under R.I Gen. Laws § 27-19;

5.5.2.3. Nonprofit medical service corporation under R.I Gen. Laws § 27-20; or

5.5.2.4. Another licensed health insurance entity that meets the following requirements that:

a) Is accredited by the NCQA as a Rhode Island Medicaid Health Plan or, if the Contractor is a newly entering plan, is NCQA accredited as Medicaid Health Plan in another state or for another line of business and will achieve full NCQA Health Plan Accreditation for Rhode Island Medicaid within twelve (12) months of the execution of this Agreement. If not yet accredited for Rhode Island Medicaid, Contractor must nonetheless follow all NCQA standards.

b) Meets the requirements under R.I Gen. Laws § 27-18.9-8, "External Appeal Procedural Requirements" of the Benefit Determination and

Utilization Review Act.

5.5.3. The Contractor certifies it meets all State requirements for licensure and operation of the applicable entity described above under Rhode Island law and DBR Regulations. If the Contractor loses State approval or qualification during the term of the Agreement, it shall report such loss to EOHHS within one (1) Business Day. Such loss may be grounds for termination of the Agreement.

5.5.4. Ensuring access to high quality and cost-effective services to all Rhode Islanders is paramount; therefore, the Contractor shall obtain NCQA Health Equity Accreditation (or Health Equity Accreditation Plus) and LTSS Distinction within twenty-four (24) months of execution of this Agreement. If not yet accredited for Rhode Island Medicaid, Contractor must nonetheless follow all NCQA standards.

5.5.5. Achievement of provisional accreditation status shall require a corrective action plan within thirty (30) Calendar Days of receipt of the Final Report from the NCQA and may result in termination of the Agreement.

5.5.6. Failure to obtain NCQA Health Plan Accreditation within twelve (12) months and Health Equity Accreditation (or Health Equity Accreditation Plus) and LTSS Distinction within twenty-four (24) months of execution of the Agreement may result in suspension of enrollment or termination of this Agreement.

5.5.7. The Contractor agrees to notify EOHHS within thirty (30) Days of any complaint, investigation, disciplinary action, or other compliance review initiated or issued to the Contractor by a Federal or State Government Agency or other regulatory body. The Contractor also agrees to forward to EOHHS a copy of any correspondence sent by the Contractor to the Rhode Island Department of Business Regulation that pertains to the Contractor's licensure or its contract status with any institution or provider group.

5.5.8. The Contractor agrees to provide EOHHS, or its designees any information requested pertaining to its licensure, accreditation, and distinction including communications with DBR or NCQA. Such information shall include communication with NCQA and Healthcare Effectiveness Data and Information System (HEDIS)® and Consumer Assessment of Healthcare Providers & Systems (CAHPS)® data, transmittals, and reports.

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

5.6. Conflict of Interest

5.6.1. The Contractor shall have conflict of interest safeguards that, at a minimum, are equivalent to conflict-of-interest safeguards imposed by Federal Law on parties involved in public contracting (42 C.F.R. § 438.3(f)(2)).

5.6.2. The Contractor is aware that: (1) 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 this Agreement shall voluntarily acquire any personal interest, direct or indirect, in the Agreement or proposed Agreement; and (2) all State employees shall be

subject to the provisions of R.I. Gen. Laws § 36-14.

5.6.3. The Contractor warrants that it presently has no pecuniary interest and shall not acquire any such interest, direct or indirect, without first disclosing in writing to the State and then subsequently obtaining written approval, , from the State, that would conflict in any manner or degree with the performance of services required under this Agreement. The Contractor further covenants that no person having any such interest shall be employed by the Contractor for the performance of any work associated with this Agreement.

5.6.4. The Contractor shall establish safeguards to prohibit employees, agents, and Subcontractors from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain. The Contractor shall operate with complete independence and objectivity without actual, potential, or apparent conflict of interest with respect to the activities conducted under this Agreement.

5.6.5. The State assures that the entity authorizing HCBS is external to the agency or agencies that provide HCBS, and that contracts with MCOs reflect this separation of assessment, treatment planning, and service provision functions.

5.6.6. The Contractor agrees to immediately notify EOHHS if potential violations of the Code of Governmental Ethics arise at any time during the term of this Agreement.

5.6.7. The Contractor shall comply with the prohibitions set forth in 42 U.S.C. § 1396(a)(4)(c).

5.6.8. Neither the Contractor nor any Material Subcontractor shall, for the duration of the Agreement, have any interest that will conflict with or appear to conflict with, as determined by EOHHS, the performance of services under this Agreement, or that may be otherwise anticompetitive. Without limiting the generality of the forgoing, EOHHS requires that neither the Contractor nor any Material Subcontractor have any financial, legal, contractual, or other business interest in any entity performing Enrollment functions for the Rhode Island Medicaid Managed Care Program.

5.7. Organizational Conflict of Interest and Warranty Removal of Conflict of Interest

5.7.1. An organizational conflict of interest is a set of facts or circumstances, a relationship, or other situation under which a Contractor or a Subcontractor has past, present, or currently planned personal or financial activities or interests that either directly or indirectly:

5.7.1.1. Impairs or diminishes the Contractor's or Representative's ability to render impartial or objective assistance or advice to EOHHS; or

5.7.1.2. Provides the Contractor or Representative an unfair competitive advantage in future EOHHS procurements (excluding the award of this Agreement).

5.7.2. The Contractor warrants that it, its officers, and its employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services hereunder.

5.7.3. The Contractor warrants that it shall remove any conflict of interest prior to signing the

Agreement and during the term of the Agreement.

5.7.4. Except as otherwise disclosed and approved by EOHHS before the Effective Date of the Agreement, the Contractor warrants that, as of the Effective Date and to the best of its knowledge and belief, there are no relevant facts or circumstances that could give rise to an organizational conflict of interest affecting this Agreement. The Contractor affirms that it has neither given, nor intends to give, at any time hereafter, any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant or any employee or representative of same, at any time during the procurement process or in connection with the procurement process except as allowed under relevant State and Federal Law.

5.7.5. If after the Effective Date the Contractor discovers or is made aware of an organizational conflict of interest, the Contractor shall immediately and fully disclose such conflict of interest in writing to EOHHS. In addition, the Contractor shall promptly disclose any relationship that might be perceived or represented as a conflict after its discovery as a potential conflict. Disclosures shall include a description of the actions the Contractor has taken or proposes to take to avoid or mitigate such conflicts. EOHHS has the sole authority to make a final determination regarding the existence of conflicts of interest, and the Contractor shall abide by EOHHS' decision.

5.7.6. If EOHHS determines an organizational conflict of interest exists, it may, at its discretion, terminate the Agreement pursuant to Article 8, "Termination and Turnover Requirements."

5.7.7. The Contractor shall include provisions in its Subcontracts that impose obligations on Subcontractors that are consistent with the obligations imposed on the Contractor pursuant to this Section.

5.8. Anti-kickback Provision

5.8.1. The Contractor certifies full compliance with the Anti-Kickback Act of 1986 (41 U.S.C. §§ 51-58) and Federal Acquisition Regulation § 52.203-7, to the extent applicable.

5.9. Reporting of Political Contributions

5.9.1. The Contractor shall comply with R.I. Gen. Laws § 17-25.10.1, regarding reporting campaign contributions and expenditures, and shall provide EOHHS copies of any form filed with the Secretary of State regarding political contributions.

5.9.2. The Contractor shall on an ongoing basis update such forms to reflect future political contributions subject to this reporting requirement. Failure to complete or update the form accurately, completely, and in conformance with its terms, or to file the form with the Secretary of State within sixty (60) Days of receipt, shall amount to a violation of the Agreement and may render the Contractor ineligible for further State contracts.

Article 6. Intellectual Property

6.1. Ownership of Intellectual Property

6.1.1. All data, technical information, encounter data, information systems, materials gathered, originated, developed, prepared, modified, used, or obtained by the Contractor in performance of the Agreement, including, all hardware, software computer programs, data files, application programs, intellectual property, source code, documentation, and manuals, regardless of state of completion shall be deemed to be owned and remain owned by the State ("State Property").

6.1.2. However, each Party shall retain all rights in any preexisting software, ideas, concepts, know-how, development tools, techniques or any other proprietary material or information that it owned or developed prior to the date of this Agreement or acquired or developed after the date of this Agreement without reference to or use of the intellectual property of the other Party.

6.1.3. All software that is licensed by a Party from a third-party vendor shall be and remain the property of such vendor.

6.2. Patent or Copyright Infringement

6.2.1. The Contractor represents 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.

6.2.2. If any claim or suit is brought against the State for the infringement of such patents or copyrights arising from the Contractor's use of any equipment, materials, software and products, or information prepared by or on behalf of the Contractor or developed in connection with the Contractor's performance of this Agreement, then the Contractor shall, at its expense, indemnify and defend the State against such claim or suit. The Contractor shall satisfy any final award for such infringement, through a judgment involving such a claim, suit or by settlement, with the Contractor's right of approval.

6.2.3. If any copyrightable material is developed during or under this Agreement, EOHHS shall receive a royalty fee, and shall have a non-exclusive, and irrevocable right to reproduce, publish, or otherwise use the work for EOHHS purposes.

6.3. Intellectual Property Indemnification

6.3.1. Contractor shall fully indemnify and hold harmless the State, without limitation, from and against any and all damages, costs, fines, penalties, judgements, forfeitures, assessments, expenses (including attorney fees), obligations, and other liabilities of every name and description that may be assessed against the State in any action for infringement of any intellectual property right, including but not limited to, trademark, trade-secret, copyright, and patent rights.

6.3.2. When a dispute or claim arises relative to a real or anticipated infringement, the Contractor, at its sole expense, shall submit information and documentation, including formal patent attorney opinions, as required by the State.

Article 7. Performance Standards and Remedies

7.1. Understanding and Expectations

7.1.1. The remedies described in this Section are directed to the Contractor's timely and responsive performance of the Agreement's requirements, and the creation of a flexible and responsive relationship between the Parties.

7.1.2. The Contractor is expected to meet or exceed all performance requirements. EOHHS may conduct performance reviews at any time, and impose the remedies described in this Section if the Contractor does not meet performance standards or other contractual requirements.

7.2. Corrective Action Plans

7.2.1. EOHHS may develop a Corrective Action Plan (CAP) to address a material breach of this Agreement. The Contractor shall accept and implement such CAP within the timeframes specified by EOHHS in the written notice of the CAP.

7.2.2. Alternatively, without waiving any of its other rights under this Agreement, EOHHS may require the Contractor to develop a Corrective Action Plan (CAP) to address a material breach of this Agreement.

7.2.3. Following notification of the original violation giving rise to the CAP, the Contractor shall immediately cease the noncompliant behavior and take actions to mitigate the harm caused by the violation.

7.2.4. A CAP developed by the Contractor shall, at a minimum, identify the following:

7.2.4.1. The finding resulting in a request for corrective action by EOHHS.

7.2.4.2. A description of how the Contractor will remediate the finding.

7.2.4.3. The timeline for implementing and completing the corrective action(s).

7.2.4.4. The names of the person responsible for leading all corrective action activities.

7.2.5. The Contractor shall submit the CAP no later than ten (10) Days after the date of EOHHS' written notice requesting a CAP. EOHHS may shorten or extend this deadline depending on the nature of the violation.

7.2.6. The Contractor's CAP must be approved by the EOHHS Contract Officer or their designee.

7.2.7. The EOHHS Contract Officer may accept the CAP as submitted, accept the CAP with specified modifications, or reject the CAP.

7.2.8. If the EOHHS Contract Officer requests modifications or rejects the CAP, the Contractor shall revise or submit a new CAP within five (5) Days, or another time specified in EOHHS' written notice. The revised or new CAP shall address all identified issues in the EOHHS notice. This process shall be repeated until EOHHS approves the CAP.

7.2.9. The Contractor shall complete all corrective actions contained in the CAP within the period determined and approved by the EOHHS Contract Officer or their designee.

7.2.10. The Contractor shall provide updates to EOHHS on the remediation of all findings

resulting in a request for corrective action at the interval requested by EOHHS.

7.2.11. EOHHS' acceptance of a CAP will not excuse the Contractor's prior substandard performance, relieve the Contractor of its duty to comply with performance standards or requirements, prohibit EOHHS from imposing other tailored remedies as it deems appropriate, and/or waive any other rights under this Agreement.

7.2.12. EOHHS or their designees, may at any time, inspect and audit any records or documents of the Contractor, or its Subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted.

7.3. Tailored Remedies

7.3.1. EOHHS may pursue one (1) or more of the following tailored remedies for each instance of noncompliance and will determine remedies on a case-by-case basis.

7.3.2. EOHHS' pursuit or non-pursuit of a tailored remedy does not constitute a waiver of any other remedy EOHHS may have in law or equity.

7.3.3. EOHHS will notify the Contractor of breaches that, in EOHHS' determination, do not result in a material deficiency. No later than five (5) Business Days after receipt of such notice, the Contractor shall provide the EOHHS Contract Officer a written response explaining the reasons for the deficiency, the Contractor's plan to cure the deficiency, and the date by which the deficiency will be cured. EOHHS may regard a repeated commission of or failure to cure of a non-material deficiency as a material breach and pursue additional remedies as described herein.

7.3.4. In addition to CAPs described in Section 7.2, "Corrective Action Plans," EOHHS may impose one (1) or more of the following remedies for a material breach of this Agreement:

7.3.4.1. Conduct accelerated monitoring of the Contractor, including more frequent or extensive monitoring.

7.3.4.2. Require additional reporting.

7.3.4.3. Decline to renew or extend the Agreement.

7.3.4.4. Impose intermediate sanctions in accordance with Section 7.4.

7.3.4.5. Suspend new enrollment of Members in accordance with Section 7.4.1.4. Require forfeiture of all of part of the Contractor's performance bond.

7.3.4.6. Terminate the Agreement in accordance with Article 8, "Termination and Turnover Requirements."

7.3.5. Except for accelerated monitoring and additional reporting, EOHHS will provide the Contractor with written notice thirty (30) Days prior to imposing one (1) or more of the tailored remedies described in this Section. The notice will include the basis for the remedy and any available appeal rights.

7.4. Intermediate Sanctions

7.4.1. In accordance with 42 C.F.R. §§ 438.700 and 438.702, EOHHS may impose the following types of intermediate sanctions for violations of this Agreement, including violations of Sections 1903(m), 1932, 1905(t) of the Social Security Act or 42 C.F.R.

Part 438:

7.4.1.1. Civil monetary penalties as described in Section 7.7.

7.4.1.2. Appoint mandatory temporary management under the circumstances described in 42 C.F.R. § 438.706.

7.4.1.3. Notify Members of the Contractor's breach and allow Members to disenroll from the Contractor's Health Plan without cause if the Contractor repeatedly fails to meet the Agreement's requirements.

7.4.1.4. Suspend all new enrollment, including default enrollment, as described in Section 7.6.1 after the date the CMS or EOHHS notifies the Contractor of a determination of a violation of any requirement under Sections 1903(m) or 1932 of the Social Security Act.

7.4.1.5. Suspend payment for Members enrolled after the effective date of the sanction and until CMS or EOHHS is satisfied that the reason for the sanction no longer exists and is not likely to recur.

7.4.2. EOHHS retains the authority to impose additional sanctions under State statutes or regulations that address areas of noncompliance specified in 42 C.F.R. § 438.700, and any additional areas of noncompliance.

7.5. Notice to External Agencies

7.5.1. EOHHS will provide written notice to CMS in accordance with 42 C.F.R. § 438.724 no later than thirty (30) Days after EOHHS imposes or lifts an intermediate sanction for any violation described in 42 C.F.R. § 438.700.

7.5.2. EOHHS shall provide notice as required by law to any other state or federal agency for violations of the terms, conditions, or requirements of this Agreement or for any other violation of applicable laws or regulations by the Contractor.

7.5.3. EOHHS shall notify the Division of Purchases in writing of any action taken under this Section, which may be considered in any future State procurement involving the Contractor.

7.6. Suspension of New Enrollment

7.6.1. EOHHS may suspend the new enrollment in the Contractor's Health Plan based on a material breach of this Agreement. The suspension period will be for a reasonable length of time specified by EOHHS, depending on the severity and circumstances of the breach.

7.6.2. EOHHS may notify enrolled Members of the Contractor's suspension and allow these Members to disenroll from the Contractor's health plan without cause.

7.7. Civil Monetary Penalties

7.7.1. EOHHS may impose civil monetary penalties for the following activities, subject to the limits described below:

7.7.1.1. Failing to substantially provide Medically Necessary Covered Services to Member that the Contractor is required to provide under the terms of this Agreement (up to $25,000 per incident).

7.7.1.2. Charging premiums or charges exceeding those permitted in the Rhode

Island Medicaid program. (Should Rhode Island Medicaid implement cost sharing requirements, EOHHS may impose up to $ 25,000 or double the amount of the excess charge, whichever is greater.)

7.7.1.3. Discriminating among Members based on their health status or need for health services (up to $ 15,000 per individual not enrolled due to a discriminatory act, subject to a maximum of $ 100,000 for each determination of discrimination).

7.7.1.4. Misrepresenting or falsifying information furnished to a Member, potential member, healthcare provider, EOHHS or other state agency or designee (up to $ 25,000 per instance).

7.7.1.5. Distributing Marketing Materials not approved by EOHHS or that contain false or misleading information, either directly or indirectly through a Representative (up to $25,000 per distribution).

7.8. Publication of Remedial Actions, Intermediate Sanctions, and Liquidated Damages

7.8.1. EOHHS may publish on its website on a quarterly basis a list of Contractors that were subject to remedial actions, intermediate sanctions, or liquidated damages. Public notification shall include the type of actions imposed on the Contractor, and the basis for the actions taken by EOHHS.

7.8.1.1. EOHHS may publish the action, sanctions or damage throughout the term of the Agreement.

7.8.2. EOHHS will not publish, as final, any actions that are under dispute with the Contractor or any remedial actions, intermediate sanctions, or liquidated damages that have been waived or lifted by EOHHS.

7.9. Damages

7.9.1. EOHHS will be entitled to actual and consequential damages resulting from the Contractor's failure to comply with any of the terms of the Agreement.

7.9.2. In some cases, the actual damage to EOHHS or the State of Rhode Island due to Contractor's failure to comply with the performance standards is difficult or impossible to determine with precise accuracy. In such cases, EOHHS will assess liquidated damages in accordance with Attachment F-6, "Liquidated Damages Matrix."

7.9.3. EOHHS, in its sole discretion, may waive, modify, or lift the imposition of any action taken against a Contractor, for good cause as determined by EOHHS, which includes the right of EOHHS to suspend the imposition of a remedial action, liquidated damages, or an intermediate sanction while the Contractor works to resolve and correct the underlying issue that resulted in the action taken by EOHHS.

7.10. Deduction from Payment

7.10.1. EOHHS may deduct civil monetary penalties, damages (actual, consequential, or liquidated), or other amounts owed to EOHHS from any amount payable to the Contractor pursuant to this Agreement.

7.10.2. The EOHHS Contract Officer or their designee will provide advance written notice to the Contractor before EOHHS deducts such sums from amounts payable to the

Contractor.

7.11. Payments Denied by CMS

7.11.1. EOHHS may recommend that CMS impose a denial of payment for new Members pursuant to 42 C.F.R. § 438.730. If the EOHHS' determination becomes CMS' determination, EOHHS will:

7.11.1.1. Provide the Contractor with written notice of the basis of the proposed sanction.

7.11.1.2. Allow the Contractor ten (10) Days from the date it received the notice to provide evidence contesting the basis for the sanction.

7.11.1.3. Conduct a reconsideration, if requested by the Contractor.

7.11.1.4. Provide the Contractor with a written decision setting forth the basis for the reconsideration decision.

7.11.2. If the Contractor does not seek reconsideration, the denial of payment will be effective fifteen (15) Days after the date the Contractor is notified.

7.12. Enforcement Costs

7.12.1. In the event of any litigation, appeal, or other legal action to enforce any provision of the Contract, the Contractor agrees to pay all reasonable expenses of such action if EOHHS is the prevailing Party.

7.13. Reservation of Rights and Remedies

7.13.1. If the Contractor fails to meet a material obligation under this Agreement, the Contractor is in default. EOHHS will suffer irreparable injury if the Contractor defaults on a material obligation and is a breach of this Agreement.

7.13.2. If EOHHS pursues any claim for default or breach of this Agreement, no provision of this Agreement shall be construed, expressly or by implication, as a waiver by EOHHS to any existing or future right or remedy available by law.

7.13.3. Any failure by EOHHS to insist upon the strict performance of any term or condition of this Agreement or to exercise or delay the exercise of any right or remedy provided in this Agreement or by law, or the acceptance of (or payment for) materials, equipment or services, shall not release the Contractor from any responsibilities or obligations imposed by this agreement or by law, and shall not be deemed a waiver of any right by EOHHS to insist upon the strict performance of this Agreement.

7.13.4. In addition to any other remedies that may be available for the Contractor's default or breach of this Agreement, in equity or otherwise, EOHHS may seek injunctive relief against the Contractor for any threatened or actual default or breach of this Agreement without the necessity of proving actual damages.

7.13.5. EOHHS reserves the right to recover any or all administrative costs incurred in the performance of this Agreement during or as result of any threatened or actual default or breach of Agreement.

Article 8. Termination and Turnover Requirements

8.1. Termination of the Agreement

8.1.1. As set forth in 220-RICR-30-00-13.20(D) and the General Conditions of Purchase, the State Purchasing Agent may terminate the Agreement, in whole or in part, for convenience at any time when the State Purchasing Agent determines in writing that the termination is in the State's best interest. EOHHS will provide reasonable advance written notice of the termination, as it deems appropriate under the circumstances. The termination will be effective on the date specified in the notice of termination.

8.2. Termination by Mutual Agreement

8.2.1. The Contract may be terminated by mutual written agreement of the Parties.

8.3. Availability of Funds

8.3.1. The Agreement may be terminated in whole or in part in accordance with 220-RICR-30-00-13.20(C) of the General Conditions of Purchase.

8.4. Termination Due to Federal Impact

8.4.1. Notwithstanding ay provision of this Agreement to the contrary, if EOHHS does not receive CMS approval of this Agreement, EOHHS shall provide at least thirty (30) Days' prior written notice of termination of this Agreement to the Contractor. The effective date of any such termination hereunder shall be the earliest date that is at least thirty (30) Days following the date the notice is sent and occurs on the last day of a calendar month.

8.4.2. EOHHS shall not be relieved of its obligation under this Agreement, including payment to the Contractor, for the period from the contract effective date through the effective date of termination.

8.5. Termination by EOHHS for Cause

8.5.1. EOHHS and/or the State Purchasing Agent may terminate the Contract, in whole or in part, in accordance with 220-RICR-30-00-13.20(A). Additionally, EOHHS and/or the State Purchasing Agent may terminate upon the following conditions and subject to the pre-termination process described in Section 8.10:

8.5.1.1. EOHHS and/or the State Purchasing Agent may terminate the Agreement if the Contractor makes an assignment for the benefit of its creditors; admits in writing its inability to pay its debts generally as they become due; or consents to the appointment of a receiver, trustee, or liquidator of the Contractor's business or any part of its property.

8.5.1.2. EOHHS and/or the State Purchasing Agent may terminate the Agreement if a court of competent jurisdiction finds the Contractor failed to adhere to any Governing Requirements of any public authority having jurisdiction, and EOHHS determines such violation prevents or substantially impairs the Contractor's performance of its duties under the Agreement.

8.5.1.3. EOHHS and/or the State Purchasing Agent may terminate the Agreement if the Contractor breaches confidentiality laws with respect to this

Agreement.

8.5.1.4. EOHHS and/or the State Purchasing Agent may terminate the Agreement if, after providing notice and an opportunity to correct, it determines the Contractor failed to supply personnel or resources and such failure results in the Contractor's inability to fulfill its duties under the Agreement.

8.5.1.5. EOHHS and/or the State Purchasing Agent may terminate the Agreement if a judicial or quasi-judicial authority determines the Contractor, its employees, agents, or representatives violated Rhode Island laws or regulations governing gifts to officers or employees of EOHHS or the State (see R. I. Gen. Laws §§ 36-14-5, 36-14.1-2, and Rhode Island Ethics Commission Regulation Rhode Island Ethics Commission Regulation 36-14-5009).

8.5.1.6. EOHHS and/or the State Purchasing Agent may terminate the Contract if a court or governmental body issues a judgement for the payment of money in excess of $ 500,000 that is not covered by insurance, and the Contractor does not: discharge the judgment, procure a stay of execution from the judgement within thirty (30) Days of entry, or perfect an appeal and cause a stay of execution of the judgment during the appeal, providing the financial reserves required by generally accepted accounting principles. Furthermore, if a writ or warrant of attachment or any similar process is issued by any court against all or any material portion of the property of Contractor, and it is not released or bonded within thirty (30) Days after its entry, EOHHS may terminate the Agreement.

8.5.1.7. EOHHS and/or the State Purchasing Agent may terminate the Agreement if it determines, at its sole discretion, that the Contractor has committed a material breach by failing to carry out or abide by substantive terms of this Agreement or meet the applicable requirements of Federal laws or regulations, including sections 1932, 1903(m), or 1905(t) of the Social Security Act.

8.5.1.8. EOHHS and/or the State Purchasing Agent may terminate the Agreement or require replacement of a Subcontractor if the Contractor or Subcontractor is convicted of a criminal offense in a state or federal court.

8.5.1.9. EOHHS and/or the State Purchasing Agent may terminate the Agreement if the Contractor violates Attachment F-3, Section 1.19, "Employment of State Personnel."

8.5.1.10. EOHHS and/or the State Purchasing Agent may terminate the Agreement if an audit or investigation discloses any material misrepresentation or falsification by the Contractor.

8.5.1.11. EOHHS and/or the State Purchasing Agent may terminate the Agreement if the Contractor did not fully and accurately make any disclosure required under 42 C.F.R. §455.106(a).

8.5.1.12. EOHHS and/or the State Purchasing Agent may terminate the Agreement if the Contractor failed to timely submit accurate information required

under 42 C.F.R. § 455.416(d).

8.5.1.13. EOHHS and/or the State Purchasing Agent may terminate the Agreement if one of the Contractor's owners failed to timely submit information required under 42 C.F.R. § 455.416(d).

8.5.1.14. EOHHS and/or the State Purchasing Agent may terminate the Agreement if the Contractor's agent, managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts day-to-day operation of the Contractor, failed to timely submit accurate information required under 42 C.F.R. § 455.416(d).

8.5.1.15. EOHHS and/or the State Purchasing Agent may terminate the Agreement if one of the Contractor's owners has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or Title XXI program in the last ten (10) years (42 C.F.R. § 455.416(b)).

8.5.1.16. EOHHS and/or the State Purchasing Agent may terminate the Agreement if the Contractor has been terminated under Title XVII of the Social Security Act, or under any states' Medicaid or CHIP program (42 C.F.R. § 455.16(c)).

8.5.1.17. EOHHS and/or the State Purchasing Agent may terminate the Agreement if one of the Contractor's owners fails to submit sets of fingerprints in a form and manner to be determined by EOHHS within thirty (30) Days of a CMS or EOHSH request (42 C.F.R. §§ 455.416(e) and 455.450(d)).

8.5.1.18. EOHHS and/or the State Purchasing Agent may terminate the Agreement if the Contractor failed to permit access to one of the Contractor's locations for site visits under 42 C.F.R. §§ 455.432 and 455.416(f).

8.5.1.19. EOHHS and/or the State Purchasing Agent may terminate the Agreement if the Contractor has falsified any information provided on its application (42 C.F.R. § 455.416(g)).

8.6. Termination Due to Serious Threat to Health of Enrollees

8.6.1. EOHHS may terminate this Contract immediately if EOHHS determines, in its sole discretion, that actions by the Contractor, its Subcontractor(s), or Provider(s) pose a serious threat to the health of its Enrollees.

8.7. Termination for Insolvency, Bankruptcy, or Instability of Funds

8.7.1. The Contractor's insolvency or the filing of a petition in bankruptcy by or against the Contractor shall constitute grounds for termination for cause. If EOHHS determines, in its sole discretion, that the Contractor has become financially unstable, EOHHS shall immediately terminate this Agreement upon written notice to the Contractor effective the close of business on the date specified in such notice.

8.7.2. The Contractor shall cover continuation of services to Enrollees for any period for which payment has been made, as well as for inpatient admissions up until discharge.

8.8. Termination for Ownership Violations

8.8.1. The Contractor is subject to termination for cause, unless the Contractor can

demonstrate changes of ownership or control, when:

8.8.2. A person with a direct or indirect ownership interest in the Contractor:

8.8.3. Has been convicted of a criminal offense under 42 U.S.C. § 1320a-7(a), (b)(1) or (3), in accordance with 42 C.F.R. § 1002.203.

8.8.4. Has had civil Monetary Penalties or assessments imposed under 42 U.S.C. §1320a-7a.

8.8.5. Has been excluded from participation in Medicare or any state health care program.

8.8.6. Any individual who is an Affiliate or an officer (if the Contractor is organized as a corporation), or who is a partner (if it is organized as a partnership), or who is an agent or a managing employee, is under temporary management as defined in the Contract Non-Compliance section.

8.8.7. The Contractor has a direct or indirect substantial contractual relationship with an excluded individual or entity.

8.9. Contractor's Non-Renewal of Contract

8.9.1. Contractor shall provide EOHHS prior written notice of at least one (1) year if Contractor intends to not renew the Contract beyond the Agreement End Date.

8.9.2. If such notice is provided, Contract will continue to be paid at the certified and CMS-approved rates for that period for the remaining days of the Agreement.

8.9.3. During the period between Contractor's notice of non-renewal and the Agreement End Date, Contractor will follow all required and requested EOHHS procedures to ensure a smooth transition for Members to another Contractor.

8.9.4. Nothing in this subsection shall be construed as:

8.9.4.1. Giving the Contractor any automatic right to the renewal of this Agreement;

8.9.4.2. Giving the Contractor any automatic right to entering into a new agreement with EOHHS; or,

8.9.4.3. Restricting EOHHS' ability to terminate or not renew this Agreement.

8.10. Pre-Termination Process

8.10.1. The following process will apply when EOHHS terminates the Agreement for any reason set forth in Section 8.5, "Termination by EOHHS for Cause."

8.10.2. In accordance with 42 C.F.R. § 438.710 and the State's Administrative Procedures Act, R.I. Gen. Laws § 42-35-1 *et. seq.*, before terminating the Agreement, EOHHS will provide the Contractor with a pre-termination hearing. EOHHS will provide the Contractor reasonable advance written pre-termination notice, which will include the following information:

8.10.2.1. The reason for the termination;

8.10.2.2. The proposed effective date of the termination; and

8.10.2.3. The time and place of the pre-termination hearing.

8.10.2.4. After the pre-termination hearing, the State Medicaid Director will provide the Contractor with a written notice of EOHHS' final decision affirming or

reversing the proposed Agreement termination and the effective date of termination, if applicable.

8.10.2.5. If the decision to terminate is affirmed, EOHHS will notify Members of the termination in accordance with Section 8.17, "Notification of Members."

8.11. Termination by Contractor

8.11.1. Contractor may terminate the Agreement upon the following conditions, subject to the notice requirements described in Section 8.12, "Contractor's Notice of Intent to Terminate."

8.11.2. Contractor may terminate the Agreement if EOHHS fails to pay undisputed charges when due under the Agreement. It is not cause for termination if EOHHS retains premiums, recoupments, sanctions, or penalties that are allowed under the Agreement and result from the Contractor's breach, failure to perform, or default. Termination does not release EOHHS from the obligation to pay undisputed charges for services provided before the termination date. If EOHHS pays all undisputed amounts within thirty (30) Days after receiving the Contractor's notice of intent to terminate, the Contractor cannot proceed with termination under this Article.

8.11.3. Except as provided below, regarding changes to the Managed Care Manual, the Contractor may terminate the Contract if EOHHS proposes an amendment or extension to this Agreement that is unacceptable to the Contractor, including a modification of the Capitation Rates.

8.11.4. If EOHHS proposes a substantive change to the Managed Care Manual that materially impacts the Contractor's financial obligations or ability to fulfill its obligations under the Agreement, the Contractor may terminate the Agreement.

8.12. Contractor's Notice of Intent to Terminate

8.12.1. If the Contractor intends to terminate the Agreement pursuant to this Article or allow the Agreement to expire, it shall give EOHHS advance written notice at least one (1) year prior to the proposed termination or expiration. The termination date will be calculated as the last Day of the month following the one-year (1) notice period.

8.12.2. The Parties can negotiate an earlier termination date by mutual written agreement.

8.13. Extension of Extension of Termination Date

8.13.1. The Parties may extend the effective date of termination one (1) or more times by mutual written agreement.

8.14. Procedures on Termination

8.14.1. Upon expiration of this Agreement or receipt of a Notice of Termination, the Contractor shall:

8.14.1.1. Stop work under this Agreement on the expiration date or the date specified in the Notice of Termination.

8.14.1.2. With the approval of the State, settle all outstanding liabilities and claims arising from orders and subcontracts.

8.14.1.3. If applicable, complete work as has not been terminated by any Notice of

Termination.

8.14.1.4. Provide all reasonably necessary assistance to EOHHS in transitioning Members out of the Health Plan. Such assistance shall include, but not be limited to, the forwarding of medical and other records; facilitating and scheduling Medically Necessary appointments for care and services; and identifying chronically ill, high risk, hospitalized and pregnant Members in their last four (4) weeks of pregnancy. The transition of all data shall be delivered at no cost and in a format determined by EOHHS.

8.14.1.5. Provide monthly reports with the following information until the earlier of six (6) months from the termination or expiration or instructed otherwise. Reports are due on the fifteenth (15^{th}) working Day of each month for the prior month:

8.14.1.6. Claims aging reports identifying providers/creditors and IBNR amounts; A summary of cash disbursements; and

8.14.1.7. Copies of all bank statements received by the Contractor in the preceding month.

8.15. Refunds of Advance Payments

8.15.1. The Contractor shall return within thirty (30) Days of receipt any funds advanced for coverage of Members for periods after the date of termination or expiration.

8.16. Liability for Medical Claims

8.16.1. The Contractor shall be liable for all medical claims incurred up to the date of termination or expiration of the Agreement. For Members hospitalized as of the date of termination, the Contractor's liability shall extend through the end of the impatient stay.

8.17. Notification of Members

8.17.1. Prior to expiration or termination of this Agreement, EOHHS will notify all impacted Members of:

8.17.1.1. The date of termination.

8.17.1.2. Their right to disenroll immediately without cause.

8.17.1.3. The process by which Members will continue to receive Covered Services.

8.18. Responsibilities Upon Termination and/or Default of Agreement

8.18.1. Upon termination or default in accordance with 220-RICR-30-00-13.20 and the delivery to the Contractor of the final decision to terminate in accordance with Section 8.10, "Pre-Termination Process," the Contractor shall:

8.18.1.1. Stop work under this Agreement on the date and to the extent specified in the notice of termination.

8.18.1.2. Take such action as may be necessary, or as the EOHHS Contract Officer may reasonably direct, for the protection and preservation of the property related to this Agreement that is in the possession of the Contractor and in which the State has or may acquire an interest.

8.18.1.3. Terminate all orders to the extent that they relate to the performance of

work terminated by the notice of termination.

8.18.1.4. Subject to the provisions of this paragraph, assign to the State all of the rights, title, and interest of the Contractor under the orders so terminated, in which case EOHHS shall have the right, at its discretion, to settle or pay any or all claims arising out of the termination of such orders, however, notwithstanding this provision, the Contractor shall not be obligated to assign any such rights, title or interest in the absence of payment therefore by the State.

8.18.1.5. With the approval or ratification of the State, initiate settlement of all outstanding liabilities and all claims, arising out of such termination of orders, the cost of which would be reimbursable in whole or in part, in accordance with the provisions of this Agreement. Final approval by EOHHS shall not be unreasonably withheld.

8.18.1.6. Subject to the provisions of this paragraph, transfer title, or if the Contractor does not have title, then transfer their rights to the State (to the extent that title has not already been transferred) and deliver in the manner, at reasonable times, and to the extent reasonably directed by the State all files, processing systems, data manuals, or other documentation, in any form, that relate to the work completed or in progress prior to the notice of termination.

8.18.1.7. If instructed, complete the performance of such part of the work as shall not have been terminated by the notice of termination. The Contractor shall proceed immediately with the performance of the above obligations notwithstanding any delay in determining or adjusting the amount of any item of reimbursable price under this clause.

8.18.1.8. Upon termination, Contractor shall ensure an orderly transition in accordance with 220-RICR-30-00-13.30 and Article 8, "Termination and Turnover Requirements."

8.19. Contractor Responsibility for Termination Costs

8.19.1. If EOHHS terminates the Agreement for any reason set forth in Section 8.5, "Termination by EOHHS for Cause," the Contractor shall be responsible to EOHHS for all reasonable costs incurred by EOHHS and the State of Rhode Island to replace the Contractor. These costs include, but are not limited to, the costs of procuring a substitute vendor and the cost of any claim or litigation reasonably attributable to Contractor's breach or failure to perform any service in accordance with the terms of the Contract.

8.20. Termination—Information on Outstanding Claims

8.20.1. If the Agreement is terminated or not renewed, the Contractor shall provide EOHHS within one (1) year, all available information reasonably necessary for the reimbursement of any outstanding claims for services to Enrollees [42 C.F.R. 434.6(a)(6)].

8.20.2. Information and reimbursement of such claims is subject to the provisions under this

Agreement.

8.21. Turnover Phase General Requirements

8.21.1. This section includes the Scope of Work for the Turnover Phase of the Agreement. During this phase, the Contractor shall provide all turnover assistance EOHHS determines necessary to close out the Agreement and transition the work to another vendor or the state.

8.21.2. Upon termination of the Agreement, the Contractor shall comply with all terms and conditions stipulated in this Agreement, including but not limited to:

8.21.2.1. Continuation of MCO Covered Services to Enrollees until the effective date of termination; and,

8.21.2.2. Compliance with all requirements that survive termination of the Agreement (e.g., provider reimbursement, encounter submissions, report submissions, record retention requirements, and other requirements with specific dates or time periods that extend beyond the effective date of termination) until the applicable date or at the end of the applicable time period specific in this Agreement and the MCM.

8.22. Turnover Events

8.22.1. The Contractor shall complete Turnover Phase activities in the following circumstances:

8.22.1.1. Expiration or termination of all or part of the Agreement.

8.22.1.2. The Contractor's merger with or acquisition by another entity.

8.22.2. During the Turnover Phase, the Contractor shall continue to perform its responsibilities under the Agreement, including rendering all contracted services, until EOHHS determines the Contractor has completed all Turnover Phase requirements.

8.22.3. Contractor shall provide all reasonably necessary assistance to EOHHS in transitioning Members out of the Contractor's Health Plan. Such assistance shall include:

8.22.3.1. Forwarding medical and other records.

8.22.3.2. Facilitating and scheduling Medically Necessary appointments for care and services.

8.22.3.3. Identifying Members with special health care needs, including those who are chronically ill, high risk, hospitalized, or pregnant.

8.22.4. The Contractor shall maintain sufficient key personnel and support staff based in Rhode Island to support all required Agreement functions. The Contractor's transition team shall assist with Member transitions to new Health Plans and share all documentation required by EOHHS, such as active Prior Authorizations, current assessments and care plans, and other necessary information to support continuity of care, particularly for Members with special health care needs.

8.23. Turnover Plan

8.23.1. No later than six (6) months after the Effective Date of the Agreement, the Contractor shall provide a comprehensive Turnover Plan for EOHHS approval. The Contractor shall provide the Turnover Plan and annual updates to the plan in accordance with

Managed Care Manual.

8.23.2. The Turnover Plan shall include the Contractor's proposed:

8.23.2.1. Schedule, activities, and resources associated with Turnover Phase tasks;

8.23.2.2. Staffing plan and retention strategies;

8.23.2.3. Continuity of care;

8.23.2.4. Enrollee support and communication strategies;

8.23.2.5. Provider network and access to care standards;

8.23.2.6. Provider support and communication strategies;

8.23.2.7. Claims management, including provider payments and recoupments;

8.23.2.8. Reporting of deliverables due after contract termination;

8.23.2.9. Process for turning over records and information maintained by the Contractor and its Subcontractors to either EOHHS or a third party designated by EOHHS;

8.23.2.10. Approach completing the data transfer activities described in Section 8.24;

8.23.2.11. Quality assurance process for monitoring Turnover Phase activities;

8.23.2.12. Approach to training EOHHS or a subsequent Health Plan's staff on the operation of the Contractor's business practices;

8.23.2.13. Third-party software used by the Contractor and its Subcontractors to perform contractual duties, including how the software is used and the terms of the license agreement, so that EOHHS can determine if the software is needed to transition operations;

8.23.2.14. Include a detailed work plan, in Excel format or another format specified by EOHHS, that includes the proposed schedule, activities, resources, and dependencies associated with the turnover tasks, including tasks that extend beyond termination of the Agreement;

8.23.2.15. Describe the Contractor's approach for the transfer of all records, data, and operational support information as applicable, to either EOHHS or a third party designated by EOHHS; include an itemization of records, data, and operational support information (in broad categories) that will be transferred and the schedule for completion. The proposed transfer schedule should be phased and align around the effective date of termination (e.g., sixty (60) Days prior, day of termination, thirty (30) Days after, etc.); and,

8.23.2.16. Include copies of all relevant Enrollee and MCO Covered Services data, documentation, and other pertinent information necessary, as determined by EOHHS, for EOHHS or a subsequent Health Plan to assume the operational activities successfully. This includes, but not limited to, correspondence, documentation of ongoing outstanding issues, and other operations support documentation.

8.23.3. The Contractor shall update the Turnover Plan within one (1) month of notifying

EOHHS of a merger or acquisition that impacts the Agreement, or at EOHHS's request prior to the expiration or termination of the Agreement.

8.23.4. EOHHS may require the Contractor to submit additional information or make modifications to the Turnover Plan.

8.24. Data Transfer

8.24.1. The Contractor shall transfer all data, records, documentation, and information (collectively "information") necessary to transition operations to EOHHS or a subsequent Health Plan, including:

8.24.1.1. Data and reference tables.

8.24.1.2. Data entry software.

8.24.1.3. License agreements for third-party software and modifications.

8.24.1.4. Documentation relating to software and interfaces.

8.24.1.5. Functional business process flows.

8.24.1.6. Operational information, including correspondence, documentation of ongoing or outstanding issues, operations support documentation, and operational information regarding Subcontractors.

8.24.1.7. Member and Covered Service information.

8.24.1.8. Any other EOHHS determines necessary for EOHHS or a subsequent Health Plan to assume operational activities successfully.

8.24.2. For purposes of this section, "documentation" includes all operations, technical, and user manuals used in conjunction with the software. The Contractor shall produce all documentation EOHHS determines is needed to view and extract application data in a proper format.

8.24.3. The Contractor shall provide, in a HIPAA-compliant format, all information needed to map information from the Contractor's systems to the replacement systems, including a comprehensive data dictionary.

8.24.4. The Contractor shall provide all information at no additional cost to EOHHS.

8.24.5. If EOHHS determines information provided by the Contractor or its Subcontractors is not accurate, complete, or HIPAA compliant, it reserves the right to hire an independent contractor, at the Contractor's expense, to assist in obtaining and transferring information.

8.25. Post-Turnover Services

8.25.1. The Contractor shall provide EOHHS with a Turnover Results Report no later than thirty (30) Days after completing Turnover Phase activities. The report shall document that all activities outlined in the Turnover Plan are complete. Turnover shall not be considered complete until EOHHS approves this plan.

8.25.2. For the last month of the Contract, EOHHS shall withhold seventy-five percent (75%) of the final payment to the Contractor for a maximum of one hundred eighty (180) Days from the due date of such amount. EOHHS may retain and offset this withhold if the Contractor does not fulfill its contractual obligations, some of which may extend past

the term of the Agreement, including, but not limited to, paying EOHHS any outstanding Monetary Penalties and sanctions assessed during the term of the Agreement, paying EOHHS any Monetary Penalties and sanctions assessed after the term of the Agreement for any Contractor noncompliance that occurred during the term of the Agreement, or repaying EOHHS for payments made on behalf of ineligible Enrollees.

8.25.3. Should EOHHS identify Contractor non-compliance with any surviving provisions of the Agreement after termination or expiration of the Contract and Contractor and EOHHS have entered into a new contract for MCO services, EOHHS may offset any such Monetary Penalties and sanctions against future payments to Contractor. Penalties for Contractor noncompliance that occurred partially during the term of the Agreement and partially during the term of the new contract for MCO services shall be assessed in accordance with the terms of the Agreement for the entirety of the noncompliance. Any notice requirements by EOHHS, and Contractor dispute rights relating to the Monetary Penalties and/or payment offsets, shall be in accordance with the terms of the Contract.

8.25.4. If the Contractor fails to provide information necessary for EOHHS or a subsequent Health Plan to assume operational activities, the Contractor shall be responsible for all costs incurred by EOHHS and its agents (including travel and attorney's fees and costs) to carry out inspection, audit, review, analysis, reproduction, and transfer functions at the locations where information is kept. EOHHS may subtract such costs from the withheld Capitation Payments or invoice the Contractor. Contractor shall pay an invoice no later than ten (10) Days after receipt.

8.25.5. The Contractor shall maintain all data and records related to Enrollees and providers for ten (10) years after the data of final payment made under this Agreement or until the resolution of all litigation, claims, financial management review or audit pertaining to the Agreement, whichever is longer. Under no circumstances shall the Contractor or any of its Subcontractors destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of EOHHS.

8.25.6. The Contractor agrees to repay any valid, undisputed audit exceptions by EOHHS in any audit of the Agreement. EOHHS may, at its sole discretion, deduct from the withhold of the final payment for reimbursement of any amounts due related to the audit exception.

Article 9. Insurance Requirements

9.1. Insurance Coverage

9.1.1. As outlined in Section 13.19 of the General Conditions of Purchase and General Conditions - Addendum A, the following insurance coverage shall be required of the Contractor:

9.1.1.1. General Requirements:

a) Liability - $1 million per occurrence and $2 million aggregate. The State should be an additional insured on a primary and non-contributory basis with a waiver of subrogation in favor of the State.

b) Workers' Compensation - $100,000 each accident, $100,000 disease or policy limit and $100,000 each employee. The State should be an additional insured on a primary and non-contributory basis with a waiver of subrogation in favor of the State.

c) Automobile liability - $1,000,000 each occurrence combined single limit. The State should be an additional insured on a primary and non-contributory basis with a waiver of subrogation in favor of the State.

d) Crime - To have a minimum combined limits of not less than $500,000 per occurrence, however, in no instance shall the combined limits be less than fifty per cent (50%) of the value of the Contract or based on the amount of funds that may be diverted, whichever is greater. The State of RI should be a loss payee.

9.1.1.2. Professional Services:

a) Professional liability ("errors and omissions") - $2,000,000 per occurrence, $2,000,000 annual aggregate. Waiver of subrogation in favor of the State to the extent that coverage to the Contract Party is not impaired.

b) Working with Children, Elderly or Disabled Persons – Physical Abuse and Molestation Liability Insurance - $1 Million per occurrence.

9.1.1.3. Information Technology and/or Cyber/Privacy:

a) Technology Errors, Omissions Coverage and Cyber/Privacy/Data Breach-$20 million per occurrence and $20 million in the annual aggregate.

9.2. Evidence of Insurance

9.2.1. Contractor must provide the following documents as evidence of insurance:

9.2.1.1. Company's General Liability and Directors' and Officer's Insurance Coverages;

9.2.1.2. Claims Reinsurance Coverage and attachment points.

Article 10. Security and Confidentiality

10.1. Definitions

The following definitions apply to Article 10, "Security and Confidentiality":

10.1.1. "Breach," is defined in accordance with Health Insurance Portability and Accountability Act ("HIPAA") and Health Information Technology for Economic and Clinical Health Act ("HITECH") guidelines, means an acquisition, access, use or disclosure or suspected acquisition, access, use or disclosure of Protected Health Information ("PHI") in violation of HIPAA privacy rules that compromise Personally Identifiable Information ("PII") security or privacy. Additionally, a Breach or suspected Breach means an acquisition, access, use or disclosure or suspected acquisition, access, use or disclosure of PII or Sensitive Information ("SI").

10.1.2. "Incident" is defined by OMB Memorandum M-17-12, "Preparing for and Responding to a Breach of Personally Identifiable Information" (January 3, 2017), as an occurrence that:

10.1.2.1. Actually or imminently jeopardizes, without lawful authority, the integrity, confidentiality, or availability of information or an information system; or

10.1.2.2. Constitutes a violation or imminent threat of violation of law, security policies, security procedures, or acceptable use policies.

10.1.3. "Confidential Information" means information that Contractor receives or has access to under this Agreement, including but not limited to; PII; SI; PHI; Return Information; other information (including electronically stored information) or 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; any other records, reports, opinions, information, and statements required to be kept confidential by state or federal law or regulation, or rule of court; any statistical, personal, technical and other data and information relating to the State's data; or other such data protected by state and federal laws, regulations.

10.1.4. "Personally Identifiable Information" or "PII" means 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 that can be used to distinguish or trace an individual's identity, either alone or when combined with other personal or identifying information that is linked or linkable to a specific individual, such as their name, social security number, date and place of birth, mother's maiden name, biometric records, etc. (as defined in 45 C.F.R. § 75.2 and OMB Memorandum M-06-19, "Reporting Incidents Involving Personally Identifiable Information and Incorporating the Cost for Security in Agency Information Technology Investments" (July 12, 2006)). PII shall also include individual's first name or first initial and last name in combination with any one (1) or more of types of information, including, but not limited to, SSN, passport number, credit card numbers, clearances, bank numbers, biometrics, date and place of birth, mother's maiden name, criminal, medical and financial records, educational transcripts (as defined in 45 C.F.R. § 75.2, "Protected Personally Identifiable Information").

10.1.5. "Protected Health Information" or "PHI" means individually identifiable information

relating to the past, present, or future health status of an individual that is created, collected, or transmitted, or maintained by a HIPAA-covered entity in relation to the provision of healthcare, payment for healthcare services, or use in healthcare operations. Health information such as diagnoses, treatment information, medical test results, and prescription information are considered protected health information under HIPAA, as are national identification numbers and demographic information such as birth dates, gender, ethnicity, and contact and emergency contact information. PHI relates to physical records, while ePHI is any PHI that is created, stored, transmitted, or received electronically. PHI does not include information contained in educational and employment records that includes health information maintained by a HIPAA covered entity in its capacity as an employer.

10.1.6. "Return Information" is defined under 26 U.S.C. § 6103(b)(2) and has the same meaning as "Federal Tax Information" or "FTI" as used in IRS Publication 1075.

10.1.7. "Sensitive Information" or "SI" means information that could be expected to have a serious, severe, or catastrophic adverse effect on organizational operations, organizational assets, or individuals if the confidentiality, integrity, or availability is lost. Further, the loss of SI confidentiality, integrity, or availability might:

10.1.7.1. Cause a significant or severe degradation in mission capability to an extent and duration that the organization is unable to perform its primary functions;

10.1.7.2. Result in significant or major damage to organizational assets;

10.1.7.3. Result in significant or major financial loss; or

10.1.7.4. Result in significant, severe or catastrophic harm to individuals that may involve loss of life or serious life-threatening injuries.

10.2. General Requirements

10.2.1. The Contractor 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, or which becomes available to the Contractor in carrying out this Agreement. The Contractor agrees to comply with and require all Subcontractors and other Representatives to comply with, all state and federal requirements for safeguarding Confidential Information. All such information shall be held in strict confidence and protected by the Contractor from unauthorized use and disclosure using same or more effective procedural requirements as are applicable to the State.

10.3. Use and Disclosure of Individually Identifiable Information

10.3.1. The Contractor shall ensure its Representatives use and disclose individually identifiable health information, such as medical records and any other health or enrollment information that identifies a particular Member, in accordance with the confidentiality requirements described in this 10.2.1 of this Section and 45 C.F.R. Parts 160 and 164.

10.4. Privacy and Security Safeguards and Obligations

10.4.1. For all Confidential Information under this Agreement, the Contractor shall comply

with the following privacy and security requirements and obligations:

10.4.1.1. Ensure that its Representatives implement the appropriate administrative, physical, and technical safeguards to protect Confidential Information received by Contractor under this Agreement from loss, theft, or inadvertent disclosure.

a) Contractor shall advise all users who will have access to the Confidential Information of its confidential nature, the safeguards required to protect the Confidential Information, and the civil and criminal sanctions for noncompliance contained in applicable federal laws.

b) Contractor shall store the Confidential Information in an area that is physically and technologically secure from access by unauthorized persons during duty hours, as well as non-duty hours or when not in use (e.g., door locks, card keys, biometric identifiers, etc.). Only authorized personnel will transport the Confidential Information. Contractor shall establish appropriate safeguards for such Confidential Information, as determined by a risk-based assessment of the circumstances involved.

c) Contractor agrees that the Confidential Information exchanged under this Agreement shall be processed under the immediate supervision and control of authorized personnel, and to protect the confidentiality of the Confidential Information in such a way that unauthorized persons cannot retrieve any such Confidential Information by means of computer, remote terminal, or other means. Contractor personnel shall enter personal identification information when accessing Confidential Information on the State's systems. Contractor shall strictly limit authorization to those electronic Confidential Information areas necessary for authorized persons to perform his or her official duties.

d) Contractor shall advise all users that they are responsible for safeguarding Confidential Information at all times, regardless of whether or not the Contractor employee, subcontractor, or agent is at their regular duty station.

e) Contractor shall ensure laptops and other electronic devices/media containing Confidential Information that constitutes PII are encrypted and/or password protected.

f) Contractor shall ensure emails containing Confidential Information that constitutes PII are encrypted and sent to and received by email addresses of persons authorized to receive such information. In the case of FTI, Contractor employees, subcontractors, and agents shall comply with IRS Publication 1075's rules and restrictions on emailing return information.

g) Contractor shall restrict access to the Confidential Information only to those authorized Contractor Representatives who need such Confidential Information to perform their official duties in connection with purposes identified in this Agreement; such restrictions shall

include, at a minimum, role-based access that limits access to those individuals who need it to perform their official duties in connection with the uses of Confidential Information authorized in this Agreement ("Authorized Users"). Contractor shall not use or access Confidential Data for independent projects unrelated to the purposes identified in this Agreement. Further, the Contractor shall advise all Authorized Users who will have access to the Confidential Information provided under this Agreement of the confidential nature of the Confidential Information, the safeguards required to protect the Confidential Information, and the civil and criminal sanctions for noncompliance contained in the applicable federal laws. The Contractor shall require its Representatives and all contractors, agents, and all employees of such Representatives who are Authorized Users to comply with the terms and conditions set forth in this Agreement, and not to duplicate, disseminate, or disclose such Confidential Information unless authorized under this Agreement

h) For receipt of FTI, the Contractor agrees to maintain all return information sourced from the IRS in accordance with IRC § 6103(p)(4) and comply with the safeguards requirements set forth in IRS Publication 1075, which is the IRS published guidance for security guidelines and other safeguards for protecting return information pursuant to 26 C.F.R. § 301.6103(p)(4)-1.

10.4.2. The Contractor shall:

10.4.2.1. Establish a central point of control for all requests for and receipt of Return Information and maintain a log to account for all subsequent disseminations and products made with/from that information, and movement of the information until destroyed, in accordance with IRS Publication 1075.

10.4.2.2. Establish procedures for secure storage of return information consistently maintaining two (2) barriers of protection to prevent unauthorized access to the information, including when in transit, in accordance with IRS Publication 1075.

10.4.2.3. Consistently label return information obtained under this Agreement to make it clearly identifiable and to restrict access by unauthorized individuals. Any duplication or transcription of return information creates new records which shall also be properly accounted for and safeguarded. Return information should not be commingled with other records unless the entire file is safeguarded in the same manner as required for return information and the FTI within is clearly labeled in accordance with IRS Publication 1075.

10.4.2.4. Restrict access to return information solely to Representatives whose duties require access for the purposes of carrying out this Agreement. Prior to access, the Contractor shall evaluate which personnel require such access on a need-to-know basis. Authorized Users may only access return information to the extent necessary to perform services related to this

Agreement, in accordance with IRS Publication 1075.

10.4.2.5. Prior to initial access to FTI and annually thereafter, the Contractor shall ensure Representatives that will have access to Return Information receive awareness training regarding the confidentiality restrictions applicable to the return information and certify acknowledgement in writing that they are informed of the criminal penalties and civil liability provided by sections 26 U.S.C. §§ 7213, 7213A, and 7431 for any willful disclosure or inspection of return information that is not authorized by the Internal Revenue Code, in accordance with IRS Publication 1075.

10.4.2.6. Contractor shall ensure information systems processing return information are compliant with Section 3554(a)(1)(A)(ii) of the Federal Information Security Management Act of 2002 (FISMA).

10.5. Ownership of Confidential Information

10.5.1. The Contractor expressly agrees and acknowledges that Confidential Information provided to and/or transferred by the State or to which the Contractor has access to for the performance of this Agreement is the sole property of the State and shall not be disclosed, used, misused, provided, or accessed by any other individuals, entities, or parties without the express written consent of the State. Further, the Contractor expressly agrees to forthwith return to the State all Confidential Information and/or databases upon the State's written request or upon cancellation or termination of this Agreement.

10.5.2. Confidential Information will remain the exclusive property of the State unless as otherwise provided for in any agreement and/or the Agreement between the State and Contractor; upon completion of the project and/or services, or whenever requested by the State, Contractor will promptly destroy or return to the State, in a form acceptable to the State, any and all Confidential Information and all copies thereof, including summaries, reports or notes based thereon, unless otherwise expressly authorized by the State in writing.

10.6. Compliance with Applicable Laws, Regulations, Policies, and Standards

10.6.1. The Contractor agrees to abide by, and require Representatives to abide by, all applicable, current and as amended federal and state laws, regulations, policies, guidance and standards governing privacy and the confidentiality of information to which it may have access to under this Agreement, including to but not limited to the Business Associate requirements of HIPAA (www.hhs.gov/ocr/hipaa) and 45 C.F.R. § 155.260. In addition, the Contractor agrees to comply with the state confidentiality policy recognizing a person's basic right to privacy and confidentiality of personal information.

10.6.2. The Contractor and its Representatives shall adhere to all applicable state and federal statutes and regulations relating to confidential health care and substance Abuse treatment including but not limited to:

10.6.2.1. 42 C.F.R. Part 2, regarding the confidentiality of substance use disorder

patient records;

10.6.2.2. Rhode Island Mental Health Law, R.I. Gen. Laws §40.1-5-26;

10.6.2.3. Confidentiality of Health Care Communications and Information Act, R.I. Gen. Laws § 5- 37.3-1 et. seq.;

10.6.2.4. Identity Theft Protection Act of 2015, R.I. Gen. Laws § 11-49.3; and

10.6.2.5. HIPAA and its implementing regulations.

10.6.3. The Contractor acknowledges that failure to comply with the provisions of this Section will result in remedies, including the termination of this Agreement.

10.6.4. In connection with all PII that Contractor receives or has access to under this Agreement, the Contractor and its Representatives shall comply with Minimum Acceptable Risk Standards for Exchanges ("MARS-E"), Version 2.0 dated November 15, 2015 which includes the following suite of documents:

10.6.4.1. Volume I: Harmonized Security and Privacy Framework;

10.6.4.2. Volume II: Minimum Acceptable Risk Standards for Exchanges;

10.6.4.3. Volume III: Catalog of Minimum Acceptable Risk Security and Privacy Controls for Exchanges; and

10.6.4.4. Volume IV: ACA Administering Entity System Security Plan.

10.6.5. Notwithstanding any other requirement set out in this Agreement, the Contractor acknowledges and agrees that the HITECH Act and its implementing regulations impose requirements with respect to privacy, security and Breach notification and contemplates that such requirements must be implemented by regulations to be adopted by the DHHS. 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 shall be adhered to.

10.7. Breach/Incident Reporting

10.7.1. Upon notice of a suspected or confirmed Incident or Breach, the Contractor shall notify the State and EOHHS, in writing, within 24 hours. Written notice shall include the nature and extent, if known, of the Incident or Breach. The State and Contractor will meet to jointly develop an Incident investigation and remediation plan as soon as possible upon notice of the suspected or confirmed Incident or Breach. 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 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 Contractor shall pay the costs of all such audits.

Depending on the nature and scope of the Incident, remedies may include:

10.7.1.1. Providing information to individuals on obtaining credit reports and notification to applicable credit card companies.

10.7.1.2. Notification to the local office of the Secret Service and affected users and other applicable Parties.

10.7.1.3. Utilization of a call center.

10.7.1.4. Offering credit monitoring services on a selected basis.

10.8. Other

10.8.1. The Contractor agrees that no findings, listing, or information derived from information obtained through performance of this Agreement may be released or publicly disclosed in any form for any purpose if such findings, listing, or information contains any combination of data elements that might allow an individual to determine a Member's identification without first obtaining written authorization from the EOHHS Managed Care Director. Examples of such data elements include, but are not limited to geographic indicators, age, sex, diagnosis, procedure, date of birth, or admission/discharge date(s). The Contractor agrees further that the State will be the sole judge as to whether any finding, listing, information, or any combination of data extracted or derived from the State's files identify or would, with reasonable effort, permit one to identify an individual, or to deduce the identifying of an individual to a reasonable degree of certainty.

10.8.2. The Contractor agrees that the conditions set forth herein apply to any materials presented or submitted review or publication that contain individual identifying elements in the information obtained, as stated above, unless such information is presented in the aggregate.

10.8.3. Under no circumstance will the Contractor publicly disclose or present or submit any materials for review or publication that contains an individual's social security number, in part or in whole.

10.8.4. The Contractor is hereby notified that all initial data received from EOHHS is considered confidential by the State.

10.8.5. Contractor shall inform the State of any change in its administrative, technical, or operational environment that would impact compliance with the terms of this Agreement, including but not limited to compliance with 45 C.F.R. § 155.260.

10.8.6. The Contractor shall monitor, periodically assess, and update its security controls and related system risks to ensure the continued effectiveness of those controls in accordance with 45 C.F.R. § 155.260(a)(5).

10.8.7. The Contractor shall not be required under the provisions of this Article to keep confidential any Confidential Information or information, which is or becomes legitimately publicly available or is rightfully obtained from third Parties under no obligation of confidentiality.

10.8.8. Contractor shall establish and maintain, throughout the term of this Agreement, policies, and procedures to ensure the safekeeping of Confidential Information and prevent unauthorized access to or use of such Confidential Information in compliance

with ISO 27001 and ISO 27002 (or any replacement standard relating to information security), applicable regulatory requirements, and consistent with industry standards. In addition to its other obligations set forth in this Agreement, whenever Contractor possesses, stores, processes or has access to the State's Confidential Information, Contractor shall comply with those information security policies and procedures reasonably required by the State from time to time.

10.8.9. Nothing herein will limit the State's ability to seek injunctive relief or any and all damages resulting from the Contractor's negligent or intentional disclosure of Confidential Information.

Article 11. Record Ownership

11.1. Record Ownership

11.1.1. All records, reports, documents and other material delivered or transmitted to Contractor by EOHHS shall remain the property of EOHHS, and shall be returned by Contractor to EOHHS, at Contractor's expense, at termination of this Agreement.

11.1.2. All records, reports, documents, or other material related to this Agreement and/or obtained or prepared by the Contractor in connection with the performance of the services contracted for herein shall become the property of the State.

11.1.2.1. Upon termination of this Agreement for any reason, the Contractor shall return or destroy, as directed by EOHHS in writing, within thirty (30) Calendar Days of the effective date of termination, all PHI received from EOHHS, or created or received by the Contractor on behalf of EOHHS. This provision shall also apply to PHI that is in the possession of Subcontractors or agents of the Contractor. The Contractor shall not retain any copies of PHI.

11.1.2.2. In the event that the Contractor determines that returning or destroying PHI is not feasible, the Contractor shall provide to EOHHS notification of the conditions, within thirty (30) Calendar Days of the effective date of termination of the Contract, that make return or destruction not feasible. Upon a mutual determination that return or destruction of PHI is not feasible, the Contractor shall extend the protections of the Contract to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction not feasible, for so long as the Contractor maintains such PHI. If EOHHS does not agree with the Contractor that the return or destruction of PHI is not feasible, the Contractor shall return or destroy the PHI within thirty (30) Calendar Days of notification of EOHHS determination.

11.1.3. All other records, reports, documents, or other material shall, upon request, be returned by the Contractor to the State, at the Contractor’s expense, at termination or expiration of the Agreement.

11.2. Use of Data

11.2.1. EOHHS shall have unlimited rights to use, disclose, or duplicate, for any purpose, all information and data developed, derived, documented, or furnished by the Contractor resulting from this Contract.

11.3. Record Retention

11.3.1. The Contractor will maintain all records relating to the administration of this Agreement, including documents and electronically stored information (collectively “Contract Records”). Contract Records include:

11.3.1.1. All financial statements and records relating to expenditures or transactions

made pursuant to this Agreement.

11.3.1.2. Reports to EOHHS and source information used to prepare the reports.

11.3.1.3. Member and Provider materials.

11.3.1.4. Records relating to claims adjudication, payments, disputes, and appeals.

11.3.1.5. Records relating to Prior Authorization and other UM activities.

11.3.1.6. Records relating to quality assurance.

11.3.1.7. Records relating to Member Grievances and Appeals.

11.3.1.8. MLR records.

11.3.1.9. Subcontracts and purchase orders.

11.3.2. The Contractor must have written policies and procedures for storing Contract Records.

11.3.3. The Contractor agrees to comply with all state and federal standards for record keeping:

11.3.3.1. 42 C.F.R. § 438.5(c), regarding base rate data.

11.3.3.2. 42 C.F.R. § 438.8(k), regarding MLR reports.

11.3.3.3. 42 C.F.R. § 438.416, regarding Member Grievance and Appeals records.

11.3.3.4. 42 C.F.R. §§ 438.604 through 438.610, regarding program integrity safeguards.

11.3.4. In accordance with 42 C.F.R. § 438.3(h), the Contractor will preserve, maintain, and provide EOHHS and the entities described in Agreement for access to all Contract Records until ten (10) years after the later:

11.3.4.1. The termination or expiration of this Agreement, or

11.3.4.2. The resolution of all litigation, claims, financial management reviews, or audits relating to the Agreement.

11.4. Access to Records

11.4.1. Upon reasonable notice, the Contractor must provide prompt, reasonable, and adequate access to all Contract Records. Requests may be for any purpose, including examination, audit, investigation, inspection, contract administration, or the making of copies, excerpts, or transcripts.

11.4.2. Access to Contract Records must be provided to EOHHS or the following officials or

entities, or their designees, at any time:

11.4.2.1. DHHS and the DHHS Inspector General;

11.4.2.2. Government Accountability Office;

11.4.2.3. CMS;

11.4.2.4. Comptroller General of the United States;

11.4.2.5. State Department of Health;

11.4.2.6. MFCU of the Rhode Island Department of Attorney General;

11.4.2.7. EOHHS Office of Program Integrity and Medicaid Compliance Unit;

11.4.2.8. A state or federal law enforcement agency;

11.4.2.9. The Auditor General of Rhode Island;

11.4.2.10. A special or general investigative committee of the Rhode Island Legislature; and

11.4.2.11. Any other entity identified in writing by EOHHS.

11.4.3. The Contractor must provide access to Contract Records wherever they are maintained and in reasonable comfort. The Contractor must provide furnishings, equipment, and other conveniences EOHHS deems reasonably necessary to fulfill the purposes described in this Section.

11.4.4. The Contractor must provide the entities described in this Section access to and copies of Contract Records free of charge.

11.4.5. Upon request by a Member, the Contractor must make available any reports provided to EOHHS or other agencies regarding transactions between the Contractor and parties in interest.

11.4.6. The right to audit under this section exists for ten (10) years from the final date of the contract term or from the date of completion of any audit, whichever is later.

11.4.7. Records shall be made available during Business Hours for this purpose.

Article 12. Liability

12.1. Indemnification

12.1.1. The Contractor shall indemnify the State in accordance with Section 13.21 of the General Conditions of Purchase.

12.2. Limitation of EOHHS' Liability

12.2.1. EOHHS will not be liable for any incidental, indirect, special, or consequential, exemplary, or punitive damages under contract, tort (including negligence), or other legal theory for the intentional acts or negligence of the Contractor. This will apply regardless of the cause of action and even if EOHHS has been advised of the possibility of such damage.

12.2.2. EOHHS' liability to the Contractor under this Contract shall not exceed the per member per month total for one (1) calendar month, including amendment or change order costs agreed to by the Parties or otherwise adjudicated.

12.2.3. The Contractor's remedies are governed by the provisions in Article 7, "Performance Standards, and Remedies."

ATTACHMENT F-3
Scope of Work

Table of Contents

Article 1. Contractor Management and Administrative Requirements

1.1. General Administration Requirements

1.1.1. Contractor shall maintain sufficient administrative staff and organizational management to comply with all program standards described and required under this Agreement. At a minimum, the Contractor shall include each of the functions contained in this Agreement.

1.1.2. No delegation of responsibility, whether by Subcontract or otherwise, will terminate or limit in any way the liability of the Contractor to EOHHS for the full performance of this Agreement.

1.1.3. The Contractor shall maintain a Staffing Plan as described in Contractor's Proposal for the entirety of this Agreement.

1.1.4. Contractor shall demonstrate that the duties of the function are being carried out unimpeded for combined or altered functional duties.

1.1.5. Contractor must receive approval from EOHHS to alter, modify, combine functional duties as originally proposed in Contractor's Proposal during the entirety of the Agreement.

1.1.6. Contractor may contract with a third-party (Subcontractor or Subsidiary) to perform one or more of these functions, subject to the Subcontractor and delegation conditions described in this Agreement contained in Article 2 of this Attachment.

1.2. Principal Obligations

1.2.1. The Contractor shall establish and maintain interdepartmental structures and processes that support the effective operation and administration of this Agreement. The focus will be an integrated approach to physical health, behavioral health, and long-term care and supports (LTSS) provisions. All services should be based on current clinical knowledge and data-backed efficacy of treatment when available.

1.2.2. All Subcontractors engaged by the Contractor shall comply with the relevant Agreement stipulations, Federal and State laws, regulations, rules, policies, procedures, manuals, the State Plan, Waivers, and other relevant subregulatory guidance.

1.2.3. The Contractor and all Subcontractors shall respond, within a reasonable timeframe provided by EOHHS, to any requests for information, records, or data from healthcare oversight agencies. This includes the Rhode Island Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), and pertains to any services rendered under this Agreement. The requirement extends to Major Subcontracts with entities that manage or coordinate certain benefits for Members on behalf of the Contractor but do not directly provide the service to Members. The Contractor and its Subcontractor shall provide the information, records, or data requested by the MFCU or EOHHS without cost to the MFCU or EOHHS, and without requiring the MFCU to enter a contract, agreement, or memorandum of understanding. The Contractor and/or Subcontractor shall acknowledge that the Agreement and/or Subcontract establishes an enforceable

right for the healthcare oversight agency, which the agency can invoke in court in case of non-compliance with an information, records, or data request.

1.2.4. The Contractor shall cooperate with EOHHS, CMS, and the External Quality Review Organization (EQRO), and any other EOHHS contractors related to the operation, evaluation, and monitoring of this Agreement, the Contractor, or the Rhode Island Medicaid Managed Care Program.

1.2.5. The Contractor shall notify EOHHS in writing when there has been a material change in its operations related to the duties and obligations under this Agreement. The written notification shall include the details of the change and an assurance that it will not impact the ability of the Contractor to comply with the requirements of this Agreement.

1.2.5.1. Any material change in the Contractor's operations or administrative services shall be communicated to EOHHS in writing. This notification must detail the change and include assurances that the Contractor's ability to comply with the Agreement's requirements will remain unaffected.

1.2.6. The Contractor must notify EOHHS within one (1) year for any proposed material change related to operational or administrative services, including the subcontracting of administrative or member facing services or benefits.

1.3. Administrative Office Requirements

1.3.1. The Contractor shall have a non-residential administrative office located within the State of Rhode Island within a twenty-five (25) mile radius from the Virks Building, 3 West Road, Cranston, Rhode Island.

1.3.2. The administrative office may be co-located with the Call Center or other key operational functions of the Contractor.

1.3.3. This office must be open to conduct the general administration functions of the Contractor during normal business hours 7:00 A.M. – 6:00 P.M. EST, except on legally observed State of Rhode Island holidays.

1.3.4. The Contractor must provide a separate administrative telephone number that will enable EOHHS staff to directly reach the Contractor’s Key Personnel, without going through other office staff or the Member Services toll free phone number.

1.3.4.1. Telephone and email addresses to contact Key Personnel directly shall be provided during Readiness and updated when there is a change to Contractor’s contacts.

1.3.5. All documentation must reflect the Contractor’s Rhode Island Street address, local and toll-free telephone number.

1.3.6. The Contractor must have the capacity to send and receive facsimiles at the central business office.

1.3.7. The Contractor’s central office must be equipped with an adequate high-speed Internet connection.

1.3.8. The Contractor must also have the capacity to reproduce documents upon request at

no cost to EOHHS and in EOHHS' preferred format and delivery method.

1.3.9. The administrative office must have space for EOHHS staff to work. EOHHS will provide twenty-four (24) hour notice if private workspace at the Contractor's office is needed, including specific technology and workspace requirements.

1.4. Organizational Staffing Requirements

1.4.1. The Contractor shall recruit, develop, and retain qualified staff in numbers sufficient and appropriate to discharge the Contractor's responsibilities.

1.4.2. The Contractor shall have in place an organizational and governance structure capable of fulfilling all requirements of this Agreement. The Contractor's staffing and resource allocation shall be adequate to achieve positive outcomes and comply with the requirements of this Agreement and the MCO Manual, including the requirement for providing culturally competent services.

1.4.2.1. If the Contractor does not achieve the desired outcomes or maintain compliance with contractual obligations, EOHHS may assess liquidated damages or Corrective Action, as specified in this Agreement, or up to termination of this Agreement.

1.4.3. The Contractor agrees to have an executive management function with clear authority over all functions noted herein. Contractor shall have personnel that will fulfill all program responsibilities and duties described herein.

1.4.4. The Contractor shall ensure that key personnel staff work full-time in Rhode Island at a central business location for ease of meeting with EOHHS staff, providers, facilities and other stakeholders.

1.4.4.1. Variances to key personnel working full-time in Rhode Island shall be at the sole discretion of EOHHS and can be revoked at any time during the term of the Agreement by EOHHS.

1.4.5. The Contractor shall submit to EOHHS the following organizational charts during Readiness Review, or promptly when a key personnel change occurs. An updated organizational chart with key personnel positions. The chart must include the person's:

1.4.5.1. Legal name;

1.4.5.2. Title descriptive of duties performed;

1.4.5.3. Email address; and

1.4.5.4. Telephone number.

1.4.6. Organizational charts shall also include major subcontractors including management, supervisory, and other key personnel that the Contractor uses to perform duties under this Agreement.

1.4.7. Organizational charts should reflect current internal reporting structures.

1.4.8. Contractor may develop a functional organizational chart of the key program areas, responsibilities and the areas of the organization that report to that position.

1.4.9. An organizational or functional chart may be requested of Contractor at any time. Contractor shall promptly provide charts to EOHHS, when requested.

1.4.10. In situations where organizational changes occur, or upon explicit written demand by EOHHS, and during Readiness Review, the Contractor is required to present a comprehensive organizational chart demonstrating the composition of senior and middle-tier management. This chart shall encapsulate the staffing infrastructure for behavioral and LTSS health services. If these services are delivered by a notable Subcontractor or Subsidiary, a corresponding organizational chart shall be submitted to illustrate the relationship with the Subcontractor, thereby substantiating the integration of physical and behavioral health services. All organizational charts should highlight any existing staff vacancies, accompanied by a projected timeline for their fulfillment.

1.4.11. The Contractor shall not employ or contract with any individual who has been debarred, suspended, or otherwise lawfully prohibited from participating in any Federal healthcare program in accordance with 42 C.F.R. § 438.602(i).

1.4.12. The Contractor must ensure that all personnel are adequately trained and qualified to perform their designated functions. Regardless of personnel changes, the Contractor is obligated to perform all duties stipulated in this Agreement without degradation and in accordance with the Agreement's terms.

1.4.13. The Contractor shall present a Staffing Plan for EOHHS during Readiness Review and updated annually. This plan should outline how the Contractor intends to maintain staffing levels necessary for fulfilling all contractual obligations.

1.4.14. EOHHS reserves the right to require the Contractor to revise or implement business processes or procedures for adequate staffing and resource allocation to meet the terms and conditions of this Agreement at no additional cost. The Contractor shall implement these changes within thirty (30) Days of the EOHHS notice, unless specified otherwise by EOHHS or mutually agreed by EOHHS and the Contractor.

1.4.15. The Contractor is prohibited from employing or subcontracting anyone debarred, suspended, or otherwise legally barred from participating in any Federal healthcare program. The Contractor shall screen all potential employees and Subcontractors using, at a minimum, the following resources:

1.4.15.1. Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE);

1.4.15.2. Rhode Island Adverse Actions List Search;

1.4.15.3. The System of Award Management (SAM); and,

1.4.15.4. Other applicable sties as determined by EOHHS.

1.4.16. The Contractor shall adhere to EOHHS policies and procedures in the MCM, which require background checks for potential and current employees or Subcontractors with access to Member Protected Health Information (PHI). Upon request, the Contractor shall provide EOHHS with a satisfactory criminal background check or an attestation

that a satisfactory criminal background check has been completed for any assigned or proposed staff for this Agreement. The Contractor is required to review all Contractor's staff and subcontracted staff at least quarterly under this Agreement.

1.4.17. The Contractor shall remove or reassign, upon written request from EOHHS, any employee or Subcontractor employee that EOHHS deems to be unacceptable. The Contractor shall hold harmless for actions taken as a result hereto.

1.4.18. The Contractor shall provide the appropriate staff representation for attendance and participation in meetings and/or events scheduled by EOHHS, in person or virtual, when required. All meetings shall be considered mandatory unless otherwise indicated.

1.4.19. The Contractor must provide notification to EOHHS within five (5) Days from receipt of formal written notice of departure for key personnel.

1.4.20. The Contractor must provide notification to EOHHS within thirty (30) Days when key personnel will be not available for more than five (5) Business Days due to scheduled leave. Such notification shall include how key personnel's work responsibilities and EOHHS escalation paths during that key personnel's absence.

1.4.21. The Contractor is required to ensure that personnel dedicated to the Rhode Island Medicaid Managed Care Program line of business who communicate via email with EOHHS or via email regarding the Rhode Island Medicaid Managed Care Program to other external parties perform these communications using an email address that is comprised of a domain address that clearly represents the entity contracted with EOHHS to provide covered services under this Agreement. Contractors with multiple email addresses must link accounts together to provide EOHHS with a single identifying email address.

1.5. Contractor's Key Personnel Requirements

1.5.1. The Contractor shall identify the individuals serving as Key Personnel.

1.5.2. Unless the Contractor requests and received a written exception from EOHHS, all Key Personnel shall be a full-time employee [minimum forty (40) hours per week], based in Rhode Island, dedicated one hundred percent (100%) to this Agreement, and serve in only one (1) Key Personnel position.

1.5.2.1. If an individual is not required to, and does not, serve exclusively in their Key Personnel position, the Contractor shall provide to EOHHS, in writing, a description of the individual's other responsibilities. Such description shall also be provided with the Contractor's request for an exception from EOHHS, if applicable.

1.5.3. All Key Personnel staff listed under Sections 1.6.2.1.3 and 1.6.3 shall be listed in Table 2: "Contractor's Non-Executive Key Personnel" located in Attachment F-10, "Contractor's Key Personnel Table" of this Agreement and shall be updated at least annually or upon request of EOHHS.

1.5.4. The Contractor shall seek prior written approval from EOHHS for all Key Personnel

positions before a candidate is hired.

1.5.5. The Contractor shall supply Key Personnel with the resources necessary to meet all contractual requirements.

1.5.6. The Contractor shall ensure project continuity by notifying the EOHHS Contract Officer in writing within two (2) Business Days of a change in Key Personnel, and by replacing Key Personnel with persons having the requisite skills, experience, and other qualifications for the function performed.

1.5.7. The Contractor shall use interim staff to fill a Key Personnel position for as brief a time as possible but not to exceed six (6) months, unless approved in writing by EOHHS.

1.5.8. Failure to recruit and retain Key Personnel timely may result in a Corrective Action or Liquidated Damages under this Agreement.

1.5.9. The Contractor shall consult with EOHHS if the Contractor promotes an employee to a new role when deciding on the hire and/or feedback on the working relationship with that employee if the employee has a role that requires direct interfacing with EOHHS. The Contractor reserves the right to demote an employee at any time during the Agreement.

1.5.10. Notwithstanding 220-RICR-30-00-13.22(A)(11), if EOHHS determines a satisfactory working relationship cannot be established with certain Key Personnel, it will notify the Contractor in writing. Upon receipt of EOHHS' notice, the Parties will attempt to resolve EOHHS' concerns on a mutually agreeable basis within forty-five (45) Business Days.

1.5.11. If EOHHS determines a satisfactory working relationship cannot be established with certain Key Personnel, it will notify the Contractor in writing. Upon receipt of EOHHS' notice, the Parties will attempt to resolve EOHHS' concerns on a mutually agreeable basis with EOHHS decision being the prevailing authority.

1.5.12. Key Personnel shall be knowledgeable regarding the Rhode Island community and geography to operate a Medicaid Managed Care Program.

1.5.13. Other functional areas may be added to the Agreement at any time based on the needs of the Rhode Island Medicaid Managed Care Program by EOHHS. Such additions will be communicated to the Contractor in writing thirty (30) days prior to requested role to be filled by the Contractor. The Contractor shall reserve the right to not fill the functional area in writing to EOHHS within five (5) Business Days of notification by EOHHS. Parties shall come to a mutually agreeable solution to meet the needs of the requested functional area required by EOHHS.

1.5.14. Contractor shall provide to EOHHS in writing its intention to combine or allocate positions with other contracted clients or other lines of business a Contractor may operate in the State of Rhode Island. EOHHS retains sole authority to approve or deny such requests in the best interests to the State, including at additional cost to the Contractor to ensure performance of all Contractual duties.

1.5.15. EOHHS may revoke approval at any time for combined positions by the Contractor due to poor performance.

1.6. Contractor's Key Personnel

1.6.1. The Contractor shall have a staffing structure in place sufficient in number and expertise to fulfill all requirements of this Agreement. All Key Personnel shall be in place within the timeframe established by EOHHS as part of Readiness Review requirements.

1.6.2. As stated in the Contractor's proposal, the Contractor shall designate Key Personnel who will be assigned to the Agreement. For the purposes of this requirement, Key Personnel include:

1.6.2.1. Chief Executive Officer (CEO);

1.6.2.2. Chief Financial Officer (CFO);

1.6.2.3. Chief Operating Officer (COO);

1.6.2.4. the Rhode Island Medicaid Contract Officer (RIM-CO);

1.6.2.5. Long-Term Services and Supports Benefit Officer (LTSS-BO);

1.6.2.6. Chief Medical Officer (MCO);

1.6.2.7. Chief Behavioral Health Officer (CBHO);

1.6.2.8. Chief Pharmacy Officer(CPO);

1.6.2.9. Chief Technology Officer (CTO);

1.6.2.10. Chief Compliance Officer (CCO);

1.6.2.11. Chief Diversity, Equity, and Inclusion Officer (CDEIO); Chief Health Equity Officer; Privacy Official;

1.6.2.12. Security Official (45 C.F.R. § 164.308); and

1.6.2.13. The following individuals, each of whom shall be fully dedicated (full time) for this Contract with management responsibility for the following functional areas:

a) Members Services;

b) Provider Network Development and Management;

c) Provider Relations;

d) Medical Management;

e) Quality Assurance and Improvement;

f) Care Management Program;

g) Benefit Administration;

h) Utilization Management for Physical, Behavioral and HCBS Services;

i) MIS and Claims Processing;

j) Grievances and Appeals;

k) Reporting;

l) HCBS Services Administration;

m) LTSS Administration;

n) Program Integrity and Compliance;

o) Value-Based Care Programs;

p) EPSDT Coordinator; and,

q) Special Investigative Units for Fraud, Waste, and Abuse.

1.6.3. The Contractor may maintain the following Key Personnel within or outside the State of Rhode Island, as appropriate:

1.6.3.1. Claims Managers; and,

1.6.3.2. Internal Audit Director.

1.6.4. The Contractor may maintain the following positions throughout Rhode Island in order to best serve the needs of Members:

1.6.4.1. Behavioral health support staff;

1.6.4.2. Physical health support staff;

1.6.4.3. LTSS and HCBS support staff;

1.6.4.4. Care Managers;

1.6.4.5. Grievance and Appeals Staff

1.6.4.6. Internal audit staff;

1.6.4.7. Pharmacy support Staff

1.6.4.8. Provider services staff;

1.6.4.9. Quality management staff;

1.6.4.10. Member services support staff;

1.6.4.11. Member marketing support staff;

1.6.4.12. Transition coordination staff; and,

1.6.4.13. UM staff.

1.7. Contractor's Requirements for Executive Management Functions and Executive Leadership

1.7.1. Executive Contract Management shall be available to attend meetings, legislative meetings or in-person meetings in Rhode Island, with or without notice, at no additional cost to EOHHS. If Executive Contractor Management cannot attend a meeting, with the prior approval of EOHHS, they shall send a delegate who is knowledgeable in their content areas.

1.7.2. Contractor will notify EOHHS promptly of any new personnel filling acting or permanent positions for Executive Contract Management prior to communicating within the Contractor's organizational structure, external parties, media or other governmental agency as permitted under law.

1.7.3. For the basis of this Agreement, Executive Management Functions and Executive Leadership will consist of the following locally-based FTEs:

1.7.3.1. Chief Executive Officer (CEO);

1.7.3.2. Chief Financial Officer (CFO);

1.7.3.3. Chief Operating Officer (COO);

1.7.3.4. Rhode Island Medicaid Contract Officer (RIM-CO);

1.7.3.5. Long-Term Services Benefit Officer (LTSS-BO);

1.7.3.6. Chief Medical Officer (CMO);

1.7.3.7. Chief Behavioral Health Officer (CBHO);

1.7.3.8. Chief Pharmacy Officer (CPO)

1.7.3.9. Chief Technology Officer (CTO);

1.7.3.10. Chief Compliance Officer (CCO);

1.7.3.11. Chief Diversity, Equity, and Inclusion Officer (CDEIO); and,

1.7.3.12. Health Equity Officer (HEO).

1.7.4. The Contractor may elect through its organizational management structure to have additional Executive Management personnel (e.g., marketing, sales, legal services, etc.), however, these are not required under this Agreement.

1.7.5. All Executive Management staff listed under Section 1.7.3 shall report to the CEO, except for the Chief Technology Officer or the Health Equity Officer and have a span of control over their roles and responsibilities and can always perform duties in an executive capacity during the Agreement on behalf of the CEO.

1.7.6. The Contractor shall notify the EOHHS Contract Officer of a change in the Executive Management Functions within one (1) Business Day and provide a transition plan no later than five (5) Business Days after the Contractor becomes aware of the staffing change.

1.7.7. All Executive Management staff listed under Section 1.7.3 shall be listed in Table 1: "Contractor's Executive Management" located in Attachment F-10, "Contractor's Key Personnel Tables" of this Agreement and shall be updated at least annually or upon request of EOHHS.

1.7.8. All staff resumes for the Executive Management Functions shall be attached in Attachment F-11, "Contractor's Executive Management Functional Resumes" of this Agreement and shall be updated at least annually or upon request of EOHHS.

1.7.9. Chief Executive Officer

1.7.9.1. The Contractor shall employ a qualified individual to serve as the Chief Executive Officer (CEO). The CEO shall be a full-time employee of the Contractor and hold a senior executive management position in the Contractor's organization.

1.7.9.2. The CEO shall provide overall direction for this Agreement, develop strategies, formulate policies, and oversee operations to ensure goals are met.

1.7.9.3. The CEO shall have an extensive experience working with health care delivery systems and health care policy issues. A master or doctorate degree is preferred in business, public health, hospital administration, or health administration, human services, healthcare, behavioral health, or related fields. A minimum of five (5) years of experience at the CEO level in a similar sized for-profit, acute-care hospital, or health system is required. The CEO should have senior level experience, ideally ten (10) years or more, working on healthcare system and policy issues for Medicaid or Medicaid-like populations prior serving in this role under this Agreement.

1.7.9.4. The CEO shall act as a liaison between the Contractor and EOHHS Executive leadership and shall be authorized and empowered to represent the Contractor on all matters pertaining to the Agreement.

1.7.9.5. The Contractor cannot propose an alternate structure for the CEO position.

1.7.9.6. The CEO shall attend all CEO designated meetings in-person as requested by EOHHS. If the CEO is unable to attend, a designee may attend with advance notification and approval by EOHHS.

1.7.9.7. The CEO is responsible for the following duties:

a) Delivering on client-satisfaction and value of all services procured under this Agreement to EOHHS;

b) Ensuring performance with the terms of this Agreement, including securing and coordinating required resources;

c) Receiving and responding to EOHHS and legislative inquiries and requests;

d) Appearing at public events or providing EOHHS approved statements to the media regarding the Contractor's participation in the Rhode Island Medicaid Managed Care Program under this Agreement;

e) Participating in regular CEO meetings or calls with EOHHS Leadership;

f) Making best efforts to promptly resolve any issues identified by the Contractor or EOHHS related to this Agreement;

g) Meeting with EOHHS representatives on a periodic, or as needed basis, to review the Contractor's performance and resolve issues or disputes;

and,

h) Execution of amendments or agreements to modify to this Agreement in an amendment.

1.7.10. Chief Financial Officer

1.7.10.1. The Chief Financial Officer (CFO) is trained and experienced in financial management, financial accounting, and financial reporting to oversee the Contractor's financial solvency for the Rhode Island Medicaid Managed Care Program under this Agreement.

1.7.10.2. The CFO shall oversee the budget, accounting systems, financial reporting, and all audit activities implemented by the Contractor.

1.7.10.3. The CFO shall have a minimum of ten (10) years of experience in various financial areas of a multi-faceted health plan, health care system, and/or multi-service Provider. The CFO shall possess a master's degree in financial management and be a Certified Public Accountant (CPA). The CFO shall have at least five (5) years of executive experience in budgeting, financial analysis, and reimbursement or five (5) years of experience in health care finance and/or contracting, including hospital and professional services billing with at least $50,000,000 in annual revenue.

1.7.10.4. The CFO shall serve exclusively in this position and shall not function in any Executive Capacity for another insurance product.

1.7.10.5. The CFO is responsible for:

a) Ensuring compliance with all financial terms of this Agreement;

b) Production and review of all financial reporting;

c) Receiving and responding to EOHHS inquiries and requests related to financial matters; and,

d) Meeting with EOHHS representatives on a periodic or as needed basis to review the Contractor's performance and resolve financial issues or disputes.

1.7.11. Chief Operating Officer

1.7.11.1. The Chief Operating Officer (COO) shall manage day-to-day operations of multiple levels of staff and multiple functions/departments across the Contractor's organization to meet the performance requirements under this Agreement.

1.7.11.2. The COO shall have a minimum of eight (8) years in senior leadership roles, preferably with experience in healthcare sector or healthcare administrative operations. The CCO shall possess a master's or doctoral degree in business administration, public administration, or operations/supply chain management. The COO shall have a strong background in government programs such as Medicaid, Medicare, or Dual

Eligible is also crucial. This experience should demonstrate a capacity for progressive management, particularly in the healthcare delivery or public benefits administration fields.

1.7.11.3. The COO shall possess a certification as Project Management Professional (PMP) or relevant certification to ensure the Contractor is using the best operational practices for health plan administration and project management. The COO is responsible for overseeing various operational activities of the Contractor, driving organizational change and efficiencies, and strong problem-solving skills related to complex programmatic operations.

1.7.11.4. The COO shall be accountable to the CEO and EOHHS for operational results and is designated to serve as the primary point-of-contact for all Contractor's operational issues.

1.7.11.5. The COO shall serve exclusively in this position and shall not function in an Executive Capacity for another insurance product.

1.7.11.6. The COO is responsible for:

a) Ensuring compliance with all operational terms of this Agreement;

b) Claims payment system performance, interfacing and reporting capabilities, integrating databases, Member Services, Provider Services, and always ensure continuity of operations during this Agreement.

c) Receiving and responding to EOHHS inquiries and requests related to all operational matters;

d) Participating in regular meetings or calls with EOHHS leadership;

e) Making best efforts to promptly resolve any operational issues identified by the Contractor or EOHHS related to this Agreement; and,

f) Meeting with EOHHS representatives on a periodic or as needed basis to review the Contractor's performance and resolve operational issues or disputes.

1.7.12. Rhode Island Medicaid Contract Officer

1.7.12.1. The Rhode Island Medicaid Contract Officer (RIM-CO) shall be a senior executive in the Contractor's organizational management structure and responsible for the day-to-day operations of the Contractor and serve as a single-point of contact for the EOHHS Contract Officer for all communications and requests related to the Agreement.

1.7.12.2. The RIM-CO shall avail themselves to EOHHS at any time during normal business hours to discuss any pertinent or urgent matters regarding the performance of the Agreement.

1.7.12.3. The RIM-CO shall ensure that all deliverables are met and is authorized to escalate and resolve all implementation and operational issues related to this Agreement.

1.7.12.4. The RIM-CO shall attend all oversight meetings conducted by EOHHS. The Rhode Island General Manager shall agree to participate in additional meetings requests by EOHHS.

1.7.12.5. The Rhode Island General Manager shall have a minimum of eight (8) years' management experience, with at least five (5) of those years managing benefits and services administered through a State Medicaid or public health insurance program of equal or greater scope. If the Contractor can demonstrate its inability to fill a role, the Contractor may in writing propose equivalent experience and/or alternative job qualifications, EOHHS may approve or reject the proposed alternative qualifications.

1.7.12.6. Contractor shall notify EOHHS promptly in writing of a change in the RIM-CO and qualifications to fulfill duties and responsibilities. EOHHS reserves the right to accept or reject Contractor substitutions to fill role in an acting or permanent position.

1.7.13. Long-Term Services and Supports Benefit Officer

1.7.13.1. The Long-Term Services and Supports Benefits Officer (LTSS-BO) is responsible for the day-to-day operations and implementation of the Contractor's LTSS benefits.

1.7.13.2. The LTSS-BO shall manage relationships with LTSS providers and ensure that the Contractor is responsive to provider inquiries, complaints, and questions.

1.7.13.3. The LTSS-BO shall ensure that the Contractor is meeting all State and Federal reporting requirements.

1.7.13.4. The LTSS-BO shall attend oversight meetings in-person as requested by EOHHS. If the LTSS-BO is unable to attend, a designee may attend with advance notification and approval by EOHHS.

1.7.13.5. The LTSs Benefits Officer (LTSS-BO) shall be licensed in a field of health and/or human services (nursing, social work, case management etc.) in the State of Rhode Island and/or have at least five (5) years minimum experience in long term care or long-term services and supports. Direct service and/or clinical experience with Medicaid and Medicare population is preferred.

1.7.13.6. The LTSS BO shall be employed full time by the Contractor and given sufficient support staff, including assistance directors to help carry out responsibility of the office.

1.7.13.7. Responsibilities include ensuring timely access to home and community-based services, the diversion of avoidable institutional placement in long term care and working cross-functional with other key officers (medical, behavioral health) and the Medicare product to ensure coordinate of care

and services for Medicaid only population and dual eligible population receiving LTSS.

1.7.13.8. Lead a diverse team of professionals LTSS to oversee the provision of LTSS services and supports.

1.7.13.9. The LTSS BO shall service exclusively in this position and may not function in any other executive capacity for another insurance product without prior written approval by EOHHS.

1.7.13.10. The LTSS BO shall attend all EOHHS designated meetings in person, as required by EOHHS as well as stakeholder meeting with key LTSS providers and advocacy organizations.

1.7.14. Chief Medical Officer

1.7.14.1. The Chief Medical Officer (CMO) shall be licensed to practice medicine in Rhode Island and be board-certified, board-eligible, or trained in his or her field of specialty, Timely medical decisions, including after-hours consultation, as needed. During periods when the CMO is not available, the Contractor shall have physician staff available to provide competent medical direction and leadership.

1.7.14.2. The CMO shall serve exclusively in this position and may not function in any Executive Capacity for another insurance product without prior written approval by EOHHS.

1.7.14.3. The CMO shall attend all CMO designated meetings in-person as requested by EOHHS. If the CMO is unable to attend, a designee may attend with advance notification and approval by EOHHS.

1.7.14.4. The CMO shall be:

a) Employed full-time by the Contractor.

b) Given sufficient support staff, including assistant or associate Medical Directors, to help carry out the responsibilities of the office.

c) Available to the Contractor's medical staff daily for consultation on referrals, denials, Appeals, Complaints, and problems.

1.7.14.5. The CMO's responsibilities shall include:

a) Development, implementation, and oversight of the Contractor's internal quality assurance program (QAP) and UM Program activities, including Prior Authorizations (PAs), concurrent reviews, and retrospective reviews. The CMO shall have adequate and appropriate experience in these areas.

b) Serving as the Contractor's senior clinical officer and participating in the development of Alternative Payment Methodologies (APMs) and related quality metrics. Additionally, the CMO shall provide clinical executive leadership as the Contractor analyzes the outcomes of quality metrics for any APMs, including APMs with Accountable Entities.

c) Participating in Medical Advisory Committee meetings with the EOHHS Chief Medical Officer.

1.7.14.6. The CMO is responsible for development, implementation, and oversight of:

a) The Contractor's UM and quality assurance (QA) committees.

b) Care Program activities, including Health Promotion, Care Coordination, Care Management, and Complex Case Management activities, as well as Service Planning activities.

c) Staff education about the Contractor's policies and procedures on advanced directives.

d) The Contractor's medical policies, practice standards, and protocols, including the use of evidence-based practice guidelines.

e) Referral process for specialty and Out-of-Plan Services.

f) The investigation of all potential quality of care problems, including but not limited to Member-specific occurrences of possible Health Care Acquired Conditions and Other Provider-Preventable Conditions or hospital acquired conditions in accordance with 42 C.F.R. § 447.26, 42 C.F.R. Parts 447, 434, 438, and Sections 1902(a)(4), 1902(a)(6), and 1903 of the Social Security Act.

g) Recommendations regarding the development and implementation of corrective action plans for Providers.

h) Processes to ensure confidentiality of medical records, information regarding sexually transmitted infection appointments, mental health and substance use appointments, and other Confidential Information belonging to the Member.

i) Provider recruitment and credentialing activities.

j) Disease management and Population Health Management programs and strategies to educate Members about health promotion, disease prevention, and efficient and effective use of health care benefits.

k) Diversity and Health Equity initiatives.

1.7.14.7. The CMO shall serve as a liaison between the Contractor and its Providers and communicate regularly with Providers, addressing areas of clinical relevance including but not limited to:

a) UM and management functions, including requirements for PAs, concurrent reviews, and retrospective reviews.

b) Prescription and over-the-counter drug formulary for Medicaid Members.

c) Health Equity, promotion, and disease management programs.

d) Clinical practice guidelines.

e) Quality indicators, such as the Contractor's performance on HEDIS®

and CAHPS® measures.

1.7.14.8. The CMO shall serve as the Contractor's representative on the EOHHS Medical Care Advisory Committee and may be tasked with providing input and feedback on clinical guidance related to their capacity as CMO to the Contractor to EOHHS leadership.

1.7.15. Chief Behavioral Health Officer

1.7.15.1. The Chief Behavioral Health Officer (CBHO) shall be licensed to provide behavioral health services in Rhode Island and have a minimum of five (5) years of experience in the provision and supervision of treatment for mental health and substance use disorders and may be board-certified in psychiatry with at least three (3) years of clinical experience with Medicaid or Medicaid-like populations. The Contractor shall propose alternative job qualifications if unable to recruit a psychiatrist.

1.7.15.2. The CBHO shall ensure Timely clinical decisions, including after-hours consultations, as needed.

1.7.15.3. During periods when the CBHO is not available, the Contractor shall have competent clinical staff available to provide direction.

1.7.15.4. The CBHO shall serve exclusively in this position and may not function in any Executive Capacity for another insurance product without prior written approval by EOHHS.

1.7.15.5. The CBHO shall attend all EOHHS designated meetings in-person, as requested by EOHHS. If the CBHO is unable to attend, a designee may attend with advance notification and approval by EOHHS.

1.7.15.6. The CBHO shall meet regularly with the Contractor's Chief Medical Officer to ensure the integration with physical health.

1.7.15.7. The CBHO shall be:

a) Employed full-time by the Contractor.

b) Given sufficient support staff, including assistant or associate Behavioral Health Directors, to help carry out the responsibilities of the office.

1.7.15.8. The CBHO's responsibilities shall include:

a) Ensuring access to, including screening, and integration of behavioral health services.

b) Promoting preventive behavioral health strategies.

1.7.15.9. Leading management and program improvement activities for enhanced coordination of behavioral health services with attention to vulnerable and at-risk populations related to the Contractor's Population Health Strategy Plan.

1.7.16. Chief Pharmacy Officer

1.7.16.1. The Chief Pharmacy Officer (CPO) shall be licensed to provide pharmacy services in Rhode Island and have a minimum of five (5) years of experience practicing in retail settings with managerial experience.

1.7.16.2. The CPO shall ensure Timely pharmacy decisions, including after-hours consultations and ensuring emergency fill requests for Members, as needed.

1.7.16.3. During periods when the CPO is not available, the Contractor shall have competent staff available to provide direction.

1.7.16.4. The CPO shall serve exclusively in this position and may not function in any Executive Capacity for another insurance product without prior written approval by EOHHS.

1.7.16.5. The CPO shall attend all EOHHS designated meetings in-person, as requested by EOHHS. If the CPO is unable to attend, a designee may attend with advance notification and approval by EOHHS.

1.7.16.6. The CPO shall be:

a) Employed full-time by the Contractor.

b) Given sufficient support staff, including assistant or associate pharmacy staff, to help carry out the responsibilities of the office.

1.7.16.7. The CPO's responsibilities shall include:

a) Oversee all pharmacy-related services and operations provided under this Agreement, including oversight of Pharmacy Benefit Managers (PBM). This includes but is not limited to formulary management, pharmacy network management, and oversight of the drug utilization review programs and 340B Rebate Program and rebate claiming of covered entities under Federal rebate programs or other rebate programs for drugs related specific to the Rhode Island Medicaid Program.

b) Ensure compliance with all applicable State and Federal Laws, Regulations, Guidelines, and Standards related to Medicaid pharmacy benefits and services.

c) Regularly review and analyze pharmacy utilization and cost trends and will make recommendations to the Contractor's management team and EOHHS for modifications to the pharmacy program as needed.

d) Ensure the accuracy and integrity of all pharmacy data reporting and analytics.

e) The CPO will work collaboratively with other members of the Contractor's management team to integrate pharmacy services with other health care services provided under this Agreement.

f) The CPO will ensure adequate training and education for all pharmacy staff including contracted pharmacies under Provider Agreements.

g) The CPO will be responsible for ensuring the timely and accurate submission of all required pharmacy reports to the State.

h) The CPO will direct and manage the Contractor's relationships with pharmacy benefit managers, pharmaceutical manufacturers, and other key pharmacy stakeholders.

i) The CPO shall serve as the Contractor's representative on the EOHHS Pharmacy and Therapeutics Committee and provide feedback to the EOHHS Medicaid Pharmacist on pharmacy related matters.

1.7.17. Chief Technology Officer

1.7.17.1. The Chief Technology Officer (CTO) is trained and experienced in information systems, data processing, and data reporting to oversee all Contractor information systems including, but not limited to, establishing and maintaining connectivity with EOHHS information systems, management and oversight of Contractor information management systems, providing necessary and timely reports to EOHHS, and ensuring API interfaces with EOHHS systems and Contractors.

1.7.17.2. The CTO shall have a minimum of seven (7) years in senior leadership roles, preferably with experience in healthcare sector data analytics. The CTO shall possess a master's or doctoral degree in health care analytics, public health, population health, data management or a related field to technology and data. The CTO shall have the ability to conduct program and financial analyses, a solid understanding of primary and population health care management principles, and strong problem-solving skills.

1.7.17.3. The CTO is responsible for:

a) Ensuring compliance with all technology terms of this Agreement;

b) Claims payment system performance, interfacing and reporting capabilities, integrating database for trip reservation, standing orders, validity testing of encounter data;

c) Receiving and responding to EOHHS inquiries and requests related to all technology matters;

d) Participating in regular meetings or calls with EOHHS leadership;

e) Making best efforts to promptly resolve any technological issues identified by the Contractor or EOHHS related to this Agreement; and,

f) Meeting with EOHHS representatives on a periodic or as needed basis to review the Contractor's performance and resolve technology issues or disputes.

1.7.17.4. The CTO may report to the COO or CEO.

1.7.18. Chief Compliance Officer

1.7.18.1. The Chief Compliance Officer (COO), shall serve as the primary point of contact for all communications and requests related to this Agreement,

including, but not limited to, all compliance issues.

1.7.18.2. The COO shall have the following qualification to fulfill the duties of the role:

a) An advanced degree, such as a Master's or Juris Doctor, would be preferred;

b) In-depth knowledge of Medicaid and Medicare regulations and standards, as well as State and Federal healthcare laws;

c) Proven leadership skills, with the ability to develop and implement effective compliance program;

d) Strong communication and interpersonal skills, with the ability to work with various stakeholders, including health plan administrators, regulators, and Members;

e) Shall be certified in health care compliance (e.g., Certified in Healthcare Compliance (CHC)); and,

f) Extensive experience, at least seven (7) years in healthcare compliance, with a focus on Medicaid managed care or Medicaid-like programs.

1.7.18.3. The CCO shall manage the connection of Contractor personnel to EOHHS Business Owners and Contract Officer, and shall develop and implement written policies, procedures, and standards to ensure compliance with the requirements of this Agreement. These primary functions may include, but are not limited to, coordinating the tracking and submission of all Contract deliverables, fielding and coordinating responses to EOHHS inquires related to compliance matters, coordinating the preparation and execution of Contract documents, audits and ad hoc visits.

1.7.18.4. This position shall report directly to the CEO and Board of Directors' Regulatory Compliance Committee in accordance with 42 C.F.R. § 438.608(a)(1)(ii).

1.7.18.5. The CCO shall be trained and experienced in compliance matters, business processes including the development of standard operating procedures, grievances and appeals, complaint resolutions, Corrective Action Plan (CAP) development and implementation by Contractor, providing necessary and timely reports to EOHHS for non-compliance matters.

1.7.18.6. The CCO shall serve exclusively in this position and may not function in any Executive Capacity for another insurance product without written approval by EOHHS.

1.7.18.7. The CCO is responsible for:

a) Ensuring compliance with all terms of this Agreement;

b) Review of standard operating procedures and implementing changes per EOHHS, Federal or State Law changes;

c) Receiving and responding to EOHHS inquiries and requests related to all compliance matters, including escalated member complaints or critical incidents for the Rhode Island Medicaid Managed Care Program;

d) Participating in regular meetings or calls with EOHHS leadership;

e) Making best efforts to promptly resolve any compliance issues identified by the Contractor or EOHHS related to this Agreement; and,

f) Meeting with EOHHS representatives on a periodic or as needed basis to review the Contractor's performance and resolve compliance issues or disputes.

1.7.19. Chief Diversity, Equity, and Inclusion Officer

1.7.19.1. The Chief Diversity, Equity and Inclusion Officer (CDEIO) is responsible for the promotion of a diversity and inclusion throughout the Contractor's organizational management and ensuring compliance with the training and development of staff and Network Providers under this Agreement.

1.7.19.2. The CDEIO shall have a master's degree in social work, Public Administration, Health Care Administration, Human Resources, or a related field. They shall have at least five (5) years of experience in diversity and inclusion roles, preferably within healthcare setting and experience in developing and implementing diversity, equity, inclusion, and inclusion strategies.

1.7.19.3. The CDEIO shall have a deep understanding of Federal and State Laws regarding equal employment opportunity, affirmative action, and civil rights. Knowledge about Medicaid policies would be beneficial. Proficiency in analyzing data related to diversity and inclusion, and ability to generate actionable insights from the same.

1.7.19.4. The CDEIO shall have relevant certifications related to diversity and inclusion such as the Certified Diversity Professional (CDP) or the Certified Diversity Executive (CDE). These certifications are required by Year 2 of the Agreement.

1.7.19.5. The CDEIO shall be an exceptional leader for change management and ability to lead diversity initiatives across the Contractor's organization and a deep commitment to promoting diversity, equity, and inclusion in previous roles and provide evidence-based outcomes to EOHHS on work during the term of this Agreement.

1.7.19.6. The CDEIO shall report to the CEO and is responsible for managing and overseeing the Contractor's efforts to:

a) Create a diverse and inclusive workforce.

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

c) Ensure compliance with yearly workforce trainings, such as anti-bias,

anti- racist, sexual harassment, and health inequities training.

d) Launch initiatives to change culture.

e) Create a supportive environment for all Members of the organization.

f) Develop, execute, and monitor compliance with a comprehensive, organization-wide Strategic Health Equity, Diversity, and Inclusion Plan, including management of AEs involved in developing and overseeing plan.

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

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

b) Developing training programs for staff.

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

1.7.20. Health Equity Officer

1.7.20.1. The Health Equity Officer (HEO) shall serve as the single-point of contact responsible and accountable for all matters related to health equity within the Contractor's organization and provider network to support the effectiveness and efforts of the Contractor's Health Equity Plan.

1.7.20.2. The HEO shall have at least eight (8) years of relevant community experience in organizing or supporting at-risk and vulnerable populations and shall have a deep knowledge of cultural competency and historical traumas within the United States healthcare delivery system and challenges serving Medicaid Members.

1.7.20.3. The HEO have strong leadership skills and knowledge about the local and underserved populations in Rhode Island.

1.7.20.4. The Contractor may hire or designate an existing employee to serve as the HEO.

1.7.20.5. The HEO shall be a high-level employee (i.e., Reporting to any of the Executive within this Section), but may have more than one area of responsibility and job title.

1.7.20.6. The roles and responsibilities of the HEO are to:

a) Oversee the Contractor's strategic design, implementation, and evaluation of health equity efforts in the context of the Contractor's population health initiatives.

b) Inform decision-making around best payer practices related to disparity reductions, including the provision of health equity, social determinants of health, and health related social needs and research to leadership and

programmatic areas;

c) Inform decision-making regarding best payer practices related to disparity reductions, including providing Contractor teams with relevant and applicable resources and research and ensuring that the perspectives of Members with disparate outcomes are incorporated into the tailoring of intervention strategies;

d) Collaborate with the CTO to ensure that Contractor collects and meaningfully uses race, ethnicity, disability and geographic data to identify disparities;

e) Coordinate and collaborate with Members, Providers, local and State government, community-based organizations, EOHHS, and other EOHHS Contractors to impact health disparities at a population level;

f) Ensure that efforts addressed at improving health equity, reducing disparities, and improving cultural competency are designed collaboratively and that lessons learned are incorporated into future decision-making.

1.8. Contractor's Executive Management Compensation and Salary Transparency Reporting for Contractor's Key Personnel

1.8.1. The Contractor shall report total compensation for each Executive Officer or Executive Leader under this Agreement to EOHHS.

1.8.2. Compensation reporting shall consist of total compensation received for Medicaid and Medicare Programs for the Rhode Island Medicaid Managed Care Program and shall not include any compensation for commercial plans that the Contractor may also operate in Rhode Island or any other state.

1.8.3. Total compensation includes, but is not limited to, Executive Management's salary, benefits, bonuses, allowances, options, or any other constituents of a compensation package for Key Personnel. The Contractor shall provide an individual report for each person identified as Executive Management, instead of a cumulative report.

1.8.4. The Contractor's report shall include any Executive Management personnel who reports directly to the CEO and/or any individual whose compensation exceeds two-and-a-half (2.5) times the average Rhode Island household median salary for the previous State fiscal year.

1.8.5. This shall be annually submitted as a report to EOHHS (Contractor's Salary Report).

1.8.6. EOHHS reserves the right to require the Contractor to include additional compensation and salary information in this annual Salary Report.

1.8.7. EOHHS may require the Contractor to publish the details of this annual compensation report on their website to enhance program transparency and ensure the economy of services provided to Members and Rhode Island taxpayers.

1.9. Substitution of Personnel

1.9.1. The Contractor's personnel assigned to this Agreement shall not be replaced without

the prior written consent of EOHHS.

1.9.1.1. Such consent shall not be unreasonably withheld or delayed provided an equally qualified replacement is offered.

1.9.2. If any Contractor personnel becomes unavailable due to resignation, illness, or other factors, excluding assignment to a project outside of the Agreement, outside of the Contractor's reasonable control the Contractor shall be responsible for providing an equally qualified replacement in time to avoid delays in competing tasks.

1.9.3. The Contractor may propose to EOHHS a staffing plan that combines positions and functions outlined in the Agreement with other positions, provided the Contractor describes how the staffing roles delineated in the Agreement will be addressed.

1.9.4. The Contractor shall address the reasons for the request to change the requirements, the organization's ability to furnish services as contractually required with the exception in place, and duration of the exception period requested.

1.9.5. EOHHS reserves the right to deny or revoke approved staffing exceptions at any time during the Agreement based on the performance of the Contractor to fulfill staffing duties.

1.10. Contractor's Key Personnel Conduct

1.10.1. The Contractor must provide a training program of the Contractor's Key Personnel prior to having public contact or answering scheduling lines for call center staff.

1.10.2. Training shall be sensitive to the sensitivity components dealing with:

1.10.2.1. Aged and disabled persons;

1.10.2.2. Multicultural contacts;

1.10.2.3. Handling hostile callers;

1.10.2.4. Public contact; and,

1.10.2.5. Communicating with hearing or speech-impaired individuals.

1.10.3. Any rudeness by Key Personnel or call center staff to Members, the public or government officials must immediately be corrected by the Contractor.

1.10.4. Key Personnel must be trained and knowledgeable in all aspects of the managed care operations, including Contractor procedures and basic supports related to Member Services.

1.10.5. The Contractor shall provide a written comprehensive Training Plan. The Training Plan shall be provided during Contract Readiness for review by EOHHS.

1.10.6. Any changes to the Training Plan must be submitted to EOHHS no later than thirty (30) days prior to requested implementation.

1.11. Contractor's Board of Directors and Ethical Conduct of Board Members

1.11.1. The Contractor shall submit to EOHHS or its designee a listing of its Board of Directors during Readiness Review and an updated list of its Board of Directors

whenever any changes are made. Notification of a change must be made to EOHHS within two (2) Business Days of the change.

1.11.2. The Contractor's Board of Directors shall be posted on the Contractor's website and be updated within two (2) Business Days when there is a change in membership. The Contractor shall communicate to EOHHS and post on their website if there is a substantial financial or conflict of interest for a Board Member's participation.

1.11.3. The Contractor shall be responsible for ensuring the ethical and conflict free conduct of all serving Board Members in all matters related to the management and operations of the Contractor under this Agreement. All Board Members shall be expected to adhere to the highest standards of conflict free and ethical conduct in all actions involving this Agreement or related to this Agreement.

1.11.4. A Code of Ethics shall be incorporated into the Contractor's bylaws for the Board of Directors of the Contractor approved by EOHHS during Contract Readiness.

1.11.5. Board Members shall not engage in any activity, practice, or act which conflicts with, or appears to conflict with, the interests of the Rhode Island Medicaid Managed Care Program. This shall include, but is not limited to, serving in any capacity (including advisory, oversight, governance, or financial management roles) where there may be a perceived or actual conflict of interest including major Subcontractor as defined under this Agreement.

1.11.6. Every Board Member shall conduct all affairs related to this Agreement with honesty, integrity, and fairness.

1.11.7. Board Members shall fully disclose, at the earliest opportunity, information that may result in a perceived or actual conflict of interest.

1.11.8. Board Members shall comply with all applicable laws, rules, and regulations of local, State, and Federal governments and appropriate private and public regulatory agencies.

1.11.9. Board Members shall treat every individual with dignity and respect and shall not engage in any form of discrimination or harassment based on race, color, religion, gender, age, national origin, sexual orientation, disability, marital status, or any other protected class.

1.11.10. Any person who believes a violation of these contractual requirements occurred is encouraged to report the matter to the EOHHS Contract Officer.

1.11.10.1. EOHHS shall promptly investigate any reported violations.

1.11.11. Any Board Member found to have violated this contractual requirement may be subject to disciplinary measures, up to and including dismissal from the Board at the request of EOHHS.

1.11.12. EOHHS reserves the right to have the Contractor dismiss any Board Member found in breach of these ethical rules related to this Agreement.

1.12. Contract Administration

1.12.1. This Agreement shall be administered for the State by EOHHS. The Contractor's CEO or their appointee shall serve as the responsible Party for all matters related to this Agreement.

1.12.2. The EOHHS Contract Officer, or their designee, shall be the Contractor's primary liaison in working with EOHHS and other state agencies. The EOHHS Contract Officer may appoint contract managers, or liaisons, to represent EOHHS on routine communications and other administrative matters.

1.12.3. In no instance shall the Contractor refer any matter to the Medicaid Program Director, Deputy Medicaid Program Director, or any other official in Rhode Island unless initial contact, both verbal and in writing, regarding the matter has been presented to the EOHHS Contract Officer.

1.12.4. Whenever the State is required by this Agreement to provide written notice to the Contractor, such notice will be signed by the EOHHS Contract Officer or his or her designee.

1.12.5. All notices regarding the failure to meet performance requirements and any assessments remedies under this Agreement will be issued by the EOHHS Contract Officer or his or her designee.

1.13. Notification of Administrative Changes

1.13.1. Any Material Changes to the Contractor's operations, staffing, or systems, including any change affecting the Contractor's ability to meet performance standards or otherwise affecting administration of this Agreement, shall be submitted to the EOHHS Contract Officer for review and approval as soon as practicable but no later than thirty (30) Calendar Days prior to the change. EOHHS may determine that such change requires an additional Readiness Review prior to go-live.

1.14. Responsibility for Contractor's Representatives

1.14.1. The Contractor's Representatives shall not in any way be considered employees of EOHHS or the State of Rhode Island.

1.14.2. Except as expressly permitted in this Agreement, neither the Contractor nor its Representatives may act in any sense as agents or representatives of EOHHS or the State of Rhode Island.

1.14.3. The Contractor agrees that anyone it employs to fulfill the terms of the Agreement remains under its sole direction and control.

1.14.4. The Contractor shall be responsible for its acts, including negligence and the acts of its Representatives.

1.14.5. Any claim on behalf of any person arising out of employment or alleged employment by the Contractor (including, but not limited to, claims of discrimination against the Contractor or its Representatives) is the sole responsibility of the Contractor. The Contractor shall indemnify and hold harmless EOHHS and the State from all claims asserted against EOHHS or the State arising from or related to the employment or alleged employment by the Contractor.

1.14.6. The Contractor understands that any person who alleges a claim arising out of employment or alleged employment by the Contractor will not be entitled to any compensation, rights, or benefits from EOHHS or the State including, but not limited to, tenure rights, medical and hospital care, sick and annual/vacation leave, severance pay, or retirement benefits.

1.14.7. The Contractor shall pay all damages incurred by the Contractor's Representatives within the scope of their duties under this Agreement.

1.14.8. The Contractor shall determine the hours to be worked and duties to be performed by its Representatives.

1.14.9. The Contractor shall inform all Representatives that there is no right of subrogation, contribution, or indemnification against EOHHS or the State of Rhode Island for any duty owed to them by the Contractor, or any judgment rendered against the Contractor.

1.14.10. The Contractor understands that EOHHS and the State do not assume liability for the actions of, or judgments rendered against, the Contractor or its Representatives. The Contractor agrees that it has no right to indemnification or contribution from EOHHS or the State for any such judgments rendered against the Contractor or its Representatives.

1.15. Written Policies, Procedures, and Job Descriptions

1.15.1. The Contractor shall develop and maintain written policies, procedures, and job descriptions for each functional area that are consistent in format and style. The Contractor shall maintain written guidelines for developing, reviewing, and approving all policies, procedures, and job descriptions.

1.15.2. All policies and procedures shall be reviewed at least annually to ensure that the Contractor's written policies reflect current practices.

1.15.2.1. Reviewed policies shall be dated and signed by the Contractor's appropriate manager, coordinator, director, or CEO.

1.15.2.2. Minutes reflecting the review and approval of the policies by an appropriate committee and also acceptable documentation.

1.15.2.3. All medical and quality management policies shall be approved and signed by the Contractor's Medical Director.

1.15.2.4. All behavioral health policies shall be approved and signed by the Contractor's Behavioral Health Director.

1.15.3. Job descriptions shall be reviewed at least annually to ensure that current duties performed by employee reflect written requirements.

1.16. Staff Training, Licensure, and Meeting Attendance

1.16.1. The Contractor shall ensure that all staff members, including Subcontractors, have met any applicable State or Federal licensure and/or certification requirements and have received appropriate training, education, experience and orientation to fulfill their requirements of the position.

1.16.2. The Contractor shall prohibit any staff person and/or Subcontractor who has failed to comply with any requirement in this Section from performing any work under this Agreement unless and util the staff and/or Subcontractor has achieved compliance with all requirements.

1.16.3. EOHHS may require additional staff training for the Contractor that has substantially failed to maintain compliance with any provision of the Agreement.

1.16.4. The Contractor shall provide initial and ongoing staff training that includes an overview of the Rhode Island Medicaid Managed Care Program, contractual requirements, State and Federal requirements specific to individual job functions.

1.16.5. The Contractor shall ensure that all staff members having contact with Members or Providers receive initial and ongoing training on health equity, HSRN, SDOH, beyond Culturally and Linguistically Appropriate Services (CLAS) requirements and with regard to the appropriate identification of handing of quality of care concern.

1.16.6. The Contractor shall educate all staff members about its policies and procedures on Advance Directives.

1.16.7. Member Services, Provider Services and UM service representatives shall be trained in the geography of Rhode Island, as well as its culture and the correct pronunciation of cities, towns, and surnames. They shall have access to GPS or mapping search engines for the purpose of authorizing services in, and recommending providers, to the most geographically appropriate location.

1.16.8. The Contractor shall comply cybersecurity training requirements of this Agreement.

1.16.9. EOHHS reserves the right to assign mandatory training for key staff, other staff, and subcontractors. The Contractor may be required to submit documentation that all staff have completed EOHHS assigned mandatory training, education, professional experience, orientation, and credentialing, as applicable, to perform assigned job duties.

1.16.10. EOHHS reserves the right to attend all training programs and seminars conducted by the Contractor. The Contractor shall provide documentation of meetings and trainings, including staff and provider trainings, upon written request. Meeting minutes, agendas, invited attendee lists, and sign-in sheets, along with action items, shall be provided upon written request.

1.17. Cooperation with Other Entities

1.17.1. The Contractor agrees to reasonably cooperate with and work with the other Contractors, EOHHS contractors, and third-party representatives as requested by EOHHS.

1.17.2. The Contractor shall ensure its Representatives cooperate with EOHHS or other State or Federal administrative agency personnel at no charge for purposes relating to the administration of the Managed Care Programs, including for the following purposes:

1.17.2.1. The investigation and prosecution of Fraud, Waste, and Abuse;

1.17.2.2. Audit, inspection, or other investigative purposes;

1.17.2.3. Testimony in judicial or quasi-judicial proceedings; and

1.17.2.4. The delivery of information to EOHHS or other agencies' investigators, auditors, or legal staff.

1.18. Employment Practices

1.18.1. The Contractor shall comply all applicable State and Federal requirements relating to fair employment practices and agrees further to include a similar provision all Subcontracts.

1.18.2. The Contractor shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, gender identity, sexual orientation, national origin, age (except as provided by law), marital status, political affiliation, or handicap.

1.18.3. The Contractor shall take affirmative action to ensure that employees and 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, disability, or handicap. Such action shall be taken in areas including: 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.

1.18.4. The Contractor shall comply with the requirements of the following laws and regulations:

1.18.4.1. Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et. seq.);

1.18.4.2. Rehabilitation Act of 1973, as amended (29 U.S.C. § 794);

1.18.4.3. Title IX of the Education Amendments of 1972 (regarding education programs and activities) (20 U.S.C. § 1681 et. seq.);

1.18.4.4. Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 et. seq.);

1.18.4.5. Age Discrimination Act of 1975 (42 U.S.C. § 6101 et. seq.);

1.18.4.6. Section 1557 of the Patient Protection and Affordable Care Act (ACA);

1.18.5. Failure to comply with this Section may be the basis for cancellation of this Agreement.

1.18.6. The Contractor shall comply with all other State and Federal laws, rules, or regulations that are or may be applicable to employment practices but not specifically mentioned in this Section.

1.19. Employment of State Personnel

1.19.1. Unless authorized in writing by the EOHHS Contract Officer, the Contractor and its Representatives may not recruit, employ, or otherwise engage EOHHS staff, consultants, or other state augmentation contractors to work on the subject matter related to this Agreement and who, in the twelve (12) month period prior to

employment or engagement, either:

1.19.1.1. Participated in the design, development, evaluation, or oversight of the managed care procurement resulting in this Agreement.

1.19.1.2. Worked on projects relating to, or had oversight responsibility for, projects relating to the Rhode Island Medicaid managed care program.

1.19.2. The penalty for violating the above conditions shall result in an administrative sanction of:

1.19.2.1. $2,500 per employee, consultant, or contractor.

1.19.2.2. An added $2,500 penalty per month if the Contractor or its Representative fails to terminate the employee, consultant, or contractor after receiving written notice of the violation.

1.20. Payments to Institutions or Entities Located Outside of the United States

1.20.1. Payments to Institutions or Entities Located Outside of the U.S. In compliance with 42 C.F.R. § 438.602(i), the Contractor shall be located within the U.S. The Contractor shall make no payments to a Network Provider, Out-Of-Network provider, Subcontractor, or financial institution located outside of the U.S. The Contractor shall issue no payments for items or services to providers, provider bank accounts or business agents located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. The Contractor is prohibited from making payments to telemedicine providers and pharmacies located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa.

1.21. Prohibited Affiliations

1.21.1. In accordance with 42 C.F.R. § 438.610, the Contractor may not knowingly contract with or employ, either directly or indirectly:

1.21.1.1. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under Federal Acquisition Regulations or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing the order.

1.21.1.2. An individual or entity that is excluded from participation in any Federal health care program under Section 1128 or 1128A of the Social Security Act.

1.21.1.3. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in Section 1.16.1.1.

1.21.2. The relationships described in this Section are as follows:

1.21.2.1. A director, officer, or partner of the Contractor.

1.21.2.2. A Network Provider, employee, consultant, or other Subcontractor of the Contractor, as governed by 42 C.F.R. § 438.230.

1.21.2.3. A person with beneficial ownership of five percent (5%) or more of the Contractor's equity.

1.21.2.4. A person with employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this Agreement.

1.22. Disclosure of Contractor's Ownership and Control Interest

1.22.1. In accordance with 42 C.F.R. § 455.104, the Contractor shall submit, for EOHHS review, forms documenting full and complete disclosure of the Contractor's ownership and controlling interest, as specified in the Managed Care Manual. Disclosures shall be due at any of the following times:

1.22.1.1. When the Contractor submits the proposal in accordance with the State's procurement process.

1.22.1.2. Upon execution, renewal, or extension of the Agreement.

1.22.1.3. Within thirty-five (35) Calendar Days after any change in the Contractor's ownership.

1.22.2. The Contractor shall disclose the following information, based on 42 C.F.R. § 455.104:

1.22.2.1. The name and address and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity or managed care entity. The address for corporate entities shall include as applicable business address, every business location, and P.O. Box address.

1.22.2.2. Date of birth and Social Security Number (in the case of an individual);

1.22.2.3. Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or managed care entity) or in any Subcontractor in which the disclosing entity (or managed care entity) has a five percent (5%) or more interest.

1.22.2.4. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or managed care entity) is related to another person with an ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling;

1.22.2.5. Whether the person (individual or corporation) with an ownership or control interest in any Subcontractor in which the disclosing entity (or managed care entity) has a five percent (5%) or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

1.22.2.6. The name of any other disclosing entity (or managed care entity) in which an owner of the disclosing entity (or managed care entity) has an ownership or control interest.

1.22.2.7. The name, address, date of birth, and Social Security Number of any

managing employee of the disclosing entity (or managed care entity).

1.22.3. The Contractor shall keep and submit copies of completed disclosure forms to the Secretary of the United States Department of Health and Human Services (DHHS) or to EOHHS within thirty-five (35) Calendar Days of a written request.

1.22.4. The information described in this Section shall be submitted concurrently with a certification from the Contractor's CEO, CFO, or a direct report of the CEO or CFO with delegated authority to sign on their behalf. The certification shall attest, based on best information, knowledge, and belief that the data, documentation, and information are accurate, complete, and truthful.

1.22.5. In accordance with 42 C.F.R. § 438.602, the Contractor shall post on its website the name and title of individuals included in 42 C.F.R. § 438.604(a)(6). This requirement applies only to any individual or entity that has a contract with the Contractor that relates directly or indirectly to the performance of the Contractor's obligations under this Agreement, not including a network provider.

1.23. Employee Education about False Claims Recovery

1.23.1. If annual payments to the Contractor equal five million dollars ($5,000,000) or more in accordance with 42 U.S.C. § 1396(a)(68) and regulations issued pursuant thereto, the Contractor shall:

1.23.2. Establish written policies for all employees of the Contractor (including management), of any Subcontractor or agent of the Contractor, that provide detailed information about the False Claims Act established under 31 U.S.C. §§ 3729 through 3733, administrative remedies for false claims and statements established under 31 U.S.C. Chapter 38, any State laws pertaining to civil or 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 42 U.S.C. § 1320a-7c(f)),

1.23.3. Include as part of such written policies, detailed provisions regarding the Contractor's policies and procedures for detecting and preventing Fraud, Waste and Abuse.

1.23.4. Include any employee handbook for the Contractor, a specific discussion of the laws described in this Section, the rights of employees to be protected as whistleblowers, and the Contractor's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

1.24. Operational Planning Documents

1.24.1. The Contractor shall develop and annually review the following operational planning documents:

1.24.1.1. Disaster Recovery Plan.

1.24.1.2. Business Continuity Plan.

1.24.1.3. Security Plan.

1.24.1.4. Joint Interface Plan.

1.24.1.5. Risk Management Plan.

1.24.1.6. Systems Quality Assurance Plan.

1.24.1.7. Continuity of Operations Plan.

1.24.2. The Disaster Recovery Plan shall, at a minimum, include the following information:

1.24.2.1. Operational procedures in case of the following occurrences:

a) The central informational technology infrastructure, including physical computer installations and resident software, are destroyed or damaged; and

b) System interruption or failure resulting from network, operating hardware, software, or operational errors that compromises the integrity of the information technology system including any stored data or live operations;

1.24.2.2. Operational recovery procedures including:

a) Provisions for back up of key personnel, identified emergency procedures and visibly listed emergency telephone numbers;

b) Procedures for allowing effective communication with EOHHS and enrolled Members;

c) Lists of current hardware and software vendors;

d) Confirmation of updated system and operations documentation and process for frequent back up of systems and data;

e) Description and location of off-site storage of system and data back-ups and ability to recover data and systems from back up files;

f) Documentation that disaster recovery tests or drills have been performed at least annually; and

g) Projected recovery times in the event of a disaster; and

h) Other elements as required by EOHHS, and other industry best practice elements, as appropriate.

1.24.3. The Business Continuity Plan shall, at a minimum, include the following information:

1.24.3.1. Procedures to recover business functions including communication with employees, contractors, Members, and EOHHS;

1.24.3.2. Procedures to recover business units;

1.24.3.3. Procedures to recover business processes including informational technology infrastructure;

1.24.3.4. Procedures for the recovery or replacement of human resources, as necessary; and

1.24.3.5. Other elements as required by EOHHS, and other industry best practice elements, as appropriate.

1.24.4. The Security Plan shall, at a minimum, include the following information:

1.24.4.1. Current policies and procedures for both physical and informational technology security;

1.24.4.2. Manual procedures that provide secure access to physical buildings and information technology systems with minimal risk;

1.24.4.3. Multilevel passwords, identification codes or other security procedures that shall be used by Contractor personnel;

1.24.4.4. Identification of current security features utilized for both physical and information technology systems;

1.24.4.5. Identification of all staff responsible for both physical and information technology systems;

1.24.4.6. A description of contingency security procedures during a disaster;

1.24.4.7. A description of how current systems are compliant with all Federal and State laws regarding the security and privacy of personally identifiable information and Protected Health Information; and

1.24.4.8. Other elements as required by EOHHS, and other industry best practice elements, as appropriate.

1.24.5. The Joint Interface Plan shall, at a minimum, include the following information:

1.24.5.1. The process for establishing and maintaining system interface information between the Contractor and EOHHS;

1.24.5.2. Procedures for identifying the file structure, data elements, frequency, media, file type, receiver and sender of the file, and file I.D for all files to be shared with EOHHS;

1.24.5.3. Identify each of the Contractor's interfaces required to conduct business under this Agreement;

1.24.5.4. How the Contractor's system will interface with each of the Contractor's partners, Subcontractors, and other entities to ensure the development and maintenance of the interface;

1.24.5.5. Procedures for the timely transfer of required data elements between the Contractor and EOHHS, Subcontractors, partners and other relevant entities; and

1.24.5.6. Other elements as required by EOHHS, and other industry best practice elements, as appropriate.

1.24.6. The Risk Management Plan shall, at a minimum, include the following information:

1.24.6.1. Policies and procedures for detecting and reporting adverse events and potentially unsafe conditions;

1.24.6.2. Procedures for the collection and analysis of data to monitor the

performance of processes that involve risk or that may result in serious adverse events;

1.24.6.3. Policies for overseeing the organizational data collection and processing and information analysis and generation of statistical trend reports for the identification and monitoring of adverse events;

1.24.6.4. Policies for conducting periodic reviews of all litigation involving CMS and its staff and health care professionals;

1.24.6.5. Procedures to support quality improvement programs; and

1.24.6.6. Other elements as required by EOHHS, and other industry best practice elements, as appropriate.

1.24.7. The Systems Quality Assurance Plan shall, at a minimum, include the following information:

1.24.7.1. Systems design and management manuals, user manuals, and quick reference guides, and any applicable updates;

1.24.7.2. Policies and procedures for how often systems are maintained, updated, and replaced;

1.24.7.3. Contact information for any vendors, support services, or installation services for current systems and program; and

1.24.7.4. Other elements as required by EOHHS, and other industry best practice elements, as appropriate.

1.24.8. The Continuity of Operations Plan shall, at a minimum, include the following information:

1.24.8.1. Procedures to recover business operating functions including communication with Network Providers, employees, contractors, Members, and EOHHS;

1.24.8.2. Procedures for processing key personnel and leadership at an alternative location, if necessary;

1.24.8.3. Procedures for implementing security protocols that may differ from current operations due to a change in facility, location, or technological access;

1.24.8.4. Procedures for adjusting or reducing operating hours and services if necessary due to the inability to locate or communicate with employees and staff;

1.24.8.5. Procedures for implementing manual workarounds or alternative processes for primary business functions; and

1.24.8.6. Other elements as required by EOHHS, and other industry best practice elements, as appropriate.

1.24.8.7. The Contractor shall maintain a Continuity of Operations Plan that addresses how the Contractor's, Material Subcontractors', and other subcontractors' operations and the ongoing provision of healthcare services shall be maintained in the event of a pandemic, natural disaster or man-made emergency including, but not limited to, localized acts of nature, accidents, and technological and/or attack-related emergencies, or other event which leads to a significant disruption in operations due to staff absence and/or loss of utilities that impacts fulfilling the requirements of this Contract. The Continuity of Operations Plan shall be invoked no later than when the fulfillment of these requirements is impacted by such an event.

1.24.8.8. As part of the Continuity of Operations Plan, the Contractor shall provide its action plan for development of an emergency preparedness plan specific to each of its Enrollees with Special Health Care Needs (SHCN) during or following an event as described above. The emergency preparedness plan must be provided to the Enrollee in a manner and format that may be easily understood and is readily accessible. Information in the plan must be communicated in a way that can be understood by Enrollees of varying functional ability and language proficiency. The plan must identify any steps the Enrollee and/or Enrollee's caregiver should take in the event of an emergency including, but not limited to, special considerations regarding medications, supplies and dietary needs, or power outages, as applicable, and corresponding contact information.

1.24.8.9. The Contractor shall follow all EOHHS directives regarding access to care and relaxation of authorization requirements during an emergency. Corresponding system edits for all services shall be implementable during an emergency.

a) The Contractor must have a method for ensuring that Prior Authorizations are extended and transferred to new providers during a pandemic, natural disaster, man-made emergency, or other event if directed by EOHHS.

1.24.8.10. As part of the Continuity of Operations Plan, the Contractor shall provide a systems contingency plan, regardless of its system architecture, to protect the availability, integrity, and security of data and to continue essential application or system functions during and immediately following these events.

a) The systems contingency plan shall include, at a minimum:

(i) A disaster recovery plan designed to recover systems, networks, workstations, applications, etc. in the event of a disaster; and

(ii) A Business Continuity Plan (BCP) for restoring the operational function of the organization in the event of a disaster and includes items related to IT, as well as operational items such as employee

notification processes and the procurement of office supplies needed to do business in the emergency mode operation environment.

b) The systems contingency plan shall address the following scenarios, at a minimum:

(iii) The central computer installation and resident software are destroyed or damaged;

(iv) The system interruption or failure resulting from network, operating hardware, software, or operations errors that compromise the integrity of transactions that are active in a live system at the time of the outage;

(v) System interruption or failure resulting from network, operating hardware, software or operations errors that compromise the integrity of data maintained in a live or archival system; and

(vi) System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system, but does prevent access to the System, such as it causes unscheduled System unavailability.

c) The systems contingency plan shall specify projected recovery times and data loss for mission-critical Systems in the event of a declared disaster.

d) The Contractor shall annually test its plan through simulated disasters and lower-level failures in order to demonstrate to EOHHS that it can restore system functions. The Contractor shall report documentation of this testing in a manner determined by EOHHS.

e) In the event the Contractor fails to demonstrate through these tests that it can restore systems functions, the Contractor shall be required to submit a Corrective Action Plan to EOHHS describing how the failure shall be resolved within ten (10) Business Days of the conclusion of the test.

1.24.8.11. The Contractor shall submit the Continuity of Operations Plan to EOHHS or its designee for approval as part of Readiness Review and no later than thirty (30) Calendar Days prior to implementation of changes.

1.24.8.12. The Contractor shall immediately inform EOHHS, in writing, when invoking its Continuity of Operations Plan. If the nature of the triggering event renders written notification impossible, the Contractor shall notify EOHHS of the invocation of the Continuity of Operations Plan through the best available means. If the nature of triggering event renders immediate notification impossible, the Contractor shall inform EOHHS of the invocation of the Continuity of Operations Plan as soon as possible.

1.25. Independent Contractor Status

1.25.1. The Contractor shall operate as an independent entity under the terms of this Agreement with the State of Rhode Island ("the State"). This Agreement does not establish an employer-employee relationship, principal-agent relationship, partnership, joint venture, or any fiduciary relationship. The Contractor and its Representatives shall not represent or assert themselves as officers or employees of EOHHS or the State of Rhode Island.

1.25.2. The Contractor and its Representatives are prohibited from representing the State or binding the State in any capacity.

1.25.3. The State is obligated to issue an IRS Form 1099 reflecting the Contractor’s gross earnings. However, it bears no responsibility for Federal, State, or local taxes arising from the Contractor’s net income. The State is also not accountable for withholding or payment of any Federal, State, and local income and other payroll taxes, workers’ compensation, disability benefits, or other legal obligations relevant to the Contractor.

1.25.4. The Contractor and its Representatives are not eligible for and shall not receive benefits that are typically provided to State employees. These terms underscore the Contractor's independent status and specify the delineation between the Contractor and the State.

Article 2. Subcontractual Relationships and Delegation

2.1. General Requirements

2.1.1. Prior to contracting with a Material Subcontractor, the Contractor shall evaluate the prospective Material Subcontractor's ability to perform the activities to be subcontracted.

2.1.2. The Contractor shall request prior approval of all Material Subcontracts, amendments, and substitutions thereto from EOHHS. To obtain such approval, the Contractor shall submit a written request and a completed checklist using the template provided by EOHHS included in the MCM. The request shall also describe how the Contractor will oversee the Material Subcontractor.

2.1.3. The Contractor shall provide EOHHS with any information requested by EOHHS in writing in addition to the information required in the checklist, including identifying whether the proposed Material Subcontractor is part of an organization related to the Contractor.

2.1.4. All Subcontracts shall:

2.1.4.1. Be written;

2.1.4.2. Specify, and require compliance with, all applicable requirements of this Agreement and the activities and reporting responsibilities the Subcontractor is obligated to provide;

2.1.4.3. Provide for imposing penalties, up to and including termination, if the State or the Contractor determines that the Subcontractor's performance is inadequate or non-compliant;

2.1.4.4. Require the Subcontractor to comply with all applicable Contract requirements, applicable Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, Waivers, and applicable subregulatory guidance;

2.1.4.5. Stipulate that Rhode Island law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the state law where the Subcontractor is based and Rhode Island law.

2.1.4.6. Comply with the requirements set forth in 42 C.F.R. § 438.230(c)(3) and 42 C.F.R. § 438.3(k).

2.1.5. The State, including EOHHS, MFCU, and the Rhode Island Auditor General, and the Federal government, including, CMS, OIG, and the Comptroller General, or their designees, shall have the right to audit, evaluate, and inspect any records or systems that pertain to any activities performed or amounts payable under this Agreement at any time.

2.1.6. This right exists for ten (10) years from the termination of this Contract for the Contractor and any Subcontractors or from the date of completion of any audit, whichever is later; provided, however that if any of the entities above determine that

there is a reasonable possibility of Fraud or similar risk, they may audit, evaluate, and inspect at any time;

2.1.7. The Contractor and any Subcontractors shall make their premises, facilities, equipment, records, and systems available for the purposes of any audit, evaluation, or inspection described immediately above;

2.1.8. The Contractor and any Subcontractors shall retain, as applicable, Enrollee Grievance and Appeal records in 42 C.F.R. § 438.416, base data in 42 C.F.R. § 438.5(c), MLR reports in 42 C.F.R. § 438.8(k), and the data, information, and documentation specified in 42 C.F.R. §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than ten (10) years following termination of the Contract; and

2.1.9. The Contractor shall monitor any Material Subcontractor's performance on an ongoing basis and perform a formal review annually. At a minimum, the annual review shall include any performance concerns identified by EOHHS. If any deficiencies or areas for improvement are identified, the Contractor shall require the Material Subcontractor to take corrective action. The Contractor shall provide EOHHS with a copy of the annual review and any corrective action plans developed as a result. If there are corrective active plans put in place, the Contractor shall provide ongoing updates to EOHHS on the Material Subcontractor's activities to improve the performance pursuant to the corrective action plan.

2.1.9.1. The Contractor shall notify EOHHS within two (2) Days if a Contractor is placed on a CAP. The notification shall include the original and supporting documentation related to the CAP.

2.1.9.2. EOHHS requires that the Contractor the CAP of their subcontractor on their website. The CAP can be removed from the Contractor's website within one-hundred eighty (180) days after the Contractor has closed the CAP.

2.1.10. Upon notifying any Material Subcontractor, or upon being notified by such Material Subcontractor, of the intention to terminate such subcontract, the Contractor shall notify EOHHS in writing no later than the same day as such notification and shall otherwise support any necessary Enrollee transition or related activities as described in the Continuity of Care section and elsewhere in this Contract.

2.1.11. Notwithstanding any relationship the Contractor may have with a subcontractor, including Material Subcontractors, the Contractor shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract. No subcontractor will operate to relieve the Contractor of its legal responsibilities under the Contract.

2.1.12. As required by 42 C.F.R. §§ 438.3(k), 438.230(a) and 438.230(b)(1),(2), the Contractor shall be responsible to oversee all subcontractors' performance and shall be held accountable for any function and responsibility that it delegates to any subcontractor.

2.1.13. In the event of a transition between subcontractors during the term of this Agreement,

the Contractor must ensure that the original subcontractor fulfills all subcontractual obligations, including those that survive the subcontract termination or expiration. In the event that the Contract terminates or expires, the Contractor must ensure that any existing subcontractor fulfills its subcontractual obligations including those that survive Agreement termination.

2.1.14. Before entering into an agreement or contract with a Subcontractor, the Contractor shall evaluate the Subcontractor's ability to perform the subcontracted duties.

2.1.15. The Contractor shall make available all Subcontracts for inspection and approval by the EOHHS, upon request. AEs and Care Management Entities (CMEs) are considered Subcontractors and any duties delegated to a Subcontractor shall be overseen by the Contractor per NCQA standards, if applicable.

2.1.16. All Subcontracts are subject to prior approval by EOHHS. At least thirty (30) Calendar Days before executing or amending a Subcontract, the Contractor shall provide the proposed Subcontract to EOHHS for review. The Contractor and Subcontractor shall promptly respond to any questions or requests for information. Notwithstanding EOHHS' approval of a Subcontract, EOHHS reserves the right to designate the Subcontract, or any portion thereof, as unacceptable for any reason or determine that it is otherwise incompatible with this Agreement or any aspect of law, regulation, or policy. Any Material Changes to a Subcontractor agreement, as well as any material change to a Subcontractor's operations, staffing, or systems, including any change affecting the Subcontractor's ability to meet performance standards or otherwise affecting administration of this Agreement, shall be submitted to the EOHHS Contract Officer for review and approval as soon as practicable but no later than thirty (30) Calendar Days prior to the change. EOHHS may determine that such a change requires an additional Readiness Review prior to go-live.

2.1.17. Failure to obtain EOHHS approval may result in contract remedies, including corrective actions plans, liquidated damages, or termination. To be eligible for approval, all Subcontractors, and employees, shall be subject to the applicable qualifications in Rhode Island state law and regulation.

2.1.18. The Contractor shall monitor the performance of all Subcontractors on an ongoing basis, consistent with industry standards and State and Federal regulations. This includes conducting formal reviews based on a schedule established by EOHHS. The Contractor and its Representatives shall take corrective action on any identified deficiencies or areas of improvement.

2.1.19. The Contractor is responsible for the performance of the Agreement, regardless of whether Subcontractors are used. In compliance with 42 C.F.R. § 438.230, the Contractor shall execute a written agreement with its Subcontractors that: specifies that Contractor's right to revoke the agreement, outlines reasons for the revocation, and specifies other remedies in instances where EOHHS or the Contractor determines the Subcontractor has not performed satisfactorily. It remains the Contractor's responsibility to assure that any use of Subcontractors is seamless and does not result in any additional burden for Members and Providers.

2.1.20. A Subcontract providing delegated services that result in direct contact with a Member shall contain a provision identifying which Party is responsible for providing sign language, oral interpretation, and oral translation services. Such services shall be provided at no cost to the Member. In addition, these Subcontracts shall require Subcontractors to comply with the notice requirements described in Section 23.7, "Adverse Benefit Determinations."

2.1.21. A Subcontract providing licensing and credentialing services for providers. or other services that result in the selection of providers, shall contain a provision that the Contractor retains the right to approve, suspend, or terminate any selected or approved provider by the Subcontractor.

2.1.22. The Contractor agrees, and shall require its Subcontractors to agree, to subrogate to EOHHS any and all claims the Contractor has or may have against any provider, including but not limited to manufacturers, wholesale or retail suppliers, sales representatives, testing laboratories, or other providers in the design, manufacture, marketing pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, durable medical equipment, or other products, in actions brought against said providers on behalf of EOHHS, through the Rhode Island Attorney General's Office. The Contractor is entitled to recoveries that are the direct result of a similar legal suit filed by the Contractor against the same Party or Parties that was initiated and properly filed prior to the date of a legal action initiated or joined by EOHHS or by Rhode Island Department of Attorney General.

2.1.23. All Subcontracts shall be consistent with the terms of this Agreement and require Subcontractors to comply with all applicable provisions of State and Federal laws. In addition, the following provisions of this Agreement shall be incorporated into all Subcontracts:

2.1.23.1. General Conditions of Purchases and Addendum A through E, if designated as applicable to the Contractor under this Agreement.

2.1.23.2. Article 24, "Program Integrity and Compliance."

2.1.23.3. Attachment F-2, Article 10, "Security and Confidentiality."

2.1.23.4. Attachment F-2, Section 2.10, "Federal Approval of Agreement and Amendments"; Article 2, "Governing Laws and Regulations"; and Article 6, "Intellectual Property."

2.1.24. If EOHHS reporting is required for a subcontracted function, the Subcontractor agreement shall include an obligation to produce those reports with the same level of detail that would have been required if Contractor had performed the function.

2.1.25. All agreements or contracts shall reference and require compliance with all applicable terms and reporting requirements of this Agreement and shall reference and require compliance with the Disclosure of Ownership and Control and Disclosure of Information on Persons Convicted of Crimes requirements as specified in Section 1.17 of this Agreement and 42 C.F.R. §§ 455.101 –- 106, 42 C.F.R. § 455.436, and State Medicaid Director Letter (SMDL) 09-001.

2.1.26. All agreements or contracts shall disclose to EOHHS the identity of any debarred, suspended, or otherwise excluded person employed by the Related Entity or Downstream Entity. The Contractor may not knowingly contract with an individual or entity that is debarred, suspended, or otherwise excluded for the performance of services in support of this Agreement.

2.1.27. The Contractor shall ensure that all Member communications furnished by a Subcontractor include the Contractor's name and comply with Member notification requirements and EOHHS document approval requirements of this Agreement.

2.2. Subcontracting with Related Entities and Downstream Entities

2.2.1. Before entering into an agreement or contract with a Related Entity or a Downstream Entity, the Contractor shall evaluate the Related Entity's or the Downstream Entity's ability to perform the subcontracted duties.

2.2.2. All agreements with Related Entities and Downstream Entities shall be considered Subcontracts and are subject to all other Subcontractor and subcontracting requirements of this Agreement.

2.2.3. During the Subcontract review process outlined in Section 2.1, the Contractor shall identify any proposed Subcontract with Related Entities and Downstream Entities.

2.2.4. All Subcontracts with Related Entities and Downstream Entities shall adhere to appropriate screening and disclosure requirements of this Agreement.

2.3. Subcontracting with Minority and Woman Business Enterprises

2.3.1. In accordance with R.I. Gen. Laws § 37.14.1, "Minority Business Enterprise," and promulgating regulations including 220-RICR-80-10-2, the Contractor shall comply with State and Federal requirements regarding participation by minority business enterprises (MBE) and women business enterprises (WBE).

2.3.2. The Contractor's responsibilities include, but are not limited to:

2.3.2.1. Complying with ISBE (MBE/WBE) requirements stated in the solicitation.

2.3.2.2. Notifying MBE/WBE-certified businesses of subcontracting opportunities.

2.3.2.3. Demonstrating good faith efforts to contract with MBE/WBE businesses to further the State's goal of awarding ten percent (10%) of the dollar value of the Contract to MBE/WBE businesses.

2.3.2.4. Submitting reports in accordance with DOA requirements.

2.3.3. Additional information regarding MBE/WBE requirements is available through the DOA Office of Diversity, Equity, and Opportunity website.

2.4. Publication of Information of Major Subcontractors on Contractor's Website

2.4.1. Contractor shall publish a dashboard on the website with information related to the subcontracted function related to this Agreement.

2.4.1.1. The dashboard shall contain the following information:

a) The legal name of the Subcontractor;

b) The term of the subcontract by the Contractor;

c) The estimated annual value of the Major Subcontractor;

d) Description of the services performed under the subcontract;

e) CAPs, critical incidents or liquidated damages accesses by the Contractor; and,

f) Other relevant information EOHHS deems necessary for the public and consumers to be aware about the nature of the Major Subcontracted relationship.

2.4.2. The Contractor shall ensure that information related to this Section's information requirements are updated at least quarterly.

2.4.3. EOHHS reserves the right to request that the Contractor amend the information contained on its website at any time.

2.5. Accountable Entity Program

2.5.1. EOHHS has established the AE Program to promote health care delivery system reform. Fundamental to this initiative is the progressive movement from volume-based to value-based payment arrangements and increased risk and responsibility for cost and quality of care. The program therefore requires certified AEs to enter APMs with managed care partners in accordance with EOHHS defined requirements.

2.5.2. The Contractor is required to enter into written Subcontracts with EOHHS-certified AEs in accordance with the EOHHS "Accountable Entity Program Requirements" in the Managed Care Manual. The Contractor is required to use EOHHS's standard base contract and terms for AE Subcontracts. The Subcontracts shall, at minimum:

2.5.2.1. Support the AE Program by promoting APMs that pay for quality, not volume.

2.5.2.2. Include Total Cost of Care (TCOC) shared shavings and shared risk arrangements.

2.5.2.3. Incorporate a uniform set of quality measures, as defined by EOHHS.

2.5.2.4. Delineate Contractor responsibility for administration of the AE Incentive Program.

2.5.2.5. Include Contractor and AE responsibility for Attribution of Members to the AE.

2.5.2.6. Delineate Contractor and AE data sharing responsibilities, including those described in Section 2.5.11. below.

2.5.2.7. Establish a uniform performance period that coincides with the EOHHS Contract Year.

2.5.2.8. Set forth the Contractor's roles and responsibilities with respect to the AE Program. AEs are considered delegates of the Contractor consistent with NCQA standards. Include a clear delineation of what Care Program functions have been delegated to the AEs, what functions remain the sole responsibility of the Contractor, and what functions are shared. The Contractor shall delegate care program responsibilities to the AE based upon an assessment of the AE's capacity to perform the delegated functions in compliance with NCQA delegation standards and the EOHHS Care Program Protocols.

2.5.3. The Contractor shall support AEs in efforts to build capacity to assume responsibility for Case Management and other delegable functions through direct support, technical assistance, and other means.

2.5.4. The Contractor shall develop and disseminate information and support tools pertaining to evidence-based practices to its subcontracted AEs and Providers at the point of care, including information on how to address initiatives that lack a connection to evidence-based practice.

2.5.5. Include a description of the agreed upon financial terms to support the administration of delegated Care Program responsibilities. EOHHS reserves the right to set minimum payment rates that the Contractor shall pay for Care Program responsibilities delegated to AEs.

2.5.6. Include a description of the Joint Operating Committee and meeting schedule that the Contractor and AE shall establish as a shared management structure to promote communication, support collaborative activities, problem-solving, and ongoing review of progress toward performance goals.

2.5.7. Submit a base contract to EOHHS prior to execution in accordance with the EOHHS' timetable included in the Accountable Entity Program Requirements. In addition, the Contractor shall submit all substantive revisions to AE Subcontracts to EOHHS. EOHHS reserves the right to require revisions to Subcontracts that do not comply with the terms of this Agreement. The Contractor shall post a draft template of the AE Subcontract on the Contractor's website.

2.5.8. Notwithstanding any provision of the arrangement between the Contractor and the AE, including delegation of Case Management or other responsibilities, the Contractor is responsible for ensuring that all elements of the EOHHS-defined system of care are available and accessible for Members and for ensuring appropriate utilization of services while adhering the NCQA delegation and oversight standards. With respect to access to care, the Contractor shall:

2.5.8.1. Ensure that AE attributed Member have access to services from Providers not affiliated with the AE.

2.5.8.2. Ensure that Participating AE Providers are permitted to make referrals to any Provider, as appropriate, regardless of the Providers' affiliation with the AE.

2.5.8.3. Prohibit additional requirements for referrals to Providers who are not Affiliated Providers.

2.5.8.4. Maintain attributed Members' access to and freedom of choice of Providers.

2.5.8.5. Maintain open access to Medically Necessary services, including from Providers not affiliated with an AE.

2.5.8.6. Ensure that AE Attributed Members may obtain emergency services from any Provider, regardless of its affiliation with the AE.

2.5.8.7. Ensure that all Members receive all Medically Necessary Care Coordination and Case Management services.

2.5.9. Upon enrollment, the Contractor is responsible for attributing each enrolled Member to contracted AEs and reconciling AE attribution on a quarterly basis, in accordance with the AE Attribution requirements in the Managed Care Manual. On a monthly basis, the Contractor shall provide the contracted AEs and EOHHS with electronic lists of attributed Members.

2.5.10. The Contractor shall develop a Care Plan Strategy for AEs that at a minimum reflects the priorities and range of services and requirements described in the "EOHHS Care Program Protocols" in the Managed Care Manual. The Care Plan Strategy for AEs shall be submitted to EOHHS for review and approval during Readiness Review, annually thereafter, and upon modification. The Contractor shall be responsible for the method of identification and stratification of members for Case Management, CM, and CCM as part of the Care Program. Stratification requirements shall meet minimum standards established by EOHHS.

2.5.11. The Contractor and AE shall enter into a data sharing agreement. The Contractor shall provide the AE with data as needed or requested to fulfill delegated responsibilities as described in the Accountable Entity Program Requirements. Before sharing data with the AE, the Contractor shall complete necessary quality checks and review data privacy to ensure data integrity. At minimum and on a monthly basis, the Contractor shall provide each Subcontracted AE with the following:

2.5.11.1. MCO Member attribution lists.

2.5.11.2. Comprehensive analytic profile of the AEs' attributed population including race, ethnicity, sex, primary language, sexual orientation, and gender identity.

2.5.11.3. High utilizers registries – collaborative data sharing arrangements.

2.5.11.4. Monthly Member-specific utilization and cost data. Data shall identify high risk, high utilizer Members, high cost Members based on high cost threshold in TCOC, Provider outlier analysis of high/low performing Providers within an AE panel.

2.5.11.5. Individual level data files for AE Outcome Measures.

2.5.11.6. Any additional files as prescribed by EOHHS in the AE Quality and Outcome Implementation Manual.

2.5.11.7. Monthly Provider Roster.

2.5.11.8. Initial and updated assessment and screening results, as applicable.

2.5.11.9. Other data reports as mutually agreed upon.

2.5.12. The Contractor shall implement the Medicaid Infrastructure Incentive Program (MIIP) in compliance with the Accountable Entity Program Requirements.

2.5.13. Make timely payment to its contracted AEs for delegated services, including payments for shared savings distributions.

2.5.14. Make timely and accurate incentive payments to AEs to support AEs in developing and enhancing the capacity and tools required for effective system transformation and for achieving quality and performance outcomes in accordance with the requirements of the MIIP.

2.5.15. Upon request and in accordance with the format and timetable in the Managed Care Manual, the Contractor shall furnish EOHHS reports regarding the financial and quality performance of contracted AEs.

2.5.16. The Contractor is responsible for Monitoring and Oversight of AE Performance, including but not limited to the following requirements:

2.5.16.1. Performing oversight and monitoring of delegated functions and contractual expectations.

2.5.16.2. Ensuring AEs comply with Member protections, including notices and Appeal rights, and requirements relating to Marketing, Member communications, and Member choice.

2.5.16.3. Calculating performance on quality and outcome measures, as prescribed in the AE Quality and Outcome Implementation Manual in the Managed Care Manual.

2.5.16.4. Determining performance with respect to the achievement of milestones and metrics tied to incentive payments in accordance with the Managed Care Manual.

2.5.16.5. Submitting historical base data and attribution to support EOHHS calculations to establish total cost of care targets, in accordance with the Managed Care Manual.

2.5.16.6. Submitting total cost of care performance data and attribution on a quarterly and final/annual basis to support EOHHS calculations to determine AE total cost of care performance, in accordance with the Accountable Entity Program Requirements.

2.5.16.7. The Contractor shall ensure that AEs provide the Contractor the requisite data to fulfill the Contractor's MLR reporting obligations. The Contractor

shall impose reporting requirements equivalent to the information required in 42 C.F.R. § 438.8(k) and remittance requirements equivalent to 42 C.F.R. § 438.8(j) on their Subcontractor plans or entities, including AEs.

2.5.17. Joint Operating Agreement

2.5.17.1. Upon execution of the Subcontract with a qualified AE, the Contractor shall undertake activities in support of a collaborative approach to program operation and management. These activities should include implementation of a shared management structure, including but not limited to:

2.5.17.2. A Joint Operating Committee that meets regularly but not less than bi-monthly to ensure ongoing communication, support of collaborative activities, problem solving, and ongoing review of progress in performance areas.

2.5.17.3. A Joint Operating Agreement that documents the agreed upon structure and approach to managing program operations, clarifies roles with respect to delegated and shared functions, and identifies the method and content of reports the AE shall submit to the Contractor. The Joint Operating Agreement shall be included within the AE Subcontract, per this Section. The final executed Agreement shall be submitted to EOHHS in accordance with the Managed Care Manual.

2.6. Case Management Entities

2.6.1. In order to facilitate the provision of Conflict Free Case Management (CFCM), EOHHS requires the Contractor to delegate the LTSS Person Centered Planning process to EOHHS certified CMEs, to the extent that CME capacity permits.

2.6.2. The Contractor is required to enter into written Subcontracts with EOHHS Certified CMEs in accordance with the requirements outlined in this Section. The Subcontract shall describe the duties delegated to the CME, including working with the Member to develop the Member's LTSS Person-Centered Care Plan, forming and convening the Member's care team, and conducting reassessments of the LTSS Person-Centered Service Plan annually or more frequently as needed. The Contractor is responsible for Monitoring and Oversight of CME Performance. The Contractor retains ultimate authority for all Care Program functions, regardless of delegation status.

2.6.3. The Contractor and CME shall enter into a data sharing agreement. The Contractor shall provide the CME with data as needed or requested to fulfill delegated responsibilities as described in this agreement.

2.6.4. EOHHS reserves the right to set minimum payment rates that the Contractor shall pay for Care Program responsibilities delegated to CMEs.

2.7. Pharmacy Benefit Manager Requirements

2.7.1. If the Contractor uses a pharmacy benefit manager (PBM), the Contractor shall identify the ownership of the PBM.

2.7.2. The Contractor shall submit a written description of the assurances and procedures that shall be in place under the PBM subcontract, such as an independent audit, to prevent patient steering, to ensure no conflicts of interests exist and ensure the confidentiality of proprietary information. The Contractor shall provide a plan documenting how it will monitor its subcontracted PBM's performance and the Contractor's oversight.

2.7.3. The Contractor's PBM shall not deny any Rhode Island-licensed pharmacy or Rhode Island licensed pharmacist the right to be a participating provider in the Contractor or PBM's provider network if the pharmacy or pharmacist meets all requirements for participation in the Rhode Island Medicaid Program.

2.7.4. Any subcontract for PBM services shall be a direct contract with the Contractor.

2.7.5. As payment in-full for the services performed under the subcontract, the Contractor shall pay the PBM an all-inclusive administrative fee, calculated by multiplying the number of processed claims by a transaction fee, which shall no exceed $1.25 per pharmacy claim processed.

2.7.6. The Contractor shall prohibit the practice of spread pricing or any form of spread pricing that increased unnecessary costs to the Rhode Island Medicaid Managed Care Program.

2.7.7. The PBM shall provide the Contractor's staff real-time, unredacted, read access to view the pharmacy claims processing system and prior authorizations records, at no cost to the Contractor.

2.7.8. The PBM shall coordinate with the Contractor the dissemination of materials to enrollees and providers such that the Contractor can obtain the appropriate prior approvals from EOHHS, when necessary.

2.7.9. If the PBM contracts with another subcontractor, the Contractor shall request prior approval of the subcontract and any amendment hereto. To obtain such approval, the Contractor shall submit a written request and copy of the proposed subcontract. The request shall also describe how the Contractor and PBM will oversee the subcontractor. The Contractor shall provide EOHHS with any additional information requested by EOHHS. EOHHS shall review and approve or deny the subcontractor contract.

Article 3. Covered Populations, Enrollment, and Disenrollment

3.1. General Information and Requirements

3.1.1. The Medicaid managed care eligibility determinations, redeterminations, and enrollment functions are the responsibility of EOHHS. Unless otherwise specified, the entirety of Article 3 applies to Members receiving Medicaid benefits only.

3.1.2. The Contractor shall accept all Members assigned to its Health Plan by EOHHS.

3.1.3. The Contractor acknowledges enrollment in managed care is mandatory for Members except in the case of voluntary enrollment programs that meet the conditions of 42 C.F.R. § 438.50(a) (see Section 3.7, regarding Voluntary Managed Care Populations).

3.1.4. The Contractor shall comply with the requirements of 42 C.F.R. § 438.3(d) by:

3.1.4.1. Accepting all Potential Members in the order in which they apply without restriction, up to the limits set under this Contract;

3.1.4.2. Not discriminating against Potential Members based on race, color, national origin, sex, or disability, or using any policy or practice that has the effect of discriminating on these grounds.

3.1.4.3. Not discriminating in enrollment, disenrollment, or reenrollment based on health status or need for Health Care Services.

3.1.5. The Contractor shall have written policies and procedures for receiving, reporting, and updating the following Member information:

3.1.5.1. Receive daily and monthly updates from EOHHS regarding Members enrolled in, or disenrolled from, the Contractor's Health Plan and other updates relating to membership. The Contractor shall incorporate these updates into its MIS within one (1) Business Day.

3.1.5.2. Identify any change in a Member's status that may impact the Member's eligibility or managed care enrollment and notify EOHHS of such changes no later than five (5) Business Days of identification. Examples of changes in status include changes in family size, changes in residence, or death. For Dually Eligible Members, this includes the Member's eligibility and coverage for Medicare.

3.1.5.3. Electronically report newborn births to EOHHS on a weekly basis. The Contractor is responsible for Medicaid newborns as of the date of birth, provided the mother was actively enrolled or retroactively enrolled as of the date of birth.

3.1.5.4. Perform outreach calls to determine a Member's most recent and accurate address telephone number. The Contractor shall ensure its Subcontracts include flow-down provisions requiring all Subcontractors to report changes in a Member's demographic information to the Contractor. The Contractor shall follow the EOHHS policy and procedures outlined in the "EOHHS Medicaid Health Plan (MCO) Requirements for Medicaid

Member Demographic Changes" in the Managed Care Manual.

3.1.6. The Contractor's Member Handbook shall include a notice that changes in status shall be reported to EOHHS, including family size, residence, births, and deaths.

3.1.7. Groups eligible for LTSS services under this Agreement as determined by the State in accordance with 210-RICR-50-00-1.

3.2. Rite Care Eligibility Groups

3.2.1. Qualification for Rite Care eligibility is based on a combination of factors; including family composition, income level, insurance status, and/or pregnancy status, depending on the aid category. Enrollment procedures, scope of benefits, and program cost-sharing vary by aid category as described below.

3.2.2. The Rite Care population is a mandatory Managed Care Program population that consists of the following six (6) eligibility groups, or aid categories. These defined groups represent a consolidation of various aid categories:

3.2.2.1. **Families**. This group consists of persons categorically eligible for Medicaid based on RI Works or RI Works-related status or families with a minor child or children under age eighteen (18) with income specified by the State.

3.2.2.2. **Children Under Age 19 and Under 250% FPL.** This group consists of children under age nineteen (19) living in families and with income under two hundred and fifty percent (250%) of the FPL, regardless of citizenship or immigration status pursuant to 210-RICR-30-00-1.

3.2.2.3. **Pregnant Individuals Under 250% FPL ("SOBRA-Extension Group").** This group consists of uninsured pregnant individuals living in families under two hundred and fifty percent (250%) of the FPL. The category is referred to as the "SOBRA-Extension Group" (Sixth Omnibus Budget Reconciliation Act). The group is eligible for Medicaid Covered Services through delivery and twelve (12) months postpartum.

3.2.2.4. **Extended Family Planning Group.** This group consists of individuals who meet the following criteria: have qualified for Rite Care; were pregnant and are now past twelve (12) months postpartum or sixty (60) Calendar Days post loss of pregnancy, pursuant to 210-RICR-30-00-1; and are subject to losing full Medicaid eligibility. The group is eligible to receive a schedule of family planning-related benefits for up to twenty-four (24) months, as described in the "Extended Family Planning Program Requirements" in the Managed Care Manual. Individuals who qualify for this category remain with the same Health Plan that provided coverage during pregnancy.

3.2.2.5. Children with Special Health Care Needs. This group includes:

a) Blind/disabled individuals up to age twenty-one (21) who are eligible for Medicaid based on SSI;

b) Individuals up to age twenty-one (21) receiving subsidized adoption assistance;

c) Children in substitute care ("foster care") (enrollment in RIte Care for these children will be based on EOHHS determination of managed care eligibility) or eligible based on participation in a Department of Children, Youth, and Family Services (DCYF)) kinship or guardian program (whether in a home- based, residential, or institutional setting, as applicable);

d) Adults age twenty-one to twenty-six (21-26) who were previously active with DCYF and do not have other comprehensive coverage;

e) Youth who opt to remain in the care of DCYF up to age twenty-one (21) if they entered foster care on or after their sixth (6^{th}) birthday and did not achieve permanency (i.e., adopted, reunified, etc.) and were set to age out of foster care; and

f) Individuals up to age twenty-one (21) that are Dually Eligible for both Medicaid and Medicare.

g) Children with Special Health Care Needs may be eligible for home and community-based services as Out-of-Plan Benefits through the Rhode Island Medicaid FFS Program but receive all In-Plan Benefits through the Managed Care Program.

3.2.2.6. **Uninsured Children Up to Age 18 above 250% FPL.** This group consists of children up to age eighteen (18) living in families who are uninsured and whose income is above two hundred and fifty percent (250%) of the FPL, regardless of citizenship or immigration status pursuant to 210-RICR-30-00-1.

3.3. Rhody Health Partners Eligibility

3.3.1. Individuals who meet the following criteria are eligible for Rhody Health Partners, and are included in the Managed Care Program as a mandatory population:

3.3.1.1. Age twenty-one (21) and older;

3.3.1.2. Categorically eligible for Medicaid;

3.3.1.3. Not covered by other third-party health insurance, including Medicare;

3.3.1.4. Residents of Rhode Island.

3.4. Affordable Care Act Eligible Population

3.4.1. Individuals who meet the following criteria qualify for ACA Expansion group eligibility, and are included in the Managed Care Program as a mandatory population:

3.4.1.1. Adults between the ages of nineteen (19) and sixty-four (64);

3.4.1.2. Who are at or below the State's specified FPL based on household income (using the application of a modified adjusted gross income);

3.4.1.3. Who are not pregnant;

3.4.1.4. Who otherwise do not qualify for Medicaid; and,

3.4.1.5. Are not eligible for or enrolled in Medicare.

3.4.2. Members in the ACA Expansion group who become pregnant while enrolled are guaranteed eligibility for comprehensive services through twelve (12) months postpartum or post loss of pregnancy, and then are eligible for an Extended Family Planning benefit for up to an additional twenty-four (24) months.

3.5. Full-Benefit Dual Eligible Populations

3.5.1. Individuals who meet the following criteria qualify for Full-Benefit Dual Eligible population group, and are included in the Managed Care Program:

3.5.1.1. Age twenty-one (21) or older; and

3.5.1.2. Entitled to or are enrolled in Medicare Part A; and

3.5.1.3. Entitled to or enrolled in Medicare Part B; and

3.5.1.4. Eligible for full Medicaid benefits under the Rhode Island Medicaid State Plan.

3.6. New Eligibility Groups

3.6.1. EOHHS reserves the right to add new eligibility groups by amending this Agreement. If a new eligibility group is amended, the Contractor shall be given sixty (60) Calendar Days' advance notice.

3.7. Voluntary Managed Care Populations

3.7.1. Eligible Indian populations are subject to voluntary enrollment in the Managed Care Program and may choose to opt out of the program.

3.8. Excluded Managed Care Populations

3.8.1. The following Medicaid populations are excluded from enrollment in the Managed Care Program:

3.8.1.1. Recipients receiving services in an Intermediate Care Facility for Intellectual or Developmental Disabilities (ICF/IID).

3.8.1.2. Partial Dual Eligible individuals that qualify for a Medicare Savings Program but do not receive full Medicaid medical benefits.

3.8.1.3. Enrolled in the PACE Program.

3.8.1.4. Incarcerated for more than five (5) days.

3.9. Effective Date of Enrollment

3.9.1. The effective date of initial Enrollment with the Contractor shall be the date provided on the outbound ANSI ASC X12N 834 Benefit Enrollment & Maintenance electronic transaction file initiated by the Enrollment Broker.

3.9.2. The Contractor shall not be liable for the cost of any MCO Covered Services rendered prior to the effective date of Enrollment. However, the Contractor shall be responsible for the costs of MCO Covered Services rendered on or after 12:01 a.m. on the effective

date of Enrollment, including reimbursement to an Enrollee for payments already made by the Enrollee for MCO Covered Services rendered during the retroactive Enrollment period in accordance with the process outlined in the MCM.

3.9.3. EOHHS shall make monthly Capitation Payments to the Contractor from the effective date of an Enrollee's Enrollment. EOHHS shall deduct from the monthly Capitation Payment any FFS claims paid for services rendered during the retroactive Enrollment period.

3.9.4. Except for cost sharing that does not exceed the cost sharing amounts in the State Plan, the Contractor shall ensure that Enrollees are held harmless for the cost of MCO Covered Services provided.

3.10. No Guarantees Eligibility

3.10.1. Except as provided above, there are no eligibility guarantees for RIte Care, Rhody Health Partners, and ACA Expansion group Members. EOHHS has the sole authority to determine whether an individual meets managed care eligibility and enrollment criteria, as well as the individual's cost sharing requirements, if applicable.

3.11. Non-Biased Enrollment Counseling

3.11.1. At the time of initial eligibility determination or re-certification, EOHHS will make available non-biased enrollment counseling ("Choice Counselors") to Potential Members. Responsibilities of the Choice Counselors include educating Potential Members and their families, guardians, or adult caregivers about:

3.11.1.1. Managed care in general, including: the option to enroll in a Health Plan; the way services typically are accessed under managed care; the role of the PCP; and Health Plan Member responsibilities.

3.11.1.2. Benefits available through the Contractor's Health Plan, both in plan and out of plan.

3.11.1.3. Available Health Plan options, including criteria that might be important when making a choice (e.g., presence or absence of an existing PCP or other Providers in a Health Plan's Network).

3.11.2. To facilitate enrollment counseling, the Contractor will provide enrollment packet materials to EOHHS annually, or more frequently if the Contractor makes substantive changes to the materials. All materials for Potential Members will be written at no higher than a sixth-grade level, in a format and manner that is easily understood in accordance with 42 C.F.R. § 438.10(c).

3.12. Selection of Health Plan by Applicant and Members

3.12.1. EOHHS will offer applicants or Members the opportunity to select a Health Plan at the time of enrollment, when a Health Plan leaves the market or is terminated, during designated Plan Change Opportunity periods, and at other times determined by EOHHS.

3.12.2. Dually Eligible Members who choose to receive their Medicare benefits through a D-SNP will participate in an exclusively aligned enrollment model in which their D-SNP

and Medicaid Health Plan will be operated by the same parent company. As such, a Member's selection for their D-SNP will automatically determine their Medicaid Health Plan enrollment. The Health Plan shall ensure that this structure allows for increased integration between Medicaid and Medicare to streamline Member experience.

3.12.3. In addition to the Plan Change Opportunities described in this Section, Dually Eligible Members shall be permitted to change their Health Plan in alignment with their initial Medicare enrollment period, Medicare's annual open enrollment period, and Medicare's special enrollment periods.

3.12.3.1. During the Medicare initial enrollment period, Dually Eligible Members can enroll in Medicare for the first time. During the three (3) month period before the month the Member turns sixty-five (65) years old through three (3) months after the month the Member turns sixty-five (65) years old, the Member can enroll in a Medicare plan.

3.12.3.2. During the annual enrollment period, Dually Eligible Members may enroll in or disenroll from Medicare plans. This period shall align with Medicare enrollment periods each year.

3.12.3.3. Dually Eligible Members may change their Medicaid plan when the Member changes their D-SNP as permitted in the Medicare special enrollment periods.

3.12.4. Dually Eligible Members receiving Medicaid benefits through managed care, who also choose to receive their Medicare benefits through a D-SNP, shall be required to enroll in the Health Plan affiliated with the D-SNP for which they are also enrolled.

3.13. Default Enrollment

3.13.1. Prior to the Contract Effective Date, EOHHS will open the Plan Change Opportunity; all Members, excluding Dually Eligible Members in an aligned D-SNP and Health Plan, will have the opportunity to select or change their current Health Plan. Unless otherwise specified, this Section applies to Members receiving Medicaid benefits only.

3.13.2. Prior to Transition Phase II, EOHHS will open the Plan Change Opportunity for current Dually Eligible Members. All Dually Eligible Members will have the opportunity to select or change their current Health Plan in accordance with Section 3.12 of this agreement.

3.13.3. EOHHS will offer all Members the opportunity to select or change their current Health Plan on a yearly basis (Plan Change Opportunity). A Member of an incumbent Health Plan who does not make a Health Plan selection will remain in the same Health Plan.

3.13.4. If an eligible applicant or Member does not select a Health Plan, EOHHS will assign one in accordance with 42 C.F.R. § 438.54.

3.13.5. If a Dually Eligible Member does not select a Health Plan but is enrolled in a D-SNP for coverage of its Medicare benefits, the Member will be assigned to the corresponding Health Plan operated by the Member's D-SNP.

3.13.6. EOHHS's Default Enrollment Assignment Methodology will seek to preserve existing provider-Member relationships. The default enrollment methodology also may include quality metrics, Health Plan performance on contract requirements including contracting with EOHHS-certified AEs, Health Plan financial performance, household affiliations, previous enrollment in a Qualified Health Plan (QHP), or other factors EOHHS determines are in the best interest of Members.

3.13.7. EOHHS's default enrollment methodology will utilize a market share cap. Enrollment in any one (1) Contractor will be limited to no more than the following total percentage of Members depending on the number of Contractors selected from the procurement:

3.13.7.1. Two (2) Contractors: Sixty percent (60%)

3.13.7.2. Three (3) Contractors: Fifty percent (50%)

3.13.8. Members, regardless of whether auto-assignment resulted in a change in Contractor, will have a ninety (90) Calendar Day without cause disenrollment period.

3.13.9. EOHHS reserves the right to implement a special default process at any time.

3.14. Suspension of and/or Limits on Enrollments into a Contractor

3.14.1. EOHHS shall notify the Contractor of the maximum number of Enrollees it is able to enroll and maintain under the Contract prior to the initial Enrollment and upon changes. EOHHS reserves the right to approve or deny the maximum number of Enrollees to be enrolled in the Contractor based on EOHHS' determination of the adequacy of its capacity.

3.14.2. In the event the Contractor's Enrollment reaches capacity thresholds established in Section 3.13.7 of the total Enrollment in the State, the Contractor shall not receive additional Enrollees through the Default Assignment algorithm. EOHHS also has the sole discretion to suspend the Contractor's Default Enrollment Assignment due to Contract noncompliance.

3.14.3. If a Contractor has more than the designated percentage of the program's eligible Members, new Members and Members seeking to disenroll from their current plan for cause may still choose any participating Contractor, regardless of the market share cap.

3.14.4. The Contractor may continue to receive new Enrollees as a result of: Enrollee choice and newborn Enrollments; automatic reenrollments when an Enrollee loses and regains eligibility within two (2) months; the need to ensure continuity of care for the Enrollee; or determination of just cause by EOHHS. EOHHS' evaluation of the Contractor's Enrollment market share will take place on a calendar quarterly basis.

3.15. Automatic Reassignment Following Resumption of Eligibility

3.15.1. Members who are disenrolled from a Health Plan due to loss of eligibility, and who regain eligibility within sixty (60) days of disenrollment, may deselect a Health Plan of their choice.

3.15.2. Members who do not make a Health Plan selection will be automatically assigned to their previous Health Plan upon reinstatement of their Medicaid eligibility. If more

than sixty (60) Days have elapsed and the Member does not make a Health Plan selection at the time eligibility was reinstated, the Member will be assigned to a Health Plan based on the default enrollment process described in Section 3.12.

3.16. Health Plan Lock-In

3.16.1. After ninety (90) Days of initial enrollment in a Health Plan, non-dual Members will be restricted to that Health Plan until the next open enrollment period, unless disenrolled under one (1) of the conditions described in Section 3.15.

3.17. Member Disenrollment

3.17.1. EOHHS has sole authority to disenroll non-dual Members from contracted Health Plans, subject to the conditions described below. The Contractor is prohibited from processing a Member's request to disenroll from the Health Plan and will direct Members to file the request directly with EOHHS, or its delegate, for a disenrollment determination.

3.17.2. The Contractor shall, at a minimum, continue to provide MCO Covered Services and all other services required under this Contract to Enrollees up to 12:00 a.m. on the Calendar Day after the effective date of Disenrollment.

3.17.3. The Contractor shall demonstrate a satisfactorily low Voluntary Disenrollment Rate as compared with other MCOs, as determined by EOHHS.

3.17.4. EOHHS will disenroll Members from a Health Plan for any of the following reasons, in accordance with procedures described in the Managed Care Manual:

3.17.4.1. Loss of Medicaid eligibility;

3.17.4.2. Loss of program eligibility;

3.17.4.3. Death;

3.17.4.4. Relocation out-of-state (unless relocation is to a Border Community or for treatment as described in this Section);

3.17.4.5. Adjudicative actions;

3.17.4.6. Change in eligibility status;

3.17.4.7. Placement in an institution for mental disease or institutional long-term care facility, such as Eleanor Slater or Tavares;

3.17.4.8. A long-term stay in an out-of-state healthcare facility;

3.17.4.9. Eligibility determination error; or,

3.17.4.10. For cause, as determined by EOHHS.

3.17.5. EOHHS will determine whether cause exists for disenrollment on an individual basis in accordance with 42 C.F.R. § 438.56(d)(2). Circumstances constituting cause include:

3.17.5.1. Poor quality of care;

3.17.5.2. Lack of access to Providers experienced in dealing with the Member's

health needs;

3.17.5.3. The Contractor does not cover a service because of moral or religious grounds; and

3.17.5.4. The Member's service needs (e.g., cesarean section and a tubal ligation) are not available within the network, and the Member's Primary Care Provider or another provider determines that not receiving the services will subject the Member to unnecessary risk.

3.17.5.5. Lack of access to services covered under this Agreement;

3.17.5.6. The Member moves out of the Contractor's service area.

3.17.5.7. For Members that use MLTSS, the Member would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the Contractor and, as a result, would experience a disruption in their residence or employment.

3.17.5.8. The Contractor does not, because of moral or religious objections, cover the service the Enrollee seeks;

3.17.5.9. The Enrollee needs related services to be performed at the same time; not all related services are available within the Enrollee's MCO and the Enrollee's PCP or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk;

3.17.5.10. Lack of access to MCO Covered Services as determined by EOHHS;

3.17.5.11. The Member's active specialized behavioral health provider ceases to contract with the Contractor for reasons other than non-compliance with the Network Provider Agreement or this Agreement; or

3.17.5.12. Any other reason deemed to be valid by EOHHS and/or its agent.

3.17.6. A Member has the right to disenroll for cause at any time.

3.17.7. A Member may request disenrollment from Health Plan by contacting EOHHS or the Contractor either in writing or orally. The Contractor shall refer the request to EOHHS within one (1) Business Day and Contractor shall provide Member with information on how to disenroll from Health Plan, including disenrollment form.

3.17.8. A Member may request disenrollment without cause:

3.17.8.1. During the ninety (90) Days following the date of the recipient's initial enrollment with the Contractor and at least once every twelve (12) months thereafter;

3.17.8.2. Upon automatic reenrollment under 42 C.F.R. § 438.56(g), if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity; and

3.17.8.3. When EOHHS imposes an intermediate sanction upon the Contractor, as

identified in 42 C.F.R. § 438.702(a)(4).

3.17.8.4. After EOHHS notifies the Contractor that it intends to terminate the Contract as provided by 42 C.F.R. § 438.722.

3.17.9. In accordance with 42 C.F.R. § 438.56(b)(2), the Contractor may not request disenrollment of a Member because of an adverse change in the Member's health status, or because of the Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the Member's special needs (except when the Member's continued enrollment in the Health Plan seriously impairs the Health Plan's ability to furnish services to either the particular Member or other Members).

3.17.10. The Contractor shall submit written disenrollment policies and procedures to EOHHS for approval. If an exception applies, the Contractor shall request the disenrollment in writing and provide justification for the request. All disenrollments are subject to approval by EOHHS.

3.17.11. If a Member is staying out-of-state to receive a service or benefit due to a lack of availability in Rhode Island, the Member may remain enrolled with their Health Plan. Policies and procedures for when a Member may be disenrolled due to long-term out-of-state care are detailed in the Managed Care Manual.

3.17.12. Dually Eligible Members will participate in an exclusively aligned enrollment model.

3.17.12.1. If a FBDE Member is enrolled in an integrated D-SNP and a Health Plan and chooses to change their Medicare coverage to another D-SNP outside of the Medicaid Plan Change Opportunity period, the Member shall be disenrolled from their current Health Plan and automatically reassigned to the corresponding Health Plan operated by the Member's new D-SNP.

3.17.12.2. If a FBDE Member is enrolled in an integrated D-SNP and a Health Plan and chooses to switch their Medicare coverage to a traditional Medicare Advantage plan or Original Medicare, the Member shall be disenrolled from their Health Plan and shall be enrolled in Medicaid FFS.

3.18. Involuntary Disenrollment Requested by the Contractor

3.18.1. The Contractor may request involuntary Disenrollment of a Member if the Member's utilization of services constitutes Fraud, Waste, and/or Abuse such as misusing or loaning the Member's MCO Member ID Card to another person to obtain services. In such case the Contractor shall report the event to EOHHS and MFCU.

3.18.2. The Contractor shall submit Disenrollment requests to the EOHHS Contractor Officer, in a format and manner to be determined by EOHHS.

3.18.3. The Contractor shall ensure that involuntary Disenrollment documents are maintained in an identifiable Enrollee record.

3.18.4. The Contractor shall not request Disenrollment because of an adverse change in physical or mental health status or because of the Enrollee's health diagnosis, utilization of medical services, diminished mental capacity, pre-existing medical

condition, refusal of medical care or diagnostic testing, attempt to exercise his/her rights under the Contractor's grievance system, or attempt to exercise her/her right to change, for cause, the PCP that he/she has chosen or been assigned. Further, the Contractor shall not request Disenrollment because of an Enrollee's uncooperative or disruptive behavior resulting from his or her special needs, except when his or her continued Enrollment seriously impairs the Contractor's ability to furnish services to either this particular Enrollee or other Enrollees. [42 C.F.R. § 438.56(b)(2)]

3.18.5. The Contractor shall not request Disenrollment for reasons other than those stated in this Contract. In accordance with 42 C.F.R. §438.56(b)(3), EOHHS shall ensure that the Contractor is not requesting Disenrollment for other reasons by reviewing and rendering decisions on all Disenrollment Request Forms submitted to EOHHS.

3.18.6. All Disenrollment requests shall be reviewed on a case-by-case basis and are subject to the sole discretion of EOHHS. All decisions are final and not subject to the dispute resolution process by the Contractor.

3.18.7. Until the Member is Disenrolled by the Enrollment Broker, the Contractor shall continue to be responsible for the provision of all MCO Covered Services to the Enrollee.

3.19. Effective Date of Disenrollment

3.19.1. EOHHS will process a Member's request for disenrollment in accordance with the timeframe specified in 42 C.F.R. § 438.56(e), no later than the first Day of the second month following receipt (the "processing deadline"). Requests processed after this timeframe will be effective as of the processing deadline.

3.19.2. EOHHS will notify the Contractor of a Member's effective date of disenrollment, which normally will be effective at 12:00 a.m. on the last date of the month in which notice was received. The Contractor shall, at a minimum, continue to provide MCO Covered Services and all other services required under this Contract to Enrollees up to 12:00 a.m. on the Calendar Day after the effective date of Disenrollment.

3.19.3. The Contractor agrees to have written policies and procedures for complying with State disenrollment orders.

3.19.4. EOHHS, the Contractor, and the Enrollment Broker shall reconcile Enrollment/Disenrollment issues at the end of each month utilizing an agreed upon procedure.

3.20. Retroactive Enrollment and Disenrollment

3.20.1. In special circumstances identified by EOHHS, the Contractor shall retroactively enroll or disenroll a Member. The Contractor is required to coordinate with EOHHS and the Member's prior Health Plan, if applicable, to successfully transition the Member to the Contractor's Health Plan, and to work with EOHHS to reprocess any necessary claims.

3.21. Reporting Demographic Changes

3.21.1. The Contractor shall report address changes, including Members who report out-of-

state address changes, to EOHHS in accordance with the EOHHS Medicaid Health Plan Requirements for Medicaid Member Demographic Changes.

3.22. Assistance with Medicaid Eligibility Renewal

3.22.1. Renewals of Rhode Island Medicaid Program eligibility are conducted annually. At least thirty (30) Calendar Days prior to the renewal date as indicated on the 834 File, the Contractor shall provide assistance to Enrollees with eligibility renewals.

3.22.2. The Contractor shall attempt to contact the Enrollee by mail and/or phone three (3) times to encourage their Timely response to the renewal. The Enrollee should be provided with information on the ways to apply / renew.

3.22.3. EOHHS reserves the right to revoke assistance of the Contractor to support Medicaid eligibility renewals at any time during the term of the Agreement.

3.22.4. Contractor must submit approved assistance policies and procedures during Contract Readiness and annually thereafter.

3.23. Newborn Enrollment

3.23.1. The Contractor shall contact Enrollees who are expectant mothers at least sixty (60) Calendar Days prior to the expected date of delivery to encourage the mothers to choose a PCP for their newborns. In the event that the pregnant Enrollee does not select a PCP, the Contractor shall provide the Enrollee with a minimum of fourteen (14) Calendar Days after birth to select a PCP prior to assigning one.

3.23.2. Newborns and their mothers, to the extent that the mother is eligible for the Rhode Island Medicaid Program, shall be enrolled in the same MCO with the exception of newborns placed for adoption, newborns who are born out-of-state and are not Rhode Island residents at the time of birth, and newborns and mothers eligible for the Rhode Island Medicaid Program after the month of birth.

3.23.3. If EOHHS discovers that a newborn was incorrectly enrolled in a different MCO than its mother for the month of birth, EOHHS shall immediately:

3.23.3.1. Disenroll the newborn from the MCO in which the newborn was incorrectly enrolled;

3.23.3.2. Enroll the newborn in the correct MCO with the same effective date as when the newborn was enrolled in the incorrect MCO;

3.23.3.3. Recoup any payments made to the incorrect MCO for the newborn ; and

3.23.3.4. Make payments only to the MCO in which the newborn is correctly enrolled for the period of coverage.

3.23.4. If the Contractor discovers that a newborn was incorrectly enrolled in a different MCO than its mother for the month of birth, the Contractor shall notify EOHHS immediately through policies and procedures contained in the MCM.

3.23.5. The MCO in which the newborn is correctly enrolled shall be responsible for the coverage of, and payment for, MCO Covered Services provided to the newborn for the full period of coverage. The MCO in which the newborn was incorrectly enrolled shall

have no liability for the coverage of, or payment for, any services during the period of incorrect Enrollment. EOHHS shall be liable only for the Capitation Payment to the MCO in which the newborn is correctly enrolled and may recoup the Capitation Payment from the MCO in which the newborn was incorrectly enrolled.

3.23.6. For newborns disenrolled, the MCO in which the newborn was incorrectly enrolled shall not recover claim payments from the provider. The MCO in which the newborn is incorrectly enrolled shall seek such claim payments from the MCO in which the newborn should have been enrolled on the dates of service.

3.23.7. The Contractor shall be responsible for ensuring that hospitals report the births of newborns within twenty-four (24) hours of birth for Enrollees in accordance with the process outlined in the MCO Manual. Enrollment of deemed eligible newborns who are Rhode Island residents at the time of birth and who are not surrendered prior to hospital discharge shall be retroactive to the date of the birth.

3.23.8. The Contractor shall require its hospital providers to register all births within fifteen (15) Calendar Days through Rhode Island Electronic Event Registration System (LEERS) administered by Rhode Island Department of Health (RIDOH).

3.24. Contractor Enrollment Procedures

3.24.1. Acceptance of All Enrollees

3.24.1.1. The Contractor shall enroll any Enrollee in a Mandatory MCO Population or Voluntary MCO Population who selects it or is otherwise assigned to it.

3.24.1.2. The Contractor shall accept new Enrollment of Beneficiaries in the order in which they are submitted by the Enrollment Broker without restriction as specified by EOHHS, up to the limits set under the Contract with EOHHS [42 C.F.R. § 438.3(d)(1)]. Enrollment is voluntary, except in the case of Mandatory MCO Populations that meet the conditions set forth in 42 C.F.R. § 438.50(a).

3.24.1.3. The Contractor shall not discriminate against Enrollees on the basis of their health history, health status, need for health care services or adverse change in health status; or on the basis of age, religious belief, sex, gender, sexual orientation, gender identity, or disability. Further, the Contractor shall not use any policy or practice that has the effect of discriminating on the basis of age, religious belief, race, color, national origin, sex, sexual orientation, gender identity, or disability. This applies to Enrollment, reenrollment or Disenrollment from the Contractor. The Contractor shall be subject to Monetary Penalties and other sanctions if it is determined by EOHHS that the Contractor has requested Disenrollment for any of these prohibited reasons.

3.24.1.4. The Contractor shall comply with all Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, and applicable Waivers governing direct reimbursement to Enrollees for payments made by them for MCO Covered Services and supplies delivered during a period

of retroactive eligibility.

3.25. Enrollment and Disenrollment Updates

3.25.1. EOHHS' Enrollment Broker shall notify the Contractor at specified times each month of the Beneficiaries that are enrolled, reenrolled, or disenrolled from the Contractor for the following month. The Contractor shall receive this notification through the ANSI ASC X12N 834 Benefit Enrollment and Maintenance electronic transaction file, or in instances of corrections to closed segments or other special circumstances, the Contractor shall receive this notification through a manual correction processing file.

3.25.2. EOHHS shall use its best efforts to ensure that the Contractor receives Timely and accurate Enrollment and Disenrollment information. In the event of discrepancies or irreconcilable differences between EOHHS and the Contractor regarding Enrollment, Disenrollment and/or termination, EOHHS' decision is final.

3.26. Updates

3.26.1. The Enrollment Broker shall make available to the Contractor daily via electronic media (ASC X12N 834 Benefit Enrollment and Maintenance transaction file) updates on Beneficiaries newly enrolled with the Contractor in the format specified in the MCO System Companion Guide. The Contractor shall have written policies and procedures for receiving these updates, incorporating them into its management information system and ensuring this information is available to their providers. Policies and procedures shall be available during Readiness Review.

3.26.2. In instances of corrections or updates to closed segments, the Contractor shall receive data through a weekly manual correction processing file.

3.26.3. EOHHS reserves the right to require the Contractor to accept real-time Enrollment updates from the Enrollment Broker upon the implementation of such functionality by the Enrollment Broker.

3.27. Reconciliation

3.27.1. Enrollment

3.27.1.1. The Contractor is responsible for monthly and quarterly reconciliation of the membership list of Enrollments and Disenrollments received from the Enrollment Broker against its internal records.

3.27.1.2. The Contractor shall provide written notification to EOHHS of any data inconsistencies within ten (10) Calendar Days of receipt of the monthly and quarterly reconciliation data file.

3.27.2. Payment

3.27.2.1. The Contractor shall receive a monthly electronic file (ASC X12N 820 Transaction) from the Fiscal Intermediary (FI) listing all Enrollees for whom the Contractor received a Capitation Payment and the amount received.

h) The Contractor is responsible for reconciling this listing against its

internal records.

i) It is the Contractor's responsibility to notify the FI of any discrepancies within sixty (60) Calendar Days of the file date.

j) Lack of compliance with reconciliation requirements shall result in the deduction of a portion of future monthly payments and/or Liquidated Damages until requirements are met.

Article 4. Covered Benefits, Service Requirements, and Limitations

4.1. General Requirements

4.1.1. The Contractor shall provide all Covered Services in Attachment F-4.1, "Schedule of In-Plan Benefits," so long as the service is Medically Necessary for the Member. In accordance with 42 C.F.R. § 438.210(a)(5) the Contractor shall apply Medical Necessity criteria in a manner that:

4.1.1.1. Is no more restrictive than Rhode Island's Medicaid FFS Program, considering Quantitative and Non-Quantitative Treatment Limits indicated in Rhode Island's State Plan or other state law or regulation.

4.1.1.2. Provides Members access to services that address the prevention, diagnosis, and treatment of diseases, conditions, or disorders that result in health impairments or disabilities.

4.1.1.3. Provides Members access to services that allow them to achieve age-appropriate growth and development.

4.1.1.4. Allows Members access to services needed to attain, maintain, or regain a Member's functional capacity.

4.1.2. The Contractor shall possess the expertise and resources to ensure the delivery of quality healthcare services to its Members in accordance with this Contract and prevailing medical community and national standards.

4.2. Failure to Provide Covered Benefits

4.2.1. If the Contractor fails to provide any Covered Services as outlined by this Agreement, EOHHS may impose contractual remedies, including civil monetary penalties up to $25,000 for each failure to provide services. EOHHS may also:

4.2.1.1. Appoint temporary management to the Contractor.

4.2.1.2. Grant Members the right to disenroll from the plan without cause.

4.2.1.3. Suspend all new enrollments after the date the Secretary or the state notifies the Contractor of a determination of a violation under this Section of the Agreement.

4.2.1.4. Suspend the payments for new Members until CMS or EOHHS is satisfied that the Contractor has taken remedial measures and the noncompliance is not likely to recur.

4.3. Amount, Duration, Scope, Caps and Limitations

4.3.1. The Covered Services described in Attachment F-4.1, "Schedule of In-Plan Benefits," shall comply with the following requirements.

4.3.1.1. Covered Services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Beneficiaries under FFS, as set forth in 42 C.F.R. § 440.230, and for Enrollees under the age of twenty-one (21), as set forth in 42 C.F.R.

Part 441, Subpart B. [42 C.F.R. § 438.210(a)(2)]

4.3.1.2. The Contractor shall ensure that Covered Services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which they are furnished.

4.3.1.3. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of Covered Services solely because of the diagnosis, type of illness, or condition of the Member.

4.3.1.4. Covered Services are subject to the benefit limits described in the Rhode Island Medicaid State Plan. The Contractor may place appropriate limits on Covered Services based on Medical Necessity or for the purpose of utilization control.

4.3.2. The Contractor shall ensure, notwithstanding any utilization controls:

4.3.2.1. Services can reasonably achieve their purpose.

4.3.2.2. Services are authorized in a manner to reflect a Member's ongoing need for services and supports, taking into account Members with ongoing or chronic conditions.

4.3.2.3. Family planning and women's health services are provided in a manner that maintains the Member's freedom of choice as required in Sections 18.38 and 18.39 of this Agreement.

4.3.3. The Contractor shall ensure that Covered Services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the Enrollee. [42 C.F.R. § 438.210(a)(3)]

4.3.4. In accordance with 42 C.F.R. § 438.210(a)(4), the Contractor may place appropriate limits on a service that are:

4.3.4.1. On the basis of criteria applied under the State Plan, such as medical necessity; or

4.3.4.2. For the purpose of utilization control, provided that:

k) The services furnished can reasonably be expected to achieve their purpose;

l) The services support Enrollees with ongoing or chronic conditions and are authorized in a manner that reflects the Enrollee's ongoing need for such services and supports; and,

m) Family planning services are provided in a manner that protects and enables the Enrollee's freedom to choose the method of family planning to be used consistent with 42 C.F.R. § 441.20.

4.3.5. The Contractor shall provide Covered Services in accordance with EOHHS' definition of medically necessary services, including quantitative and non-quantitative treatment

limits, as indicated in State statutes and regulations, the State Plan, and the Managed Care Manual. [42 C.F.R. § 438.210(a)(5)(i)]

4.3.6. A public health quarantine or isolation order or recommendation also establishes medical necessity of healthcare services.

4.3.7. The Contractor shall cover medically necessary services that address:

4.3.7.1. The prevention, diagnosis and treatment of an Enrollee's disease, condition, and/or disorder that results in health impairments and/or disability;

4.3.7.2. The ability for an Enrollee to achieve age-appropriate growth and development; and

4.3.7.3. The ability for an Enrollee to attain, maintain, or regain functional capacity.

4.3.8. The Contractor shall ensure that each Member has an ongoing source of care appropriate to their needs as required under 42 C.F.R. § 438.208(b)(1) and shall formally designate a PCP as primarily responsible for coordinating services accessed by the Member.

4.3.9. The Contractor shall not avoid costs for services covered in its Contract by referring Enrollees to publicly supported health care resources. [42 C.F.R. § 457.1201(p)]

4.3.10. The Contractor shall provide a mechanism to reduce inappropriate and duplicative use of healthcare services, including, but not limited to, potentially preventable hospital emergency department (ED) visits and inpatient readmissions.

4.3.11. The Contractor shall not condition the provision of care or otherwise discriminate against an Member based on whether or not the Member has executed an Advance Directive. [42 C.F.R. § 438.3(j)(1) and (2); 42 C.F.R. § 489.102(a)(3).]

4.3.12. The Contractor and its providers shall deliver services in a culturally competent manner to all Member, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity and provide for cultural competency and linguistic needs, including the Member prevalent language(s) and sign language interpreters in accordance with 42 C.F.R. § 438.206(c).

4.3.13. In the event that EOHHS determines that the Contractor failed to provide one or more Covered Services, EOHHS shall direct the Contractor to provide such service. If the Contractor continues to refuse to provide the Covered Service(s), EOHHS shall authorize the Enrollees to obtain the Covered Service from another source and shall notify the Contractor in writing that the Contractor shall be charged the actual amount of the cost of such service.

4.3.14. In such event, the charges to the Contractor shall be obtained by EOHHS in the form of deductions from the next monthly Capitation Payment made to the Contractor or a future payment as determined by EOHHS. With such deductions, EOHHS shall

provide a list of the Members for whom payments were deducted, the nature of the service(s) denied, and payments EOHHS made or will make to provide the medically necessary MCO Covered Services.

4.4. Telemedicine

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

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

4.4.1.2. It is Clinically Appropriate to provide the service via Telemedicine.

4.4.2. The Contractor shall comply with the requirements of Section 4 of the Rhode Island Telemedicine Coverage Act, (R.I. Gen. Laws § 27-81-4) which prohibits the Contractor from:

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

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

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

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

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

4.4.2.6. Imposing restrictions on specific technologies used to deliver Telemedicine services, unless authorized by State or Federal law, EOHHS guidance, or other applicable State regulatory requirements.

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

4.4.4. Section 7 of the Rhode Island Telemedicine Coverage Act (R.I. Gen. Laws § 27-81-7) requires the Contractor to submit reports to OHIC regarding its telemedicine policies, practices, and experience. The Contractor shall provide EOHHS copies of all such OHIC reports within three (3) Business Days of filing.

4.4.5. In accordance with Section 5.14, "Behavioral Health Innovation Plan," the Contractor's Behavioral Health Innovation Plan shall include strategies to expand

access to services across the behavioral health continuum through Telemedicine.

4.4.6. The Compliance Plan described in Section 24.2, "Compliance Program," shall include the Contractor's policies and procedures for demonstrating compliance with this Section and the Rhode Island Telemedicine Coverage Act. The Contractor shall assist EOHHS and the officials and entities described in Section 25.4, "Audit of Services and Deliverables" with audits or reviews of payment parity, utilization management, and other telemedicine requirements.

4.4.7. In addition to meeting all standards established by the Rhode Island Telemedicine Coverage Act, the Contractor shall adopt a unified list of minimum service codes, established by EOHHS, that can be provided through telemedicine. The Contractor may authorize the coverage of additional services via telemedicine.

4.5. Provider Requirements for Telemedicine

4.5.1. The Contractor shall ensure Healthcare Providers meet State, Federal, and EOHHS requirements for:

4.5.1.1. Participating in the Medicaid program;

4.5.1.2. Coding Telemedicine claims, as described in the Managed Care Manual.; and

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

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

4.5.3. As specified in Section 1.20, "Payments to Institutions or Entities Located Outside of the U.S." and 42 C.F.R. § 438.602(i), the Contractor is prohibited from making payments to Telemedicine providers located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Marina Islands and American Samoa.

4.5.4. In accordance with Section 18.30, "Provider Manual," the Contractor's Provider Manual shall include clear instructions on how to:

4.5.4.1. Request Prior Authorization for Telemedicine Services.

4.5.4.2. Submit claims for Telemedicine Services.

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

4.6. Member Education for Telemedicine

4.6.1. In accordance with Section 22.9, "Member Education," the Contactor shall educate Members about the availability of Telemedicine services and include clear instructions on how to access Healthcare Services through Telemedicine on the Contractor's website and in the Member Handbook.

4.7. In-Lieu of Services

4.7.1. The Contractor may offer In-Lieu of Services (ILOS), as approved by EOHHS, in accordance with the policies and procedures outlined in the Managed Care Manual. ILOS may be substituted for a Rhode Island Medicaid State Plan service when all of the following conditions are met:

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

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

4.7.1.3. The approved ILOS is listed in the Attachment F-4.4, "In-Lieu of Services."

4.7.1.4. If the Contractor seeks to provide an ILOS that is not listed in Attachment F-4.4, the Contractor shall receive approval from EOHHS' prior to delivery of the ILOS.

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

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

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

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

4.7.6. The Contractor shall inform Members of any newly approved ILOS on its website, in accordance with Section 21.13, "Contractor Website," and in an update to the Member Handbook. All updates shall be posted no later than thirty (30) Days after EOHHS's approval of the ILOS.

4.7.7. The Contractor shall utilize a consistent process to ensure that a provider (either a Health Plan's licensed clinical staff or contracted network Provider), using their professional judgment, determines and documents that the ILOS is medically appropriate for the specific Member. This documentation shall be included in the Member's Care Plan.

4.7.8. The Contractor shall document and report utilization data and associated costs with all ILOS to EOHHS on a monthly basis and in a format determined by EOHHS.

4.8. Termination of an In-Lieu of Service

4.8.1. EOHHS, in its sole discretion, may terminate an ILOS if it determines the service is

not medically appropriate, cost effective, may be harmful to Members, or does not align with EOHHS program goals. EOHHS will provide notice to the Contractor of its decision to terminate.

4.8.2. The Contractor may terminate its offer of an ILOS after receiving approval from EOHHS to do so. The Contractor shall submit their intent to terminate an ILOS in accordance with the Managed Care Manual.

4.8.3. The Contractor shall notify Members of an ILOS termination, regardless of whether EOHHS or the Health Plan initiated the termination. The Contractor shall post notice on its website, in accordance with Article 21, "Member Materials," and in an update to the Member Handbook. All updates shall be posted no later than thirty (30) Days in advance of the termination date.

4.8.4. The Contractor shall develop a transition plan for Members receiving the terminated ILOS and ensure Subcontractors and Providers follow the transition plan or otherwise maintain continuity of care for Members. The Contractor is required to submit the transition plan to EOHHS.

4.9. Out-of-Plan Benefits

4.9.1. The Contractor is not responsible for directly providing or reimbursing Out-of-Plan Benefits as outlined in Attachment F-4.2 of this Agreement.

4.9.2. Out-of-Plan Benefits are not available to the following populations:

4.9.2.1. SOBRA-extension group Members who have an income above two hundred and fifty percent (250%) of the Federal Poverty Level.

4.9.2.2. Members receiving Extended Family Planning Benefits.

4.10. Contractor Responsibilities

4.10.1. Notwithstanding the foregoing, the Contractor shall provide coordination for Out-of-Plan Benefits or otherwise ensure the Out-of-Plan Benefit is accessible to the Member. This includes:

4.10.1.1. Educating Members and Providers about the availability of these services (via the Member Handbook, Provider Handbook, outreach, and education materials, etc.).

4.10.1.2. Ensuring the Member's Primary Care Provider or specialty Provider refers the Member to the Out-of-Plan Service, as appropriate.

4.10.1.3. Facilitating communication and information sharing between the Contractor and Network Providers, out-of-network providers, brokers, and other state agencies for access to Out-of-Plan Services.

4.10.1.4. Verifying whether Members are receiving these services.

4.10.1.5. Ensuring the Member's Primary Care Provider, Case Manager, Primary Care Case Manager, or other entity creating the Member's plan of care is integrating Out-of-Plan Services when creating and executing the Member's Plan of Care.

4.10.1.6. Coordinating all Out-of-Plan Benefits with the In-Plan Benefits in the Member's Plan of Care.

4.10.1.7. Develop data sharing agreements between the Contractor and other vendors and state agencies providing out-of-plan services.

4.11. Value-Added Services

4.11.1. The Contractor may offer Value-Added Services to its Members, as approved by EOHHS in accordance with the Managed Care Manual.

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

4.11.3. The Contractor shall include a description of the Value-Added Services offering in all Member Materials as described in Article 21 of this Agreement.

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

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

4.12. Terminating a Value-Added Service

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

4.12.2. Prior to terminating a Value-Added Service, the Contractor shall notify the following entities:

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

4.12.2.2. The Contractor shall notify the Choice Counselors no later than thirty (30) Days in advance of the proposed effective date of termination.

4.12.2.3. The Contractor shall notify all Members no later than thirty (30) Days in advance of the proposed effective date of termination. The notification shall be on the Member facing page of the Contractor's website as described in 21.13 of this Agreement and in an updated version of all Member Materials. The Contractor should make a best effort to communicate directly with Members receiving the Value-Added Service.

4.13. Coordination of Benefits

4.13.1. Members may have other comprehensive health coverage. The Contractor is responsible for coordinating all benefits and ensuring that Medicaid is the payer of last resort. The Contractor shall identify and pursue other forms of health coverage and retain any reimbursement obtained from third-party coverage prior to paying a claim for service under Medicaid.

4.13.2. In the case of a FBDE Member, Contractor shall work with its affiliated D-SNP plan to pay a claim for service under Medicare benefit, prior to paying the claim for service under Medicaid.

4.14. Provisions for Members Who are Eligible Through the Katie Beckett Pathway

4.14.1. For those Members who are eligible for Medicaid benefits through the Katie Beckett eligibility pathway, the Contractor will provide the following additional provisions:

4.14.1.1. Individualized assessment of concerns and needs with the family and child, using the existing Health Risk Assessment;

4.14.1.2. Person-centered planning;

4.14.1.3. Development of a Family Care Plan that includes a "crisis support care plan" which details individuals or agencies (e.g., child's Primary Care Physician (PCP), local mental health center) for the family to contact in the event of a specific crisis and actions to take to ensure the safety of the child and family.

4.14.1.4. Care coordination and assistance in accessing services, including multiple provider care coordination if it is determined that more than one (1) provider is required to provide services;

4.14.1.5. Support during transitions through levels of care; and entry into adult service of care;

4.14.1.6. Implementation of the multiple provider policy (HBTS/ABA Certification Standards addendum, June 8, 2021);

4.14.1.7. Advocate and assist in ensuring that a beneficiary and family's service needs are met;

4.14.1.8. Serve as the coordinator/manager of services to facilitate and coordinate services when families need to access home-based community services;

4.14.1.9. Navigate the Medicaid children's services system; and

4.14.1.10. Provide oversight of service delivery to Members and their families to ensure accountability and delivery of medically necessary covered services.

4.14.2. The Contractor shall provide Members, Members' families, and Member Representatives with the EOHHS Ombudsman e-mail and phone number to contact in the event that they have any concerns about the services received.

4.14.2.1. EOHHS shall engage the MCOs in the Active Contract Management Process by:

a) Collecting relevant data on a quarterly cadence, this data includes, but is not limited to:

(i) Data related to family care plan goals being met;

(ii) Family care plan coordination;

(iii) Annual family satisfaction surveys; and

(iv) Complaints and resolutions.

4.14.2.2. Meeting with Contractor, on a monthly basis, to review the following:

a) Performance;

b) Utilization of services;

c) Compliance;

d) Quality assurance; and

e) Continuous quality improvement.

Article 5. Behavioral Health Benefits

5.1. General Requirements

5.1.1. The Contractor shall provide the full continuum of Behavioral Health Benefits described in this Agreement, including Mental Health Benefits and Substance Use Disorder Benefits for children and adults. These benefits are described at a high level in this Section. For additional information regarding Behavioral Health Benefits, see Attachment F-4.1 – Schedule of In-Plan Benefits ("Services"), the Managed Care Manual, the Rhode Island Medicaid Provider Manual's Chapter on "Rehabilitative Services," and the Rhode Island Medicaid State Plan. The Contractor shall provide Member-centered, clinically, and developmentally appropriate behavioral health services.

5.1.2. Recognizing that Members' behavioral health needs may change over time, the Contractor shall implement a stepped approach to providing Behavioral Health Benefits that addresses all levels of need. Members can enter the continuum at any step and shall receive care and treatment based on their individual needs and acuity levels.

5.1.3. The MCO shall ensure physical and behavioral health Providers provide co-located or Integrated Care as defined in the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Six Levels of Collaboration/Integration or the Collaborative Care Model to the maximum extent feasible.

5.1.4. The Contractor shall establish policies and procedures to facilitate the integration of physical and behavioral health and to provide for continuity of care. These policies shall include mechanisms for collaborating with healthcare facilities and other social services agencies that may be involved in the Member's care.

5.1.5. The Contractor shall ensure that its clinical standard and operating procedures are consistent with trauma-informed models of care. If the Member has an ICP, the Contractor shall ensure that the ICP reflects the Member's behavioral health needs.

5.1.6. The Contractor's behavioral health program shall include strategies to promote early diagnosis, intervention, and treatment. These strategies shall include early screening and referral practices, to ensure treatment is provided at the right time and setting, thereby reducing the need for inpatient, emergency room (ER), and other high-cost settings. The Contractor shall specifically ensure that a Member's PCP addresses a Member's behavioral health needs as soon as possible after enrollment.

5.1.7. The Contractor shall comply with the Rhode Island Medicaid State Plan, Rhode Island Medicaid Provider Manual's Rehabilitative Services Coverage Guidelines, and EOHHS Certification Standards as they relate to coverage of Behavioral Health Benefits, benefit limits, and authorized provider types, including any applicable prior authorization requirements.

5.1.8. Subject to the requirements of Sections 5.3, "Behavioral Health Workgroup" and 5.13, "Mental Health Parity Requirements," the Contractor is responsible to develop its own claims billing guidelines and level of care (LOC) and UR criteria for Behavioral

Health Benefits. These guidelines and criteria shall be approved by EOHHS prior to implementation and any subsequent substantive revision.

5.1.9. In accordance with Sections 18.27 and 22.9, the Contractor's Provider and Member education programs shall include descriptions of covered Behavioral Health Benefits, Out-of-Plan Behavioral Health Benefits, and how to access these services.

5.1.10. In accordance with Section18.22, "Self-Referrals" the Contractor shall have written policies and procedures allowing Members to self-refer for in-network Behavioral Health Benefits, as appropriate to the type of service.

5.1.11. The Contractor shall comply with reporting requirements regarding behavioral health quality metrics and outcomes, as described in the Managed Care Manual. The Contractor is subject to contractual remedies, including liquidated damages and payment withholds, for failure to report on or meet performance targets. The Contractor shall submit to the state a plan regarding its program, policies, and procedures for providing integrated behavioral and physical health. The report shall address all elements required by this Section.

5.1.12. If the Contractor elects to Subcontract any behavioral health benefits, the requirements of Article 2 shall apply.

5.2. Approach to Behavioral Health Services

5.2.1. The Contractor shall ensure that its clinical standard and operating procedures are consistent with trauma-informed models of care, as defined by SAMHSA and reflect a focus on Recovery and resiliency.

5.2.2. The Contractor shall offer training inclusive of mental health first aid training, to Contractor staff who manage the behavioral health contract and Participating Providers, including Care Managers, physical health Providers, and Providers on Recovery and resiliency, Trauma-Informed Care, and Community Mental Health Services and resources available within Rhode Island and out of state.

5.2.3. The Contractor shall track training rates and monitor usage of Recovery and resiliency and Trauma-Informed Care practices.

5.2.4. The Contractor shall ensure that Providers, including those who do not serve behavioral health Members, are trained in Trauma-Informed Models of Care.

5.3. Behavioral Health Workgroup

5.3.1. The Contractor shall participate in an ongoing workgroup with EOHHS, BHDDH, DCYF, health plans, AEs, Member advocates, and other stakeholders and interested parties identified by EOHHS. The purpose of the workgroup is to identify gaps, implement changes, and evaluate needs including:

5.3.1.1. Practices and protocols to promote health equity and access to integrated and coordinated physical health, behavioral health, SUD, and SDOH services.

5.3.1.2. Opportunities to reduce provider burden through streamlined and

standardized claims billing guidelines; LOC criteria; and prior authorization, retrospective review, and other UM processes.

5.3.1.3. Standardized screening and assessment tools to promote early diagnosis and treatment of behavioral health conditions for all Members, including Members with developmental delays, and to identify SDOH and other risk factors that impact behavioral health outcomes.

5.3.1.4. Standardized and evidence-based provider education and training tools to address workforce challenges, early diagnosis and intervention, health equity, and SDOH. When appropriate, trainings should be designed to meet continuing education requirements for maintaining provider licensure or certification.

5.3.1.5. Standardized tool to support evidence-based practices, including technical bulletins, certification standards, and program guidelines.

5.3.1.6. Standardized transition of care protocols, including discharge planning protocols for Members following inpatient psychiatric or residential treatment services or a recent hospitalization related to an overdose.

5.3.2. Examples of standardized screening and assessment tools the workgroup may consider include:

5.3.2.1. Child and Adolescent Needs and Strengths Assessment (CANS);

5.3.2.2. Adult Needs and Strengths Assessment (ANSA);

5.3.2.3. Screening, Brief Intervention, and Referral to Treatment (SBIRT);

5.3.2.4. National Institute of Mental Health suicide screening tools;

5.3.2.5. Adverse Childhood Experiences (ACEs);

5.3.2.6. Brief Questionnaire for Initial Placement (BQuIP);

5.3.2.7. The Level of Care Utilization System (LOCUS); and

5.3.2.8. Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE).

5.3.3. The following table includes examples of standardized and evidence-based provider education and training activities the workgroup may consider:

Adult Specific	Child/Adolescent Specific	All Populations
• SAMHSA Assertive Community Treatment (ACT) • Cognitive Behavioral Therapy (CBT) and Cognitive Processing Therapy (CPT) • SAMHSA Illness Management and Recovery (IMR) • SAMHSA Integrated Treatment for Co-occurring Disorders • SAMHSA Supported Employment and Permanent Supportive Housing • Housing First • "SAMHSA Medication Assisted Treatment (MAT)"	• Nurturing Parent Training • Trauma Focused CBT • Case Management using the NWIC Wraparound model, when indicated	• Screening, Brief Intervention, and Referral to Treatment (SBIRT) Model • Motivational Interviewing • Person-Centered Recovery Planning • Patient Activation • Seeking Safety • Cultural Competency and Implicit Bias

5.3.4. The workgroup will provide a report with preliminary recommendations no later than six (6) months after the Operational Start Date and will continue to meet on a quarterly basis as directed by EOHHS.

5.3.5. All workgroup recommendations are subject to EOHHS review and final approval. Policies and procedures developed through workgroup activities will be added to the Managed Care Manual as needed.

5.4. Behavioral Health Network

5.4.1. The Contractor is responsible for maintaining and promoting access to a robust Provider network. The Contractor's Provider network shall be sufficient to provide timely access to all medically necessary covered services to all Members, including those with limited English proficiency or physical and mental disabilities in accordance with 42 C.F.R. § 438.206. The Contractor shall monitor compliance with provider network requirements and take corrective action as needed. The network shall include a broad mix of Providers, including:

5.4.1.1. Qualified Clinicians – including Rhode Island Department of Health licensed psychiatrists, psychologists, mental health counselors, marriage and family therapists, chemical dependency providers, and clinical social workers with the requisite skills and training for the services provided and the Members served. In some cases, providers working toward licensure can provide services under the supervision of a licensed provider.

5.4.1.2. Psychiatric hospitals and acute care hospital with units designated as psychiatric facilities under R.I. Gen. Laws § 40.1-5;

5.4.1.3. BHDDH-licensed: inpatient psychiatric facilities for SUD services; inpatient psychiatric facilities; Medication Assisted Treatment (MAT) providers; substance use treatment programs and facilities; Community Mental Health Centers (CMHCs); Community Residential Service providers and facilities; Adult Day Health Service providers; Certified Community Behavioral Health Clinics (CCBHCs); acute and crisis stabilization units; and crisis intervention centers.

5.4.1.4. Other community-based providers meeting the education and qualification standards for the services provided, including housing stabilization services.

5.4.2. For the provider types identified above, refer to Article 18, "Provider Networks and Requirements, Access to Care," for additional information regarding provider network and access standards. The Contractor shall monitor the behavioral health access standards to promote parity and geographic accessibility, and to ensure the full continuum of behavioral health needs is met on a timely basis.

5.4.3. Unless otherwise noted in the Contract or Managed Care Manual, the Contractor is responsible for negotiating reasonable reimbursement rates with Behavioral Health Network Providers, and for reaching the EOHHS performance targets regarding APMs described in Article 17, "Value-Based Payment and Alternative Payment Model Methodologies."

5.5. General Rehabilitative Services

5.5.1. The Contractor is responsible for providing child and adult Member access to the full continuum and array of behavioral health rehabilitative Covered Services.

5.5.2. The primary purpose of rehabilitative services is to provide diagnosis, treatment, or rehabilitation of a mental disorder, or a dysfunction related to a mental disorder. Rehabilitative services also include clinical diagnostic and treatment services for individuals with behavioral health disorders. These services typically include:

5.5.2.1. Assessment and diagnostic evaluation;

5.5.2.2. Psychological and neuropsychological assessment and evaluation;

5.5.2.3. Developmental evaluation;

5.5.2.4. Psychological testing;

5.5.2.5. Individual, family, couple, and group therapy;

5.5.2.6. Crisis intervention, including mobile crisis intervention through a community mental health center; and

5.5.2.7. Medication treatment, evaluation, and management.

5.5.3. Rhode Island Medicaid also provides specialized rehabilitative behavioral health

Covered Services to children and adults with complex needs. These services are described below.

5.6. Mental Health Targeted Case Management

5.6.1. Targeted Case Management (TCM) includes services provided by qualified mental health providers for the purpose of monitoring and assisting clients in maintaining their overall wellbeing. This includes gaining access to needed medical, social, educational, and other services necessary to meet basic human needs. TCM services may include:

5.6.1.1. Maintaining up-to-date assessments and evaluations necessary for establishing eligibility for Behavioral Health Benefits.

5.6.1.2. Participating in the treatment planning process and monitoring client progress in meeting the goals and objectives of the individualized treatment plan.

5.6.1.3. Locating, coordinating, and monitoring all necessary medical, educational, vocational, social, and psychiatric services.

5.6.1.4. Assisting in the development and execution of an individualized treatment plan that supports income maintenance.

5.6.1.5. Assisting in the development of appropriate social networks and natural supports.

5.6.1.6. Assisting with other activities necessary to maintain behavioral health stability in a community-based setting.

5.6.2. To qualify for TCM, Members shall meet the eligibility criteria for "target groups" described in the Rhode Island Medicaid State Plan.

5.6.3. The Contractor shall ensure child and adult Members in the following target groups have access to TCM as a Covered Service:

5.6.3.1. Severely Mentally Disabled: children, adolescents, and adults with severe and/or persistent mental or emotional disorders.

5.6.3.2. DCYF Children: children between the ages of one (1) day and five (5) years in DCYF care or custody, who have or are at risk of acquiring human immunodeficiency virus (HIV).

5.6.3.3. Children Receiving Early Intervention: children ages of one (1) and three (3) receiving early interventions services due to developmental delays or other established conditions.

5.6.3.4. Victims of Incest, Sexual Molestation, and Sexual Assault: child and adolescent victims.

5.6.3.5. Children in the Lead Program: children under the age of twenty-one (21) with elevated screening or blood levels, or under the age of six (6) with developmental delays.

5.6.3.6. HIV/AIDS Program: children, adolescents, or adults with HIV or Acquired Immune Deficiency Syndrome (AIDS).

5.6.3.7. Children at Risk of Developmental Disabilities (DD): children under the age of twenty-one (21) who are either at risk of developing a developmental disability due to specific medical conditions, such as genetic disorders, birth defects, inborn diseases of metabolism or are demonstrating developmental delays.

5.6.4. Members in other target groups also may receive TCM as an Out-of-Plan Benefit if they meet the eligibility criteria described in the Rhode Island Medicaid State Plan. These Members include:

5.6.4.1. Members participating in the Adolescent Parenting Program;

5.6.4.2. Children ages three to twenty-one (3-21) receiving special education services;

5.6.4.3. Homebound adults ages sixty-five (65) and over;

5.6.4.4. Blind or visually impaired children and adults; and

5.6.4.5. Children under age twenty-one (21) who are involved in the juvenile justice system.

5.6.5. The Contractor shall develop and implement strategies to coordinate care with all TCM providers, whether delivering TCM as a Covered Service or an Out-of-Plan Benefit. Coordination efforts shall include strategies to:

5.6.5.1. Share data;

5.6.5.2. Identify and address SDOH;

5.6.5.3. Coordinate Out-of-Plan Benefits, including out-of-plan TCM; and

5.6.5.4. Verify Members receive services and supports not covered by Medicaid from community-based organizations following referrals to these entities (i.e., “close the loop on referrals”).

5.6.6. The Contractor shall implement UR strategies and Care Plan protocols to ensure that Members receiving TCM services do not receive duplicate services through other Medicaid programs, such as the Health Homes for Children program (also called “Cedar Health Homes”) and Assertive Community Treatment/Integrated Health Homes programs for adults.

5.7. Home Based Therapeutic Services for Children

5.7.1. The Contractor is responsible for providing homebased therapeutic services to children with complex needs. These specialized services are intended to meet the needs of children with serious or chronic health needs and allow them to attain their fullest potential while remaining as independent as possible in their home communities.

5.7.2. Home-based therapeutic services include:

5.7.2.1. Applied Behavior Analysis (ABA);

5.7.2.2. Adolescent Residential Substance Use Treatment;

5.7.2.3. Personal Assistance Services and Supports (PASS); and,

5.7.2.4. Respite Services.

5.7.3. Home-based therapeutic services shall be provided through a holistic, person and family-centered approach, and should be designed to improve Member outcomes by integrating mental health, physical health, SUD, and SDOH health needs.

5.7.4. The Contractor shall ensure home-based therapeutic services comply with Evidence-Based Practices (EBP) treatment modalities specific to each service.

5.7.5. The Contractor shall provide home-based therapeutic services in accordance with EOHHS and Federal HCBS settings requirements, including 42 C.F.R. Part 441.

5.7.6. For child Members with behavioral health conditions, developmental delays and/or at risk of DD who receive HCBS as Out-of-Plan Benefits, the Contractor is responsible for overseeing all Care Program activities, including coordination of In-Plan Benefits and Out-of-Plan HCBS.

5.8. Intermediate Services

5.8.1. The Contractor is responsible for providing intermediate services for child and adult Members requiring alternatives to, or step-down from, hospitalization and other acute services described in Section 5.9, "Acute Services."

5.8.2. Intermediate services include:

5.8.2.1. Partial Hospitalization (PHP)/Day Treatment Program/Intensive Outpatient Treatment (IOP) (for children and adults);

5.8.2.2. Enhanced Outpatient Services (EOS) (for children)/Community Psychiatric Supported Treatment (CPST) (for adults);

5.8.2.3. Assertive Community Treatment (ACT) (for adults);

5.8.2.4. Health Homes for Children services (for children);

5.8.2.5. Peer Recovery Specialist services (for adults) and Family Support services (for children);

5.8.2.6. Integrated Dual Diagnosis Treatment for SUD Services (for adults);

5.8.2.7. Center of Excellence Program (COE) Medications (for adults).

5.8.3. Most COE Program services are Out-of-Plan Benefits reimbursed by Medicaid FFS; except for medications (table or films), which shall be included on the Contractor's formulary as the Pharmacy Services In-Plan Benefit.

5.9. Acute Services

5.9.1. The Contractor shall provide acute Behavioral Health Benefits for children and adults. Acute services represent the highest level of service intensity based on the Member's need for either a locked or staff secured twenty-four (24) hour clinical setting that offers full behavioral health management and supervision.

5.9.2. Acute services include:

5.9.2.1. Inpatient Acute Hospitalization;

5.9.2.2. Acute Residential Treatment Services (ARTS);

5.9.2.3. Observation/Crisis Stabilization; and

5.9.2.4. Emergency Service Intervention; including mobile crisis response services.

5.9.2.5. Long Term Residential Programs

5.9.3. The Contractor shall provide long term residential program services to adult Members who meet clinical criteria described in the Managed Care Manual. Long term residential program services include:

5.9.3.1. SSTAR Birth Residential Program;

5.9.3.2. Mental Health Psychiatric Rehabilitative Residence (MHPRR);

5.9.3.3. SUD residential services; and

5.9.3.4. Supportive Mental Health Psychiatric Rehabilitative Residence Apartments (MHPRR-A).

5.9.4. Providers shall meet state licensure or certification standards, as appropriate to the service provided.

5.9.5. The Contractor shall coordinate with these Providers on discharge planning, to ensure Members have the medical and community supports needed to successfully transition to the community.

5.10. Opioid Treatment Program Home Health

5.10.1. The Contractor shall provide Opioid Treatment Program (OTP) Health Home (HH) program services to adults with opioid dependence who meet the clinical criteria for program service (e.g., co-occurring chronic conditions or risk of chronic conditions), as described in the Managed Care Manual.

5.10.2. The OTP HH program includes comprehensive Care Coordination, health promotion, chronic condition management, population management, transitional care, individual and family support services, and other services described in the Managed Care Manual.

5.10.3. The Contractor shall provide the following oversight and support activities for OTP Health Home Providers:

5.10.3.1. Provide reports to Providers to facilitate coordination of medical and behavioral health care.

5.10.3.2. Use utilization data (inpatient admissions, readmissions, ER visits, and pharmacy reports) and predictive modeling to identify Members with new health risks and share this information with Providers.

5.10.3.3. Provide technical support and assistance to Providers regarding quality

and data reporting, and submission of HIPAA compliant claims data.

5.10.3.4. Oversee Provider performance, including HIPAA compliant claims submission for OTP HH bundles, and withhold payments as needed and in accordance with the Reporting Calendar in the Managed Care Manual.

5.10.3.5. Work with Network Providers and Out-of-Network Providers to ensure Members receive coordinated care and can maintain relationships with established treating providers.

5.11. Court Ordered Behavioral Health Benefits

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

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

5.12. Care Coordination and Discharge Planning

5.12.1. The Contractor shall require PCPs to have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health or SUD conditions or disorders. PCPs may provide any clinically appropriate behavioral health or SUD service within the scope of their practice.

5.12.2. The Contractor shall provide training to network PCPs on:

5.12.2.1. How to screen and identify behavioral health disorders.

5.12.2.2. The Contractor's referral processes for Behavioral Health Benefits.

5.12.2.3. The Contractor's clinical care coordination requirements.

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

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

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

5.12.5.1. Contracting with Network hospitals or other Providers.

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

5.12.5.3. Contracting with another Care Coordination entity in the community.

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

5.12.7. The Contractor shall work with hospital delivery systems to develop:

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

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

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

5.13. Mental Health Parity Requirements

5.13.1. The Contractor shall comply with the Mental Health Parity Addiction Equity Act (MHPAEA) requirements and establish coverage parity between Mental Health Benefits and Substance Use Disorder Benefits (collectively "Behavioral Health Benefits") and Medical/Surgical Benefits.

5.13.2. Behavioral Health Benefits in a manner that is no more restrictive than the coverage for Medical/Surgical Benefits.

5.13.3. Attachment F-4.1, "Schedule of In-Plan Benefits" regarding "Behavioral Health Benefits for Children and Adults," identifies the types and amount, duration, and scope of services and is consistent with EOHHS' parity analysis. The Contractor may cover additional services necessary to comply with the requirements for parity in Behavioral Health Benefits in 42 C.F.R. Part 438, Subpart K; however, the Contractor shall provide advance written notice to and receive prior written approval from the EOHHS Contract Officer when it believes this requirement is triggered.

5.13.4. The Contractor shall not:

5.13.4.1. Impose treatment limitations through financial requirements, quantitative treatment limitations, or nonquantitative treatment limitations on Behavioral Health Benefits that are more restrictive than the predominant treatment limitations applied to substantially all Medical/Surgical Benefits.

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

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

5.13.4.4. In accordance with the Managed Care Manual, the Contractor shall submit reports documenting the number of Prior Authorization requests received for Behavioral Health Benefits and Medical/Surgical Benefits and the outcomes of these requests.

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

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

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

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

5.13.8. The Contractor shall ensure its NQTL for Behavioral Health Benefits shall not be more restrictive, nor applied more stringently, than NQTL for its Medical/Surgical Benefits. This includes, but is not limited to, policies and procedures for medical necessity determination, prior approval, and concurrent and retrospective review.

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

5.13.10. At EOHHS' request, the Contractor shall participate in claims reviews and audits regarding parity. The Contractor shall provide a copy to EOHHS of, as well as publish the results on its website for, all parity reports and audits. The Contractor shall report claims reviews and audits regarding parity in a standardized format and tool

established by EOHHS.

5.13.11. The Contractor shall, upon request from EOHHS, provide EOHHS with its analysis ensuring parity compliance:

5.13.11.1. On an annual basis through an independent evaluator procured by the Contractor as required by EOHHS in Reporting Requirements to attest compliance and for CMS submission.

5.13.11.2. When new services are added as an In-Plan Benefits for Members; or

5.13.11.3. Prior to implementing changes to NQTL.

5.13.11.4. If a Member suspects a parity violation, the Contractor shall handle the complaint via its internal Complaint, Grievance, and Appeals process as appropriate. If the matter is not resolved to the Member's satisfaction through this process and forum, the Contractor shall instruct the Member that he or she may file an external medical review and/or a State Fair Hearing in accordance with their rights under Article 23, "Grievances and Appeals."

5.13.12. If a Provider or third-party suspects a parity violation, the Contractor shall handle the complaint via its internal Compliant, Grievance, and Appeals process as appropriate.

5.13.13. The Contractor shall track and trend Complaints and Grievances related to parity, from all sources, in accordance with the Managed Care Manual.

5.14. Behavioral Health Innovation Plan

5.14.1. To promote seamless transitions through the care continuum and expanded capacity for services, the Contractor shall develop programs to support and promote practice transformation and coordinated care for Members with co- occurring physical health, behavioral health, SDOH, and/or substance use disorder needs.

5.14.2. No later than thirty (30) Days after the Contract Effective Date, the Contractor shall update the Behavioral Health Innovation Plan (Plan) submitted with its proposal. The revised Plan is subject to EOHHS approval and shall, at a minimum, include the Contractor's implementation strategy and timelines for the following Plan activities:

5.14.2.1. Promoting Integrated Care Delivery Systems through evidence-based integration models and other strategies in collaboration with AEs, CCBHCs, PCPs, TCM and other behavioral health providers. This Section of the Plan shall include the Contractor's strategies and activities to further the state's goal of providing integrated and coordinated whole-person care. Examples of evidence-based integration models include:

Evidence-Based Integration Model	Description
Collaborative Care Model	Supported American Psychiatric Association (APA) and Academy of Psychosomatic Medicine (APM), which focuses on primary care settings.
Integrated Care Models	Promoted by the SAMHSA-HRSA Center for Integrated Health Solution for behavioral health providers and PCPs.
Health Homes	Also known as "Medical Health Homes" under Section 2703 of the Affordable Care Act. Features a team-based clinical approach, links to community support and resources, and coordinated physical and behavioral health care for people with multiple chronic illnesses.
Patient-Centered Medical Homes	Recognized by the NCQA or other nationally recognized programs.
Certified Community Behavioral Health Clinics	Authorized under Section 223 of the Protecting Access to Medicare Act (PAMA) and subsequent legislation. Focuses on coordinated physical health, behavioral health, and SUD services.

5.14.2.2. Addressing Gaps in the Care Continuum: at a minimum, the Plan shall include specific Member and Provider education and contracting strategies to increase access for child and adult Members to:

a) Behavioral Health Benefits for individuals with mild to moderate needs, including early screenings and interventions to promote access to care.

b) Behavioral Health Benefits for individuals with cognitive and intellectual disabilities.

c) Intermediate Services, including IOP.

d) Emergency Services Interventions, including interventions for children in DCYF out-of-home care (e.g., residential placement settings, the child's home, police stations, and other community settings).

e) Observation/Crisis Stabilization/Holding Beds and Respite, including services for children in DCYF care or custody.

f) Mobile Crisis Response services.

g) Home-based therapeutic services, life skills training, and other evidence- based practices.

h) The Contractor may also propose ILOS for EOHHS' consideration to address potential service gaps.

i) The analysis shall include MCO interventions which require improvement, including improvements in SAMHSA Standard Framework for Levels of Integrated Healthcare, continuity, coordination (i.e., enhanced Care Coordination and Care Management to minimize inpatient readmissions, emergency department utilization, and psychiatric boarding), and collaboration for physical health and Behavioral Health Services.

5.14.2.3. Strategies to promote coordinated and seamless transitions between care settings.

5.14.2.4. Promoting Health Equity by implementing processes to identify specific populations (i.e., racial/ethnic, geographic, etc.) that have experienced disproportionately poor health outcomes, then developing a methodology to improve outcomes and Health Equity and access to Behavioral Health Services for these populations. This Section should include strategies to train Contractor staff, Network Providers, and Provider offices on DEI topics, such as cultural competency and implicit bias.

5.14.2.5. Fostering Partnerships with AEs, CCBHCs, PCPs, TCM and other behavioral health providers, SUD providers, I/DD Providers, Primary Prevention entities, criminal justice systems, school-based behavioral health providers, and community-based organizations to address gaps in care and improve care coordination. Communication and data-sharing are key to these partnerships. The Contractor shall develop strategies to identify and address barriers to data sharing, and develop clear processes for care planning, referrals to behavioral health treatment and community supports, and mechanisms to share information (such as sharing clinical data between electronic medical record systems).

5.14.2.6. Training and Technical Support for Network Providers and office staff on plan requirements and activities.

5.14.2.7. Telemedicine strategies to expand care across the behavioral health continuum of care.

5.14.2.8. APMs that support Plan activities, foster innovation and integrated care, and promote access to the full care continuum of Behavioral Health Benefits. APM methodologies shall be submitted to EOHHS for review and approval prior to implementation, in accordance with the Managed Care Manual.

5.14.2.9. After the Operational Start Date, the Contractor shall provide quarterly reports, in a format approved by EOHHS, describing Behavioral Health Innovation Plan activities and outcomes. The Contractor is subject to contractual remedies, including liquidated damages and payment withholds, for failing to report on or complete plan activities.

5.15. Certified Community Behavioral Health Clinics

5.15.1. The purpose of a Certified Community Behavioral Health Clinic (CCBHC) is to ensure access to coordinated comprehensive behavioral health care. CCBHCs are required to serve any Member who requests care for mental health or substance use including developmentally appropriate care for children and youth.

5.15.2. The Contractor shall enter into a Network Provider agreement with every CCBHC certified by EOHHS as a provider. Contracts between the Contractor and the CCBHC shall be executed within ninety (90) Days of a CCBHC being certified by EOHHS.

5.15.3. The Contractor shall include in the Contractor's Provider network, all CCBHCs certified by EOHHS.

5.15.4. The Contractor will fully comply with the operational, quality, and financial reporting requirements as established by EOHHS for the CCBHC Initiative. The Contractor's submission of CCBHC-related reporting shall comply with requirements outlined in the Managed Care Manual.

5.15.5. CCBHCs payments may be included in a risk mitigation strategy as detailed in Section 27.18 of this Agreement.

5.16. Behavioral Health Subcontracts

5.16.1. If the Contractor enters into a Subcontractor relationship with a behavioral health (Mental Health, Community Mental Health or Substance Use Disorder Provider) Subcontractor to provide or manage Behavioral Health Services, the Contractor shall provide a copy of the agreement between the Contractor and the Subcontractor to EOHHS for review and approval.

5.16.2. Subcontracts shall address the coordination of services provided to Members by the Subcontractor, as well as the approach to Prior Authorization, claims payment, claims resolution, contract disputes, performance metrics, quality health outcomes, performance incentives, and reporting.

5.16.3. The Contractor remains responsible for ensuring that all requirements of this Agreement are met, including requirements to ensure continuity and coordination between physical health and Behavioral Health Services, and that any Subcontractor adheres to all requirements and guidelines.

5.16.4. EOHHS reserves the right to request the termination of a behavioral health subcontractor due to poor performance.

5.17. Prior Authorization for Behavioral Health Services

5.17.1. Contractor shall ensure that prior authorization requirements and submission processes for Behavioral Health Providers are no less burdensome them any other prior authorization protocols for other covered services.

5.17.2. Methadone received at a methadone clinic shall not require Prior Authorization.

5.17.3. The Contractor shall not impose any Prior Authorization requirements for MAT urine drug screenings (UDS) unless a Provider exceeds thirty (30) UDSs per month per

treated Member.

5.17.4. The MCO shall not impose any Prior Authorization on screening for multiple drugs within a daily drug screen.

5.17.5. The MCO may with the prior written approval of EOHHS require prior authorization for SUD treatments, excluding MAT services.

5.17.6. The Contractor shall utilize ASAM Criteria when determining medical necessity for continuation of covered services.

5.17.7. Nothing in this section shall be construed to require coverage for services provided by a non-participating provider.

5.17.8. The Contractor may require prior authorization for covered services only if;

5.17.8.1. The Contractor has a medical clinician or licensed alcohol and drug counselor available on a twenty-four (24) hour hotline to make the medical necessity determination and assist with placement at the appropriate level of care; and

5.17.8.2. The MCO provides a prior authorization decision as soon as practicable after receipt from the treating clinician of the clinical rationale consistent with the ASAM criteria, but in no event more than one full business day of receiving such information; provided that until such hotline determination is made, coverage for substance use disorder services shall be provided at an appropriate level of care consistent with the ASAM criteria.

5.17.9. EOHHS reserves the right to require the Contractor to modify its prior authorization requirements for behavioral health services at any time during the term of the Agreement.

5.18. Primary Care Provider Screening for Behavioral Health Needs

5.18.1. The Contractor shall ensure that the need for Behavioral Health Services is systematically identified by and addressed by the Member's PCP at the earliest possible time following initial enrollment of the Member and ongoing thereafter or after the onset of a condition requiring mental health and/or Substance Use Disorder treatment.

5.18.2. At a minimum, this requires timely access to a PCP for mental health and/or Substance Use Disorder screening, coordination and a closed loop referral to Behavioral Health Providers if clinically necessary.

5.18.3. The Contractor shall encourage PCPs and other Providers to use a screening tool approved by EOHHS, as well as other mechanisms to facilitate early identification of behavioral health needs.

5.18.4. The Contractor shall require all PCPs and behavioral health Providers to incorporate the following domains into their screening and assessment process:

5.18.4.1. Demographic;

5.18.4.2. Medical;

5.18.4.3. Substance Use Disorder;

5.18.4.4. Housing;

5.18.4.5. Family & support services;

5.18.4.6. Education;

5.18.4.7. Employment and entitlement;

5.18.4.8. Transportation;

5.18.4.9. Legal; and,

5.18.4.10. Risk assessment including suicide risk and functional status (ADL, IADL, cognitive functioning).

5.18.5. The Contractor shall require that pediatric Providers ensure that all children receive standardized, validated developmental screening, such as the Ages and Stages Questionnaire and/or Ages and Stages Questionnaires: Social Emotional at nine (9), eighteen (18) and twenty-four (24)/thirty (30) month pediatric visits; and use Bright Futures or other AAP recognized developmental and behavioral screening system. The assessment shall include universal screening via full adoption and integration of, at minimum, two (2) specific evidenced-based screening practices:

5.18.5.1. Depression screening (e.g., PHQ 2 & 9); and,

5.18.5.2. Screening, Brief Intervention, and Referral to Treatment (SBIRT) in primary care.

5.19. Comprehensive Assessment and Care Plans for Behavioral Health Needs

5.19.1. The Contractor's policies and procedures shall identify the role of physical health and behavioral health Providers in assessing a Member's behavioral health needs as part of the Comprehensive Assessment and developing a Care Plan.

5.19.2. For Members with chronic physical conditions that require ongoing treatment who also have behavioral health needs and who are not already treated by an integrated Provider team, the MCO shall ensure participation of the Member's physical health Provider (PCP or specialist), behavioral health Provider, and, if applicable, Care Manager, and Care Plan development process as well as the ongoing provision of services.

5.20. Reduction in Behavioral Health Readmissions and Emergency Department Utilization

5.20.1. The Contractor shall develop and detail its plan to reduce readmissions and emergency department utilization attributed to a Member's behavioral health. The plan shall include but is not limited to:

5.20.1.1. The Contractor's approach to monitoring the thirty (30) Day, ninety (90) Day, and one hundred and eighty (180) Day readmission rates to Rhode Island Hospital, other State determined IMDs for mental illness, designated receiving facilities and other equivalent facilities to review

Member specific data with each of the CMHC Programs, and other CMHC Providers and Mental Health providers, as applicable, and implement measurable strategies within ninety (90) Calendar Days of the execution of this Agreement to reduce thirty (30) Day, ninety (90) Day and one hundred and eighty (180) Day readmission.

5.20.1.2. The Contractor's approach to monitoring the thirty (30) Day, ninety (90) Day, and one hundred and eighty (180) Day readmission rates to acute care hospitals attributed to substance misuse and Substance Use Disorder, to review Member specific data with the Member's community-based care team, which may include the Member's PCP and other Mental Health or Substance Use Disorder Treatment Programs, as applicable, and implement measurable strategies within ninety (90) Calendar Days of the execution of this Agreement to reduce these rates.

5.20.1.3. The Contractor's approach to monitoring the thirty (30) Day, ninety (90) Day, and one hundred and eighty (180) Day repeated ED utilization rates attributed to mental illness, to review Member specific data with each of the CMHC Programs, and other CMHC Providers and Mental Health providers, as applicable, and implement measurable strategies within ninety (90) Calendar Days of the execution of this Agreement to reduce these rates.

5.20.1.4. The Contractor's approach to monitoring Members' repeated ED utilization rates within thirty (30) Days and ninety (90) Days attributed to substance misuse and Substance Use Disorder, to review Member specific data with the Member's community-based care team, which may include the Member's PCP and other Mental Health or Substance Use Disorder Treatment Programs, as applicable, and implement measurable strategies within ninety (90) Calendar Days of the execution of this Agreement to reduce these rates.

5.20.1.5. The Contractor's approach to ensuring Members experiencing readmissions or repeated ED utilization have access to a full array of Medically Necessary outpatient medication and Behavioral Health Services after discharge from inpatient or ED care due to a Behavioral Health reason, with sufficient frequency and amounts, to support the Member's progress on achieving their Behavioral Health goals.

5.20.1.6. For Members with readmissions to any inpatient psychiatric setting within thirty (30) Days and one hundred and eighty (180) Days, the MCO shall report on the CMHC and related service utilization that directly proceeded readmission.

5.21. Coordination Among Behavioral Health Providers

5.21.1. The Contractor shall support communication and coordination between mental health and Substance Use Disorder service Providers and PCPs by providing access to data and information when the Member consent has been documented in accordance with

State and federal law, including:

5.21.1.1. Assignment of a responsible party to ensure communication and coordination occur and that Providers understand their role to effectively coordinate and improve health outcomes;

5.21.1.2. Determination of the method of mental health screening to be completed by Substance Use Disorder service Providers;

5.21.1.3. Determination of the method of Substance Use Disorder screening to be completed by mental health service Providers;

5.21.1.4. Description of how treatment plans shall be coordinated among Behavioral Health Service Providers; and

5.21.1.5. Assessment of cross training of behavioral health Providers (i.e. mental health Providers being trained on Substance Use Disorder issues and Substance Use Disorder Providers being trained on mental health issues).

5.22. Special Requirement for Member Service Line for Behavioral Health

5.22.1. The Contractor shall operate a Member Services toll-free phone line that is used by all Members, regardless of whether they are calling about physical health or Behavioral Health Services.

5.22.2. The Contractor shall not have a separate number for Members to call regarding Behavioral Health Services, but may either route the call to another entity or conduct a transfer to another entity after identifying and speaking with another individual at the receiving entity to accept the call (i.e., a "warm transfer").

5.22.3. If the Contractor's nurse triage/nurse advice line is separate from its Member Services line, the nurse triage/nurse advice line shall be the same for all Members, regardless of whether they are calling about physical health and/or behavioral health term services.

5.23. Behavioral Health Member Experience of Care Survey

5.23.1. The Contractor shall contract with a third party to conduct a Member behavioral health experience of care survey on an annual basis.

5.23.2. The survey shall be approved by EOHHS and the Contractor's results shall be reported in accordance requirements of the Managed Care Manual.

5.23.3. The survey shall comply with necessary NCQA Health Plan Accreditation standards.

5.24. Naloxone Availability

5.24.1. The Contractor shall work with each contracted Substance Use Disorder program and/or Provider to ensure that naloxone kits are available on-site and as needed, training on naloxone administration and emergency response procedures are provided to program and/or Provider staff at a minimum annually.

5.25. Response After Overdose

5.25.1. Whenever a Member receives emergency room or inpatient hospital services as a result

of a non-fatal overdose, the Contractor shall work with hospitals to ensure a seamless transition of care upon admission and discharge to the community, and detail information sharing and collaboration between the Contractor and the participating hospital.

5.25.2. Whenever a Member discharges themselves against medical advice, the Contractor shall make a good faith effort to ensure that the Member receives a clinical evaluation, referral to appropriate treatment, Recovery support services and intense Case Management within forty-eight (48) hours of discharge or the Contractor being notified, whichever is sooner.

Article 6. Pharmacy Services

6.1. Comprehensive Pharmacy Benefits

6.1.1. The Contractor shall provide comprehensive inpatient and outpatient pharmacy benefits for Members, including all categories of prescription and non- prescriptions drugs, biological products, and supplies identified in Attachment F-4.1, "Schedule of In-Plan Benefits," the EOHHS Pharmacy Provider Manual, and the "Medicaid Managed Care Services Pharmacy Benefit Plan Protocols" ("PBM Protocols") in the Managed Care Manual.

6.1.2. The Contractor shall also provide the pharmacy products and supplies identified in the PBM Protocols, including glucometers, continuous glucose monitors, syringes, test strips, lancet and lancet devices, alcohol swabs, calibration fluid, and other miscellaneous supplies.

6.1.3. The Contractor shall ensure coverage of outpatient drugs meets the standards of Section 1927(a) of the Social Security Act [42 U.S.C. § 1396r-8], as applied to Medicaid managed care in 42 C.F.R. § 438.3(s).

6.1.4. EOHHS reserves the right to transition toward a single PBM pharmacy services model at a future time. By entering into this agreement, the Contractor agrees to comply if notified that EOHHS has elected to impose this requirement or other options that may be cost effective to the State.

6.2. Generics First Program

6.2.1. The Contractor shall comply with EOHHS' Generic First Program. This program promotes the use of generic products or the lowest net cost alternative products. The program is described in further detail described in PBM Protocols.

6.3. Formulary and Preferred Drug List

6.3.1. The Contractor may establish its own drug formulary, provided the formulary meets the requirements of this Section and Section 1927(d) of the Social Security Act [42 U.S.C. § 1396r-8]. At a minimum, the formulary shall cover the same drugs, biologic products, or supplies approved by the state for FFS Medicaid coverage.

6.3.2. The formulary shall be limited to drug products manufactured by pharmaceutical companies that have signed a Federal rebate agreement pursuant to Section 1927(a) of the Social Security Act unless an exception under the Act applies.

6.3.3. The Contractor shall provide:

6.3.3.1. Information in electronic or paper form about which generic and name brand medications are covered on the Contractor's formulary.

6.3.3.2. Information in electronic or paper form about what tier each medication is on.

6.3.3.3. Formulary lists on the Contractor's website in a machine-readable file and format as specified the Secretary of the United States Department of Health and Human Services.

6.3.4. The formulary cannot include the drugs, biologic products, or supplies:

6.3.4.1. Identified in PBM Protocols as "excluded drugs," or

6.3.4.2. Otherwise excluded from coverage under the Rhode Island Medicaid State Plan or State or Federal law.

6.3.5. The PBM Protocols include a list of brand name therapeutic classes of drugs/single agents the Contractor shall include on its formulary. Within each class, the Contractor may maintain its own preferred drug list (PDL). Brand name drugs that are neither on the Contractor's PDL nor in one (1) of the listed therapeutic classes identified in the PBM Protocols are considered non- preferred. The Contractor shall cover non-preferred drugs on a case-by-case basis as described in the PBM Protocols. Such coverage shall be based on Medical Necessity and a demonstrated lack of efficacy of a preferred or generic drug for an individual patient.

6.4. Non-Prescription Drugs

6.4.1. Some over the counter (OTC) drugs are Covered Services when prescribed by a physician or other authorized Provider.

6.4.2. Examples of OTC drugs covered under the Generics First Program are:

6.4.2.1. Emergency contraception;

6.4.2.2. Nicotine cessation supplies;

6.4.2.3. Nutritional supplements.

6.4.3. At a minimum, the Contractor shall cover the OTC agents and classes included in the EOHHS Medicaid FFS Program (see the "OTC Listing" in the Medicaid Pharmacy Provider Manual).

6.5. Drug Utilization Review Program

6.5.1. The Contractor shall operate a Drug Utilization Review Program (DUR) that complies with all of the requirements contained in Section 1927(g) of the Social Security Act and all of the requirements contained in 42 C.F.R. Part 456, Subpart K, as if the requirements applied to the Contractor instead of the State. The program shall:

6.5.1.1. Assure that prescriptions are appropriate, Medically Necessary, and not likely to result in adverse medical results.

6.5.1.2. Be designed to educate Providers and pharmacists to identify and reduce the frequency of patterns of Fraud, Abuse, gross overuse, or inappropriate or medically unnecessary care.

6.5.1.3. Include, at minimum, prospective DUR, retrospective DUR, and an educational program.

6.5.2. The Contractor can apply reasonable clinical review criteria to all Pharmacy Benefits, as necessary to demonstrate a Member meets medical and clinical criteria ("clinical Prior Authorizations"). In addition, the Contractor can apply Prior Authorization requirements to drugs that are not on the Contractor's PDL based on their non-

preferred status ("PDL Prior Authorizations").

6.5.3. The Contractor shall submit changes to all clinical prior authorization and PDL prior authorization criteria to EOHHS for approval at least thirty (30) Days before they are adopted or revised.

6.5.4. The Contractor shall comply with the SUPPORT for Patients and Communities Act, Title 1, Section 1004 (2018), as codified in Sections 1902(oo)(1)(A)(i)(I) and 1932(i) of the Social Security Act, which mandates that the Contractor has the capacity to and engages in the following Utilization Review processes:

6.5.4.1. Automating DUR safety edits for opioid refills.

6.5.4.2. Automating claims review process to identify refills in excess of state limits.

6.5.4.3. Monitoring of concurrent prescribing of opioids, benzodiazepines and/or antipsychotics (Including children's antipsychotics).

6.5.4.4. Establishing maximum daily morphine equivalent safety edits.

6.5.4.5. Activating concurrent utilization alerts for Members concurrently prescribed opioids and benzodiazepines and/or antipsychotics.

6.5.5. The Contractor shall provide annual reports on DUR Program activities as specified in Reporting Calendar in the Managed Care Manual.

6.5.6. The Contractor shall comply with EOHHS' "Treatment of Hepatitis C Prior Authorization Guidelines," in the Managed Care Manual.

6.6. Post Authorization and 72-Hour Emergency Fills

6.6.1. In accordance with 42 C.F.R. § 438.3(s)(6) and Section 1927(d)(5) of the Social Security Act, the Contractor shall respond to a request for prior authorization of a covered outpatient drug that is received by telephone or other telecommunication device within twenty-four (24) hours of the request.

6.6.2. Unless prohibited under State or Federal laws, such as the Controlled Substances Act (P.L. 91-513), the Contractor shall allow a seventy-two (72) hour emergency supply to be dispensed any time a Prior Authorization is not available, and the prescribed drug shall be filled. If the prescriber cannot be reached or is unable to request the Prior Authorization, the Contractor shall allow the pharmacy to submit and fill an emergency seventy-two (72) hour prescription. The Contractor shall allow pharmacists to use their professional judgment regarding whether there is an immediate and urgent need every time the seventy-two (72) hour option is used. The seventy-two (72) hour emergency procedure should not be used for routine and continuous overrides.

6.7. Pharmaceutical and Therapeutics Committee

6.7.1. The Contractor shall maintain a Pharmaceutical and Therapeutics (P&T) Committee, or a similar entity, to develop Prior Authorization criteria. The P&T Committee shall:

6.7.1.1. Represent the needs of all of the Contractor's Members, including Members with special health care needs.

6.7.1.2. Allow Network physicians, pharmacists, behavioral health Providers and other specialists to participate in the approval of criteria for clinical prior authorizations.

6.7.1.3. Consist of at least six (6) committee members, including at least three (3) Network Providers not employed by the Contractor nor its Subcontractors. The Contractor's Medical Director shall participate in all P&T meetings.

6.7.1.4. Meet at least semi-annually in Rhode Island. Meetings shall be open to public comment before the P&T Committee votes on any PDL or prior authorization items. The Contractor shall keep written minutes of all P&T meetings.

6.7.2. The Contractor shall notify the EOHHS when its P&T Committee meeting has been scheduled and include official notification of the meeting on its Provider website and through other applicable avenues, such as Provider training and newsletters.

6.8. EOHHS Pharmacy Benefit Review Committee

6.8.1. The EOHHS Medicaid Managed Care Services Prescription Drug Benefit Review Committee will meet at least annually to:

6.8.1.1. Review and update the allowed list of brand name therapeutic classes of drugs and single agents,

6.8.1.2. Review criteria for case-by-case exceptions described in the PBM Protocols.

6.8.1.3. Develop recommended protocols for communicating changes.

6.8.2. The Contractor's Medical Director or his or her designee shall represent the Contractor on the committee and provide support to EOHHS as needed.

6.9. Drug Rate Reporting

6.9.1. The Contractor shall report data that EOHHS determines is necessary to bill manufacturers for rebates in accordance with Section 1927(b)(1)(A) of the Social Security Act no more than forty-five (45) Days after the end of each quarterly rebate period, pursuant to 42 C.F.R. § 438.3(s)(2). Such utilization information shall include, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code of each covered outpatient drug dispensed or covered by the Contractor.

6.9.2. Covered outpatient drugs dispensed to Medicaid Members from covered entities purchased at 340B prices, which are not subject to Medicaid rebates, should be excluded from the Contractor's reports to EOHHS.

6.9.3. To ensure that drug manufacturers will not be billed for rebates of drugs purchased and dispensed under the 340B Drug Pricing Program, the Contractor shall have mechanisms in place to clearly identify these drugs and exclude the reporting of this utilization data to EOHHS to prevent duplicate discounts on these products.

6.9.4. Covered outpatient drugs are not subject to the rebate requirements if such drugs are

both subject to discounts under 340B and dispensed by Health Plans, including Medicaid MCOs.

6.10. Patient Protection and Affordable Care Act

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

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

6.11. Cost and Pricing Transparency

6.11.1. The Contractor shall ensure full transparency when administering the pharmacy services and benefits described in this Section.

6.11.2. The Contractor shall identify any PBM associated with the Contractor and the ownership of such organization. Any such association shall be disclosed to EOHHS and the Members in a format determined by EOHHS. The PBM shall meet the following obligations:

6.11.2.1. The PBM shall not deny any Rhode Island-licensed pharmacy or pharmacist the right to be a participating provider so long as the pharmacy has contractually accepted the terms and conditions set forth by the Contractor to be a participating provider.

6.11.2.2. The PBM shall provide the Contractor's staff and EOHHS with real-time, unredacted, read access to view all pharmacy claims processing systems and prior authorization records, at no cost to the Contractor or EOHHS.

6.11.2.3. All Member and Provider materials from the PBM shall be submitted to EOHHS for approval prior to use or dissemination.

6.11.2.4. The PBM shall not make or allow any direct or indirect reduction of payment to a pharmacist or pharmacy for a drug, device, or service under a reconciliation process to an effective rate of reimbursement.

6.11.3. The Contractor shall implement safeguards to prohibit PBMs or other Subcontractors from engaging in activities that may result in inaccurate financial reporting or errors in Medical Loss Ratio reporting. The Contractor and the PBM shall follow all reporting requirements of this Agreement, including Article 27 "Financial Requirements."

6.11.4. If the Contractor subcontracts all or a portion of the pharmacy services described in this Section to a PBM or another Subcontractor, the Contractor shall ensure the PBM or other Subcontractor complies with all requirements in this Section. The Contractor shall submit a plan for oversight of the PBM's performance and require advance approval of any PBM Subcontracts.

6.11.5. Within five (5) Business Days of an EOHHS request, the Contractor and its

Subcontractors shall provide EOHHS unredacted copies of or access to all books, records, contracts, and rebate agreements with pharmaceutical manufacturers, intermediaries, PBM, other Subcontractors, wholesalers, or other third-parties related to this Agreement.

6.11.6. As specified in the Reporting Calendar in the Managed Care Manual, the Contractor shall provide EOHHS a quarterly report itemizing:

6.11.6.1. All amounts received, by National Drug Code (NDC) number and manufacturer, for rebates, discounts, credits, fees, or other payments that are based on actual or estimated utilization of a covered drug, or price concessions based on the effectiveness of a covered drug (collectively "rebates");

6.11.6.2. Amounts of rebates paid to the Contractor, PBM, or another Subcontractor;

6.11.6.3. The share of rebates attributable to the Contractor, PBM, Subcontractors, or other participants in a rebate arrangement;

6.11.6.4. The timeframes when the rebates were received.

6.11.7. Within five (5) Business Days of EOHHS' request, the Contractor shall provide the following information:

6.11.7.1. The Wholesale Acquisition Cost (WAC), Maximum Allowable Cost (MAC), Average Wholesale Price (AWP), or any other reimbursement construct utilized by the Contractor, PBM, or another Subcontractor at any point in time for each covered drug purchased pursuant to this Agreement.

6.11.7.2. The dollar amount of any reimbursements the Contractor, PBM, or another Subcontractor pays to contracted pharmacies and dispensing fees for each Covered Drug purchased under this Agreement.

6.11.7.3. The net cost of all brand name drugs that are eligible for non-Federal rebates.

6.11.8. In accordance with Article 25, "Records Retention, Audits, and Inspections," EOHHS or its designee has the right to audit all financial aspects of the Contractor's business associated with claims, administrative fees, dispensing fees, rebates, pricing, or any other financial term or revenue source that results from the Contractor's Members' utilization under this Agreement. In addition, EOHHS or its designee has the right to audit all legal, contractual, and operational aspects of the Contractor's business.

6.11.9. The Contractor shall establish a mechanism to prevent duplicate discounts in the 340B Drug Pricing Program. The Contractor shall establish procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B Drug Pricing Program from any required drug utilization reports.

6.11.10. The Contractor shall have a network pharmacy audit program that includes, at a minimum:

6.11.10.1. Random audits to determine provider compliance with the policies, procedures and limitations outlined in the Network Provider Agreement and this Agreement. The Contractor shall not utilize contingency fee-based pharmacy audits.

6.11.10.2. The Contractor shall submit to EOHHS or its designee the policies of its audit program for approval during Readiness Review.

6.11.10.3. The Contractor shall ensure that pharmacies submit the NPI of the prescriber on all pharmacy claims. The Contractor shall deny claims submitted without the NPI of the prescriber.

6.11.10.4. The Contractor shall educate Network Providers on how to access the PDL on their websites. The Contractor shall also provide provider education on pharmacy claims processing and payment policies and procedures.

6.11.11. The Contractor and the Contractor's PBM shall not charge pharmacy providers claims processing or provider Enrollment fees. This Section does not prohibit sanctioning pharmacy providers.

6.12. Pharmacy Claims Dispute Management

6.12.1. The Contractor shall maintain an internal claims dispute process to permit pharmacies to dispute the reimbursement paid for any claim made for the dispensing of a drug.

6.13. Mail Order/Mail Service Pharmacy

6.13.1. The Contractor shall not require its Members to use a mail service pharmacy.

6.13.2. Enrollees shall not be charged any amounts above applicable copays for mail order (e.g. shipping and handling fees).

6.13.3. EOHHS reserves the right to place a limit on the amount of pharmacy claims are through mail order or mail service pharmacies during the term of this Agreement.

6.14. Reports of Out-of-State Activities

6.14.1. The Contractor shall provide monthly reports on Out-of-State pharmacy activity in accordance with the reporting template in the Managed Care Manual.

6.14.2. For Members who routinely use Out-of-State pharmacies, the Contractor shall conduct research as necessary to determine whether there is a pattern suggestive of Out-of-State residency (e.g., the Member picks up maintenance medication at an Out-of-State pharmacy for three (3) consecutive months).

6.15. Prohibition on Restocking and Double Billing Drugs

6.15.1. To conform to Section 1903(i)(10) of the Social Security Act, payment shall not be made with respect to any amount expended for reimbursement to a pharmacy for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment (other than with respect to a reasonable restocking fee for such drug).

6.16. Pharmacy Lock-in Program

6.16.1. In accordance with 42 C.F.R. § 440.230, EOHHS has established a pharmacy lock-in program to restrict Members whose utilization of prescription drugs is documented inappropriate or excessive. The program is intended to prevent Medicaid Members from obtaining inappropriate or excessive quantities of prescribed drugs through visits to multiple providers and pharmacies.

6.16.2. In accordance with EOHHS guidance in the Managed Care Manual, the Contractor shall develop policies and procedures to implement a pharmacy Lock-in Program.

6.16.3. The policies and procedures shall:

6.16.3.1. Provide that any Member identified as having engaged in inappropriate or excessive utilization of one (1) or more prescription drugs will be required to designate a primary physician and pharmacy and will be restricted to that physician and pharmacy to obtain or fill prescriptions for a minimum of fifteen (15) months from the date of enrollment in the Lock-in Program.

6.16.3.2. Identify the criteria to be used to identify Members who are engaged in excessive or inappropriate prescription drug utilization. Such criteria shall be based upon current medical and pharmacological references as identified by EOHHS.

6.16.3.3. Provide for written notice to any Member who has been identified as engaged in inappropriate or excessive use of prescription drugs at least thirty (30) Days prior to the proposed implementation of the restriction. The notice shall inform the Member:

a) Of the specific basis for finding the Member has engaged in inappropriate or excessive utilization of one (1) or more prescription drugs.

b) That he or she has thirty (30) Days to designate a primary physician and pharmacy as a single source of medical care.

c) That if the Member fails to designate a primary physician and pharmacy in accordance with the notice, the Contractor will make the designation for the Member based upon the Member's previous use and geographic location.

d) That the Member has the right to request a State Fair Hearing within thirty (30) Days of the date of the notice if they disagree with the Contractor's findings.

e) That the Member may request a change of their primary physician/pharmacy for reasonable cause by notifying the Contractor and choosing a new primary physician/pharmacy.

6.16.4. Once a Member is enrolled in the Pharmacy Lock-in Program, the Contractor shall monitor the Member's drug-usage profile. If after fifteen (15) months, the review establishes that the Member's drug utilization is appropriate and not excessive, the Contractor shall remove the restriction. If the restriction is not removed after the initial

fifteen (15) months, the Contractor shall continue to monitor the Member's drug-usage profile and review whether it should continue or be removed not less often than every twelve (12) months.

6.16.5. The Contractor is responsible for ensuring its Network pharmacies that are designated as primary pharmacies understand and are compliant with the requirements of the Pharmacy Lock-In program, including the requirement to:

6.16.5.1. Exercise sound professional judgement when dispensing drugs in order to prevent inappropriate drug utilization.

6.16.5.2. Notify the prescribing physician (or practitioner) to verify the authenticity and accuracy of any prescription whenever the pharmacist reasonably believes the Member is attempting to obtain excessive drugs through duplicate or altered prescriptions or other inappropriate means.

6.16.6. Pharmacies that are found on review to be dispensing drugs in a manner that is inconsistent with professional standards may be subject to administrative sanction including the recovery of Overpayments or a referral to the RI OIG.

Article 7. Long-Term Services and Supports Benefits

7.1. General Requirements

7.1.1. Long Term Services and Supports (LTSS) refers to both institutional care, including nursing facilities and long-term care hospitals, and home-and community-based services (HCBS). LTSS are available to individuals who demonstrate a need for the level of care typically provided in an institutional setting, as determined by EOHHS.

7.1.2. LTSS is available to members who meet RI EOHHS LTSS eligibility criteria. RI EOHHS has sole authority for determining eligibility for LTSS and will communicate eligibility to the Contractor.

7.2. Services

7.2.1. The Contractor shall cover all LTSS authorized by EOHHS which allow LTSS-eligible Members to receive care in their preferred setting, fully participate in their communities, and provide alternatives to institutional placement where appropriate.

7.2.2. Skilled nursing level of care may be provided in a long-term care facility and/or skilled nursing facility without a preceding acute care inpatient stay for Members when the provision of this level of care is clinically appropriate and can avert the need for an inpatient stay. As a condition for payment the contractor shall ensure that the nursing facility has met all Federal and State pre-admission screen and resident review (PASRR) requirements for all Members seeking admission or re-admission to a nursing facility, subsequent to the provisions in 42 C.F.R. § 483 Subpart C and 210-RICR-50-05-1.

7.2.3. The Contractor shall provide three hundred and sixty-five (365) Days of nursing facility care as medically and/or functionally necessary for the Member, inclusive of skilled care, custodial care, and any other level of nursing facility care including, but not limited to emergency placement, hospice, and respite care.

7.2.4. Transition services shall be covered for those Members meeting criteria who are transitioning back to the community from a Nursing Facility or long-term care hospital. The contractor shall collaborate with and adhere to the State's Nursing Home Transition, Money Follows the Person Program, criteria and reporting requirements.

7.2.5. The Contractor shall notify the Member of their right to seek additional advocacy from the State's Long-Term Care ombudsman during any transition period.

7.2.6. The Contractor shall allow the Member's legally responsible individual (typically the parent of a minor child or a spouse) to provide personal care services to the Member and shall provide written notification to the legally responsible individual of that option.

7.2.7. The Contractor shall cover all LTSS programs identified in the Schedule of In-Plan Benefits including, but not limited to, the following programs:

7.2.7.1. Shared living;

7.2.7.2. Self-directed care; and

7.2.7.3. Habilitation Services.

7.3. Patient Share

7.3.1. When a Member's income exceeds an allowable amount, as determined by EOHHS, they shall contribute toward the cost of their LTSS. This contribution, known as the Patient Share amount, is required for Members residing in a nursing facility and for those receiving home and community-based LTSS. Patient Share is required to be calculated for every Member receiving nursing facility or community-based LTSS, although not every eligible Member will end up having a Patient Share amount due each month. EOHHS will provide information to the Contractor that identifies Members who are required to pay a Patient Share amount and the amount of the obligation. It is the responsibility of the LTSS providers to collect the patient share amount from members and the contractor shall reduce reimbursement to LTSS providers equal to the patient share amount each month.

7.4. Level of Care

7.4.1. The Contractor is responsible for ensuring that each Member receiving LTSS is receiving the appropriate level of care. Level of care determinations shall be conducted by EOHHS, or its designee, utilizing the InterRAI Home Care assessment tool. The determination by EOHHS or its designee shall be updated in the Member's records for the Contractor to access.

7.4.2. EOHHS requires the Contractor to support and provide coverage for two (2) LTSS levels of care for Members:

7.4.2.1. The "Highest" level of care is for Members who are determined based on medical need to require the level of care typically provided in an institutional setting. This population shall receive services through nursing homes, long-term care hospitals, or ICF/IDs. Members meeting this level of care shall have the option to choose HCBS; and

7.4.2.2. The "High" level of care is for Members who are determined based on medical need to benefit from a significant level of home and community-based services. This population shall have access to HCBS.

7.5. Federal Compliance

7.5.1. The Contractor shall comply with all requirements of the HCBS Settings Final Rule. [42 C.F.R. § 441.301(c)(4)(5)]

7.6. Quality Reporting

7.6.1. The Contractor shall measure and report to the State on its performance, using standard measures required by the State or as required by CMS, per the states approved 1115 Waiver special terms and conditions.

7.6.2. The Contractor shall submit specified data to the State that enables the State to measure Contractor's performance using standardized measures, as specified by the State's approved 1115 Waiver special terms and conditions.

7.6.3. The Contractor shall assist EOHHS in conducting an annual quality and experience of

care survey for Members receiving HCBS/LTSS services, such assistance may include but not be limited to data collection for pre-survey and sampling purposes.

7.6.4. The Contractor shall be provided with the results of the survey by EOHHS and incorporate into the Contractors quality improvement planning. This may include the implementation of a specific quality improvement project to address opportunities identified in the survey to improve Member experience and quality of life.

Article 8. Early and Periodic Screening, Diagnostic, and Treatment

8.1. Coverage of EPSDT Benefits

8.1.1. The EPSDT program provides comprehensive and preventative Health Care Services for Medicaid Members under age twenty-one (21), including Members receiving managed LTSS.

8.1.2. The Contractor's EPSDT Coordinator will be primarily responsible for ensuring Members receive all medically necessary EPSDT services as outlined in this Agreement, and coordinating assistance for identified member needs specific to EPSDT.

8.1.3. EPSDT Benefits include screening, diagnostic, and treatment services, such as:

8.1.3.1. Physician and hospital services;

8.1.3.2. Home care services (including personal care and private duty nursing);

8.1.3.3. Medical equipment and supplies;

8.1.3.4. Rehabilitative service, including Behavioral Health Benefits;

8.1.3.5. Vision care;

8.1.3.6. Hearing services, and,

8.1.3.7. Dental services.

8.1.4. EPSDT Benefits also include other Medically Necessary measures described in Section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses or conditions discovered through screenings, even if the services are not listed in the Rhode Island Medicaid State Plan. If a Member under age twenty-one (21) requires a Medically Necessary service that is not listed in Attachment F-4.1, "Schedule of In Plan Benefits," or the Rhode Island Medicaid State Plan, the Contractor shall consult with the EOHHS Contract Officer before authorizing or denying the service, to verify the service meets Federal coverage criteria.

8.1.5. The Contractor is responsible for providing the full range of EPSDT Benefits, with the exception of Out-of-Plan Benefits described in Attachment F-4.2.

8.1.6. The need for EPSDT Benefits is based on Medical Necessity and the Contractor cannot limit the volume, scope, or duration of EPSDT Benefits, regardless of established limitations in Attachment F-4.1 "Schedule of In-Plan Benefits," the Rhode Island Medicaid State Plan, or regulation. The Contractor may place reasonable UM protocols in place for EPSDT Benefits, such as Prior Authorization requirements, which take into consideration the availability of other medically appropriate, cost-effective alternatives.

8.2. EPSDT Periodicity Requirements

8.2.1. The Contractor shall work with Network Providers to deliver EPSDT Benefits in accordance with the Rhode Island EPSDT Periodicity Schedule in the Managed Care Manual.

8.2.2. The Contractor shall provide EOHHS a list of all established CPT/HCPC codes used to identify all billable services included in the EPSDT Periodicity Schedule.

8.2.3. The Contractor's claims and billing procedures shall require providers to code EPSDT billable services with established CPT/HCPC codes in accordance with the EPSDT Periodicity Schedule.

8.3. EPSDT Education and Outreach Activities

8.3.1. In accordance with Sections 18.28, "Provider Contact Information," and 21.7, "Member Handbook," the Contractor's Provider Manual, Member Handbook, and EPSDT educational programs shall include information regarding:

8.3.1.1. EPSDT Benefits covered by the Contractor and how to access these services.

8.3.1.2. The Rhode Island EPSDT Periodicity Schedule.

8.3.1.3. How and where Members can access Out-of-Plan EPSDT Benefits.

8.3.2. The Contractor shall have an established process for reminders, follow-ups, and outreach to Members and Providers that includes:

8.3.2.1. Written notification to Members of upcoming or missed appointments.

8.3.2.2. Telephone protocols to remind Members of upcoming visits and follow-up on missed appointments.

8.3.2.3. Protocols for conducting outreach with non-compliant Members, such as telephone calls, emails, home visits, and other acceptable forms of communication with Members under State and Federal Law.

8.3.2.4. Protocols for addressing access barriers such as arranging transportation, interpreters, and connections with multi-lingual/multi-cultural service providers.

8.3.3. The processes described above shall consider:

8.3.3.1. Members' literacy capabilities.

8.3.3.2. The multi-lingual, multi-cultural nature of the Medicaid population in Rhode Island.

8.3.3.3. Other unique characteristics of this population, such as a greater frequency of changes of address and absence of telephones.

8.4. PCP Report

8.4.1. The Contactor shall provide reports to each PCP in the Contractor's Network, on at least a quarterly basis, with a list of Members assigned to the PCP who have not had an encounter during the past year and/or have not completed the services under the EPSDT Periodicity Schedule.

8.4.2. Either the Contractor or the PCP shall contact these Members to arrange an appointment and document outreach efforts in accordance with the Managed Care

Manual.

8.5. EPSDT Screening and Related Services

8.5.1. The Contractor shall work with Network Providers to conduct EPSDT screens to identify health and developmental problems. Screening shall be conducted in accordance with the EPSDT Periodicity Schedule in Managed Care Manual; however, the Contractor shall cover additional EPSDT screens as Medically Necessary.

8.5.2. At a minimum, EPSDT screens shall include:

8.5.2.1. A comprehensive health and developmental history including assessments of both physical and mental health development. As described in Section 8.1, "Coverage of EPSDT Benefits," EPSDT services also include all diagnostic and treatment services that are Medically Necessary to correct or ameliorate a physical or mental condition identified during a screening visit.

8.5.2.2. Appropriate immunizations according to age, health history and the EOHHS Periodicity Schedule or the schedule established by Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines. The Contractor and its Providers shall adjust for periodic changes in recommended types and schedule of vaccines. Immunizations shall be reviewed at each screening examination and during acute care visits and necessary immunizations shall be administered when not contraindicated. The Contractor shall require Providers to document deferral of vaccine administration for any reason.

8.5.2.3. A comprehensive unclothed physical examination including vision and hearing screening; dental inspection; and nutritional assessment.

8.5.2.4. Laboratory tests including lead toxicity, TB, and newborn screenings as medically indicated.

8.5.2.5. Vision testing that, at a minimum, includes diagnosis and treatment for defects in vision, including eyeglasses. Vision screening in an infant means, at a minimum, eye examination and observation of responses to visual stimuli. In an older child, screening for distant visual acuity and ocular alignment shall begin at age three (3).

8.5.2.6. Hearing testing.

8.5.2.7. Dental screening oral examination by PCP as part of a comprehensive examination required before age one (1).

8.5.2.8. Health education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention).

8.5.2.9. Referral for further diagnosis and treatment or follow-up of all abnormalities that are treatable/correctable or require maintenance therapy uncovered or suspected (referral may be to the provider conducting the screening examination, or to another provider, as appropriate.)

8.5.2.10. Lead screening and testing, in accordance with the Contractor's screening program. The program shall provide for screening for the presence of lead toxicity in children and shall consist of two (2) components: verbal risk assessment and blood lead testing as described in Managed Care Manual.

8.5.2.11. All other medically indicated screening services.

8.6. EPSDT Diagnosis and Treatment Services

8.6.1. Under EPSDT requirements, if a suspected problem is detected by a screening examination, the Member shall be evaluated as necessary for further diagnosis and treatment needs.

8.6.2. EPSDT coverage includes all follow-up diagnostic and treatment services deemed Medically Necessary to correct or ameliorate a problem discovered during an EPSDT screen. Subject to the process described in Section 8.1, the Contractor shall provide all such diagnostic and treatment services, regardless of whether they are covered by the State Medicaid Plan, if they are Medicaid- Covered Services as defined in Sections 1905(a) aI(r) of Social Security Act.

8.7. ESPDT Tracking

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

8.7.1.1. Initial visit for newborns. The initial EPSDT screen will be the newborn physical examination at the place of birth.

8.7.1.2. Preventive pediatric visits in accordance with the Rhode Island EPSDT Periodicity Schedule.

8.7.1.3. Diagnosis and/or treatment, or other referrals in accordance with EPSDT screen results.

8.7.2. The Contractor shall designate a EPSDT Coordinator responsible for the tracking and implementation of any QI activities to ensure compliance with EPSDT screening requirements and timely access to services.

8.8. Minimum Performance Standards for EPSDT and Lead Screening

8.8.1. The Contractor shall strive to ensure EPSDT and lead screening services are received by all eligible children. The following minimum annual performance standards for EPSDT and lead screening services will apply:

8.8.1.1. **Well-child Visits:** at least seventy-five percent (75%) of Members under age twenty-one (21) shall receive well- child visits in accordance with the EOHHS Periodicity Schedule.

8.8.1.2. **Immunizations**: at least one hundred percent (100%) of children in DCYF substitute care, and seventy-five percent (75%) of other child Members under age twenty-one 21, shall receive immunizations in accordance with the EOHHS Periodicity Schedule.

8.8.1.3. **Lead Screening:** at least sixty-five percent (65%) of Members under age

twenty-one 21 shall receive blood lead testing in accordance with the EOHHS Periodicity Schedule.

8.8.2. Failure to achieve the stated EPSDT and Lead Screening performance standards shall result in the Contractor being subject to remedies and corrective action, including liquidated damages as outlined in Attachment F-6, "Liquidated Damages."

8.8.3. EOHHS will not impose liquidated damages for the first two (2) years a Health Plan participates in the Rhode Island Medicaid managed care market but reserves the right to impose other contractual remedies at its discretion.

Article 9. Home Health for Children Program

9.1. Contracting with Certified Providers

9.1.1. The Contractor shall enter into a Network Provider agreement with any willing Cedar Family Center certified by EOHHS as a Health Home provider. These providers are known as "Cedar Health Homes" or "CHHs," and are designated providers of Health Homes services under the Rhode Island Medicaid State Plan (see TN# 18-0009).

9.1.2. The purpose of Cedar Health Homes is to provide children with special health care needs and their families a structured system to:

9.1.2.1. Assess their need for medical and community-based services and supports.

9.1.2.2. Refer them to providers and entities that offer these services and supports.

9.2. Eligibility for Health Home Services

9.2.1. Members under age twenty one (21) are eligible for Health Homes services if they meet at least one (1) of the following criteria:

9.2.1.1. Suspected of having a severe mental illness or severe emotional disturbance.

9.2.1.2. Suspected of having two (2) or more of the following chronic conditions: mental health condition, asthma, diabetes, DD, Down Syndrome, intellectual or developmental disability, or seizure disorders.

9.2.1.3. Have one (1) of the chronic conditions listed above and are at risk for developing a second.

9.2.2. The Contractor shall allow families to access a Cedar Health Homes provider through self-referral or by other referral sources, including the Contractor's Care Program staff, PCPs, or other providers.

9.2.3. The Contractor shall ensure that Members who meet eligibility criteria can:

9.2.3.1. Choose their Health Homes provider from any EOHHS-certified provider; or

9.2.3.2. Opt out of receiving Health Homes services at any time.

9.3. Description of Health Home Services

9.3.1. Through Cedar Health Homes, the Contractor shall provide family-centered, intensive care management and coordination services to children, including:

9.3.1.1. Comprehensive Care Management;

9.3.1.2. Care Coordination;

9.3.1.3. Referral to community and social support services (formal and informal);

9.3.1.4. Individual and family support services;

9.3.1.5. Comprehensive transitional care; and

9.3.1.6. Health promotion.

9.3.1.7. These services are defined in further detail in the Rhode Island Medicaid State Plan (TN# 18-0009).

9.4. Home Health Service Requirements

9.4.1. Through Cedar Health Homes, the Contractor shall deliver Health Homes services to children, within the following parameters:

9.4.1.1. The services shall focus on providing enhanced guidance and psychoeducation to promote health and wellness by helping families understand their child's clinical needs, health conditions, medical needs, and/or risk and protective factors.

9.4.1.2. The care coordination shall include in-home, hands-on support and coaching that build a family's skills to successfully navigate systems of care and advocate for their children and family to ensure access and participation in services that meet the child and/or family needs.

9.4.1.3. Services shall be delivered by providers who have experience in delivering health homes in a family's place of residence/community and are trusted members of the communities in which the Member resides.

9.5. Other Requirements

9.5.1. The Contractor shall educate Cedar Health Home providers about their responsibility to:

9.5.1.1. Contact a family within ten (10) Days of referral.

9.5.1.2. Document attempts to reach the family.

9.5.1.3. Respond to referral sources.

9.5.1.4. Provide a copy of the Cedar Screening Tool to the Contractor no later than five (5) Business Days after completion.

9.5.2. The Contractor shall have policies and procedures to:

9.5.2.1. Educate Members and Providers about the availability of Health Homes services in accordance with the Member Education requirements in Section 22.9.

9.5.2.2. Facilitate communication, coordination, and data sharing between Cedar Health Homes providers and the Contractor's Care Program staff.

9.5.2.3. Provide technical assistance and support to Cedar Health Homes providers as needed.

Article 10. Extended Family Planning Services

10.1. Program Description

10.1.1. The Extended Family Planning Program provides family planning services and supplies to Members of childbearing age who lose Medicaid eligibility at twelve (12) months post-partum or following a birth or loss of pregnancy.

10.1.2. EOHHS will determine eligibility in accordance with the EOHHS "Extended Family Planning Program Requirements" in the Medicaid Managed Care Manual.

10.2. Covered Services

10.2.1. Covered Services are limited to family planning services and supplies identified in the EOHHS Extended Family Planning Program Requirements

10.2.2. The Contractor shall coordinate Covered Services for Extended Family Program Members and make referrals for primary care, social support, and other Health Care Services not covered by the program.

10.2.3. The Contractor shall have written policies and procedures to inform Members of Extended Family Planning benefits.

10.2.4. In accordance with Section 21.7, the Contractor's Member Handbook shall include information about the program, Covered Services, and how to request the Contractor's help finding non-covered services.

10.2.5. The Contractor shall cover medically necessary doula services for eligible pregnant Members.

10.2.6. The Contractor shall cover abortion services for eligible pregnant Members in accordance with R.I. Gen. Laws § 42-12.3, "Medical assistance expansion for pregnant individuals/RIte Start."

10.3. Maternal Health

10.3.1. The Contractor shall have written policies and procedures for educating Members about the importance of early prenatal care as well as postpartum care.

10.3.2. The Contractor is encouraged to offer Value-Added Services as incentives to Members who seek prenatal care during their first trimester of pregnancy and who complete the requisite number of prenatal and postpartum visits, as specified in the American College of Obstetricians and Gynecologists' guidelines for routine prenatal care.

10.3.3. The Contractor shall:

10.3.3.1. Perform appropriate clinical and social risk assessment of pregnant Members;

10.3.3.2. Ensure all pregnant or postpartum Members and their infants receive risk appropriate medical and referral services.

10.3.3.3. Allow pregnant Members to meet with the child's PCP (if known) prior to delivery;

10.3.3.4. Provide coverage for a welcome visit for pregnant Members to meet their PCP.

10.3.3.5. Require PCPs or the Member's obstetrician to schedule postpartum visits no more than six (6) weeks after delivery. The Contractor's care management staff shall verify visits are completed;

10.3.3.6. Ensure family planning counseling is provided and, if appropriate, the Extended Family Planning benefit explained during the last trimester of pregnancy and at the postpartum visit; and

10.3.3.7. Require care coordination through the gestational and postpartum periods according to the Member's needs.

10.3.4. The results of the assessments completed in Section 10.3.3 shall be maintained by the Provider as part of the obstetrical record and shall include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components. The risk assessments shall be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. Risks identified shall be followed up on by appropriate interventions, which shall be documented in the medical record.

Article 11. Enhanced Services

11.1. General Requirements

11.1.1. In addition to the services provided under the traditional Medicaid FFS model, the Contractor shall provide the enhanced Services and benefits described in this Section. The Contractor shall deliver these Services and benefits in a manner that considers the unique social, cultural, and linguistic needs of the Rhode Island Medicaid population.

11.2. General Tracking, Follow-up and Outreach

11.2.1. The Contractor shall have written policies and procedures to promote primary and preventative care, including tracking, follow-up, and outreach activities. These policies and procedures shall extend beyond the EPSDT program requirements described in Article 8 and shall include:

11.2.1.1. Member education about how to access services, the role of the PCP, Prior Authorization requirements, and after-hours access requirements;

11.2.1.2. Member education about preventative visit and screening recommendations;

11.2.1.3. Tracking systems to verify all Members have received an initial visit with a PCP;

11.2.1.4. Tracking systems to measure Member compliance with the Rhode Island EPSDT Periodicity Schedule for children, U.S. Preventative Services Task Force recommendations for adults, and Centers for Disease Control recommendations for immunizations for children, adolescents, and adults. The systems should also measure Member compliance with referral recommendations that result from preventive visits;

11.2.1.5. Processes to remind Members about and support Care Coordination for upcoming preventive visits, screenings, and appointments;

11.2.1.6. Processes for follow-up and outreach with Members who miss visits, using mail, telephone, home visits, and other outreach methods as appropriate;

11.2.1.7. Processes to identify and resolve barriers to preventive care such as language or transportation barriers;

11.2.1.8. Provider contracting, outreach, and education, activities to assure compliance with EPSDT screening; and

11.2.1.9. Processes to track EPSDT and other primary and preventative care services, including appropriate CPT/HCPC codes.

11.3. Tobacco Cessation

11.3.1. The Contractor shall have written policies and procedures to assess Members for smoking behavior, particularly adolescents, pregnant Members, and persons with chronic medical conditions.

11.3.2. The Contractor shall offer tobacco cessation programs and services to all Members at

convenient times and in accessible locations.

11.3.3. The Contract shall cover tobacco cessation supplies specified in Attachment F-4.1, "Schedule of In-Plan Benefits."

11.4. Nutrition Services

11.4.1. The Contractor shall implement policies and procedures to ensure:

11.4.1.1. Comprehensive nutrition assessments, education, and counseling is incorporated into preventive medical care, including prenatal and preventive pediatric visits.

11.4.1.2. Referrals are made to licensed dietitians or nutritionists for therapeutic nutrition counseling in accordance with EOHHS Nutrition Standards.

11.4.2. EOHHS Nutrition Standards are included in the Managed Care Manual.

11.5. Transportation

11.5.1. The Contractor shall provide emergency transportation for Members when medically necessary, including out-of-state transportation.

11.5.2. In accordance with Attachment F-4.2, "Schedule of Out-of-Plan Benefits," services provided by non-emergency medical transportation (NEMT) brokers are Out-of-Plan Benefits.

11.5.3. The Contractor's Member Handbook and Provider Manual shall include descriptions of the emergency transportation benefit, the non-emergency medical transportation Out-of-Plan Benefits provided by NEMT brokers, and how Members can access these services.

11.5.4. The Contractor shall help Members experiencing transportation barriers access these services through NEMT brokers. Depending on the Member's need and circumstances, the Contractor shall contact the NEMT broker on the Member's behalf or help the Member reach the broker via a warm handoff to the NEMT call center staff.

11.5.5. The Contractor shall ensure that it has the capacity to access the NEMT broker's secure portal and will utilize the portal as necessary to request and revise trips and track the status of requests.

11.5.6. The Contractor shall coordinate with the NEMT broker regarding Members who have been identified as "chronic no-shows" for appointments. The Contractor shall coordinate with the NEMT broker to promote compliance and behavior change to encourage Members to cancel trips within program guidelines and requirements.

11.6. Dental Services

11.6.1. The Contractor is responsible for providing the following dental benefits:

11.6.1.1. Services to diagnose and treat an oral health condition in either an inpatient or outpatient hospital setting;

11.6.1.2. Services to diagnose or treat an emergency oral health condition in a hospital emergency department;

11.6.1.3. Medically Necessary oral surgery services, including anesthesia; and

11.6.1.4. A complete list of In-Plan Benefits for oral health is found in Attachment F- 4.1.

11.6.2. In accordance with Attachment F-4.2, "Schedule of Out-of-Plan Benefits," children receive routine and preventative dental services as Out-of-Plan Benefits through RIte Smiles MCOs (also called "dental maintenance organizations," or "DMOs"). Adults receive a more limited set of dental services as Out-of-Plan benefits through Medicaid FFS. Additional information regarding Out-of-Plan dental benefits is available on the EOHHS website in the "Dental Services Coverage Manual."

11.6.3. The Contractor's Member Handbook and Provider Manual shall include a description of covered dental services, Out-of-Plan dental benefits, and how to access these services.

11.6.4. The Contractor shall help Members experiencing challenges accessing Out-of- Plan dental services schedule these services. Depending on the Member's need and circumstances, the Contractor shall either contact the RIte Smiles children's dental vendor, or Medicaid FFS vendors on the Member's behalf or help the Member reach these entities via a Warm Handoff to call center staff.

Article 12. Other Requirements for Covered Services

12.1. Anti-Gag

12.1.1. In accordance with Section 1932(B)(3)(A) and 42 C.F.R. § 438.102(a)(1), the Contractor shall not prohibit or restrict a Health Care Provider, acting within the lawful scope of practice, from advising or advocating on behalf of a Member about:

12.1.1.1. The Member's health status, medical care, or treatment options including any alternative treatment that may be self-administered.

12.1.1.2. Any information the Member needs to decide among all relevant treatment options.

12.1.1.3. The risks, benefits, and consequences of treatment or non-treatment.

12.1.1.4. The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

12.1.2. Furthermore, as specified in 42 C.F.R. § 438.410(b) and Section 23.3 "Appeals," the Contractor is prohibited from taking punitive action against a Provider who either requests an expedited resolution or supports a Member's Grievance or Appeal.

12.2. Advance Directives

12.2.1. The Contractor shall maintain written policies and procedures for Advance Directives that comply with all Federal and State requirements, including 42 C.F.R. §§ 422.128, 438.3 and 489 Subpart I, and R.I. Gen. Laws §§ 23-4.10 and 23-4.11.

12.2.2. The Contractor is prohibited from conditioning the provision of care or otherwise discriminating against an individual based on whether a Member has executed an Advance Directive.

12.2.3. The Contractor's policies and procedures shall identify staff, Subcontractors, or Network Providers responsible for providing Member education on Advance Directives.

12.2.4. The Contractor shall educate all staff, Subcontractors, and Network Providers regarding its Advance Directive policies and procedures. Those responsible for educating Members about Advance Directives shall receive additional instruction regarding:

12.2.4.1. Situations in which Advance Directives may be of benefit to Members.

12.2.4.2. How to educate Members about Advance Directives.

12.2.4.3. How to help Members make use of Advance Directives.

12.2.5. As specified in Article 21, "Member Materials," the Contractor's Member Materials and Member Handbook shall include information about Advance Directives, including Member's ability to direct their care through Advance Directives. In accordance with 42 C.F.R. § 438.3(j)(4), the Contractor shall update this information no later than ninety (90) Days after the effective date of a change in state law.

12.2.6. The Contractor shall provide annual notice to Members of their right to request information regarding Advance Directives, in accordance with Section 20.8, "Distribution of Member Materials."

12.3. Moral Objections

12.3.1. The Contractor affirms the assurance made in its Proposal that it does not object to providing any Covered Services based on moral or religious objections (see Attachment F-8, "Contractor's Proposal").

12.3.2. The Contractor therefore cannot refuse to provide Covered Services based on these grounds.

Article 13. Population Health

13.1. Purpose and General Requirements

13.1.1. EOHHS seeks to advance population health management strategies being used in support of the Rhode Island Medicaid managed care program. The Contractor shall have a Population Health Management (PHM) Program and strategy in place that includes written policies and procedures for advancing population health. PHM Program strategies should be designed to promote equity, redress health disparities, and achieve optimal health outcomes for all Medicaid Members. The Contractor is required to submit its PHM Program and strategy to EOHHS for approval.

13.1.2. The Contractor's PHM Program shall seek to advance Health Equity. Achieving Health Equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and disparities.

13.1.3. If the Contractor elects to delegate population health functions, it shall do so in accordance with the state standards outlined in Article 2 and in compliance with NCQA delegation standards.

13.1.4. The Contractor shall share data with AEs as necessary to facilitate AE efforts to manage population health and succeed under total cost of care contracts. EOHHS reserves the right to set standards for the types of data that shall be shared with AEs performing certain delegated functions. On a monthly basis, the Contractor shall provide timely, Member specific utilization and cost data to AEs, as well as other data reports as specified in the Managed Care Manual.

13.2. Health Equity Strategy

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

13.2.2. The Contractor's Health Equity, Diversity, and Inclusion Plan and strategy shall:

13.2.2.1. Be developed in consultation with the Contractor's Subcontracted Network Providers.

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

13.2.2.3. Identify disparities for Contractor's Members in health care access, service provision, satisfaction and outcomes and the factors that drive those outcomes including social risk factors. The Contractor shall ensure that data reflects demographics including race, ethnicity, sexual orientation, and gender identity.

13.2.2.4. Prioritize the Health Equity outcomes that align with EOHHS' priorities and are most meaningful to the Contractor's Members. EOHHS reserves the right to require that the Contractor implement specific Health Equity

initiatives, or Contractor-selected initiatives on designated topics selected by EOHHS, that are aligned with EOHHS-identified priorities.

13.2.2.5. Establish measurable targeted reductions for specified health disparities.

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

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

13.2.2.8. Solicit engagement and feedback from a representative group of Members to ensure that Contractor's Health Equity, Diversity and Inclusion Plan and strategy reflects the ethnic and cultural diversity of Members. The Contractor shall solicit engagement and feedback from Members on at least a quarterly basis using the Member Advisory Committee as a forum for input. This feedback shall be documented in a report that is submitted to EOHHS. The Contractor shall obtain input on a variety of population health topics to inform its PHM Program.

13.2.3. Population health management strategies being used in support of the Rhode Island Medicaid managed care program. The Contractor shall have a Population Health Management (PHM) Program and strategy in place that includes written policies and procedures for advancing population health. PHM Program strategies should be designed to promote equity, redress health disparities, and achieve optimal health outcomes for all Medicaid Members. The Contractor is required to submit its PHM Program and strategy to EOHHS for approval.

13.2.4. The Contractor's PHM Program shall seek to advance Health Equity. Achieving Health Equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and disparities.

13.2.5. If the Contractor elects to delegate population health functions, it shall do so in accordance with the state standards outlined in Article 2 and in compliance with NCQA delegation standards.

13.2.6. The Contractor shall share data with AEs as necessary to facilitate AE efforts to manage population health and succeed under total cost of care contracts. EOHHS reserves the right to set standards for the types of data that shall be shared with AEs performing certain delegated functions. On a monthly basis, the Contractor shall provide timely, Member specific utilization and cost data to AEs, as well as other data reports as specified in the Managed Care Manual.

13.3. Health Risk Assessment

13.3.1. The Contractor is responsible for ensuring that:

13.3.1.1. A Health Risk Assessment (HRA) is conducted on every enrolled Member

in accordance with EOHHS Care Program Protocols in the Managed Care Manual The HRA shall be conducted annually or five (5) days post-discharge from a significant event or hospitalization. If this requirement is not met, the MCO may be subject to penalties at the discretion of EOHHS;

13.3.1.2. Data from the HRA shall be stratified by Member characteristics including race, ethnicity, language, disability and by attributed AE; and

13.3.1.3. Whether conducted by the Contractor, a subcontracted entity, or a Provider, the HRA used shall be approved by EOHHS and shall:

a) Be made available to Members in multiple formats including web-based, print, and telephone.

b) Be conducted with the consent of the Member.

c) Identify individuals for referral to case management for more in depth plan of care development, and

d) Include disclosure of how the information will be used.

13.3.1.4. For LTSS Members, the contractor is required to use the State's designated assessment tool and electronic system of record.

13.3.1.5. For LTSS Members, the contractor is required to conduct an in person HRA in the member's home or place of choice (with member consent).

13.3.2. The Contractor shall use the results of the HRA to create a Care Plan for each Member to manage their health needs.

13.3.3. The Contractor shall use the results of the HRA to determine if a Member qualifies for CM or CCM. Members deemed to require LTSS will automatically qualify for CCM.

13.3.4. The Contractor's data system shall have sufficient IT infrastructure and data analytics capacity to support EOHHS' vision and goals for quality improvement, measurement, and evaluation, including the capability to:

13.3.4.1. Identify service access, utilization, health outcomes, intervention effectiveness, social risk factors, and survey (e.g., CAHPS) results by Member characteristics including race, ethnicity and language, disability, and by attributed AE; and

13.3.4.2. Employ advanced analytic methods such as hot spotting and predictive analytics and modeling to improve the identification of Members and Member communities disproportionately impacted by or at risk for poor health outcomes and social risk factors.

13.3.4.3. Support the monitoring and comparison of process and outcome measures over time to inform disparity reduction efforts.

Article 14. Care Program and Continuity of Care

14.1. General Requirements

14.1.1. The Contractor shall develop a comprehensive Care Program that encompasses the full continuum of care management and coordination activities. This comprehensive care program should include cost effective care and case management strategies that improve and/or maintain a Member's quality of care by using payment incentive among other tools. These strategies should focus on decrease of avoidable utilizations, reduced nursing facility admissions and lengths of stay, with a focus on high utilizers and promotion of integrated community-based care in the least restrictive setting possible.

14.1.2. As described in the table below, the Care Program will consist of three tiers of care management and coordination:

14.1.2.1. Care Coordination;

14.1.2.2. Care Management; and

14.1.2.3. Complex Case Management.

14.1.3. The "tier" at which at Member will receive services is determined by their level of need as assessed by the HRA.

14.2. Care Program Framework and Protocols

14.2.1. The Managed Care Manual includes the EOHHS Care Program Protocols, including minimum requirements for Care Program activities, including:

14.2.1.1. Division of duties and partnership expectation between Health Plans, AEs, CMEs, and other Care Program participants.

14.2.1.2. The care continuum framework.

14.2.1.3. Key components of the Care Program, including program design and planning; HRAs; Care Coordination, Service Planning, CM (care and case management), Transitional case management, and CCM.

14.2.1.4. Qualifications and location of Service Coordinators, Lead Care Managers, Case Managers, transitional case managers, and Complex Case Managers.

14.2.1.5. Individualized Care Plans (ICPs) for Members receiving CM and CCM.

14.2.1.6. Person centered care plans for LTSS Members receiving CFCM.

14.2.1.7. Oversight and coordination of services by Targeted Case Management providers, including AIDS Case Management Agencies to ensure Member receives the referred services and to avoid duplication.

14.2.1.8. Oversight and coordination of services care by Health Home providers, including Opioid Treatment Program Health Homes and Health Homes for Children Programs to ensure delivery of services and to avoid duplication.

14.2.1.9. Additional Care Coordination procedures for Members recently discharged from correctional institutions, including coordination with the local Reentry Councils.

14.2.1.10. Specialized Care Coordination for populations needing CCM (collectively "Specialized Populations,"), which shall include but are not limited to:

a) Members receiving LTSS.

b) Members with high-risk pregnancies.

c) Members receiving services in the Neonatal Intensive Care Units (NICUs).

d) Adult and child Members with Special Healthcare Needs.

e) Children with complex medical needs or adverse childhood experiences.

f) People living with HIV, AIDS, Hepatitis C, severe mental illness, or addiction.

g) People recently discharged from correctional institutions.

14.2.1.11. EOHHS reserves the right to modify the Care Program Protocols at any time, as described in Attachment F-2, Section 3.9, "Modifications to the Managed Care Manual."

14.3. Care Program Plan Components

14.3.1. The Contractor shall make Care Program services available to all Members based on their individualized needs. Key components of the Care Program are described in EOHHS Care Program Protocols, as found in the Managed Care Manual, and include:

Component	Brief Description
Care Coordination (Tier I)	• The deliberate organization of Members' care activities between two (2) or more participants (including the Member) involved in a Member's care to facilitate the appropriate delivery of Health Care Services and supports. • Care Coordination participants can include Members, their families, and caregivers; AEs; CMEs; patient-centered medical homes, health homes, community health teams; Targeted Case Management providers; and providers of community and social supports.
Care Management (CM) (Tier II)	• A team-based, person-centered approach designed to improve Members' health and situational health-related needs (as documented in an ICP) by facilitating access to clinical and non-clinical services. • Situational health care needs include time-limited episodes of instability, such as following an acute medical event (e.g., heart attack, sepsis, surgery, high-risk pregnancy) or gaining self- care skills following a new diagnosis (e.g., diabetes).

Component	Brief Description
Care Program Design and Planning	• Includes activities to coordinate Care Program functions with and delegate Care Program functions to AEs, CMEs, and other program participants. • Also includes activities to identify Members needing Care Program services, including data analytics, HRAs, and referrals.
Care Team	• A team of professionals serving Members identified as requiring CM or CCM that collaborate, in person and/or through other means, with Members to develop and implement an ICP that meets Members' medical, behavioral, LTSS, and social needs. The Care Team will be jointly developed by the Contractor and CME, if applicable. • The Care Team shall include the Member, the Lead Care Manager, and the PCP. For Members with a Service Plan, the Service Coordinator shall be a member of the Care Team as well. With the Member's consent, the Care Team should also include all other appropriate individuals, including but not limited to: the Member's family, guardian, and/or other caregiver; physicians; physician assistants; LTSS providers; nurses; specialists; pharmacists; behavioral health specialists; social workers; and peer supports, as appropriate for the Member's medical diagnoses and health condition, co-morbidities, and community support needs. • The Care Team shall serve as a communication hub to coordinate services across the full continuum of care, including but not limited to primary care, specialty care, behavioral health, LTSS, and other services.
Caregiver Assessment [R.I. Gen. Laws § 40-8.11-3]	• The caregiver assessment shall be performed when a Member's plan of care or ICP depends on a family caregiver for providing assistances with ADL/IADL needs. This assessment should be used to develop a plan of care that recognizes both needs of the Member and the caregiver. The assessment shall also serve as the basis for development and provision of an appropriate plan for caregiver information, education and training, referral, and support services. Information about available respite programs, caregiver training, and education programs, support groups, and community support services shall be included as part of the caregiver support plan.
Complex Case Management (CCM) (Tier III)	• Builds on Care Management requirements and includes evidence-based coordination services for Members with multiple or complex conditions in accordance with NCQA standards. • Delivered to the highest risk Members with complex conditions and high-risk populations. • CCM functions include a comprehensive initial assessment and development of an ICP with Member/family input; delineation of available services and resources; ongoing monitoring and follow-up by care team. • Cannot be delegated to a subcontractor under Section 14.5, Case Management Delegation.

Component	Brief Description
Conflict Free Case Management (CFCM)	• Requires that case management activities, including the development of the LTSS Person-Centered Plan, shall not be performed by any individual or entity who is employed by or has an interest in a provider of services included in the person-centered plan.
Conflict Free Case Manager and/or MCO Service Coordinator	• An appropriately qualified professional who is responsible for facilitating and coordinating the provision of a Member's LTSS in accordance with their LTSS Person-Centered Service Plan
HCBS Person-Centered Care Plan	• A written plan that addresses the HCBS needs of individuals who meet Medicaid LTSS eligibility criteria. Any modification of additional conditions, under 42 CFR § 441.710(a)(1)(vi)(A) shall be supported by a specific assessed need and documented in the person centered plan. The HCBS Person-Centered Care Plan includes, but is not limited to, the individual's goals and desired outcomes, choice of care setting and delivery, is integrated into the greater community to allow the Member to engage in community life, control personal resources, clinical and non-clinical supports and services, a risk mitigation plan, reflect Member's strengths and preferences, and any other plan components as required by EOHHS. The HCBS Person-Centered Care Plan is part of the ICP, should clearly identify the individual or entity responsible for monitoring the plan, be finalized and agreed to with informed consent by the Member in writing and signed by individuals responsible for its implementation. The HCBS Person-Centered Care Plan should be distributed to the Member and others involved in the plan.
Health Promotion and Wellness	• Includes strategies for wellness care and immunizations, general health promotion and prevention, and behavioral health rehabilitation and recovery. • The Contractor shall work with AEs, CMEs, and other Providers to integrate health education, wellness, and preparation training into Member care.
Health Risk Assessment (HRA)	• The HRA is used to determine Members' needs for and access to medical and health-related social services and supports; to coordinate care; and to determine whether risk factors indicate a need for CM or CCM.
Individualized Care Plan (ICP)	• The ICP is a written plan developed for Members receiving CM and CCM. The ICP is developed in collaboration with the Member, their family and/or caregiver, key providers such as their PCP, and/or the Member's care team. The ICP delineates the activities to be undertaken to address key issues of risk for the Member across the full care continuum. For Members receiving LTSS, the ICP shall include an LTSS Person-Centered Service Plan.

Component	Brief Description
Lead Care Manager	• An appropriately qualified professional who is the Contractor's designated accountable point of contact for each Member receiving CM or CCM. The LCM is the primary individual responsible for implementing all responsibilities associated with the delivery of CM or CCM.
Transitional Case Management	• Development of a transition plan of care in coordination with the care setting, the Member, and other key members of a Member's interdisciplinary care team prior to the transition to which is provided in writing to the Member upon discharge, includes post discharge appointments and linkages as appropriate, medication reconciliation, patient education and self-management strategies, and address prior authorization needs. The Member should be given the case manager's name and contact information prior to discharge.

14.4. General Care Program Requirements

14.4.1. The Contractor shall develop and implement a Care Program Plan. As described in Article 30, "Contract Transition and Readiness Review", the Care Program Plan shall be approved by EOHHS prior to the Operational Start Date. EOHHS approval is also required any time the Contractor makes substantive revisions to the Care Program Plan.

14.4.2. To the extent the Contractor delegates Care Program responsibilities to CMEs, AEs, other Subcontractors, or Providers, whether to avoid duplication with Contractor responsibilities or otherwise, the Contractor shall maintain overall responsibility for ensuring compliance with the terms of this Agreement and the Care Program Plan. The Contractor shall identify delegated functions in the Care Plan. See Section 2.5, "Accountable Entity Program," for a description of Care Program activities that can be delegated to qualified Accountable Entity partners.

14.4.3. The Contractor shall develop, implement, and maintain policies and procedures subject to EOHHS approval. Such policies and procedures shall:

14.4.3.1. Operate the Care Program, including all key components described in Section 14.3, above, and the EOHHS Care Program Protocols.

14.4.3.2. Include procedures for contacting Members to complete the HRA, including number of contact attempts, methods of contact, documentation of case and care management activities, including successful linkages to community resources and supports, as applicable.

14.4.3.3. Include procedures for acquiring and documenting Members consent or that of Member family/caregiver or authorized representative to receive care and/or case management and for the contract to share information about a Member's care with Member providers to promote coordination and integration.

14.4.3.4. Include a plan describing how management of behavioral health services and HCBS (if applicable) is integrated into the overall care and case management.

14.4.3.5. Include criteria and protocols for ensuring appropriate staffing ratios and caseloads for case managers and other staff involved in care management in line with industry practices.

14.4.3.6. Include processes for the contractor to measure the effectiveness and quality of the contracts case management, including but not limited to tracking and frequency and type of case management contact, outcomes from different tiers of case management (impact analysis on avoidable utilization and follow up care), and use of valid quantitative method to measure outcomes again performance goals and other relevant measure processes and outcomes.

14.4.3.7. Include protocols for providing case and care management in a variety of setting, including, but not limited to a Member's home, shelter, or other care setting.

14.4.3.8. Include protocols and criteria for graduation between tiers of case management support and/or discharge of Members from case and/or care management.

14.4.3.9. Include processes for engagement with the Member to complete HRA tools approved by EOHHS within ninety (90) Days of enrollment for all new Members. The HRA shall include required questions from EOHHS to address health inequities and SDOH (e.g., housing instability, transportation needs, food insecurity), and comply with other requirements in the EOHHS Care Program Protocols. The Contractor may request to include additional information, subject to approval by EOHHS. The Contractor shall incorporate any other available assessment data from sources such as the InterRAI, and/or nursing home assessments. Results of the HRA assessment shall be shared with EOHHS and with AEs and CMEs, if applicable, to prevent duplication of efforts. For LTSS eligible Members, all assessment data shall be stored in a single state-selected platform, as selected by EOHHS for the Contractors, and CMEs to access.

14.4.3.10. If the HRA identifies that the Member qualifies for CM or CCM, develop ICPs for those Members. ICPs shall be updated annually or more frequently as needed to address changes in Members' medical conditions or needs. Members, their families, and caregivers should be active participants in ICP development. The Lead Care Manager is responsible for the creation and oversight of the ICP in collaboration with the Member's care team.

14.4.3.11. Require the ICP to include the Member's care goals; an LTSS Person-Centered Care Plan (if necessary, as described below); barriers to service

delivery; measures taken to reduce risks; and medical, behavioral, and psychosocial support needs. The ICP shall include information on how the Member may contact their Lead Care Manager and, if applicable, their Service Coordinator.

14.4.3.12. Include processes to oversee and actively monitor all delegated Care Program activities, including activities delegated to AEs as described in Section 2.5 and CMEs as described in Section 14.6.

14.4.3.13. Include processes to ensure Members have ongoing sources of care appropriate to their needs and are actively involved in decisions relating to their care.

14.4.3.14. Include processes to coordinate health-related social services for all Members with identified needs (based on HRA screening or other means of identification), including:

a) Documenting in ICP any positive/social needs.

b) Referring to social service Providers and/or providing enhanced services designed to meet the Member's social needs.

c) "Closing the loop" by ensuring services were received and documented in the Member's records.

d) Monitoring the level of Member engagement and utilization of these services.

e) EOHHS reserves the right to require Contractor to use electronic community resource platform procured by EOHHS, AEs, or other Providers to coordinate tasks noted above.

14.4.3.15. Designate a Lead Care Manager with primary responsibility for coordinating Member services and Care Program activities and notify Members how to contact this person or entity.

14.4.3.16. Ensure staff and delegates who provide Care Coordination, CM, CCM, and Service Planning meet minimum qualifications identified in the EOHHS Care Program Protocols.

14.4.3.17. Provide additional supports to Specialized Populations during times of transition (e.g., between care settings, from child to adult services, etc.), as described in the EOHHS Care Program Protocols.

14.4.3.18. Coordinate Care Coordination activities with TCM programs (e.g., HIV) and provide additional support if the Member has unmet needs. Care Coordination activities can include participating in Member case conferences, data sharing, and other strategies.

14.4.3.19. Implement continuity and transition of care policies consistent with 42 C.F.R. 438.62(b), 42 C.F.R. § 438.206(b), and Sections 14.7 and 14.8, below. The Contactor's Member Handbook shall educate Members about their rights under these policies.

14.4.3.20. Facilitate coordination of services between care settings, including appropriate discharge planning from hospitals, residential treatment facilities, and institutional care. Facilitation shall include processes and procedures to share data regarding admissions, discharges, transfers, assessments and screenings, and prescription drugs with Members' PCPs and behavioral health providers (see also Section 14.9, regarding "Continuity and Transition of Care for Exiting Members").

14.4.3.21. Coordinate and collaborate on Out-of-Plan and other health and social services, as described in Section 14.11, below.

14.4.3.22. Use information systems to support monitoring and management of ICPs and electronic community resource platforms to coordinate and track referrals to community-based services.

14.4.3.23. Ensure the Contractor, Subcontractors, and Providers use and disclose individually identifiable health information, including Member records, in accordance with confidentiality requirements in 45 C.F.R. Parts 160 and 164 and applicable Federal and State laws, rules, regulations, and professional standards.

14.4.3.24. Ensure Members are not held responsible for costs of transferring medical records to Providers.

14.4.3.25. Implement standardized procedures or methodologies for predictive modeling and risk stratification to identify Members to include in the Care Program, including processes for self-referral and regular reviews of claims, utilization data, and information collected through HRAs. Risk stratification criteria and methodology shall include SDOH data from all available screenings.

14.4.3.26. Collect, aggregate, analyze, and interpret all available SDOH data so that it can be incorporated into the ICPs. SDOH data shall be included, to the extent available, from the Contractor, the AEs, Health Homes, participating providers, or other sources. The Contractor is responsible for entering into data sharing agreements with these sources to facilitate sharing of this information.

14.4.3.27. The Contractor shall be responsible for the method of identification and stratification of Members for care management, case management, and complex case management as part of the Care Program. Stratification requirements shall meet minimum standards established by EOHHS.

14.4.3.28. Implement the requirements described in Section 2.5, "Accountable Entity Program," including a Care Plan Strategy specific to AEs. The strategy shall include minimum requirements described in the EOHHS Care Program Protocols, such as how the Contractor shall assess AE's capacity to perform delegated functions, identify which functions are delegated to AEs, and the Contractor's framework for financing Care Program

activities as more responsibilities are delegated to AEs over time.

14.5. Delegated Case Management

14.5.1. The Contractor shall develop a program to delegate Case Management services to Subcontracted Providers, including reimbursement for services rendered. The purpose of such a program is to reimburse for Case Management services in settings where enrollees are already accessing care and to avoid duplication with MCO Case Management services.

14.5.2. Delegated Case Management Entity Program shall include:

14.5.2.1. Include AEs, PCPs, obstetrics and gynecology providers, and behavioral health providers.

14.5.2.2. Establish minimum provider qualifications for each tier of delegated Case Management services.

14.5.2.3. Tier III cannot be delegated to subcontractors under this Agreement.

14.5.2.4. Establish criteria to distinguish when an Enrollee is eligible for delegate Case Management versus MCO Case Management to prevent duplication of services. Wherever appropriate, the Contractor should utilize delegated Case Management for eligible Enrollees including an EOHHS approved case management matrix approved by EOHHS under this Agreement.

14.5.2.5. Establish monitoring and oversight procedures to ensure delegated Case Management providers are adhering to applicable Case Management requirements described in this Agreement, including audit and oversight procedures of the Contractor.

14.5.3. EOHHS shall review and approve all subcontractors who are delegated to provide case management services under this Agreement.

14.5.4. EOHHS reserves the right to deny or revoke case management services at any time for a subcontractor entity during the term of this Agreement.

14.5.5. Contractor shall demonstrate that the subcontractor has met minimum case management standards, including NCQA accreditation and the ability to successfully manage the Rhode Island Medicaid Managed Care population or selected approved populations.

14.5.6. Contractor shall establish an administrative rate for members who are delegated to an approved delegated case management entity through a PMPM fee or another approved methodology.

14.5.7. EOHHS reserves the right to modify, enhance or reduce the allowable uses of case management functions during the term of this Agreement. The Contractor shall promptly comply with changes under the direction of EOHHS.

14.5.8. The Contractor shall work cooperatively with subcontractors to implement approved delegated case management functions.

14.5.9. EOHHS reserves the right to set performance goals and standards to assist the movement towards a delegated case management program.

14.6. LTSS-Specific Requirements

14.6.1. The Contractor is responsible for providing Care Program functions to Members who receive LTSS; including performing an HRA, developing an ICP, inclusive of a a Person-Centered Care Plan, and delivering CCM, unless those functions have otherwise been delegated to a CME, AE, or other Subcontractor as described in this agreement. Members who have been determined eligible for LTSS automatically qualify for CCM.

14.6.2. Members are determined eligible for LTSS by EOHHS. Members who are identified in the HRA as needing LTSS, but are not already eligible shall be referred to EOHHS to be evaluated for LTSS eligibility. The Contractor may not authorize the provision of LTSS to a Member until they are determined eligible for LTSS by EOHHS.

14.6.3. Members receiving LTSS and qualifying for CCM shall receive an ICP. For Members eligible for LTSS, the ICP shall include an LTSS Person-Centered Care Plan which authorizes HCBS, including the amount, duration, and scope of services for which a Member qualifies. The Contractor or its delegated CME shall assign a HCBS trained Conflict Free Case Manager to facilitate and coordinate the provision of LTSS and be responsible for person-center plan oversight and monitoring.

14.6.4. The Contractor shall delegate the LTSS Person Centered Planning process to certified CMEs, to the extent that CME capacity permits. Where CME capacity does not permit delegation, the Contractor shall provide LTSS Person Centered Planning. All Members who receive LTSS shall be provided with CFCM through the separation of eligibility determination from direct services provision, regardless of whether the MCO or CME delivers CFCM.

14.6.5. Person Centered Planning processes shall include working with the Member to develop the Member's LTSS Person-Centered Care Plan, forming and convening the Member's care team, and conducting reassessments of the LTSS Person-Centered Service Plan annually or more frequently as needed. The Contractor or its delegate shall utilize a strengths-based, person-centered service plan development process. The person-centered care plan shall be participant-driven, holistic, involve caregivers, and address SDOH as necessary to achieve person-centered goals for Members to participate in the settings of their choosing. The Member's care team will provide input regarding the development of the person-centered care plan. The Contractor shall ensure that the Health Plan's Lead Care Manager coordinates with the Member's assigned CFCM case manager. The Contractor shall retain oversight responsibilities for any delegated person-centered planning activities and shall have ultimate authority for the overarching care planning process.

14.6.6. The Member's service plan shall encompass the following minimum components in order to fulfill CMS requirements:

14.6.6.1. Reflect that the setting in which the individual resides is chosen by the

individual and meets the HCBS Settings Rule requirements of 42 C.F.R. § 441.301(c)(4)-(5);

14.6.6.2. Reflect the Member's strengths and preferences;

14.6.6.3. Reflect the Member's specific and individualized assessed need(s), including clinical and support needs as identified through an assessment of functional need;

14.6.6.4. Include individually identified goals and desired outcomes;

14.6.6.5. Include the Services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural Supports are those relationships the Member has with friends, family, and their community at large that enhance the quality and security of a Member's life;

14.6.6.6. Services for which the individual elects to self-direct, meeting the requirements of 42 C.F.R. § 441.740;

14.6.6.7. Identify risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed, and prevent the provision of unnecessary or inappropriate services and supports;

14.6.6.8. Be understandable to the Member and those whom supports the Member, and as such be written, at a minimum, in plain language and in a manner accessible to the Members with disabilities and those who are Limited English proficient consistent with 42 C.F.R. § 435.905(b).

14.6.6.9. Identify the individual and/or entity responsible for monitoring the plan.

14.6.6.10. Be finalized and agreed to in writing and with the informed consent and signature of the Member, caregiver, and all individuals responsible for its implementation. The final plan should be distributed to the Member and other people involved in the plan.

14.6.6.11. Document any modification of the additional conditions, under 42 C.F.R. § 441.710(a)(1)(vi)(A) through (D) shall be supported by a specific assessed need and justified in the person-centered care plan.

14.6.7. The Contractor shall share with any CME that has been subcontracted to perform LTSS service coordination the following data elements: care plans, most recent HRA and due dates, risk stratification and approved contact schedule, claims including inpatient hospitalizations, emergency department and LTSS services, and risk agreements, as applicable.

14.6.8. The Contractor shall utilize the state LTSS e-record system and have bi-directional data exchange capabilities.

14.7. Continuity of Care for New Members

14.7.1. The continuity of care requirements described herein are intended to ensure the seamless transfer of clinical care, and that services are not interrupted or disrupted for

new Members. This includes Members who move from the FFS Medicaid Program to the Managed Care Program or from one (1) Health Plan to another. This also includes Members with short-term care disruptions. For Members who have lost Medicaid coverage for thirty (30) Days or less, the Contractor is expected to make reasonable efforts to connect the Member to care as described in this Section.

14.7.2. The Contractor shall allow newly enrolled Members to continue seeing Out-of-Network Providers and honor existing Prior Authorizations for Medically Necessary Covered Services until the shorter of:

14.7.2.1. Six (6) months after enrollment in the Contractor's Health Plan;

14.7.2.2. Expiration of the Prior Authorization period; or

14.7.2.3. The Contractor has completed the HRA and applicable ICP for the new Member and either:

a) Issued or denied a new Prior Authorization for the service; or

b) Transitioned the Member's medical records to a Network Provider with comparable or greater expertise in treating the Member's needs and

c) The Member agrees to the transition prior to the expiration of the continuity of care period.

14.7.3. The Contractor shall extend the timeframes described above when the Member has Appealed an Adverse Benefit Determination and has requested benefits continue pending resolution ("Aid Pending"), as described in Section 23.8, "Continuation of Benefits."

14.7.4. Dual Eligible Members who are permanent residents of nursing facilities or assisted living facilities may remain in that nursing facility or assisted living facility regardless of whether that nursing facility or assisted living facility is in the Contractor's Provider Network

14.8. Continuity of Care for Members Transitioning to the Community

14.8.1. The Contractor shall adopt and/or implement a transition model to ensure seamless and effective transitions and continuity of care when Members move between levels of care. A key element to effective transitions management is to have strategies that prevent Members from moving to an acute and/or higher level of care when it is preventable or avoidable.

14.8.2. The Contractor shall have transitional case management and support during transitions across care settings twenty-four (24) hours a day, seven (7) days a week. Transitional case manager provide onsite visits, discharge planning, and care coordination when Members are to be discharged from hospitals, nursing facilities, and other institutional settings.

14.8.3. For Members residing in nursing facilities who are found to have the desire and/or opportunity to return to the community, the Contractor shall ensure the timely development of a person-centered Community Transition Plan designed to support community reintegration.

14.8.4. The Community Transition Plan shall include, but is not limited to:

14.8.4.1. Identification of community supports;

14.8.4.2. Identification and assistance with finding available housing;

14.8.4.3. Safety assessment of residence;

14.8.4.4. Identification of Environmental Modification needs; and

14.8.4.5. Identification of DME needs.

14.8.5. The Contractor shall follow all requirements of the NHTP and Money Follows the Person programs, as described in the Managed Care Manual, for eligible Members.

14.8.6. The Contractor shall have a sufficient team of Transition Coordinators to assist all Members transitioning from Nursing Facility to the Community.

14.8.7. The Transition Coordinator shall have final determination in all coordination and transition efforts for the Member between the Contractor and the AE.

14.9. Continuity and Transition of Care for Existing Members

14.9.1. The Contractor shall allow the following Members to receive Medically Necessary Covered Services from Out-of-Network Providers:

14.9.1.1. Pregnant Members past the twenty-fourth (24th) week of pregnancy can remain under their current obstetrician's/gynecologist's care through the post-partum checkup.

14.9.1.2. Members diagnosed with and receiving treatment for a terminal illness can remain with established providers for up to nine (9) months.

14.9.1.3. Members with chronic or acute medical, behavioral health, or substance Abuse conditions whose providers leave the Contractor's Network can remain with these providers for up to six (6) months.

14.9.2. Upon expiration of the above-referenced continuity periods, the Contractor shall help Members transition to qualified Network Providers and have policies to ensure, at a minimum:

14.9.2.1. Transitions do not create a lapse in services;

14.9.2.2. Necessary information exchange (including transferring Member records);

14.9.2.3. Compliance with patient confidentiality requirements; and

14.9.2.4. Members can request additional changes in Network Providers.

14.10. Services Not Available in Network

14.10.1. The Contractor shall allow Members to receive services from Out-of-Network Providers when Medically Necessary Covered Services are not available from a qualified Network Provider within the appointment availability standards described in 18.33.4. These services shall be made available at no cost to Members.

14.11. Additional Requirements for Out-of-Network Providers

14.11.1. Out-of-Network Providers shall satisfy all EOHHS and state requirements, including standards for enrollment, licensure, accreditation, or certification, as appropriate to the Covered Service provided.

14.11.2. The Contractor shall reimburse an Out-of-Network Provider of Emergency Medical Services, Emergency Services, Emergency Room Care, or Early Intervention services at one hundred percent (100%) of the Medicaid FFS rate. In all other circumstances where the Contractor is required to cover services provided by an Out-of-Network Provider, the Contractor shall reimburse the Provider at a rate equal to the Contractor's usual and customary rate, or another rate agreed to in writing with the Provider.

14.12. Coordination with Out-of-Plan Medicaid Services and Other Health Related Needs Social Services

14.12.1. EOHHS supports various Federal, State and community programs targeted to persons who may be covered by the Managed Care Program. These services are significant to promote the health of Members and their families.

14.12.2. The Contractor is not obligated to provide or pay for Out-of-Plan Medicaid Services as described in Attachment F-4.2, "Schedule of Out-of-Plan Benefits," or other non-plan, non-capitated services. To avoid service fragmentation, however, the Contractor's Care Program Plan shall include policies and procedures to:

14.12.2.1. Educate Members and Providers about the availability of these services (via the Member Handbook, Provider Handbook, outreach, and education materials).

14.12.2.2. Make referrals to and help Members access these services.

14.12.2.3. Coordinate these services with In-Plan Benefits.

14.12.2.4. "Close the loop" by verifying Members are receiving these services.

14.12.2.5. Develop data sharing agreements between the Contractor and vendors or state agencies providing out-of-plan services in order to exchange relevant data and support delivery of care. Relevant data may vary by the out-of-plan service provider but may include:

a) Assessments,

b) Risk stratification results,

c) Care management plans,

d) Encounter data,

e) Provider enrollment, and

f) Referrals.

14.12.3. The Contractor is encouraged to coordinate and partner with Rhode Island Department of Health (RIDOH) disease management programs including diabetes education, asthma, tobacco cessation, nutrition.

14.12.4. Examples of Out-of-Plan Medicaid Services, state programs, and community supports are described below, but this list is not exhaustive.

14.12.4.1. Non-Emergency Medical Transportation.

14.12.4.2. Dental Services for Children and Young Adults (RIte Smiles).

14.12.4.3. Intellectual and Developmental Disabilities (I/DD) waiver services provided through the Medicaid FFS Program (including services provided through consumer/self-directed and agency/provider delivery models).

14.12.4.4. Special Education services.

14.12.4.5. Services not otherwise described in this Section provided through Department of Behavioral Health, Developmental Disabilities and Hospitals, Rhode Island Department of Human Services, and Rhode Island Department of Health Services.

14.12.4.6. Lead Program.

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

14.13. Transitional Care Management Closed-Loop Referrals and Warm Handoffs

14.13.1. Transition of Care Management Teams are required to use closed-loop referrals for all referrals made for Members, using the warm handoff method when possible, meaning that the referral will be made through connecting the Member directly to the entity in receipt of the referral, no matter if that is a health care provider or a State or community-based organization.

14.13.1.1. The Contractor shall utilize a closed-loop referral to support Members unless the Member advocates for a warm handoff. It is the responsibility of the Contractor to ensure that all closed-loop referrals are completed by different parties during Care Management

14.13.2. If a referral is made for a Member, a Transition of Care Team representative must follow-up with the Member about that referral within forty-eight (48) hours after the referral is made.

14.13.3. When the referral is made, a Transitional of Care Team Representative must discuss any challenges utilizing the referral with the Member and work to resolve any issues the Member may have in accessing the referral.

14.13.4. At follow-up, the Transition of Care Team Representative must determine why the referral was not utilized and assist the Member in utilizing the referral. The Contractor will report on the number and type of referrals made, follow ups, and number of referrals completed by Members quarterly.

14.13.5. EOHHS reserves the right to require the Contractor to procure an EOHHS approved closed-loop referral subcontractor related to the referral and warm handoffs. Contractor must ensure that subcontractor shall be able to integrate and interface with Contractor, Providers and EOHHS systems through approved APIs. Contractor shall

bear the costs associated with the integration of APIs and referrals within the closed-loop network ecosystem.

Article 15. General Reporting Requirements

15.1. Instructions

15.1.1. The Contractor and its Subcontractors shall comply with all reporting requirements described in this Agreement, including the Managed Care Manual.

15.1.2. Unless otherwise directed by EOHHS, reporting requirements relating to Members, or services provided to Members, include all eligibility groups described in Article 3, "Covered Populations, Enrollment, and Disenrollment."

15.1.3. EOHHS will provide technical assistance regarding reporting requirements as needed.

15.1.4. The Managed Care Manual includes reporting requirements, templates, timeframes, and submission requirements. Unless otherwise indicated in the Reporting Calendar, reports are generally due within the following timeframes:

Report/Deliverable	Due Date
Daily Reports	Within two (2) Business Days
Weekly Reports	Wednesday of the following week
Bi-Weekly Reports	5th and 20th Day of the 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 31st and July 31st
Annual Reports	As specified by EOHHS
Ad Hoc/On Demand	As specified by EOHHS

15.1.5. As part of its QM/QI program, the Contractor shall review all reports and data submitted to EOHHS, including reports generated by Subcontractors. If the Contractor identifies instances or patterns of noncompliance with reporting requirements, it shall notify EOHHS of the errors, omissions, or deficiencies, and describe the corrective actions the Contractor is taking to resolve such issues.

15.1.6. EOHHS may require revisions to reports, including corrections to address errors, omissions, or deficiencies. EOHHS reserves the right to impose contractual remedies, including liquidated damages, if the Contractor fails to comply with reporting requirements.

15.1.7. At its discretion, EOHHS may change the content, format, or frequency of reports, or require additional or ad hoc reports. The Contractor will have thirty (30) Days to implement changes to reporting templates, unless otherwise indicated in EOHHS' notice of revision.

15.1.8. At EOHHS' request, the Contractor shall provide any other data, documentation, or information relating to its performance under this Agreement.

15.2. Modification of Reporting Templates by EOHHS

15.2.1. Any modification to an EOHHS approved reporting template shall be prohibited by the Contractor.

15.2.2. Upon notification of a final reporting template by EOHHS, the Contractor shall have fourteen (14) Days to implement and utilize the modified template.

15.2.3. Any new reports or larger modifications to a reporting requirement that requires system modifications by the Contractor shall be implemented within thirty (30) Days of notification by EOHHS.

Article 16. Quality Assurance

16.1. General Requirements

16.1.1. The Contractor shall develop and implement an ongoing, comprehensive Quality Program and Performance Improvement Program (QAPI) for services it furnishes to its Members, regardless of payor source or eligibility category. The Contractor's Quality Program shall meet NCQA standards. If the Contractor elects to delegate quality assurance functions, it shall do so in accordance with the state standards outlined in Article 2 and in compliance with NCQA delegation standards. However, the Contractor may not delegate development and oversight of the QAPI.

16.1.2. The QAPI shall align with the objectives of Rhode Island's Medicaid Managed Care Quality Strategy (Quality Strategy), as amended or updated and found on the EOHHS website (Quality Strategy) and any priorities identified by EOHHS, including the goals of advancing Health Equity and promoting value-based, high-quality care for all Rhode Island residents.

16.1.3. The Contractor's Quality Management and Quality Improvement (QM/QI) and Quality Assessment and Performance Improvement (QAPI) programs shall align with EOHHS' priorities, goals and objectives as detailed in the Quality Strategy.

16.1.3.1. The Contractor's QM/QI program shall provide a comprehensive, organization-wide quality structure and formal process to monitor, evaluate, and improve the quality, safety, equity, and effectiveness of care and services provided to Members throughout the duration of care. Quality management is an ongoing process that requires the Contractor's regular evaluation of its own internal processes and approaches to care. The QM/QI program shall advance the principles of quality care, as described below, and facilitate continuous quality improvement as described in Section 16.1. The QM/QI program shall also include the facilitation of a QM/QI Committee, described in Section 16.6.

16.1.3.2. The Contractor's QAPI program shall meet the Federally required standards for improving the quality of care as described in section 16.4. The QAPI program shall support proactive steps by the Contractor to improve the quality of care and be responsive in key areas where quality can be enhanced. This should include robust Performance Improvement Projects (PIPs), described in Section 16.7, and other interventions to improve care. In documenting the structure of the QAPI program, the Contractor is required to include details about the Program in the aggregate but shall also describe distinct-population-specific program structures and elements such as those for Members receiving LTSS.

16.1.4. The Contractor shall deliver quality care that enables Members to stay healthy, prevent poor outcomes and manage chronic illnesses or disabilities. Quality care refers to:

16.1.4.1. Clinical quality of physical health care.

16.1.4.2. Clinical quality of behavioral health care focusing on recovery, resilience,

and rehabilitation.

16.1.4.3. Access and availability of primary, behavioral health, home and community-based services, and specialty care Providers and services.

16.1.4.4. Continuity, coordination, and transitions of care across settings.

16.1.4.5. Mechanisms to assess the quality and appropriateness of care provided to Members at risk for health disparities due to race, ethnicity, sex, primary language, sexual orientation, and gender identity.

16.1.4.6. Member experience with respect to all of the quality indicators described above.

16.1.5. The Contractor shall apply the principles of continuous quality improvement (CQI) to all aspects of the Contractor's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:

16.1.5.1. Quantitative and qualitative data collection with data-driven decision-making.

16.1.5.2. Up-to-date evidence-based practice guidelines consisting of explicit criteria developed by professional societies or, where evidence-based practice guidelines do not exist, consensus of professionals in the field. The guidelines shall:

a) Be based on valid and reliable clinical evidence or a consensus of providers in the particular field.

b) Consider the needs of Members.

c) Be adopted in consultations with Network Providers.

d) Reviewed and updated periodically as appropriate.

e) Be consistent with the Contractor's decisions regarding Utilization Management, Member education, coverage of services, and other areas covered by the guidelines.

16.1.5.3. Feedback provided by Members and Providers in the design, planning, and implementation of CQI activities.

16.1.5.4. Issues identified by EOHHS, the Contractor, or AEs.

16.1.5.5. QM/QI requirements of this Agreement applied to the delivery of both physical health and behavioral health services.

16.2. Quality Measurement

16.2.1. The Contractor is responsible for:

16.2.1.1. Collecting and reporting data to EOHHS on select quality measures as identified by EOHHS that can be stratified based upon Members' age, race, ethnicity, language, disability, sexual orientation, gender identity, or other characteristics as specified by EOHHS and by attributed AE, if applicable. EOHHS reserves the right to provide additional guidance on

how and what data the Contractor shall collect to track information regarding Health Equity; and

16.2.1.2. Requiring that when AEs and Providers report data on quality measures that such data captures information and can be stratified based upon Members' age, race, ethnicity, language, disability, sexual orientation, gender identity, or other characteristics as specified by EOHHS.

16.3. Quality Reporting

16.3.1. The Contractor shall measure and report to the EOHHS on its performance, using the standard quality measures required by the EOHHS, and submit data to the EOHHS according to the schedule described in the Managed Care Manual.

16.4. Quality Program Basic Elements

16.4.1. The Quality Program shall be specific to the Managed Care Program requirements, guided by the current NCQA standards and Guidelines for the Accreditation of Health Plans, and shall align with the Contractor's Health Equity and Utilization Management strategies as required by Section 13.2.

16.4.2. In accordance with 42 C.F.R. § 438.330, the Quality Program shall include a well-defined Quality Assessment and Performance Improvement (QAPI) Program that includes all of the following:

16.4.2.1. The systematic collection, submission, and evaluation of performance measurement data, including any required by EOHHS, CMS, and nationally validated initiatives and frameworks.

16.4.2.2. A mechanism to detect both the underutilization and overutilization of services.

16.4.2.3. A mechanism to assess the quality and appropriateness of physical health and behavioral health care furnished to Members with special health care needs, as defined by EOHHS and the RI Medicaid Managed Care Quality Strategy.

16.4.2.4. Performance Improvement Projects (PIPS), that meet the requirements of Section 15.7, below, including any required by EOHHS or CMS that focus on clinical and non-clinical areas.

16.4.2.5. Implementation of system interventions to remediate identified problems and achieve improvement in quality.

16.4.2.6. A process to evaluate the effectiveness of interventions.

16.4.2.7. Planning and initiation of activities for increasing or sustaining improvement.

16.4.2.8. A mechanism to interpret and disseminate data pertaining to quality to Subcontractors and Network Providers.

16.4.2.9. Mechanisms to assess the quality and appropriateness of care furnished to Members using long-term services and supports, including assessment of

care between care settings and a comparison of services and supports received with those set forth in the Member's treatment/service plan, if applicable.

16.4.2.10. Participation in efforts by the state to prevent, detect, and remediate Critical Incidents that are based, at a minimum, on the requirements on the state for home and community-based services. See Section 7.1 for additional requirement.

16.4.2.11. Support of EOHHS quality improvement programs for Members receiving Home and Community Based Services, including assistance with meeting CMS requirements for HCBS quality improvement and reporting.

16.5. Quality Program Structure

16.5.1. The Contractor shall maintain a well-defined organizational structure for its Quality Program.

16.5.2. In accordance with Section 1.7.14, the Contractor's Medical Director is responsible for QAPI development, implementation, and oversight.

16.5.3. At a minimum the Quality Program shall:

16.5.3.1. Be implemented organization-wide, with clear lines of accountability within the organization that establish that the Contractor's Board of Directors and Executive Management are ultimately accountable for the effectiveness of the QAPI Program, and the quality of care provided the Contractor's Members.

16.5.3.2. Include a set of functions, roles, and responsibilities for the oversight of QAPI Program activities that are clearly defined and assigned to appropriate individuals and meet the requirements of this Section.

16.6. Quality Management/Quality Improvement Committee

16.6.1. The Contractor shall have a Quality Management/Quality Improvement (QM/QI) Committee that shall be responsible for informing the development and providing oversight of the Contractor's Quality Program.

16.6.2. The QM/QI Committee shall include at a minimum:

16.6.2.1. The Contractor's Medical Director shall serve as the chairperson for the QM/QI Committee and have experience in successful QAPI Programs.

16.6.2.2. Behavioral Health Director.

16.6.2.3. The Contractor's Health Equity Officer.

16.6.2.4. Medical, behavioral health, and clinical Provider representation, including Providers serving dual eligible Members and Members receiving LTSS

16.6.3. Committee Responsibilities include:

16.6.3.1. Reviewing and approving for submission to EOHHS the annual QI Program evaluation, including QAPI and PIPS, work plan, and QI

Program description.

16.6.3.2. Identifying benchmarks and setting achievable performance goals for improvement initiatives.

16.6.3.3. Ensuring quality improvement activities take place throughout the Contractor's organization and ensuring the Contractor's subcontracted AEs and Network Providers are involved in the QAPI Program, even though they are not formal members of the Committee. The Contractor shall require through contract terms that all Subcontractors and all Network Providers who are not subcontracted AEs are required to participate in appropriate quality improvement activities.

16.6.3.4. Reviewing and evaluating results of the QM/QI activities, recommending policy decisions, and suggesting new or improved QM/QI activities.

16.6.3.5. Directing task forces/committees to identify, review, and address areas of concern in the provision of Health Care Services to Members including instituting needed action and ensuring that appropriate follow up occurs.

16.6.3.6. Designating evaluation and study design procedures.

16.6.3.7. Reviewing Provider network performance, including individual PCP, AEs, specialized behavioral health Providers, and practice quality performance measure profiling to identify and address patterns.

16.6.3.8. Directing and analyzing periodic reviews of Members' service utilization patterns.

16.6.3.9. Recommending needed corrective actions and ensure that appropriate follow-up occurs.

16.6.3.10. Providing progress reports to the Contractor's leadership.

16.6.3.11. Disseminating information to the Contractor's Subcontractors and Network Providers.

16.6.3.12. Formulating recommendations to advance quality objectives changes in policy and procedures including the adoption of evidence-based practices.

16.6.3.13. Providing the results of any quality improvement studies/projects and Medicaid HEDIS® and CAHPS® results to EOHHS within thirty (30) Days of their presentation to the Contractor's QM/QI Committee.

16.6.3.14. Periodically updating Provider Manuals and other relevant clinical content as determined by the Medical Director.

16.6.4. The QM/QI Committee shall:

16.6.4.1. Meet at least quarterly.

16.6.4.2. Maintain written minutes of all Committee and subcommittee meeting minutes and submit meeting minutes to EOHHS. Meeting minutes for all Committee and subcommittee meetings shall clearly include a list of

action items identified during the Committee discussion, as well as follow up or action item closure activities based upon action items from the previous meeting. A copy of the signed and dated written minutes for each meeting shall be available after the minutes are approved and shall be available for review upon request and during NCQA accreditation and EQRO reviews.

16.6.4.3. Provide the EOHHS' Chief Medical Officer advance notice of all regularly scheduled meetings of the QM/QI committee within ten (10) Days of the meeting. To the extent allowed by law, the EOHHS' Chief Medical Officer or his/her designee may attend the QM/QI Committee at his/her option.

16.7. Performance Improvement Projects

16.7.1. On an annual basis, the Contractor shall conduct not less than four (4) PIPs that focus on both clinical and non-clinical areas.

16.7.2. EOHHS may require the Contractor to perform up to two (2) additional projects for a maximum of six (6) projects.

16.7.3. EOHHS, in consultation with CMS and other stakeholders, may require specific performance measures and PIP topics. The Contractor shall report the status and results of each PIP as specified in the Managed Care Manual. If CMS specifies a PIP, the Contractor shall participate, and this shall count toward the EOHHS-approved projects.

16.7.4. Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, high-volume services, high risk services, health care disparities, and continuity and coordination of care. Non-clinical PIPs include projects focusing on availability, accessibility, interpersonal aspects of care, Appeals and Grievances and other opportunities for improvement.

16.7.5. The focus areas may be established by EOHHS: however, for Contractor initiated PIPs, the Contractor shall submit PIP proposals in to EOHHS in accordance with the Managed Care Manual.

16.7.6. The Contractor shall ensure CMS protocols for PIPs, including those requirements specified at 42 C.F.R. § 438.330, are followed and that all steps outlined in the CMS protocols for PIPs are documented.

16.7.7. The Contractor shall, in collaboration with EOHHS, identify benchmarks and set achievable performance goals for each of its PIPs. The Contractor shall identify and implement intervention and improvement strategies for achieving the performance goal set for each PIP to promote sustained improvements.

16.7.8. Each PIP shall be designed to achieve significant, measurable improvement, sustained over time, in health outcomes and Member satisfaction, and shall be completed in a reasonable time period so as to allow information on the success of PIPs in the aggregate to produce new information on quality of care every year. Each PIP shall include the following elements:

16.7.8.1. Measurement of performance using objective quality indicators.

16.7.8.2. Identification of benchmarks and set achievable performance goals for each of the PIPS.

16.7.8.3. Identification and implementation of interventions for achieving the performance goals set for each PIP and promoting sustained improvements.

16.7.8.4. Evaluation of the effectiveness of the interventions based on the objective quality indicators identified in this Section.

16.7.8.5. Planning and initiation of activities for increasing or sustaining improvement.

16.7.9. The results of each PIP shall be able to be validated by EOHHS or a contracted third-party.

16.7.10. The Contractor shall report the status and results of each PIP to EOHHS or its designees, as requested, but at least thirty (30) Days following presentation to the Contractor's QM/QI Committee.

16.7.11. Each project shall be completed in a reasonable time period to allow information on the success of PIPs in the aggregate to produce new information on quality of care every year. If a PIP will run for the duration of more than one (1) year, the Contractor is required to produce an annual report outlining the PIPs ongoing functions and impact for each year during the course of the PIP.

16.8. Written Work Plan

16.8.1. The Quality Program shall be included in a written document that clearly describes its organizational structure, processes, and includes an Annual Work Plan that identifies the objectives, performance goals, and quality improvement activities that will be undertaken that year. The Contractor shall submit a copy of the written Quality Program and Annual Work Plan during Readiness Review, annually thereafter, and upon modification.

16.8.2. The Annual Work Plan, at a minimum, shall:

16.8.2.1. Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results.

16.8.2.2. Include processes to evaluate the impact and effectiveness of the QAPI Program.

16.8.2.3. Include a description of the Contractor staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities.

16.8.2.4. Describe the role of its Providers in giving input to the QAPI Program.

16.8.2.5. Be specific to the Rhode Island Managed Care Program and not contain documentation from other state Medicaid programs or product lines

operated by the Contractor.

16.8.2.6. Describe the methods for ensuring data collected and reported to EOHHS is valid, accurate, and reflects Providers' adherence to clinical practice guidelines as appropriate.

16.9. QAPI Reporting

16.9.1. In accordance with the standards, reporting formats, and timetables established by EOHHS as set forth in the Medicaid Managed Care Manual, the Contractor shall measure and report at least annually its performance on:

16.9.1.1. EOHHS specified quality measures.

16.9.1.2. EOHHS specified measures associated with the EOHHS Pay for Performance Program.

16.9.1.3. CMS specified quality measures.

16.9.1.4. HEDIS® measures that support the EOHHS Comprehensive Quality Strategy.

16.9.1.5. EOHHS specified quality measures related to Home and Community Based Services (where applicable).

16.9.1.6. CMS Home and Community Based Services Quality Measure Set (where applicable)

16.9.1.7. Health disparity results including the methodology utilized to collect this data.

16.9.1.8. CAHPS® results.

16.9.1.9. PIP results.

16.9.1.10. Recommended new or improved QI activities.

16.9.1.11. Results of the evaluation of the impact and effectiveness of the QAPI Program.

16.9.2. EOHHS reserves the right to request additional reports as deemed necessary.

16.9.3. The Contractor shall provide data reports, including ad-hoc reports and reports for special populations using the specifications and format approved by EOHHS and required in the EOHHS Reporting Calendar found in the Managed Care Manual. The Contractor shall submit the reports based on the agreed upon dates established by the Contractor and EOHHS if not provided in the Reporting Calendar.

16.10. Evaluation

16.10.1. The Contractor shall conduct an annual evaluation of the Quality Program, inclusive of the QAPI and PIPs, to inform the written work plan and any updates to the Quality Program. This evaluation should include stratification of program results to assess equity in performance for different population groups, as well as breakout for dual eligible Members and Members receiving LTSS.

16.11. Additional Quality Assurance Reporting Requirements

16.11.1. The Contractor shall make internal quality assurance reports available to EOHHS upon request.

16.11.2. The Contractor shall perform medical record abstracts in selected quality assurance areas for use in external quality reviews.

16.11.3. At a minimum, the Contractor shall provide:

16.11.3.1. Four (4) selected quality assurance areas for RIte Care, including one (1) related to Children with Special Health Care Needs,

16.11.3.2. One quality assurance area for Rhody Health Partners;

16.11.3.3. One (1) quality assurance area for Members receiving LTSS (dual eligible Members and non-dual Members);

16.11.3.4. Others as requested by EOHHS.

16.11.4. EOHHS will provide the precise methodology for these abstracts. The Contractor shall work cooperatively with EOHHS in developing and implementing this methodology.

16.11.5. The Contractor shall provide the results of any quality improvement studies/projects and Medicaid HEDIS® and CAHPS® results no later than thirty (30) Days after presentation to the Contractor's Quality Improvement Committee.

16.12. Reporting, Accuracy, Completeness and Timeliness

16.12.1. Performance measures reported by the Contractor shall be accurate, complete, and timely. Failure to comply with these requirements may result in contractual remedies, including liquidated damages.

16.12.2. The Contractor shall cooperate fully with EOHHS or its designees in any efforts to validate PIPs or quality reporting.

16.12.3. The Contractor shall participate in joint quality improvement projects, as selected by EOHHS, involving Health Plans, AEs, and EOHHS.

16.13. Member Satisfaction

16.13.1. The Contractor shall collect Member satisfaction data for adults and children, or other populations or sub-populations as identified by EOHHS through an annual survey of a representative sample of its Members using a tool approved by EOHHS.

16.14. Provider Satisfaction

16.14.1. The Contractor shall collect Provider satisfaction data through an annual survey of a representative sample of the Contractor's Providers using a tool approved by EOHHS.

16.15. Mandatory Meetings

16.15.1. The Contractor shall attend monthly oversight meetings with EOHHS staff to review contract performance, compliance, quality assurance, and continuous quality improvement.

16.16. Clinical Data Exchange

16.16.1. The Contractor shall contract with a state-approved vendor to ensure the appropriate and timely exchange of clinical data related to their quality performance (i.e., HEDIS®).

16.17. External Quality Review

16.17.1. The Contractor is subject to annual, external independent review of the quality, timeliness and access to services covered under its contract and to external validation of its performance improvement plans.

16.17.2. The Contractor shall:

16.17.2.1. Cooperate fully with EOHHS or its designated EOHHS' EQRO in any efforts to independently review the Contractors' performance or validate performance improvement projects.

16.17.2.2. Comply with any requests for data from the EOHHS' EQRO in the conduct of any independent review or access-related focused studies, including requests from the EQRO regarding Home and Community Based Services access or quality.

16.18. EOHHS Pay for Performance Program

16.18.1. The Contractor shall participate in the EOHHS Pay for Performance Program as set forth in the Managed Care Manual.

16.18.2. In support of the state's quality goals, EOHHS has established a Pay for Performance Program supported by payment incentives that the Contractor may earn if certain conditions are met. The compensation under the Program is subject to the Contractor's achievement of performance measures and related targets in alignment with Rhode Island's Medicaid Managed Care Quality Strategy to support improved healthcare outcomes and financial savings.

16.18.3. The Program is designed percentage withhold from the Contractor capitation amount that can be earned back in full or in part by the Contractor through achievement of the designated performance measures. The amount increases based on the number of measures achieved. The total withhold amount starts at one and one-half percent (1.5%) and increases by one-quarter percent (0.25%) each Contract year, until it reaches two percent (2%) where it remains for the rest of the contract. The two percent (2%) withhold includes the one-half percent (0.5%) from the APM withhold pursuant to Section 15.18 of this Agreement.

16.18.4. In Contract Year 1 the non-APM portion of the withhold will be one percent (1%). In Contract Years 2 and 3, the non-APM portion of the withhold will increase by one-quarter percent (0.25%) each year so that the non-APM portion of the withhold for Contract Year 2 will be one and one-quarter percent (1.25%) and the non-APM portion of the withhold for Contract Year 3 through Contract Year 6 will be one and a one-half percent (1.5%).

Capitation Withhold by Contract Year			
Contract Year	**Pay for Performance Withhold (non-APM)**	**APM Withhold**	**Total Withhold**
Contract Year 1	1.0%	0.5%	1.5%
Contract Year 2	1.25%	0.5%	1.75%
Contract Year 3+	1.5%	0.5%	2.0%

16.18.5. The specific measures, weights, and targets for the Program are detailed in the Managed Care Manual.

16.18.6. EOHHS reserves the right to modify the Program, its performance measures, weights, or targets, at its sole discretion and in consultation with the Contractor, on a year-to-year basis during the Contract Term as program priorities shift and as necessary to support continuous quality improvement. For any performance measures selected, EOHHS shall consult with the Contractor regarding the methodology for qualifying the Contractor's success in achieving targets and related incentives. Note that if a performance measure is retired during the course of a performance period, EOHHS, at its sole discretion and in consultation with the Contractor, may replace the performance measure for that performance period.

16.18.7. The Pay for Performance Program is designed to support the transformation of the Rhode Island Medicaid program from one that pays for volume to one that pays for value and aligns with EOHHS Quality Strategy. As a requirement of participation, the Contractor shall:

16.18.7.1. Collect and accurately report data to EOHHS for all specified measures on a timetable and in a format specified by EOHHS in the Medicaid Managed Care Manual.

16.18.7.2. Factor in Health Equity into the Contractors decision making, its impacts on health and social outcomes for Members and opportunities for culturally competent care delivery. This may include analyzing performance at specific sub-population levels at EOHHS's discretion.

16.18.7.3. Participate in all required training and information sharing sessions pertaining to the Quality Incentive Program.

16.18.7.4. Collaborate with EOHHS to support improvements to the Pay for Performance Program.

16.18.7.5. Implement changes to the Pay for Performance Program as directed by EOHHS.

16.19. APM Withhold

16.19.1. Except as provided below, for each Contract Year, EOHHS will:

16.19.1.1. Withhold one-quarter percent (0.25%) from the Contractor's capitation payments pending demonstration the Contractor has met one hundred percent (100%) of the APM targets for AEs.

16.19.1.2. Withhold one-quarter percent (0.25%) from the Contractor's capitation payment pending demonstration the Contractor has met one hundred percent (100%) of the APM targets for non- AEs.

16.19.2. The withholds described above do not apply for the first two (2) Contract Years for a Health Plan who is a new entrant to Rhode Island's Medicaid Managed Care Program.

Article 17. Value-Based Payment and Alternative Payment Methodologies

17.1. Purpose

17.1.1. EOHHS seeks to significantly reduce the use of FFS payment to Managed Care Program Providers and to replace them with qualified APMs that incentivize better quality and more efficient delivery of Health Care Services. EOHHS seeks to increase the use of value-based payment strategies, both through the AE program and with non-AE Providers, and expects that its health plans will actively contribute to this strategy.

17.2. Qualified APMs

17.2.1. A qualified APM is a payment arrangement between the Contractor and AEs or other Network Providers that are within Categories 2 through 4 of the Health Care Payment Learning and Action Network (HCP-LAN, or LAN) APM Framework.

17.2.2. Payment arrangements in Category 2A are not considered qualified APMs.

17.2.3. For AEs, the Contractor's APM strategy shall conform to the "EOHHS Medicaid Managed Care: Alternative Payment Methodology Requirements," located in the Managed Care Manual.

17.2.4. For Network Providers, the Contractor's APM strategies shall include qualified APMs that conform to the EOHHS requirements. These APM arrangements shall be categorized into the following payment model classifications as defined by the LAN-APM framework:

17.2.4.1. Category 2 Fee for Service-Link to Quality and Value

17.2.4.2. Category 3 APM Built on Fee-For Service Architecture

17.2.4.3. Category 4 Population Based Payment

17.3. Requirement

17.3.1. The Contractor shall meet EOHHS APMs targets for both AEs and Network Providers and demonstrate progressive movement toward HCP-LAN Category 4 population-based payment methodologies.

17.3.2. The Contractor shall participate in primary care capitation policy, planning, and design processes led by OHIC and EOHHS and leveraging the technical expertise of contractors, including but not limited to Bailit Health and CTC-RI. Participation shall include attendance at relevant meetings, providing requested data, financial analysis, design preferences, and any other such effort to support the development of both financial and clinical models to enable implementation of primary care capitation. The Contractor shall also stimulate practice revenues under the designed model to test the efficacy of the model per guidance from EOHHS.

17.3.3. The Contractor acknowledges and agrees that EOHHS may require the development and implementation of primary care capitation models with its network contracted providers during the term of this Contract. If EOHHS develops and seeks to implement primary care capitation models, the Contractor shall implement the capitation models as determined by EOHHS.

17.4. EOHHS APM Targets

17.4.1. The APM Targets identified in this Section are conditionally effective based on the Contractor's total RI Medicaid product Members and the opportunity for AEs to reach minimum attributed lives from this Contractor. As such, the Contractor may have a separate withhold calculation until total RI Medicaid membership is at or exceeds ten-thousand (10,000) Members.

17.4.1.1. If the Contractor's total RI Medicaid membership is less than ten-thousand (10,000) Members, the entire APM withhold shall be based on the "Non-AE APM Targets" which shall consist of all attributed Members.

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

17.4.2. Subject to Section 17.4.1, the Contractor shall meet the following EOHHS defined AE APM target and non-AE APM targets:

17.4.2.1. AE APM Target: Beginning with the Contract Year 1 (July 1, 2025 – June 30, 2026), at least sixty percent (60%) of the Contractor's payments to AEs shall be made for Members attributed to an AE participating in a Total Cost of Care (TCOC) arrangement. If the Contractor has more than ten-thousand (10,000) Member lives in a Contract Year, the Contractor may enter into a different EOHHS-approved APM with AEs that have fewer than two- thousand (2,000) attributed Members. Members attributed to an AE participating in these EOHHS-approved APMs will count toward the numerator of the AE APM Target calculation, along with Members attributed to an AE participating in a TCOC arrangement. EOHHS will continue to monitor the AE market through the course of the Contract Year and adjust this target annually. AE APM Targets shall not include those Members that are Dually Eligible.

17.4.2.2. The Contractor shall meet the following EOHHS defined non-AE APM targets. These are separate targets related to qualified APMs with Network Providers who are not affiliated with an AE (non-AE Providers).

a) AE TCOC arrangements are excluded from the numerator of all calculations related to these targets; however, other qualified APMs with AE Providers can be included, along with qualified APMs with non-AE Providers. EOHHS-approved APMs that count toward the AE APM Target will also count toward the Non-AE APM Target.

b) In Contract Year 1 (July 1, 2025 – June 30, 2026), the Contractor shall complete the APM Reporting Template, as described in the Managed Care Manual, to meet the non-AE APM Target.

c) Below are the targets for each year, which gradually increase the proportion of payments made under qualified APMs.

d) For Contract Years 2 through 6, the Contractor's total payments to Network Providers through qualified APMs shall meet the following minimum standards:

Non-AE Targets					
LAN Category	**Contract Year 2**	**Contract Year 3**	**Contract Year 4**	**Contract Year 5**	**Contract Year 6**
Category 2B-C	At least **8%** of the medical portion of capitation shall be made to providers participating in Category 2B-C, 3, or 4 contracts	At least **11%** of the medical portion of capitation shall be made to providers participating in Category 2B-C, 3, or 4 contracts	At least **14%** of the medical portion of capitation shall be made to providers participating in Category 2B-C, 3, or 4 contracts	At least **17%** of the medical portion of capitation shall be made to providers participating in Category 2B-C, 3, or 4 contracts	At least **17%** of the medical portion of capitation shall be made to providers participating in Category 2B-C, 3, or 4 contracts
Category 3	At least **6%** of the medical portion of capitation shall be made pursuant to Category 3 or 4 contracts.	At least **7%** of the medical portion of capitation shall be made pursuant to Category 3 or 4 contracts.	At least **8%** of the medical portion of capitation shall be made pursuant to Category 3 or 4 contracts.	At least **9%** of the medical portion of capitation shall be made pursuant to Category 3 or 4 contracts.	At least **9%** of the medical portion of capitation shall be made pursuant to Category 3 or 4 contracts.
Category 4	At least **3%** of the medical portion of capitation shall be made pursuant to Category 4 contracts.	At least **4%** of the medical portion of capitation shall be made pursuant to Category 4 contracts.	At least **5%** of the medical portion of capitation shall be made pursuant to Category 4 contracts.	At least **6%** of the medical portion of capitation shall be made pursuant to Category 4 contracts.	At least **6%** of the medical portion of capitation shall be made pursuant to Category 4 contracts.

17.5. Changes to Targets

17.5.1. EOHHS reserves the right to review and modify the APM targets described above with advance notice to the Contractor.

17.6. APM Strategy and Implementation Plan

17.6.1. The Contractor shall develop an APM Strategy and Implementation Plan that outlines how it intends to achieve EOHHS' defined targets and describes the APM methodologies it intends to adopt, both for AE and non-AE providers. The APM Strategy shall conform to the "EOHHS Medicaid Managed Care: Alternative Payment Methodology Requirements" in the Managed Care Manual. The APM Strategy and Implementation Plan shall be submitted to EOHHS for review and approval during Readiness Review, annually thereafter and upon modification.

17.7. APM Reporting

17.7.1. The Contractor shall complete EOHHS' APM Reporting Template in accordance with the Managed Care Manual.

17.8. Enrollee Attribution in APM Arrangements

17.8.1. VBP models involve Enrollees being clearly attributed to providers for consideration of quality performance, and in some cases, total cost of care performance of the provider's attributed population, as defined in the APM model and payment arrangements. The Contractor shall develop and share its Attribution approach for APM arrangements with EOHHS and Network Providers in a transparent and accessible manner.

17.8.2. The Contractor shall collaborate with providers engaged in APM models to develop and maintain an accurate, up-to-date list of attributed Enrollees and associated providers. At least monthly, the Contractor shall share complete lists of attributed Enrollees with APM providers. At a minimum, the Contractor shall share performance and claims data for attributed Enrollees with APM providers on a quarterly basis.

17.8.3. For a APM arrangement that includes primary care, the Contractor shall attribute Enrollees to the same provider which has been selected, either by choice or assignment, as the Enrollee's PCP. The Contractor shall educate providers on how to access, utilize, and share data on attributed Enrollees.

17.8.4. Additional policies regarding APM requirements are contained within the Medicaid Managed Care Manual.

17.9. Mechanisms for Providers to Dispute Enrollee Attribution

17.9.1. The Contractor shall have a process by which a provider may dispute the Contractor's Attribution of an Enrollee in relation to a APM arrangement as it relates to the measurement of the provider's quality or financial performance in the model. The Contractor shall inform providers of such dispute process and must respond to and address provider complaints related to Enrollee Attribution within fifteen (15) Calendar Days of receipt.

17.9.2. For Attribution to PCPs, the Contractor shall attribute Enrollees to their assigned PCP.

17.9.3. The Contractor shall consider altering its Attribution and related PCP assignment when an Enrollee is regularly seeing a different provider for primary care services than the PCP to which the Enrollee has been attributed and when an Enrollee has not seen the attributed PCP in the past twelve (12) months.

17.9.4. The Contractor shall have clear methods for adjusting its PCP assignment and APM Attribution methodologies based on data analysis, and shall implement any EOHHS-directed PCP assignment and Attribution policies and methodologies to ensure uniformity across MCOs.

17.9.5. Additional policies regarding APM requirements are contained within the Medicaid Managed Care Manual.

17.10. Financial Benchmarks, Shared Savings Calculations, and Risk Mitigation

17.10.1. The Contractor's financial benchmarks in APM models shall incentivize high-quality, efficient care, enable accountability, and establish targets that fairly reward provider organizations. As part of its APM agreements, the Contractor shall not hold providers accountable for meeting a higher target for the incentive-based measure than the target to which EOHHS holds the MCO for the same measure unless the provider is already performing above the benchmark set by EOHHS for MCO performance on the incentive-based measure.

17.10.2. The Contractor shall risk-adjust provider payment rates when feasible and appropriate in APM models to reflect the risk of the attributed population.

17.10.3. The Contractor shall transparently communicate to providers the shared savings and risk-sharing parameters involved in participating in a APM model, such that providers can access the information they need to fully comprehend the opportunities and risks associated with participation. The Contractor shall clearly articulate when and how it will determine provider financial performance and how it will set the targets.

17.10.4. The Contractor shall offer providers in good standing and with prior APM experience with the Contractor the option to obtain a portion of anticipated APM payments prospectively based on interim financial and quality performance results rather than waiting for potential payments from shared savings calculations after the end of the performance period.

17.10.5. The Contractor shall offer providers an audit or appeal process on APM budget and shared savings or shared risk calculations.

17.10.6. For shared risk arrangements, the Contractor shall consider whether and how to use stop-loss or other risk protections in consultation with Network Providers, and consider provider size, financial stability, the potential for random variation in medical expenditures of a population, and a provider's APM experience. The Contractor shall share financial modeling data with providers to demonstrate potential changes in provider payments prior to accepting downside risk arrangements.

17.10.7. Additional policies regarding APM requirements are contained within the Medicaid Managed Care Manual.

17.11. Commitment to Work Collaboratively to Implement a Primary Care Capitation Model

17.11.1. Contractor agrees to work collaboratively with EOHHS during the term of the Agreement to develop a Primary Care Capitation Model (PCCM) for APMs.

17.11.1.1. EOHHS reserves the right to implement this during the term of the Agreement and the Contractor shall agree to timeframes for implementation established by EOHHS.

17.11.2. Capitation payments will be made monthly based on the enrolled Medicaid population assigned to the PCP. Rates will be adjusted based on factors such as beneficiary age, gender, geographic location, and risk score.

17.11.3. PCPs must adhere to specified quality and performance measures to ensure high standards of care. These measures will be monitored and may impact future capitation rates.

17.11.4. The capitation rate will be risk-adjusted to account for the varying health care needs and expense profiles of different beneficiary populations.

17.11.5. Providers are subject to regular financial audits to ensure appropriate use of capitation payments. Any discrepancies or fraudulent activities may lead to contract termination or legal action.

17.11.6. Members retain the right to choose their PCP and access primary care services in accordance with Medicaid rules and regulations and terms of this Agreement.

17.11.7. PCPs are required to submit regular reports detailing service utilization, patient outcomes, and other relevant data to facilitate ongoing monitoring and improvement of the capitation model.

17.11.8. The terms of the capitation agreement, including payment rates and service scope, are subject to periodic review and renegotiation to reflect changes in healthcare costs, regulations, and beneficiary needs.

17.11.9. Any disputes arising under this capitation arrangement will be resolved through a predefined dispute resolution process, ensuring timely and fair handling of any disagreements.

17.11.10. Provisions for contract termination and the orderly transition of beneficiaries to alternative care arrangements are outlined to ensure continuity of care.

17.11.10.1. This PCCM framework may be customized according to the specific requirements and regulations of EOHHS and the Rhode Island healthcare environment.

Article 18. Provider Network and Requirements, Access to Care

18.1. General Requirements

18.1.1. The Contractor shall establish and maintain a robust geographic Provider Network providing the full range of Covered Services described in Attachment F-4.1, "Schedule of In-Plan Benefits" and in accordance with State and Federal regulations and NCQA accreditation requirements. This includes preventive, primary, acute, behavioral health, substance use, and other specialty care, as well as long-term services and supports (including nursing home and community-based care). Covered Services shall be available and accessible to all Members in a timely manner without unreasonable delay in accordance with the access standards described in this Section.

18.2. Accessibility

18.2.1. The Contractor shall participate in the State's efforts to promote the delivery of Covered Services in a culturally competent manner to all Members including those with Limited-English Proficiency and diverse cultural and ethnic backgrounds, disabilities and regardless of sex.

18.2.2. The Contractor shall ensure its Network Providers provide physical access, reasonable accommodations, accessible equipment, and language assistance for Members who have Limited-English Proficiency or physical or mental disabilities.

18.2.3. To the extent possible and appropriate, Members shall have the opportunity to choose their Network Primary Care Provider, Women's Health Provider, or Family Planning Provider before the Contractor assigns them to such Providers.

18.3. Qualifications of Network Providers – General

18.3.1. Network Providers shall meet the qualifications described in this Article 18, "Provider Networks and Requirements, Access to Care."

18.4. Licensure

18.4.1. All Network Providers shall be appropriately licensed, certified, or registered in accordance with all applicable Rhode Island General Laws and Regulations or, if located in another jurisdiction outside of Rhode Island, in accordance with the health occupations regulatory requirements in the jurisdiction where the Provider practices.

18.5. Enrollment as a Participating Provider

18.5.1. All Participating Providers, including ordering and referring providers, shall be enrolled with the State as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. §§ 455 Subpart B, Subpart E, and 42 C.F.R. § 438.608(b). This provision does not require the Network Provider to render services to FFS Members.

18.6. Credentialing

18.6.1. All Network Providers shall be credentialed and recredentialed in accordance with NCQA standards (excluding HCBS providers), unless required for the provision of Medicare covered services and applicable Federal law, including 42 C.F.R. §§ 422.204 and 438.214(b), as may be amended, and the policies and procedures in this Section.

18.7. Credentialing Process

18.7.1. The Contractor shall have a documented process for credentialing and recredentialing Network Providers that, at minimum meets the following requirements:

18.7.1.1. Is supported by written policies and procedures.

18.7.1.2. Prohibits discrimination against particular Providers including those that serve high-risk populations or specialize in conditions that require costly treatment.

18.7.1.3. Includes sufficient safeguards and screening mechanisms to ensure the Contractor neither employs nor contracts with a provider who has been excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

18.7.2. If the Contractor declines to include an individual provider or a group of providers in its Network, the Contractor shall provide the applicant provider written notice of the reason for its decision and the right to appeal the decision to the Contractor.

18.8. Written Agreement

18.8.1. The Contractor shall execute written agreements with all Network Providers. When the Contractor contracts with Providers, it shall:

18.8.1.1. Not execute Provider agreements with Providers who have been debarred, suspended, or otherwise excluded from participation in Medicaid, CHIP or Medicare programs pursuant to Section 1128 or Section 1156 of the Social Security Act or who are not in good standing with RI Medicaid.

18.8.1.2. Not discriminate for the participation, reimbursement, or indemnification of Providers acting within the scope of their license or certification as defined by state law, solely on the basis of that license or certification.

18.8.1.3. Have policies and procedures to ensure Network Providers and office staff comply with the requirements of Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000D et seq.); Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 79420 U); Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.); Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 et. seq.); and all other Federal and State laws that prohibit discrimination.

18.8.1.4. Require that each individual or group Provider in the Network is assigned a unique identifier.

18.8.1.5. Not prohibit or restrict a Provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member regarding:

a) The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

b) Any information the Member needs to decide among all relevant treatment options.

c) The risks, benefits, and consequences of treatment or non-treatment.

d) The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

e) Take no punitive action against a Provider who either requests an expedited resolution or supports a Member's Grievance or Appeal.

f) Encourage Providers to use the State's Health Information Exchange ("CurrentCare"), including the hospital alert system and help high utilizing patients to enroll in CurrentCare.

18.8.2. The Contractor shall offer a contract to any willing Provider in the following classes that agrees to the terms of the Contractor's Network Provider Agreement, including the payment terms:

18.8.2.1. Federally Qualified Health Centers (FQHCs);

18.8.2.2. Rural Health Centers (RHCS);

18.8.2.3. All Medicaid enrolled BHDDH-licensed substance use disorder Providers;

18.8.2.4. All Medicaid enrolled DCYF Providers;

18.8.2.5. Community Mental Health Centers; and

18.8.2.6. All Medicaid enrolled LTSS providers that accept MCO contract provisions and meet all applicable licensing, credentialing, certification, and Medicaid requirements, including HCBS setting rules at 42 C.F.R. § 441.301 as applicable.

18.8.3. All physician incentive plan arrangements, as defined by 42 C.F.R. §§ 438.3(i) and 422.208(a), shall be in writing and included in the Network Provider Agreement. The Contractor is only allowed to operate physician incentive plans if payments do not incentivize Providers to reduce or limit Medically Necessary Covered Services. Incentive arrangements that place Providers at substantial financial risk shall include adequate stop-loss protections.

18.8.4. All Network Provider Agreements shall conform to and be consistent with the provisions of the EOHHS Medicaid Provider Agreement.

18.9. School-Based Clinics

18.9.1. The Contractor shall include all state-approved school-based clinics in its Network and allow these clinics to provide all Medicaid Covered Services available through the clinics.

18.9.2. The Contractor's Network Provider Agreements with school-based clinics shall be executed no later than the Effective Date of this Agreement.

18.10. Related Providers

18.10.1. The Contractor is prohibited from entering into an exclusive Provider agreement with any Provider entity that is associated with the Contractor through any form of common

ownership, control, or investment. This prohibition applies when the related-party arrangement is carried out through one (1) or more unrelated parties.

18.11. Provider Terminations

18.11.1. The Contractor shall comply with EOHHS' requirements for "Provider Terminations and Network Changes," in the Managed Care Manual.

18.11.2. In accordance with the EOHHS requirements, the Contractor shall provide EOHHS written notice of any actions undertaken to terminate or suspend a Network Provider due to Fraud, Waste, Abuse, or quality or program integrity concerns within five (5) Business Days of the Contractor's action.

18.11.3. The Contractor shall develop a written notification template, to be approved by EOHHS, informing Members of any Network Provider termination. The notification shall include information regarding the availability of assistance by Contractor to find a replacement provider, as well as Contractor's policies for honoring any prior authorized services with the terminated provider.

18.11.4. If a Network Provider is terminated, the Contractor shall provide written notice, based on the template approved by EOHHS, to Members who have received services from the Network Provider within the last twelve (12) months. The notice shall be sent to each applicable Member at least thirty (30) days prior to the effective date of the Network Provider's termination or immediately upon the Contractor becoming aware of the termination if prior notice is not possible.

18.11.5. If the Contractor terminates a Network Provider Agreement without cause, the Member's notification shall inform the Member of their ability to change their Health Plan and include a pre-paid return envelope.

18.12. Network Changes

18.12.1. The Contractor shall create written policies and procedures to address any Network Provider terminations and any changes to the Network that negatively impact Network composition or Members' ability to access Covered Services.

18.12.2. These policies and procedures shall comply with EOHHS' Provider Terminations and Network Changes Policy.

18.13. Notification to EOHHS

18.13.1. Section 17.19 describes the Member to PCP ratio applicable to this Agreement. The Contractor shall submit a monthly report on Member to PCP ratio and any changes in its Network composition. The Contractor shall take corrective action if the report indicates it does not comply with the required Member to PCP ratio.

18.13.2. The Contractor shall notify EOHHS of any Provider termination, regardless of whether the Provider or Contractor initiated the separation. This notification shall be submitted in writing, via email, and no later than three (3) Days from the date of notification of the Provider termination.

18.13.3. The Contractor shall complete all applicable forms described in the EOHHS Provider Terminations and Network Changes Policy no later than thirty (30) Days from the Provider termination notice.

18.13.4. The Contractor shall submit a Member Transition Plan to address changes in Network composition no later than fifteen (15) Days before the effective date of a Network Provider termination. The plan shall comply with the continuity of care requirements in Article 14, "Care Program and Continuity of Care."

18.14. Notification to Members

18.14.1. The Contractor shall make a good faith effort to give written notice of a Provider termination to all impacted Members regardless of whether the Provider or Contractor initiated the termination.

18.14.2. For purposes of this Section, and "impacted Members" include Members:

18.14.2.1. Attributed to a PCP, or

18.14.2.2. Who were seen on a regular basis by the Provider, as evidenced by receiving at least one (1) Covered Service from the Provider within the preceding twelve (12) months.

18.14.3. Upon request, the Contractor shall provide a Member an EOHHS Plan Change Request Form, including translated versions of the form, free of charge.

18.14.4. The Contractor shall document all Member outreach related to a Provider termination or Network change in accordance with EOHHS' "Provider Terminations and Network Changes Policy." The Contractor shall begin the Member outreach no later than fifteen (15) Days before the Provider's effective date of termination.

18.15. Network Development Plan

18.15.1. The Contractor shall develop and maintain a Network Development Plan that contains all of the following elements:

18.15.2. Addresses continuous recruitment and retention of new Providers.

18.15.3. Considers the importance of developing a diverse Provider Network that reflects the demographics and language preferences of the population served and has the capacity to provide services in a culturally competent manner to all Members.

18.15.4. Monitors Network adequacy against the standards set forth in this Agreement and the needs of Members.

18.15.5. Includes strategies to address identified gaps when Network adequacy falls below standards or is inadequate to meet Members' needs.

18.15.6. The Contractor shall allow Members to choose their Network Providers to the extent possible and appropriate.

18.15.7. Encourages providers to participate in both the Contractor's Medicaid and Medicare networks, as appropriate.

18.16. Network Considerations

18.16.1. In establishing and maintaining the network, the Contractor shall consider the following:

18.16.1.1. Anticipated number of Members enrolled in the Contractor's Health Plan.

18.16.1.2. Expected utilization of Covered Services, taking into consideration the characteristics and health care needs of Members for which the Contractor is, or will be, responsible.

18.16.1.3. The characteristic and health care needs of specific Member populations including children, adults, medically underserved populations, children and adults with serious chronic and/or complex health conditions, physical and/or mental disabilities, persons with Limited English Proficiency, Dual Eligible Members, and LTSS-eligible Members.

18.16.1.4. The number of Network Providers accepting new Medicaid patients, and whether there are a sufficient number of PCPs and other providers accepting new Medicaid patients to comply with this Section's access to care requirements.

18.16.1.5. The Network's ability to provide all children and adult Members the full continuum of Behavioral Health Benefits, including Substance Use Disorder Benefits.

18.16.1.6. A sufficient number of subspecialists or specialty Providers experienced in sexual abuse, domestic violence, rape, and dual diagnosis (mental health and substance use disorder) to meet the needs of the population served in a timely manner.

18.16.1.7. A sufficient number of Providers experienced in serving low-income populations, persons with polypharmacy and dual diagnosis in sufficient numbers to meet the needs of the population served in a timely manner.

18.16.1.8. Numbers and types (in terms of training, experience, and specialization) of Network Providers, specifically specialty Providers, required to furnish all Covered Services.

18.16.1.9. Geographic location of Providers and Members, considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities.

18.16.1.10. Ability of Network Providers to communicate with Members with Limited English Proficiency in their preferred language and provide Culturally competent care and services to all Members regardless of race, ethnicity, gender, or background.

18.16.1.11. Ability of Network Providers to support the health and wellness of people with disabilities through their disability knowledge, experience, and expertise.

18.16.1.12. Availability of triage lines or screening systems and the use of telemedicine or other evolving and innovative technological solutions.

18.17. Documentation

18.17.1. The Contractor shall submit documentation to support that is has established an adequate Provider Network, including a Network Development Plan demonstrating the Contractor:

18.17.1.1. Has the capacity to meet expected enrollment in accordance with the service accessibility requirements described in this Article 18, "Provider Networks and Requirements, Access to Care."

18.17.1.2. Offer an appropriate range of preventative, primary care, and specialty care that is adequate for the anticipated number of Members.

18.17.1.3. Maintain a Network that is sufficient in number, mix and geographic distribution to meet the anticipated number of Members.

18.17.2. Such documentation shall be provided to EOHHS for review and approval during Readiness Review in accordance with the timeframes described in EOHHS's Readiness Review Schedule, and on a quarterly basis thereafter. If EOHHS determines, either through an independent or CMS-led review, that the Contractor does not meet the minimum network adequacy requirements, EOHHS may require a gap analysis or corrective action plan to address the deficiency.

18.18. Primary Care Providers (PCPs)

18.18.1. The Contractor shall ensure every Member, excluding those that are Dually Eligible, has a PCP who serves as the Member's primary point of contact with the Contractor's Provider Network.

18.18.2. The Contractor shall have policies and procedures for assigning Members who have not selected a PCP at the time of enrollment to a PCP. The Contractor's assignment methodology shall consider:

18.18.2.1. The Provider's panel size and established relationship with the Member or the Member's household;

18.18.2.2. The proximity of the Provider's office to the Member's home; and

18.18.2.3. The Member's language needs and other demographic information.

18.18.2.4. The Provider's ability to comply with EOHHS and CMS specified access standards.

18.18.3. Where possible, the Contractor shall select NCQA accredited Patient Centered Medical Homes as PCPs. In addition, for Members with Special Health Care Needs, the Contractor's assignment methodology shall consider the Provider's ability to accommodate the Member's needs. In the event of a full panel, the algorithm for auto assignment shall allow a Provider to be skipped until the Provider has available capacity.

18.18.4. The Contractor shall submit its proposed PCP assignment methodology to EOHHS for

review and approval during Readiness Review and at least thirty (30) Days prior to modification. The Contractor is responsible for any costs associated with modifying the algorithm to meet EOHHS's specifications. The Contractor shall obtain EOHHS approval prior to implementation. Once this logic is approved, the Contractor shall operationalize the auto-assignment algorithm within sixty (60) Days or by the implementation date agreed to with EOHHS in its approval, whichever is later.

18.18.5. The Contractor is responsible for compliance with the algorithm at all times. EOHHS may request access to the algorithm or reports at any time to review compliance with algorithm standards. The Contractor may be subject to sanctions if found to be non-compliant.

18.18.6. The Contractor shall promptly notify the Member in writing or by phone with the following PCP information:

18.18.6.1. Name;

18.18.6.2. Location;

18.18.6.3. Office telephone number; and

18.18.6.4. How to change PCPs.

18.18.7. While the Contractor is not responsible for PCP assignment for dual eligible Members, the Contractor shall have a means of identifying the PCP of all Members and maintaining current PCP contact information to incorporate into the Members' medical records to improve care coordination.

18.19. Member to PCP Ratio

18.19.1. The Contractor agrees to maintain a ratio of PCPs to assigned Members of no more than fifteen hundred (1,500) Members to a single PCP.

18.20. Physical and Behavioral Health Integration

18.20.1. In accordance with Section 5.14, "Behavioral Health Innovation Plan," the Contractor shall develop strategies to promote integrated physical and behavioral health care through Network Providers.

18.20.2. The Contractor's strategies should promote Provider education, training, and incentives to increase screening, identification, and referral for behavioral health conditions commonly identified in primary care settings.

18.21. Patient-Centered Medical Homes (PCMH)

18.21.1. The Contractor shall include NCQA certified PCMHs in its Provider Network.

18.22. Self-Referrals

18.22.1. The Contractor shall allow Members to self-refer for the following Covered Services. Unless otherwise noted, the Contractor is not required to allow self- referral to Out-of-Network Providers:

18.22.1.1. Women's health/gynecological/family planning services – one (1) annual and up to five (5) GYN/Family Planning visits annually (includes Out-of-

Network Providers).

18.22.1.2. Behavioral Health Benefits.

18.22.1.3. Substance Use Disorder Benefits.

18.22.1.4. Abortion services (includes Out-of-Network Providers).

18.22.2. The Contractor's Member Handbook shall notify Members of the right to access these services without a referral from a PCP.

18.22.3. The Contractor's Care Program Plan shall include processes and procedures to coordinate self-referred care with PCPs.

18.23. Public Health Reporting

18.23.1. To assist in monitor and reporting of lead poisoning and other reportable diseases throughout the State, the Contractor shall:

18.23.2. Require Network Providers to submit to the RI Department of Health (RIDOH) State Health Laboratories specimens for HIV testing and mycobacteria (TB) analysis as well as blood lead samples as described in the Reporting and Testing of Infectious, Environmental, and Occupational Diseases (216-RICR-30-05-01).

18.23.3. Submit specimens from suspected cases of measles, mumps, rubella and pertussis or other infection diseases when required by the state to facilitate investigations of outbreaks.

18.23.4. Comply with all other directives of the Rhode Island Department of Health.

18.24. Equal Access to Network Providers (Mainstreaming)

18.24.1. Contractors who offer commercial or other health insurance products in Rhode Island shall have policies and procedures to ensure the following:

18.24.1.1. Network Providers may not treat Medicaid Members differently than other patients who are enrolled in non-Medicaid products.

18.24.1.2. A Network Provider who refuses to accept a referral of a new Medicaid Member shall be considered closed for all referrals and may not receive referrals of new patients insured through the Contractor's other insurance products.

18.24.1.3. Discriminatory practices with regard to Members such as separate waiting rooms, separate appointment days, separate physical locations, or preference to private pay.

18.24.2. Contractor agrees that all Participating Providers will accept all Members, including all eligible Medicaid populations contained in this Agreement, for treatment pursuant to the Rhode Island Code of Regulations, [210-RICR-30-05-2.13].

18.24.3. The Contractor agrees to have policies and procedures in place such that any provider credentialed and enrolled its network shall accept a Medicaid Member for treatment and cannot accept non-members for treatment and remain in the network.

18.24.4. The Contractor also agrees to accept responsibility for ensuring that network providers do not provide separate office space, examination rooms or otherwise segregate Medicaid Members in any way from other persons receiving services.

18.24.5. A violation of these terms may be considered a material breach and any such material breach may be grounds for termination of this Agreement under the provisions of Attachment F-2, Article 8.

18.24.6. When the Contractor becomes aware of a Network Provider's failure to comply with mainstreaming, the Contractor shall develop a written plan for coming into compliance with the Contract requirement for mainstreaming with the Network Provider within thirty (30) Calendar Days and provide the plan to EOHHS in writing.

18.24.7. The Contractor shall ensure that providers do not exclude treatment or placement of Enrollees for authorized behavioral health services solely on the basis of State agency (DCYF, BHDDH, EOHHS, DOC, etc.), discharge from an IMD or referral.

18.25. Networks Related to Native Americans

18.25.1. The Contractor is required to:

18.25.1.1. Demonstrate that there are sufficient I, Tribal, and Urban Indian (ITU) Providers in the Network to ensure timely access to services available under the contract for Native American Members who are eligible to receive services from such Providers.

18.25.1.2. Ensure that ITU Providers enrolled in Medicaid as Federally Qualified Health Centers (FQHCs) but are not participating in the Contractor's Network are paid an amount equal to the amount the Contractor would pay a FQHC that is Network Provider but is not an ITU, including any supplemental payment from the state to make up the difference between the amount the Contractor pays and what the ITU FQHC would have received under the FFF Program.

18.25.1.3. Ensure that ITU Providers that are not enrolled in Medicaid as a FQHC, regardless of whether they participate in the Contractor's network, has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health ServiceIIHS), or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State's FFS payment methodology.

18.25.1.4. Make timely payment to all I/T/U Providers in its Network in accordance with Section 26.8, "Timely Payment."

18.25.2. Permit any Native American who is enrolled in a non-Native American MCO and eligible to receive services from a participating I/T/U Provider to:

18.25.2.1. Choose to receive covered services from that I/T/U Provider, and

18.25.2.2. If that I/T/U Provider participates in the Network as a PCP, to choose that I/T/U as his or her PCP, as long as that Provider has capacity to provide the services.

18.26. Provider Services Department and Hotline

18.26.1. The Contractor shall establish, maintain, and appropriately staff a Provider Services Department, or similar organizational structure, and a toll-free Provider Services Hotline.

18.26.2. The Provider Services Hotline shall direct an incoming call to a single, integrated call center for providers, regardless of Medicare or Medicaid enrollment status or delegation of services. Staff shall be trained to respond to both Medicaid and Medicare inquiries. The Contractor shall utilize a call tree structure to manage incoming calls. Staff shall ensure warm transfer of telephone calls from Providers to the correct entity where appropriate. The Contractor may also employ an answer service or use an interactive voice response (IVR) to route calls as appropriate. The Provider Services Hotline shall be available to respond to Providers' questions, comments, and inquiries. This includes proving appropriate and timely responses regarding the following:

18.26.2.1. Eligibility and Benefits.

18.26.2.2. Prior Authorizations, referral requirements, Care Coordination and Network questions.

18.26.2.3. Assisting with Grievance and Appeals made on behalf of Members, and an escalation path, if requested.

18.26.2.4. Assisting Providers with questions concerning Member eligibility status.

18.26.2.5. Assisting Providers with Prior Authorization and referral procedures.

18.26.2.6. Assisting Providers with claims payment procedures and appeals.

18.26.2.7. Handling Provider complaints.

18.26.2.8. Assisting with Care Program requirements.

18.26.3. The Contractor shall operate the Provider Services Hotline at least during the regular business hours of 8 a.m. to 6 p.m. EST, including lunch hours, on all Business Days, in alignment with the State of Rhode Island's holiday schedule on the Rhode Island Secretary of State's website.

18.26.4. The Contractor shall develop policies and procedures that address staffing, training, hours of operations, access, response standards, and monitoring of the Provider Services Hotline that comply with the EOHHS call center performance standards outlined in Section 22.3.

18.26.5. The Contractor shall produce and disseminate a quarterly newsletter for Network Providers.

18.26.6. The Contract shall timely communicate changes in Covered Services, Member's rights and responsibilities, and other programmatic changes to Network Provider.

18.27. Provider Training

18.27.1. The Contractor shall have an ongoing Provider education and training program that at a minimum, addresses the following topics:

18.27.1.1. Network access and services accessibility requirements.

18.27.1.2. The equal access to treatment requirements described in Section 18.24.

18.27.1.3. An overview of EPSDT.

18.27.1.4. The Contractor's policies on Advance Directives and End of Life Care.

18.27.1.5. Billing.

18.27.1.6. Utilization Management and Prior Authorization.

18.27.1.7. Fraud, Waste and Abuse.

18.27.1.8. The Contractor's Health Equity Plan.

18.27.1.9. Cultural Competency, and the unique needs of Medicaid Members.

18.27.1.10. Provider reporting requirements, including Critical Incident reporting

18.27.1.11. Privacy and confidentiality.

18.27.1.12. Anti-bias workshops as outlined in Section 13.3, "Health Risk Assessment."

18.27.1.13. Member rights and responsibilities, including Grievances and Appeals.

18.27.1.14. Long-Term Services and Supports, including CFCM training.

18.27.1.15. Critical Incident Reporting

18.27.1.16. Integration and coordination of Medicare covered services.

18.27.1.17. Single claims submission process for Medicaid and Medicare claims.

18.27.2. The Contractor shall attend and require Providers to attend additional trainings as directed by EOHHS.

18.27.3. The Contractor shall conduct initial education and training for Network Providers at least thirty (30) Days before the Operational Start Date and within thirty (30) Days of a Provider joining the Contractor's Network.

18.28. Provider Contact Information

18.28.1. The Contractor shall require Providers to report any changes in demographic information, including addresses and telephone numbers, within five (5) Business Days of a change.

18.29. Provider Practice Changes

18.29.1. The Contractor shall require Providers to comply with the notice requirement in the EOHHS Network Changes or Provider Termination Policy, including sale, dissolution, and other changes in provider practices.

18.30. Provider Manual

18.30.1. The Contractor shall develop a Provider Manual and make it available to all Network Providers.

18.30.2. The Contractor may distribute the Provider Manual electronically (i.e., via website) as

long as Providers are notified about how to obtain the electronic copy and how to request a hard copy at no charge.

18.30.3. At a minimum, the Provider Manual shall contain the following information:

18.30.3.1. Description of the RI Medicaid Program and Covered Services.

18.30.3.2. Medical Necessity standards and clinical practice guidelines. PCP responsibilities.

18.30.3.3. Care Program requirements, including coordination and transition of care expectation.

18.30.3.4. Prior Authorization and referral requirements.

18.30.3.5. Members' rights and responsibilities. Reporting suspected Fraud, Waste, and Abuse. Medical record standards.

18.30.3.6. Claims submission requirements and payment policies. Important phone numbers.

18.30.3.7. The Contractor's or the Contractor service standards (access and availability). twenty-four (24)hour coverage requirements.

18.30.3.8. Long-term services and supports.

18.30.3.9. Medicare coordination.

18.30.3.10. Single claims submission process.

18.31. Network Adequacy and Access to Care

18.31.1. Pursuant to 42 C.F.R. § 438.68, the Contractor shall ensure the Provider Network adheres to the time and distance standards established by EOHHS, published on the EOHHS website, and outlined in this Article 18, "Provider Networks and Requirements, Access to Care." These standards are subject to change based on EOHHS review and may be modified by EOHHS at any time.

18.31.2. The Contractor shall create policies and implement procedures to monitor its compliance with all access and service availability standards. The Contractor shall submit these policies and procedures during Readiness Review, annually thereafter, and upon modification. The Contractor's policies shall comply with EOHHS' Provider Terminations and Network Changes Policy.

18.31.3. The Contractor shall at least quarterly conduct access and availability audits to validate Provider Network access of individual Providers. The Contractor shall review twenty-five percent (25%) of the combined network. Reviews shall include the use of "secret shopper calls" to collect information such as address, phone, email, and website; whether the Provider is participating in the Network; open/closed panel status; and/or appointment availability. The Contractor shall provide EOHHS with results of audits upon request. The Contractor shall take corrective action to remediate non-compliance and report all non-compliance to EOHHS within thirty (30) Days of the audit.

18.31.4. The Contractor shall take correction action to correct all Network deficiencies.

18.31.5. The Contractor shall comply with any requests for data from EOHHS' EQRO regarding access-related focused studies.

18.31.6. EOHHS has the right to review network adequacy and access to care standards at any time. If EOHHS determines that the Contractor's network may not meet the minimum network adequacy requirements or there are potential deficiencies, the State may require documentation regarding the potential deficiency and/or a plan of corrective action from the contractor. The contractor shall have up to fifteen (15) Business Days to correct any identified reporting deficiencies. Upon determination that a Contractor has failed to meet such requirements, EOHHS may require a correction action plan or impose other remedies, including imposing liquidated damages or suspending enrollment.

18.32. Time and Distance Standards

18.32.1. The Contractor shall ensure every Member has access to Providers meeting either the time or distance standard in this Section.

18.32.2. Members, in their sole discretion, may select a Provider located further away than the standards require.

18.32.3. Providers in state-specified Border Communities are considered to be in-state providers for the purpose of the Rhode Island Medicaid program per 210-RICR-20-00-3.

18.32.4. The time and distance standards in the following table apply statewide.

Provider Type	Time and Distance Standard *Provider office located within*
Primary Care Provider - Adult & Pediatric	Twenty (20) minutes or Twenty (20) miles from the Member's home
OB/GYN Specialty Care	Forty-five (45) minutes or Forty-five (45) miles from the Member's home
Outpatient Behavioral Health- Adult Prescriber	Thirty (30) minutes or Thirty (30) miles from the Member's home
Outpatient Behavioral Health- Pediatric Prescriber	Forty-five (45) minutes or Forty-five (45) miles from the Member's home
Outpatient Behavioral Health- Adult Non-Prescriber	Twenty (20) minutes or Twenty (20) miles from the Member's home
Outpatient Behavioral Health- Pediatric Non-Prescriber	Twenty (20) minutes or Twenty (20) miles from the Member's home

Provider Type	Time and Distance Standard *Provider office located within*
Outpatient Substance Abuse Treatment Prescribers	Thirty (30) minutes or Thirty (30) miles from the Member's home
Outpatient Substance Abuse Treatment Non-Prescribers	Twenty (20) minutes or Twenty (20) miles from the Member's home
Top Five Adult Specialties by Total Claims Volume	Thirty (30) minutes or Thirty (30) miles from the Member's home
Top Five Pediatric Specialties- by Total Claims Volume	Forty-five (45) minutes or Forty-five (45) miles from the Member's home
Hospital	Forty-five (45) minutes or Forty-five (45) miles from the Member's home
Ambulatory Surgery Center	Forty-five (45) minutes or Forty-five (45) miles from the Member's home
Imaging	Forty-five (45) minutes or Forty-five (45) miles from the Member's home
Dialysis	Thirty (30) minutes or Thirty (30) miles from the Member's home
Adult Day Centers	Twenty (20) minutes or Twenty miles from the Member's home
Pharmacy	Ten (10) minutes or Ten (10) miles from the Member's home
Assisted Living Facilities, , and other Community-Based LTSS Agencies	Twenty (20) minutes or Twenty (20) miles from the Member's home

18.33. Appointment Availability

18.33.1. The Contractor is responsible for ensuring Members can schedule appointments within the standards outlined in this Section. EOHHS reserves the right to conduct secret shopper surveys to determine compliance with these standards. If the Contractor does not comply with appointment accessibility standards, the Contractor will be subject to liquidated damages based on the number of months that the Contractor remains out of compliance.

18.33.2. Network Providers shall maintain hours of operation comparable to business hours under the Medicaid Program and no less than the business hours available to patients with commercial coverage.

18.33.3. The required services shall be in place within five (5) Days of a Member's need being determined.

18.33.4. The appointment accessibility standards in the following table apply statewide.

Appointment	Access Standard
Outpatient Mental Health an– SUD - Pediatric and Adult	Wait time of no more than ten (10) Days
Primary–Care - Pediatric and Adult	Wait time of no more than fifteen (15) Days
OB/GYN	Wait time of no more than fifteen (15) Days
Emergency Care	Immediately or referred to an emergency facility
Urgent Care Appointment	Within twenty-four (24) hours

18.34. Exceptions to Network Adequacy Standards

18.34.1. The Contractor may seek an exception to the network adequacy standards described in this Article 18, "Provider Networks and Requirements, Access to Care," by submitting a request and supporting evidence to EOHHS in writing.

18.34.2. EOHHS may, in its sole discretion, grant the Contractor's request for the exception. The EOHHS Contract Officer shall provide written notice of such acceptance.

18.34.3. All EOHHS-approved exceptions will expire one (1) year after they are granted unless otherwise specified in EOHHS' written notice. Exceptions will not automatically renew. The Contractor shall reapply for the exception at the end of each exception term and include supporting evidence in its application.

18.34.4. If EOHHS grants an exception, EOHHS will monitor access to that Provider type and may require the Contractor to comply with additional Network adequacy reporting requirements.

18.34.5. EOHHS will not grant an exception to the Network adequacy requirements for PCPs or for the network adequacy standards for primary care Providers or for any appointment availability standards as defined in Section 18.33, above.

18.35. Twenty-Four (24) Hour Coverage

18.35.1. The Contractor shall ensure Medically Necessary Covered Services are available through Network Providers twenty-four (24) hours a Day, seven (7) Days a week. The Contractor can satisfy this requirement by requiring PCPs to assume primary responsibility for twenty-four/seven (24/7) after hours and on call services.

18.35.2. PCPs may have on-call arrangements with other qualified Providers for urgent or emergent care, consistent with the Member Services Phone Line and Urgent and Emergent Phone Line outlined in Article 22 of this Contract. After-hours calls cannot

be answered by an automated answering service.

18.35.3. The Contractor shall educate Members on how to access services after regular business hours and on weekends. In addition, the Contractor shall have written policies and procedures on how Members can reach their Primary Care Providers for Emergency Medical Conditions and Urgent Medical Conditions.

18.35.4. Medicaid HCBS services shall be available twenty-four (24) hours a Day, seven (7) days a week to eligible Members.

18.36. Emergency Medical Services

18.36.1. In accordance with 42 C.F.R. § 438.114, the Contractor shall cover Emergency Medical Services for Members, including Emergency Medical Services related to a behavioral health or substance use disorder conditions. The Contractor cannot limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

18.36.2. Emergency Medical Services shall be available twenty-four (24) hours a Day, seven (7) Days a week and delivered upon Member presentation.

18.36.3. In covering and reimbursing for Emergency Medical Services, the Contractor shall:

18.36.3.1. Cover Emergency Medical Services regardless of whether that Provider is a contracted Provider. However, the Contractor may not reimburse out-of-network providers above the Medicaid FFS Program rate for the Emergency Medical Services.

18.36.3.2. Not deny payment for treatment when the Member has an Emergency Medical Condition or when a Representative of the Contractor instructs the Member to seek Emergency Medical Services.

18.36.3.3. Not deny payment for Emergency Medical Services because the Provider, hospital, or fiscal agent failed to notify the Contractor of the Member's screening and treatment within ten (10) Days of presentation for Emergency Services.

18.36.3.4. Cover subsequent screening and treatment needed to diagnose or stabilize the Member's condition.

18.36.4. The Contractor shall share the Federal and State requirements governing Emergency Services with Members in a clear, accurate, and standardized form at the time of enrollment and annually thereafter in accordance with the Member's Annual Notification as outlined in the Managed Care Manual.

18.37. Post-Stabilization Care Services

18.37.1. The Contractor shall cover Post-Stabilization Care Services in accordance with 42 C.F.R. §§ 438.114(e) and 422.113(c)(3). Post-Stabilization Care Services shall be available to meet the needs of Members following delivery of Emergency Medical Services and a hospital admission for an Emergency Medical Condition.

18.37.2. Generally, a Provider shall obtain Prior Authorization for Post-Stabilization Care

Services. The Contractor may either pre-approve such services or authorize services in accordance with the Managed Care Manual.

18.37.3. Notwithstanding the foregoing, the Contractor is responsible for paying for Post-Stabilization Care Services without Prior Approval, regardless of whether the services were delivered by a Network Provider or out-of-network provider, when the services maintain, improve, or resolve the Member's stabilized condition and the Contractor:

18.37.3.1. Did not respond to a request for Prior Authorization within one (1) hour;

18.37.3.2. Could not be contacted; or

18.37.3.3. Utilization Management representative and the treating physician could not reach an agreement concerning the Member's care and the Contractor's Medical Director or his or her designee was not available for consultation.

18.37.4. The Contractor is no longer financially responsible for non-prior-approved Post Stabilization Care Services provided by an out-of-network provider when:

18.37.4.1. A Network physician with privileges at the treating hospital assumes responsibility for the Member's care;

18.37.4.2. A Network physician assumes responsibility for the Member's care through transfer;

18.37.4.3. The Contractor's Utilization Management representative and the treating physician reach an agreement concerning the Member's care; or

18.37.4.4. The Member is discharged from the hospital.

18.37.5. The Contractor may not reimburse an out-of-network provider for Post Stabilization Care Services at a rate higher than the Contractor would use if the Member obtained services through the Medicaid FFS Program.

18.37.6. The Contractor shall share the Federal and State requirements governing Post Stabilization Care Services with Members in a clear, accurate, and standardized form at the time of enrollment and annually thereafter in accordance with the Member's Annual Notification as outlined in the Managed Care Manual.

18.38. Family Planning Services

18.38.1. The Contractor shall demonstrate its Network includes sufficient family planning Providers to ensure timely access to Family Planning Services.

18.38.2. In accordance with 42 C.F.R. § 431.51(b)(2), the Contractor shall provide Members freedom of choice among family planning Providers, including access to these services from out-of-network providers.

18.38.3. If a Member selects a out-of-network provider to deliver Family Planning Services, the Contactor shall cooperate with that Provider by establishing a relationship for accepting referrals from them for continued medical care and management and exchange of Member information. The Contractor may not deny the coverage of

Family Planning Services for a covered diagnostic, preventative, or treatment service solely on the basis that the diagnosis was made by an out-of-network provider.

18.39. Women's Health Services

18.39.1. shall provide female and assigned female at birth Members with direct access to a Network women's health specialist for covered care necessary to provide women's routine and preventative Health Care Services. This Provider will be in addition to the Member's PCP, if the PCP is not a women's health specialist.

18.39.2. The Contractor shall provide Members freedom of choice among women's health Providers, including access to these services from out-of-network providers.

18.39.3. The following Provider types are considered women's health specialists:

18.39.3.1. Obstetricians;

18.39.3.2. Gynecologists;

18.39.3.3. Certified nurse midwives;

18.39.3.4. Nurse Practitioners;

18.39.3.5. Doulas; and

18.39.3.6. Any other qualified health care professional specializing in women's health.

18.40. Services for Members with Special Needs

18.40.1. The Contractor shall allow Members with Special Healthcare Needs, as identified in 42 C.F.R. § 438.208(c)(1) and defined in this Agreement, direct access to specialists as medically appropriate. The Contractor may Prior Authorize the specialty care through a standing referral or an approved number of visits.

18.40.2. To facilitate Care Coordination, the Contractor shall require ongoing communication and collaboration between specialty Providers and the Member's PCP.

18.41. Reporting Out-of-Network Services

18.41.1. The Contractor is responsible for building a Network sufficient to provide all Covered Services. If the Contractor is not able to provide a Covered Service through Network Providers, it shall provide the service through an Out-Of-Network Provider in accordance with the requirements described in Article 14, "Care Program and Continuity of Care."

18.41.2. The Contractor shall report Out-Of-Network utilization by provider type as part of the monthly access reporting to EOHHS.

18.41.3. The Contractor shall submit copies of all data sharing agreements and report data shared with Out-Of-Network Service Providers to EOHHS pursuant to Articles 4 and 14 of this Agreement. All reports shall be submitted in a format and process prescribed by EOHHS.

18.42. Second Opinions

18.42.1. The Contractor shall ensure Members have access to second opinions regarding the use of any Medically Necessary Covered Service. Members shall be allowed to access second opinion from Out-of-Network Providers if a Network Provider is not available to the Member in accordance with 42 C.F.R. § 438.206(b)(3).

18.43. Provider Satisfaction Report

18.43.1. The Contractor shall collect Provider satisfaction data for all lines of business through an annual survey of a representative sample of the Contractor's Network Providers and provide to EOHHS upon request.

Article 19. Utilization Management

19.1. General Requirements

19.1.1. The Contractor shall develop a utilization management (UM) program for all Covered Services that facilitates the delivery of high quality, cost-efficient, and effective care.

19.1.2. The Contractor shall develop and maintain written program policies and procedures with defined structures and processes that meet NCQA standards.

19.1.3. The Contractor shall submit written policies and procedures to EOHHS or its designee for approval as part of Readiness Review and prior to any substantive changes. Policies and procedures shall include, but not be limited to:

19.1.3.1. The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;

19.1.3.2. Provisions for ensuring confidentiality of clinical information;

19.1.3.3. The reporting of Fraud and Abuse information identified through the program to EOHHS in accordance with 42 C.F.R. § 455.1(a)(1);

19.1.3.4. Policies and procedures to maintain, or require providers and contractors to maintain, an individual health record for each Enrollee, in accordance with the Managed Care Manual. The Contractor shall collect and provide health records to EOHHS upon request;

19.1.4. Where applicable, the requirement that each Member's record includes information needed to perform utilization reviews. This information must include, at least, the following:

19.1.4.1. Identification of the Enrollee;

19.1.4.2. The name of the Enrollee's physician;

19.1.4.3. Date of admission, and dates of application for and authorization of Rhode Island Medicaid Program benefits if application is made after admission;

19.1.4.4. The POC required under 42 C.F.R. §§ 456.80 and 456.180;

19.1.4.5. Initial and subsequent continued stay review dates described under 42 C.F.R. §§ 456.128, 456.133, 456.233 and 456.234;

19.1.4.6. Date of operating room reservation, if applicable; and

19.1.4.7. Justification of emergency admission, if applicable.

19.1.5. All documentation and/or records maintained by the Contractor, its Material Subcontractors, and its Network Providers related to MCO Covered Services, charges, operations and agreements under this Agreement shall be maintained for at least ten (10) calendar years after the last good, service or supply has been provided to an Enrollee or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or

federal government. Under no circumstances shall the Contractor or any of its Material Subcontractors destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of EOHHS.

19.1.6. The Contractor shall submit utilization management reports as specified by EOHHS.

19.2. Utilization Management Program and Plan

19.2.1. The Contractor shall have a Utilization Management (UM) Program in place that includes written policies and procedures for processing requests for initial and continuing authorizations of services. The UM Program shall facilitate the delivery of high quality, cost efficient and effective care.

19.2.2. The Contractor's Utilization Management activities shall include:

19.2.2.1. Authorization of Covered Services, including modification of denial or request for such services; assisting providers to effectively provide inpatient discharge planning; behavioral health treatment and discharge planning; monitoring and assuring the appropriate utilization of specialty services, including behavioral health;

19.2.2.2. Providing training and supervision to the Contractor's Utilization Management clinical staff and health care professionals on the standard application of medical necessity criteria and Utilization Management policies and procedures to ensure that staff maintain and improve their clinical skills;

19.2.2.3. Utilization Management policies, practices, and data reporting to ensure that it is standardized across all health care professionals within the Provider Network; and

19.2.2.4. The consistent application and implementation of the Contractor's clinical criteria and guidelines, including the behavioral health clinical criteria approved by EOHHS.

19.2.2.5. If the Contractor elects to delegate utilization management functions, it shall do so in accordance with the standards outlined in Article 2 and in compliance with NCQA delegation standards.

19.2.3. The Contractor shall assume responsibility for all Covered Services authorized by EOHHS or a previous Contractor, which are rendered after the enrollment effective date, in accordance with the continuity of care policies as described in Section 14.7, "Continuity of Care for New Members." The UM Program shall follow a written UM Program Plan that clearly defines the Program's organizational structure, standards, and policies and procedures.

19.2.3.1. The UM Program Plan description shall include procedures to evaluate medical necessity, criteria used, information source, and the process used to review and approve or deny the provision of medical and long-term care services.

19.2.3.2. The Contractor's Utilization Management program shall ensure consistent application of review criteria for authorization decisions; and shall consult with the requesting health care professional when appropriate.

19.2.3.3. The program shall demonstrate that Members have equitable access to care across the network and that Utilization Management decisions are made in a fair, impartial, and consistent manner that serves the best interests of the Members and in accordance with the CFCM requirements.

19.2.3.4. The program shall reflect the standards for Utilization Management from the most current NCQA Standards when applicable.

19.2.3.5. The program shall have mechanisms to detect under-utilization and/or over-utilization of care including, but not limited to, provider profiles.

19.2.3.6. An electronic copy of the UM Program Plan shall be submitted to EOHHS for review and approval during Readiness Review, annually thereafter, and upon modification.

19.2.4. At a minimum, the UM Program Plan shall include policies and protocols to:

19.2.4.1. Ensure consistent review criteria for authorization decisions, and that required Covered Services are not arbitrarily denied or reduced in amount, duration, or scope solely because of diagnosis, type of illness, or condition of the Member.

19.2.4.2. Ensure each Member's record includes the information described in 42 C.F.R. § 456.111.

19.2.4.3. Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the Member's medical, behavioral health, or long-term service and support needs.

19.2.4.4. Provide for consultation with the requesting Provider for medical services when appropriate.

19.2.4.5. Identify overutilization and underutilization of services and take corrective action, as appropriate.

19.2.4.6. Ensure compliance with notice and timeliness standards in accordance with CMS regulations and this Agreement.

19.2.4.7. Ensure any LTSS covered by this Agreement are based on the Member's current needs assessment and consistent with the Person-Centered Care Plan. The Contractor shall authorize LTSS to meet LTSS-eligible Members' needs for assistance with ADLs and Instrumental Activities of Daily Living (IADLs). The Contractor shall consider the Member's need for physical assistance as well as prompting or monitoring in order for the Member to perform an ADL or IADL. Authorizations shall also consider

the medical and independent living needs and preferences of the Member. The Contractor shall report all reductions, suspensions, or terminations of LTSS to EOHHS.

19.2.4.8. Ensure coverage parity between Mental Health/Substance Abuse benefits and Medical/Surgical benefits in accordance with Section 5.13, "Mental Health Parity Requirements."

19.2.4.9. Provide a mechanism to interface with the Contractor's Program Integrity responsibilities under Article 24.

19.2.4.10. Routinely assess the effectiveness and the efficiency of the Utilization Management program;

19.2.4.11. Evaluate the appropriate use of medical technologies, including medical procedures, diagnostic procedures and technology, behavioral health treatments, pharmacy formularies, and devices;

19.2.4.12. Target areas of suspected inappropriate service utilization (detect over and under-utilization);

19.2.4.13. Routinely generate provider profiles regarding utilization patterns and compliance with utilization review criteria and policies (including a system to identify utilization patterns by significant data elements and established outlier criteria for all services);

19.2.4.14. Compare Member and provider utilization with norms for comparable individuals and network providers;

19.2.4.15. Routinely monitor inpatient admissions, emergency room use, ancillary, out-of-area services and out-of-network services as well as Behavioral Health Inpatient and Outpatient Services and diversionary services;

19.2.4.16. Ensure that treatment and discharge planning are addressed at the time of authorization and concurrent review and that the treatment planning includes coordination with PCP, other Health Care Professionals and other supports identified by the Member as appropriate;

19.2.4.17. Conduct retrospective and peer reviews of the medical records of selected cases to assess the medical necessity and whether services were authorized and billed in accordance with requirements;

19.2.4.18. Consider clinical appropriateness of care and duration and level of care; and

19.2.4.19. Provide for referral of suspected cases of Health Care Professional or Member fraud or abuse to Medicare and EOHHS.

19.3. UM Program Structure

19.3.1. As described in Section 1.7.14, "Chief Medical Officer," the Contractor's Chief Medical Officer is responsible for development, implementation, and oversight of the Contractor's UM Program. The Contractor shall also have one (1) or more Medical

Officer's designees available to enable the timely review of service authorization requests and provide program consultation regarding behavioral health Utilization Management. The designee shall be board certified or board-eligible in psychiatry and be available twenty-four (24) hours per Day, seven (7) Days a week for consultation and decision-making with the Contractor's clinical staff and Health Care Professionals.

19.3.2. Utilization Management staffing shall be in compliance with all Federal, State, and local professional licensing requirements and include the following:

19.3.2.1. Representative from appropriate specialty areas (at minimum having available staff with expertise in cardiology, epidemiology, obstetrics and gynecology, psychiatry, substance abuse disorders, geriatrics, and any other area of expertise as required to meet the needs of Contractor's Members;

19.3.2.2. Have at least two (2) or more years in managed care or peer review activities or both;

19.3.2.3. Have no disciplinary actions or other type of sanction ever taken against them in any state or territory, by the relevant professional licensing board or Medicare and Medicaid; and

19.3.2.4. Have no legal sanctions related to their professional practice, including but not limited to malpractice actions resulting in entry of judgment against him or her, unless otherwise agreed to by Medicare and EOHHS.

19.3.3. The UM Program shall include a UM Committee that is responsible for:

19.3.3.1. Reviewing and approving the UM Program Plan including its policies and procedures.

19.3.3.2. Monitoring the UM Program on an ongoing basis in accordance with the requirements of Section 19.4, below.

19.3.3.3. Monitoring for updates to EOHHS clinical coverage criteria, evidence-based nationally recognized Medical Necessity guidelines, and other professional literature to inform and update the Contractor's clinical coverage policies and criteria.

19.3.3.4. Evaluating and updating the UM Program requirements at least annually.

19.3.3.5. Ensuring that staff responsible for rendering UM decisions are appropriately licensed with sufficient clinical expertise to review and render Prior Authorization decisions and are supervised by appropriately licensed clinical professionals.

19.3.3.6. Reviewing, updating, and approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task;

19.3.3.7. Monitoring the medical appropriateness and necessity of health care

services provided to its members;

19.3.3.8. Monitoring providers' requests for Prior Authorization of health care services to its members;

19.3.3.9. Monitoring consistent application of Service Authorization criteria;

19.3.3.10. Monitoring over- and under-utilization;

19.3.3.11. Review of Outliers; and

19.3.3.12. Monitoring of health record reviews.

19.4. UM Program Monitoring

19.4.1. The Contractor is responsible for ongoing monitoring and oversight of its UM Program and making necessary updates when deficiencies are identified.

19.4.2. Monitoring activities shall include:

19.4.2.1. Reviewing the timeliness of service authorizations.

19.4.2.2. Monitoring for consistency in the application of service authorization criteria.

19.4.2.3. Assessment of whether the Contractor's Prior Authorization procedures unreasonably limit Member access to Covered Services.

19.4.2.4. Reviewing services subject to Prior Authorization to determine if there is ongoing need for Prior Authorization to ensure appropriate utilization of services.

19.4.2.5. Using Provider feedback to identify opportunities to standardize and streamline service authorization processes to reduce administrative burden for Providers.

19.5. Standard Authorization Decisions

19.5.1. For standard authorization decisions, excluding those for pharmacy services described in Article 6, the Contractor shall provide notice to the Member or their Authorized Representative, and the requesting or treating Provider, as expeditiously as the Member's condition requires but no later than fourteen (14) Days following the receipt of the request for services.

19.5.2. The timeframes for standard authorization decisions may be extended by fourteen (14) Days if the Member requests an extension or the Contractor justifies a need for additional information and the Contractor can demonstrate how the extension is in the Member's interest.

19.5.3. For the processing of requests for initial and continuing authorizations of Covered Services, the Contractor shall:

19.5.3.1. Have in place and follow written policies and procedures;

19.5.3.2. Have in place procedures to allow Members to initiate requests for provision of services;

19.5.3.3. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions;

19.5.3.4. Ensure adherence to the requirements of CFCM; and

19.5.3.5. Consult with the requesting provider when appropriate.

19.5.4. Contractor shall ensure that Members have access to timely authorization of Medically Necessary Services twenty-four (24) hours per day, seven (7) days a week, including, if necessary, the transfer of the Member who presented to an emergency department with an emergency medical condition that has been stabilized. The Contractor's Medical Necessity guidelines shall, at a minimum, be no more restrictive than Medicare standards for acute services and prescription drugs and fee-for-service Medicaid standards for LTSS and community mental health and substance abuse services.

19.5.5. The Contractor's denial process shall follow NCQA standards and additional process requirements as listed in the Managed Care Manual.

19.5.6. In accordance with Section 23.7.3, if following the timeframe for a standard service authorization would seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function the Contractor shall make an expedited authorization decision and provide notice to the Member and the requesting or treating provider as expeditiously as the Member's health conditions requires but no later than seventy-two (72) hours after the receipt of the request for services. The Contractor may extend the seventy-two (72) hour time period by up to fourteen (14) Days if the Member requests an extension or the contractor justifies to the EOHHS a need for additional information and how the extension is in the Member's best interest.

19.5.7. For an urgent concurrent request for Medicaid or Medicare Part B coverage of pharmacy benefits, a coverage decision shall be made within twenty-four (24) hours of receipt of the request.

19.6. Denials for Out-of-Network Services

19.6.1. The Contractor shall send formal written notice to Members, their Authorized Representative, and their Provider for denials of Out-of-Network services if the services were delivered six (6) months after the Member's enrollment into the Health Plan and there is no existing Prior Authorization requiring the Contractor to extend the six-month (6) transition of care period.

19.7. Compensation Arrangements

19.7.1. The Contractor shall demonstrate to EOHHS that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Covered Services to any Member.

19.8. Behavioral Health Service Authorizations

19.8.1. The Contractor shall have policies and procedures for conducting utilization review for Behavioral Health Services, including SUD services, that comply with EOHHS

policy as set forth in the Managed Care Manual and Section 5.11, "Court Ordered Behavioral Health Benefits."

19.8.2. For Behavioral Health Services, a clinical interpretation and clinical judgement from a mental health professional is required for service authorization approvals or denials.

19.8.3. The Contractor shall respond to the provider's service authorization submission within two (2) calendar days for requests for placement at behavioral health outpatient or partial hospitalization programs as these services are deemed as urgent.

19.9. Services Requiring Prior Authorizations

19.9.1. When notifying a Member, their Authorized Representative, and the Provider of a service authorization, include an Adverse Benefit Determination, the Contractor shall:

19.9.2. Comply with all timely and adequate notice requirements as specified in this Agreement and 42 C.F.R. § 438.404(c).

19.9.3. Ensure notices and the content thereof are accessible to individuals with Limited English Proficiency and to people with disabilities in accordance with the requirements of 42 C.F.R. § 438.10(a).

19.10. Other Service Authorization Provisions

19.10.1. Service authorization requests for Members under twenty-one (21) shall be reviewed and authorized consistent with EPSDT criteria.

19.10.2. The Contractor shall ensure that service authorization requirements do not apply to emergency services or family planning services.

19.10.3. In accordance with 42 C.F.R. § 438.3, the Contractor or its PBM shall provide decisions for all covered outpatient drug authorizations by telephone or other telecommunication device within twenty four (24) hours of a request for authorization, in accordance with Section 1927(d)(5)(A) of the Social Security Act. Decisions shall be made in a manner that complies with NCQA standards.

19.11. Adverse Benefit Determination and Appeal

19.11.1. The Contractor shall provide a written Notice of Adverse Benefit Determination or a Coverage Decision Letter to the requesting provider and the Member for service authorization decisions. The content and timing of the notice shall meet the requirements of 42 C.F.R. § 438.404. Members may appeal decisions regarding medical necessity per the appeal standards outlined in this contract.

19.12. Expedited Service Authorization

19.12.1. In the event a provider indicates, or the Contractor determines, that following the standard Service Authorization timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization determination and provide notice as expeditiously as the Enrollee's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.

19.12.2. The Contractor may extend the seventy-two (72) hour time period by up to fourteen

(14) Calendar Days if the Enrollee requests the extension or if the Contractor justifies to EOHHS a need for additional information and how the extension is in the Enrollee's best interest.

19.13. Post Authorization

19.13.1. The Contractor shall make retrospective review determinations within thirty (30) Calendar Days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred eighty (180) Calendar Days from the date of receipt of request for Service Authorization.

19.13.2. The Contractor shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous Service Authorization approval, unless the approval was based upon a material omission or misrepresentation about the Enrollee's health condition made by the provider.

19.13.3. The Contractor shall not use a policy with an effective date subsequent to the original Service Authorization request date to rescind its Prior Authorization.

19.14. Notices of Determinations

19.14.1. Service Authorization Approvals

19.14.1.1. For Service Authorization approval for a non-emergency admission, procedure or service, the Contractor shall notify the provider verbally or as expeditiously as the Enrollee's health condition requires but not more than one (1) Business Day of making the initial determination and provide written notification to the provider within two (2) Business Days of making the determination.

19.14.1.2. For Service Authorization approval for extended stay or additional services, the Contractor shall notify the provider rendering the service, whether a health care professional or facility or both, and the Enrollee receiving the service, verbally or as expeditiously as the Enrollee's health condition requires but not more than one (1) Business Day of making the initial determination and shall provide written notification to the provider within two (2) Business Days of making the determination.

19.14.2. Adverse Action

19.14.2.1. The Contractor shall notify the Enrollee, in writing using language that is easily understood by the Enrollee, of determinations to deny a Service Authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in the Enrollee Grievances, Appeals and State Fair Hearings section. The notice of action to Enrollees shall be consistent with requirements in 42 C.F.R. §§ 438.404, 438.10 and 438.210, the Marketing and Education section for Enrollee written materials, and any agreements that the Department may have entered into relative to the contents of Enrollee notices of denial or partial denial of services, regardless of whether such agreements are

related to legal proceedings or out-of-court settlements.

19.14.2.2. The Contractor shall notify the requesting provider of a determination to deny an authorization or reauthorization request or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested. The Contractor shall provide written notification to the provider rendering the service, whether a health care professional or facility or both, within two (2) Business Days of making the determination.

19.14.3. Informal Reconsideration

19.14.3.1. As part of the Contractor's Appeal Procedures, the Contractor shall include an Informal Reconsideration process that allows the Enrollee (or provider/agent on behalf of an Enrollee) a reasonable opportunity to present evidence, and allegations of fact or law, in person and in writing.

19.14.3.2. In a case involving an initial determination or a concurrent review determination, the Contractor shall provide the Enrollee or a provider acting on behalf of the Enrollee and with the Enrollee's written consent an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination [42 C.F.R. § 438.402(c)(1)(ii)].

19.14.3.3. The informal reconsideration shall occur within one (1) Business Day of the receipt of the request and shall be conducted between the provider rendering the service and the Contractor's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) Business Day.

19.14.3.4. The Informal Reconsideration does not extend the thirty (30) Calendar Day required timeframe for a Notice of Appeal Resolution.

19.15. Service Authorization Requirements for New Enrollees

19.15.1. General Requirements

19.15.1.1. The Contractor shall not require Service Authorization for the continuation of medically necessary MCO Covered Services of a new Enrollee transitioning into the Contractor, regardless of whether such services are provided by an in-network or out-of-Network Provider, however, the Contractor may require Prior Authorization of services beyond thirty (30) Calendar Days.

19.15.1.2. For the first thirty (30) Calendar Days of Enrollment, the Contractor is prohibited from denying Prior Authorization solely on the basis of the provider being an out-of-Network Provider.

19.15.2. Pregnancy

19.15.2.1. In the event a new Enrollee is in the first trimester of pregnancy and is actively receiving medically necessary covered prenatal care services at

the time of Enrollment, the Contractor shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal, without any form of authorization needed and without regard to whether such services are being provided by a network or non-Network Provider until such time as the Contractor can reasonably transfer the Enrollee to a Network Provider without impeding service delivery that might be harmful to the Enrollee's health.

19.15.2.2. In the event a new Enrollee is in her second or third trimester of pregnancy and is actively receiving medically necessary covered prenatal care services at the time of Enrollment, the Contractor shall be responsible for providing continued access to the prenatal care provider (whether network or non-Network Provider) for sixty (60) Calendar Days postpartum, provided the Enrollee remains covered through Contractor, or referral to a safety net provider if the Enrollee's eligibility terminates before the end of the postpartum period.

19.15.2.3. In the event a new Enrollee is actively receiving medically necessary Covered Services other than prenatal services at the time of Enrollment, the Contractor shall be responsible for the costs of continuation of such medically necessary services, without any form of authorization needed and without regard to whether such services are being provided by network or non-Network Providers. The Contractor shall provide continuation of such services up to ninety (90) Calendar Days or until the Enrollee may be reasonably transferred to an in-Network Provider without disruption, whichever is less. The Contractor may require Prior Authorization for continuation of the services beyond thirty (30) Calendar Days; however, the Contractor is prohibited from denying authorization solely on the basis that the provider is a non-contract provider.

19.15.3. The Contractor shall ensure that the Enrollee is held harmless by the provider for the costs of the above medically necessary MCO Covered Services.

19.15.4. Special Health Care Needs

19.15.4.1. Where a new Enrollee with SHCN is actively receiving medically necessary MCO Covered Services at the time of Enrollment, the Contractor shall provide continuation/coordination of such services up to ninety (90) Calendar Days or until the Enrollee may be reasonably transferred to a Network Provider without disruption, whichever is less. The Contractor may require Prior Authorization for continuation of the services beyond thirty (30) Calendar Days; however, the Contractor is prohibited from denying authorization solely on the basis that the provider is a non-contract provider.

19.15.5. Maintenance Medications

19.15.5.1. The Contractor shall submit for approval, a transition of care program that

ensures Enrollees can continue treatment of maintenance medications for at least sixty (60) Calendar Days after Enrollment with the Contractor or switching from one plan to another. The Contractor shall continue any treatment of antidepressants and antipsychotics for at least sixty (60) Calendar Days after Enrollment with the Contractor. Additionally, an Enrollee that is, at the time of Enrollment with the Contractor, receiving a prescription drug that is not on the PDL shall be permitted to continue to receive that prescription drug if medically necessary for at least sixty (60) Calendar Days.

19.15.6. DME, Prosthetics, Orthotics, and Certain Supplies

19.15.6.1. In the event an Enrollee who is newly enrolled with the Contractor is actively receiving Medicaid covered durable medical equipment, prosthetics, orthotics, and certain supplies services at the time of Enrollment, whether such services were provided by another MCO or FFS, the Contractor shall be responsible for the costs of continuation of these services, without any form of authorization and without regard to whether such services are being provided by network or non-Network Providers. The Contractor shall provide continuation of such services for up to ninety (90) Calendar Days or until the Enrollee may be reasonably transferred to a Network Provider (within the timeframe specified in this Contract) without disruption, whichever is less.

19.15.6.2. The Contractor shall also honor any Prior Authorization for durable medical equipment, prosthetics, orthotics and certain supplies services issued while the Enrollee was enrolled in another MCO or FFS for a period of ninety (90) Calendar Days after the Enrollee's Enrollment.

19.16. Other Service Authorization Requirements

19.16.1. The Medicaid Director, in consultation with the Medicaid Medical Director, may require the Contractor to authorize services on a case-by-case basis.

19.16.2. The Contractor shall not deny continuation of higher-level services (e.g., inpatient hospital or PRTF) for failure to meet medical necessity unless the Contractor can provide the service through an in-network or out-of-Network Provider at a lower level of care.

19.16.3. The Contractor shall utilize a common hospital observation policy that is developed and maintained collectively by the MCOs with approval by EOHHS in writing. Any revisions shall be reviewed and approved by EOHHS in writing at least thirty (30) Calendar Days prior to implementation.

19.16.4. The Contractor shall perform Prior Authorization and concurrent utilization review for admissions to inpatient general hospitals and concurrent utilization review for psychiatric admissions to inpatient general hospitals, specialty psychiatric hospitals in Rhode Island or out-of-state.

19.16.5. The Contractor shall ensure that initial and concurrent inpatient psychiatric hospital

utilization reviews are completed by a Qualified Mental Health Professional (QMHP) or psychiatrist for each Member.

19.16.6. The Contractor should coordinate the development of Service Authorization policies with other MCOs where appropriate to avoid providers receiving conflicting policies from different MCOs.

19.16.7. The Contractor shall not require Service Authorization for:

19.16.7.1. Emergency Services or post-stabilization services as described in this Section whether provided by an in-network or out-of-Network Provider;

19.16.7.2. Non-emergency inpatient hospital admissions for normal newborn deliveries; and

19.16.7.3. EPSDT screening services.

19.17. Health Record Review

19.17.1. By sampling or other methods and on a regular basis, the Contractor shall verify that services for which reimbursement was made were provided to Members as billed.

19.17.2. The Contractor shall maintain a written strategy for conducting health record reviews, reporting results and the corrective action process. The strategy shall be provided to EOHHS or its designee for approval as part of Readiness Review and sixty (60) Calendar Days prior to the implementation of any updates. The strategy shall include, at a minimum, the following:

19.17.2.1. Designated staff to perform this duty;

19.17.2.2. The method of case selection;

19.17.2.3. The anticipated number of reviews by practice site;

19.17.2.4. The tool the Contractor shall use to review each site;

19.17.2.5. How the Contractor shall link the information compiled during the review to other Contractor functions (e.g. quality improvement [QI], credentialing, peer review, etc.); and

19.17.2.6. Schedule of reviews by provider type.

19.17.3. The standards, which shall include all health record documentation requirements addressed in the Contract, shall be distributed to all providers.

19.17.4. The Contractor shall conduct reviews at all PCP sites with fifty (50) or more linked Enrollees and practice sites which include both individual offices and large group facilities. The Contractor shall review each site at least one (1) time during each two (2) year period.

19.17.5. The Contractor shall review a reasonable number of records at each site to determine compliance. Five (5) to ten (10) records per site is a generally accepted target. For large group practices (six [6] or more providers in the group), three (3) record reviews per provider shall be required.

19.17.6. The Contractor shall report the results of health record reviews to EOHHS quarterly with an annual summary.

Article 20. Marketing

20.1. General Provisions

20.1.1. The Contractor shall ensure compliance with all State and Federal marketing requirements, including monitoring and overseeing the activities of its Subcontractors and all persons acting for, or on behalf of, the Contractor and the EOHHS guidelines regarding marketing, as set forth in the RI EOHHS Guidelines for Marketing Materials and Member Communications [42 C.F.R. §§ 438.10 and 438.104].

20.1.2. The Contractor shall not market nor distribute any marketing materials without first obtaining EOHHS approval. [42 C.F.R. § 438.104(b)(1)(i)]

20.1.3. The Contractor shall ensure that marketing, including marketing plans and materials, is accurate and does not mislead, confuse, or defraud recipients or EOHHS. [42 C.F.R. § 438.104(b)(2)]

20.1.4. The Contractor shall not distribute marketing materials that are materially inaccurate, misleading, or otherwise make material misrepresentations.

20.1.5. The Contractor may participate in social networking (e.g., Facebook, Twitter, Scan Code, YouTube, LinkedIn, Instagram or QR Code) in accordance with the requirements of this Contract and Federal and State law. Websites and social/electronic media posts that contain marketing content shall be submitted to EOHHS for review and approval.

20.1.6. The Contractor shall provide an opt-out process for Members and potential Members who previously voluntarily agreed to receive emails or other electronic communications to no longer receive such communications.

20.1.7. The Contractor shall Submit an initial Marketing Plan during Readiness Review and annual updates thereafter in accordance with the Managed Care Manual. The Contractor shall submit amendments to the Marketing Plan to reflect new Marketing Materials and Marketing events during the year.

20.1.8. The Contractor shall distribute all Marketing Materials statewide. [42 C.F.R. § 438.104(b)(1)(ii)]

20.1.9. The RI EOHHS Guidelines for Marketing Materials and Member Communications include requirements regarding:

20.1.9.1. Material Submissions, Review, and Approval Processes;

20.1.9.2. Marketing Activities;

20.1.9.3. Marketing Activities by Marketing Representatives and Subcontractors;

20.1.9.4. Choice Counseling;

20.1.9.5. Prohibited Marketing Activities;

20.1.9.6. Marketing Claims; and

20.1.9.7. Marketing Materials.

20.1.10. If the Contractor distributes Marketing Materials that have not been approved by EOHHS or that contain false or misleading information, either directly or indirectly through any Representative, EOHHS may impose contractual remedies, including civil monetary penalties up to $25,000 for each distribution.

20.2. Marketing Multiple Lines of Business

20.2.1. The Contractor shall ensure that marketing materials requested by Members or Potential Members describing other health-related lines of business contain instructions that describe how Members or Potential Members may opt-out of receiving such communications. The Contractor shall not send such communications to Members or Potential Members who have asked to opt-out of receiving future marketing communications.

20.2.2. If the Contractor advertises multiple lines of business within the same marketing material or at the same event, it shall keep their other lines of business clearly and understandably distinct from the Medicaid Managed Care Plan. The Contractor shall not influence enrollment in conjunction with the sale or offering of any private insurance. [42 C.F.R. § 438.104(b)(1)(iv)]

20.2.3. The Contractor shall not include enrollment applications for other health-related lines of business in Medicaid Managed Care marketing materials.

20.3. Allowable Marketing Activities

20.3.1. Any individual, whether employed, subcontracted, or otherwise engaged by the Contractor, that is performing Marketing activities shall be considered a Marketing Representative for the purposes of this Agreement.

20.3.2. The Contractor and its Marketing Representatives may engage in the following Marketing activities:

20.3.2.1. Distribute general information through mass media (i.e., newspapers, magazines and other periodicals, radio, television, the Internet, public transportation advertising, billboards, and other media outlets) in keeping with prohibitions as detailed in the RI EOHHS Guidelines for Marketing Materials and Member Communications.

20.3.2.2. Targeted Marketing efforts, including having Marketing Representatives answer questions by phone or in-person from Members or Potential Members. In conducting targeted Marketing efforts, the Contractor shall comply with all guidance on prohibited Marketing activities, including a prohibition on Cold Call Marketing.

20.3.2.3. Marketing efforts to engage the community more broadly, including hosting events (Marketing Events), participating in community health education programming (Community Events), or advertising at or otherwise supporting a community event or health education program (Sponsorship).

20.3.2.4. The Contractor shall get prior written approval from EOHHS for

participating in any press or media events or activities that includes the Contractor acting as a sponsor of the event.

20.3.2.5. EOHHS reserves the right to require the Contractor to discontinue or modify any Marketing or Member education events after approval.

20.3.2.6. Respond to verbal or written requests for information made by Potential Members, in keeping with the response plan outlined in the Marketing Plan approved by EOHHS.

20.3.3. The Contractor shall ensure all Marketing Representatives complete Marketing activities in a non-discriminatory manner and uphold the mission and goals of the Rhode Island Medicaid Program.

20.3.4. The Contractor shall create and oversee a Marketing focused training required for all Marketing Representatives. The training shall include all critical elements as defined in the Managed Care Manual.

20.3.5. In any instance where an allowable activity as defined by the Contractor's Marketing guidance conflicts with the EOHHS Marketing Policies and Procedures, the EOHHS Marketing Policies and Procedures shall prevail.

20.4. Marketing Activities by Providers

20.4.1. For purposes of this Section, any reference to a Provider also includes AEs.

20.4.2. The Contractor shall provide Marketing guidance in Provider training materials and is responsible for any Marketing Activities engaged in by contracted Providers. The Contractor shall prohibit Providers from distributing any Marketing Material this is not approved by EOHHS.

20.4.3. In addition to the Marketing guidelines in the Managed Care Manual, the Contractor shall ensure Providers comply with the following Marketing policies. The Contractor may include the following language in its Network Provider Agreements to prevent prohibiting Marketing activities:

20.4.3.1. Providers shall distribute or display Marketing Materials for all Health Plans participating in the Managed Care Program or choose not to distribute or display for any Health Plans. The Provider may choose which Marketing Materials to distribute or display so long as the Provider does not give the appearance of supporting one (1) Health Plan over another.

20.4.3.2. Providers may inform Members and Potential Members which Health Plans they contract with.

20.4.3.3. Providers may educate Members and Potential Members of the benefits and services, including Value-Added Services, that each contracted Health Plan offers.

20.4.3.4. Providers shall not recommend one (1) Health Plan over another, provide any other commentary on or comparison between Health Plans, offer Members or Potential Members incentives to select a particular Health

Plan, or assist the Member or Potential Member in deciding to select a particular Health Plan.

20.4.3.5. If a Member or Potential Member requests contact information for a Health Plan or assistance with the Medicaid application, the Provider may distribute that information or refer the Potential Member to Health Source Rhode Island or navigators. The Contractor and its employees, Subcontractors, and Providers are strictly prohibited from assisting a Potential Member with the application.

20.4.4. The Contractor, in its sole discretion, may institute additional policies around Marketing and Marketing Materials, so long as those policies do not conflict with this Agreement or the Managed Care Manual. The Contractor is responsible for educating contracted Providers of and enforcing those additional policies and procedures.

20.4.5. The Contractor is subject to contractual remedies, including Liquidated Damages in accordance with Attachment F-6, for failure to ensure Provider compliance with Marketing requirements.

20.5. Prohibited Statements and Claims

20.5.1. The Contractor shall not, whether orally or in writing:

20.5.1.1. Claim that a Member shall enroll in the Health Plan in order to obtain or not lose Medicaid benefits or any other health or welfare benefits. [42 C.F.R. § 438.104(b)(2)(i)]

20.5.1.2. Claim that the Health Plan is recommended or endorsed by CMS, the Federal or State government, or similar entity. [42 C.F.R. § 438.104(b)(2)(ii)]

20.5.1.3. Claim that EOHHS recommends that the Member or Potential Member enroll with the Contractor.

20.5.1.4. Claim that marketing agents are employees of the Federal or State government or of anyone other than the Contractor.

20.5.1.5. Compare itself to another Managed Care Plan, verbally or in writing, unless the Contractor can support the comparison and such comparisons are factually based and not misleading.

20.6. Prohibited Activities

20.6.1. The Contractor and its Subcontractors are prohibited from engaging in the following activities:

20.6.1.1. Enlisting the assistance of any government employee, government officer, elected official or the State's enrollment broker in recruitment of potential Members or the retention of Members.

20.6.1.2. Providing any gift, commission, or any form of compensation to the enrollment broker, including its full-time, part-time, or temporary employees and Subcontractors.

20.6.1.3. Directly or indirectly, engaging in door-to-door, telephone, email, texting or other cold-call marketing activities or market through unsolicited contacts.

g) If the Contractor receives permission to call or otherwise contact a Member or Potential Member, the Contractor, shall treat the permission as event-specific and shall not interpret the permission as an open-ended permission to contact the Member or Potential Member after the inquiry or questions have been answered by the Contractor.

20.6.1.4. Renting or purchasing email lists to distribute information about its Medicaid Managed Care plan to Members or Potential Members.

20.6.1.5. Making unsolicited offers of business cards directly to attendees of marketing events.

20.6.1.6. Treating social media interaction (e.g., like, comment, follow a Managed Care Plan, or participation in a virtual event) on social/electronic media as an agreement to receive communications from the Contractor outside the social media forum, unless there is a request for follow-up from the Contractor. The Contractor shall not address subjects beyond the question or statement initiated by the individual.

20.6.1.7. Visiting a resident of a long-term care facility (e.g., nursing homes, assisted living facilities, board and care homes), unless requested by a resident or guardian.

20.6.1.8. Marketing to Potential Members in state offices or any location where a Potential Member may receive an eligibility determination.

20.6.1.9. Marketing or distributing Marketing Materials, including Member handbooks, and soliciting Potential Members in any other manner, inside, at the entrance, or within fifty (50) feet of check cashing establishments, public assistance offices, DHS eligibility offices for the Supplemental Nutrition Assistance Program (SNAP), Provider locations (including health care facilities, freestanding urgent care centers, store-based clinics), pharmacies, Medicaid Eligibility Offices, or certified Medicaid Application Centers without prior approval from EOHHS.

20.6.1.10. Using terms that would influence, mislead, or cause Potential Members to contact the Health Plan, rather than the EOHHS-designated Choice Counselor, for enrollment.

20.6.2. The Contractor is subject to contractual remedies, including Liquidated Damages in accordance with Attachment F-6, for violations of Marketing requirements.

20.7. Marketing Materials

20.7.1. EOHHS shall approve all Marketing Materials before the Contractor may distribute them to Members or Potential Members. Materials shall comply with 42 C.F.R. §§ 438.10(d)(6) and 438.104 and shall not contain any prohibited Marketing Claims as

outlined in Section 20.5.

20.7.2. Marketing Materials are further described and regulated in the RI EOHHS Guidelines for Marketing Materials and Member Communications.

20.7.3. The Contractor shall:

20.7.3.1. Provide information to Members and Potential Members in a manner and format that may be easily understood and is readily accessible by such Member and Potential Members. This includes drafting all Marketing Materials in an easily understood language and format. EOHHS requires literature to be in at least a twelve (12) point font and at a sixth (6^{th})-grade reading level.

20.7.3.2. Make available Marketing Materials in alternative formats upon request of the Member or the Potential Members. The alternative formats should consider special needs of Members and Potential Members with disabilities or Limited English Proficiency.

20.7.3.3. Include taglines in the prevalent non-English languages in the state as well as in large print. The taglines should community the availability of written translation, oral interpretation, or TTY/TDY to understand the information provided.

20.7.3.4. Provide all written Marketing Materials in a conspicuously visible font size, no smaller than twelve (12) point.

20.7.4. Marketing Materials shall not contain any language or other indication that the Contractor would discriminate against individuals eligible to enroll based on their health status, need for Health Care Services, race, color, national origin, sex, sexual orientation, gender identity, or disability.

20.7.5. The Contractor shall obtain specific EOHHS approval of any materials, regardless of whether they are produced by the Contractor, that features the Contractor's logo. This includes Member and Potential Member facing materials produced by other Health Plans and Accountable Entities.

20.7.6. All Marketing Materials shall contain the EOHHS logo as appears in the Managed Care Manual. The MCO may not alter or modify the EOHHS logo but may change the size so long as the logo remains visible and legible in all Marketing Materials. EOHHS, in its sole discretion, may move, resize, or otherwise alter the use of its logo as part of its approval of Market Materials.

20.8. Remedial Actions for Marketing Violations

20.8.1. EOHHS shall notify the Contractor in writing of the determination of non-compliance, of the remedial action(s) that must be taken, and of any other related conditions such as the length of time the remedial actions shall continue and the corrective actions that the Contractor shall perform.

20.8.2. EOHHS may require the Contractor to recall previously authorized marketing material(s).

20.8.3. EOHHS may suspend Enrollment of new Members to the Contractor for an amount of time specified by EOHHS.

20.8.4. EOHHS may require the Contractor to contact, in a manner specified by EOHHS, each Member who enrolled during the period while the Contractor was out of compliance, in order to explain the nature of the non-compliance and inform the Enrollee of his or her right to transfer to another MCO.

20.8.5. EOHHS may prohibit future marketing activities by the Contractor for an amount of time specified by EOHHS.

Article 21. Member Materials

21.1. General Requirements

21.1.1. The Contractor shall design and distribute Member Materials, including identification cards, a Member Handbook, a Provider Directory, and other resources described in the Managed Care Manual and in accordance with NCQA accreditation standards.

21.1.2. In designing Member Materials, the Contract shall:

21.1.2.1. Use a format that is readily accessible as described in Sections 21.11 and 21.12.

21.1.2.2. Create a permanent landing page for Member Materials on the Health Plan's website that is prominent and readily accessible.

21.1.2.3. Create all electronic materials in a searchable, downloadable, and savable format.

21.1.2.4. Notify all Members that Member Materials are available in paper form upon request.

21.1.2.5. Provide paper materials, upon request, within five (5) Business Days of the request and at no charge to the Member.

21.2. State Approval

21.2.1. In accordance with the process in the Managed Care Manual. Contractor agrees to submit all Member Materials, including substantive changes to approved materials, to EOHHS prior to use. Materials shall be submitted at least thirty (30) Days in advance.

21.2.2. The Contractor shall submit all initial versions of Member Materials to EOHHS during Readiness Review, in accordance with Article 30, "Contract Transition and Readiness Review Schedule."

21.3. Contractor Review

21.3.1. The Contractor shall review all Member Materials at least annually for any needed revisions. Further, Contractor shall communicate revisions to EOHHS for approval before incorporating into the Member Handbook or other Member Materials.

21.4. New Member Materials

21.4.1. The Contractor shall issue Member ID cards to Members for their use in obtaining Medicaid In-Plan Benefits. The Contractor's ID cards shall look similar for all Members and the format shall be approved by EOHHS prior to use. Each ID card shall include a unique Medicaid identification number that is not the Member's Social Security Number and the name of the Member's PCP. The ID card shall also contain an alpha or numeric indicator to designate RIte Care, Rhody Health Partners, or ACA Expansion Population eligibility.

21.4.2. The Member ID cards shall contain the Member Services phone line number and the dedicated purpose of the phone line (including ability to access the Urgent and Emergent Call Line).

21.4.3. The Member ID cards shall contain the NEMT Broker and Children's Dental Benefits customers service phone numbers. EOHHS may require the Contractor to include the Member's attributed AE and/or CCBHC on the Member ID card.

21.4.4. The Contractor shall also distribute a New Member Packet to all new Members. The New Member Packet shall include at a minimum the following:

21.4.4.1. New Member Letter;

21.4.4.2. Notice of Advance Directives;

21.4.4.3. Information about the Member Portal, and

21.4.4.4. Information about where to obtain a copy of the Member Handbook and Provider Directory if full versions are not sent in the New Member Packet.

21.4.5. New Member Packets shall also include member marketing material from the NEMT Broker and Children's Dental Benefits provider.

21.4.6. EOHHS reserves the right to require additional items at their discretion.

21.4.7. The Contractor shall mail the Member's ID Card within two (2) Business Days, and the Member's New Member Packet within three (3) Business Days, of receiving notification from EOHHS of the Member's enrollment. If the Member changes PCP, the Contractor shall provide an updated Member ID card within two (2) Business Days of receiving notice of the change.

21.4.8. The Contractor shall also make a downloadable version of the ID card and New Member Packet available to the Member in addition to the mailed version, per the requirements for a Member Portal in this Agreement.

21.4.9. For Dual Eligible Members, the aligned integrated D-SNP retains responsibility for providing the Member with an integrated Member ID card to be used for both programs.

21.5. Pharmacy ID Card Requirements

21.5.1. The Contractor shall provide on the MCO Member ID Card, or on a separate Pharmacy ID Card, or through other technology, prescription billing information that:

21.5.1.1. Complies with the standards set forth in the National Council for Prescription Drug Programs Pharmacy ID Card prescription benefit card implementation guide at the time of issuance of the card or other technology; or

21.5.1.2. Includes, at a minimum, the following data elements:

a) The name or identifying trademark of the MCO and the prescription benefit manager (see co-branding restrictions in the Marketing and Education section);

b) The name and MCO member identification number of the Enrollee;

c) The telephone number that providers may call for pharmacy benefit assistance, 24-hour Enrollee services and filing Grievances, Provider

services and Prior Authorization; and reporting Fraud;

d) All electronic transaction routing information and other numbers required by the Contractor or its benefit administrator to process a prescription claim electronically.

21.5.2. If the Contractor chooses to include the prescription benefit information on the MCO Member ID Card, the Contractor shall ensure all Enrollees have a card that includes all necessary prescription benefit information, as outlined above.

21.5.3. If the Contractor chooses to provide a separate Pharmacy ID Card, the card mailer that accompanies the card shall include language that explains the purpose of the Pharmacy ID Card, how to use the card and how to use it in tandem with the Medicaid ID Card and the MCO-Member ID Card.

21.6. Member Materials and Programs for Current Enrollees

21.6.1. The Contractor shall develop and distribute Member educational materials, including but not limited to, the following:

21.6.1.1. An Member-focused website which can be a designated section of the Contractor's general informational website, and interactive media content such as a mobile device application, a mobile optimized website, or interactive social media;

21.6.1.2. Bulletins or newsletters distributed not less than two (2) times per calendar year that provide information on preventive care, access to PCPs and other providers, and other information that is helpful to Members;

21.6.1.3. Literature, including brochures and posters, such as calendars and growth charts, regarding all health or wellness promotion programs offered by the Contractor. This would also include, but not be limited to, EPSDT outreach materials and Enrollee appointment and preventive testing reminders;

21.6.1.4. Targeted brochures, posters and pamphlets to address issues associated with Members with chronic diseases and/or special heath care needs;

21.6.1.5. Materials focused on health promotion programs available to the Members;

21.6.1.6. Communications detailing how Enrollees can take personal responsibility for their health and self-management;

21.6.1.7. Materials that promote the availability of health education classes for Members;

21.6.1.8. Materials that provide education for Enrollees with, or at risk for, a specific disability or illness;

21.6.1.9. Materials that provide education to Members, Member' families and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or

disabilities;

21.6.1.10. Notification to its Members of their right to request and obtain the welcome packet (including all items noted in this section except for the MCO Member ID card) at least once a year;

21.6.1.11. Notification to its Enrollees of any change EOHHS defines as significant at least thirty (30) Calendar Days before the intended effective date; and

21.6.1.12. All materials distributed must comply with the relevant guidelines established by EOHHS for these materials and/or programs.

21.7. Member Handbook

21.7.1. The Contractor shall create a Member Handbook based on Rhode Island's Model Member Handbook for non-Dual Eligible Members.

21.7.2. For Dual Eligible Members, the aligned integrated D-SNP retains responsibility for providing the Member with an integrated Member Handbook to be used for both programs.

21.7.3. The Contractor shall publish the Member Handbook in a searchable, downloadable, and savable format on the Contractor's website for all Members and Potential Members to access. The Member Handbook shall comply with all language and format requirements as outlined in Section 21.11, below, and 42 C.F.R. §438.10(c)-(d).

21.7.4. The Contractor's Member Handbook shall cover, at a minimum, the following topics:

21.7.4.1. An overview of how to effectively use the Managed Care Program.

21.7.4.2. How to access In-Plan Benefits, including after-hours care and emergency services, and the procedures for obtaining benefits such as requirements for service authorizations and/or referrals.

21.7.4.3. The amount, duration, and scope of In-Plan Benefits, including LTSS and HCBS and a statement clarifying eligibility for these services.

21.7.4.4. How to access Out-of-Plan Benefits, including dental services for children and medical transportation.

21.7.4.5. Member's freedom of choice to access Out-of-Network Providers for family planning and women's health services

21.7.4.6. Accessing Non-Covered Benefits, including the Member's payment responsibilities for such services.

21.7.4.7. Transition of care policies for Members and Potential Members, including transitions for LTSS and nursing facility care.

21.7.4.8. The process of selecting and changing a Member's PCP.

21.7.4.9. Services available to Members under Article 22, "Member Services."

21.7.4.10. Advance Directives as outlined in Section 12.2 and 42 C.F.R. §438.3(j).

21.7.4.11. Critical Incident Reporting.

21.7.4.12. Grievances and Appeals processes.

21.7.4.13. How to report Fraud, Waste, and Abuse.

21.7.4.14. How to disenroll from the Contractor's Health Plan.

21.7.4.15. How to access Auxiliary Aids and Services and how to make a standing request to receive all future notifications and communication in a specified Alternative Format.

21.7.4.16. How to access the Online Provider Directory and how to request a paper copy.

21.7.4.17. The telephone number for Member services.

21.7.4.18. Member rights and responsibilities.

21.7.4.19. Any restrictions on the Member's freedom of choice among Network Providers.

21.7.4.20. In the case of a counseling or referral service that the Contractor does not cover because of moral or religious objections, information that the service is not covered and how to obtain information from the State about how to access the service.

21.7.5. Unless otherwise directed by EOHHS, the Contractor shall provide Members notice of any substantive changes to the Member Handbook at least thirty (30) Days before the effective date of the change. The Contractor shall publish notice of substantive changes on its website in the same location as the Member Handbook.

21.8. Member Bill of Rights

21.8.1. The Contractor shall include the Member Bill of Rights in the Member Handbook. The Member Bill of Rights shall cover, at a minimum, the Member's right to:

21.8.1.1. Obtain available and accessible health care Services as covered under this Contract.

21.8.1.2. Receive information on Member and plan information.

21.8.1.3. Be treated with respect and with due consideration for their dignity and privacy.

21.8.1.4. Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.

21.8.1.5. Participate in decisions regarding their health care, including the right to refuse treatment.

21.8.1.6. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

21.8.1.7. Request and receive a copy of their medical records and request they be amended or corrected.

21.9. Provider Directory

21.9.1. The Contractor shall maintain an electronic Provider directory that contains an online, searchable database. The directory shall be machine readable, accessible, and viewable via mobile device. Paper copies shall be made available upon request. The database shall profile each contracted Provider, including pharmacies, and include the following Provider information:

21.9.1.1. Demographics, including name, group affiliations, street address, telephone number, whether the Provider is accessible via public transportation, and if applicable, website URL for the provider.

21.9.1.2. Specialties, as appropriate.

21.9.1.3. Whether the Provider is accepting new Members.

21.9.1.4. Whether appointments are available via Telehealth.

21.9.1.5. Cultural and linguistic capabilities, including American Sign Language, and whether the Provider has completed Cultural Competency training.

21.9.1.6. Office information, including office hours and available accommodations for Members with physical disabilities, including offices, exam rooms, and equipment.

21.9.2. The Contractor shall incorporate any changes to the paper directory on a monthly basis and to the electronic directory no later than thirty (30) Days of receiving the Provider's updated information.

21.9.3. For Dual Eligible Members, the aligned integrated D-SNP retains responsibility for providing the Member with an integrated Provider Directory to be used for both programs.

21.10. Distribution of Member Materials

21.10.1. In accordance with 42 C.F.R. § 438.10(g)(3), the Contractor may distribute Member Materials, except for the Member ID card, through any of the following methodologies:

21.10.1.1. Mail as a printed copy of to the Member's mailing address.

21.10.1.2. Email to the Member after obtaining the Member's permission to contact them via email.

21.10.1.3. Post on the Health Plan's website and advise Members in paper or electronic form where the information is available and of the option to request Member Materials in an alternative format at no charge to the Member.

21.10.1.4. Any other method that can reasonably be expected to result in a Member receiving the Member Materials.

21.10.2. The Contractor shall annually redistribute all Member Materials. If the Contractor has made any changes to the Member Materials, including the Member Handbook or

Provider Directory, the Contractor shall include a summary of the changes alongside the updated materials.

21.11. Language and Format

21.11.1. In accordance with 42 C.F.R. § 438.10, the Contractor shall publish all materials in a manner and format easily understood and readily accessible by Members and Potential Members.

21.11.2. EOHHS requires literature to be in at least a twelve (12) point font and at a sixth (6th)-grade reading level.

21.11.3. All written materials should include taglines in the prevalent non-English languages in the state and in large print explaining the availability of written translations, oral interpretation, auxiliary aids, and TTY/TDY telephone numbers for Members to use to understand Member Materials at no cost to the Member.

21.12. Alternative Format

21.12.1. The Contractor shall have a process for ensuring that Members, including Members with limited English proficiency, can make a standing request to receive materials in alternate formats at the time of the request and on an ongoing basis thereafter. The process should include how the Contractor will keep a record of the Member's information and utilize it as an ongoing standing request so the Member does not need to make a separate request for each material and how a Member can change a standing request for a preferred language and/or alternative format. Members may request paper, audio, or translated versions of any Member Material by contacting the Contractor's Member Services Department. If the Member Material is readily available, the Contractor shall provide the requested Member Materials within five (5) Business Days at no cost to the Member.

21.12.2. Spanish and Portuguese Member Materials shall be readily available. If a Member requests materials translated in another language, the Contractor shall provide a native translation of the Member Material, in accordance with Section 22.6.4 of this Contract, at no cost to the Member.

21.13. Contractor Website

21.13.1. The Contractor shall maintain Rhode Island specific Member facing webpage. The site may be navigable through its main website or at a standalone domain name. The webpage shall either directly display or provide hyperlinks to all Member Materials, the Contractor's formulary as described in Section 6.3, and other critical elements as outlined in the Managed Care Manual.

21.13.2. The Contractor shall reserve the main webpage for the most critical information for Members, including:

21.13.2.1. All Call Center phone lines and their hours of operation, including the Urgent and Emergent Call Line.

21.13.2.2. Links to all Member Materials, including the Provider Directory.

21.13.2.3. Instructions to replace a lost or stolen Member ID Card.

21.13.2.4. A description of In-Plan Benefits.

21.13.2.5. The meeting schedule and information for the Member Advisory Committee established under Section 22.8.

21.13.2.6. Instructions on how to file an Appeal and request a State Fair Hearing.

21.13.2.7. Instructions on how to file a Complaint with the Contractor and to contact the Office of Program Integrity's Tip Line to report an alleged Provider committing Medicaid Fraud or Abuse to the state.

21.13.2.8. Customer service phone numbers for the NEMT Broker and Children's Dental Benefits administrator.

21.13.3. The Contractor shall ensure that the hyperlink language accurately and concisely describes the material linked and the hyperlink itself leads directly to the described material. Hyperlinks should be organized by topic where material is not dispersed among several hyperlinks.

21.13.4. The Contractor's webpage shall follow all readability and accessibility requirements contained in 21.13 of this Section. This includes having all default fonts be at least twelve (12) point and all materials written at no higher than a sixth (6^{th})-grade reading level.

21.13.4.1. All webpages on the Provider's website should have an option to link to a translated version of that page.

21.13.4.2. The Contractor shall offer real-time electronic communication methods for Members on the webpage, such as a live chat feature.

Article 22. Member Services

22.1. General Requirements

22.1.1. The Contractor shall establish, staff, and maintain a Member Services Department dedicated to responding to questions, comments, Grievances, Appeals, and inquiries from Members and Providers in accordance with NCQA accreditation standards.

22.1.2. The Member Services Department shall oversee the following areas of Health Plan operations:

22.1.2.1. Member Call Center;

22.1.2.2. Translation and Interpreter Services;

22.1.2.3. Member Education;

22.1.2.4. Member Advisory Committee; and

22.1.2.5. Other areas identified by the Contractor.

22.2. Member's Rights and Responsibilities

22.2.1. The Contractor shall have written policies regarding Member's rights and responsibilities. The Contractor shall comply with all applicable Federal and State laws, regulations, rules, policies, procedures, and manuals pertaining to Member rights and privacy. The Contractor shall further ensure that the Contractor's employees, subcontractors and providers consider and respect those rights when providing services to Enrollees.

22.2.2. The rights afforded to current Members are detailed in the Medicaid Managed Care Manual.

22.2.3. The Contractor shall encourage each Enrollee to be responsible for their own health care by becoming an informed and active participant in his/her care. Members have the responsibility to cooperate fully with providers in following mutually acceptable courses of treatment, providing accurate medical and personal histories, being present at scheduled appointments and reporting on treatment progress, such as notifying their health care provider promptly if serious side effects and complications occur, and/or worsening of the condition arises.

22.2.4. The Contractor shall inform Members of their responsibilities which shall include, but are not limited to:

22.2.4.1. Informing the Contractor of the loss or theft of their MCO Member ID Card;

22.2.4.2. Presenting their MCO Member ID Card when using health care services;

22.2.4.3. Being familiar with the Contractor's procedures to the best of the Enrollee's abilities;

22.2.4.4. Calling or contacting the Contractor to obtain information and have questions answered;

22.2.4.5. Providing participating Network Providers with accurate and complete medical information;

22.2.4.6. Asking questions of providers to determine the potential risks, benefits and costs of treatment alternatives and following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible;

22.2.4.7. Living healthy lifestyles and avoiding behaviors known to be detrimental to their health;

22.2.4.8. Following the Grievance system established by the Contractor if they have a disagreement with a provider; and

22.2.4.9. Making every effort to keep any agreed upon appointments and follow-up appointments, accessing preventive care services, and contacting the provider in advance if unable to keep the appointment.

22.3. Member Call Centers

22.3.1. The Contractor shall develop policies and procedures for the Member Services Department, including staffing, training, hours of operations, and access and response standards for calls to the Member and Provider phone lines ("Call Center.")

22.3.2. The Contractor shall operate Call Center during regular business hours of at least eight (8) a.m. to six (6) p.m. EST, including lunch hours, on all Business Days, in alignment with the State of Rhode Island's holiday schedule on the Rhode Island Secretary of State's website.

22.3.3. All calls with Members shall be recorded and the Call Center shall inform the Member that the call is being recorded for quality assurance. The Contractor shall retain recorded calls for at least twelve (12) months.

22.3.4. The Contractor shall operate a toll-free telephone line or telephone lines for Member use ("Member Services Phone Line"). The Contractor shall staff the line with trained and knowledgeable Call Center representatives.

22.3.5. Members may use the Member Services Phone Line to address questions, comments, Grievances, Appeals, and inquiries related to all aspects of the managed care system.

22.3.6. In addition to the call center requirements above, the Contractor shall operate an Urgent and Emergent Phone Line. that is available for urgent care and emergency calls from Members twenty (24) hours per Day, seven (7) Days per week. The Urgent and Emergency Phone Line shall be staffed by qualified clinical professionals acting within the scope of their licensure to practice a health-related profession including, for example, physicians, physician assistants, licensed practical nurses, and registered nurses. Members shall be able to access this phone line using the same number as the Member Services Phone Line.

22.3.7. The Contractor shall train staff for both the Member Services Phone Line and the Urgent and Emergent Phone Line to provide culturally competent, appropriate, and timely responses to questions regarding:

22.3.7.1. Health Plan operations, including coordination with PCPs.

22.3.7.2. In-Plan Benefits and access to services.

22.3.7.3. Coordinating and accessing Out-of-Plan Services.

22.3.7.4. Making appointments to obtain services.

22.3.7.5. Referrals and the process for receiving authorization for procedures or services.

22.3.7.6. Accessing care in an emergency or urgent situation.

22.3.7.7. Selecting a PCP.

22.3.7.8. Providers in a particular specialty or geographic area.

22.3.7.9. Accessing Member Materials as described in Article 21.

22.3.7.10. Arranging interpreter services described in Section 22.6.

22.3.7.11. Member Grievances, Appeals, and State Fair Hearings.

22.3.7.12. Updating Member addresses, phone numbers, emails, and other contact information EOHHS following the process in the Managed Care Manual.

22.3.7.13. Other topics identified by the Contractor.

22.3.8. The Contractor shall ensure that the Member Services Phone Line and the Urgent and Emergent Phone Line have properly trained staff and equipment to communicate with callers with Limited English Proficiency or disabilities, including speech and hearing disabilities. The Contractor shall ensure that the translation and interpreter services referenced in Section 22.6 are available to all Members using the Member Services Phone Line and Urgent and Emergent Phone Line.

22.3.9. For Dual Eligible Members, the aligned integrated D-SNP retains the responsibility for establishing a single Member Services phone line for Member's to contact access information concerning their integrated benefits and services for both programs.

22.4. Automated Call Distribution (ACD) System

22.4.1. The Contractor shall install, operate, and monitor a system for the customer service telephone call center. The system shall:

22.4.1.1. Effectively manage all calls received and assign incoming calls to available staff in an efficient manner;

22.4.1.2. Transfer calls to other telephone lines;

22.4.1.3. Provide detailed analysis as required for the reporting requirements, as specified by EOHHS, including the quantity, length and types of calls received; elapsed time before the calls are answered; the number of calls transferred or referred; abandonment rate; wait time; busy rate; response time; and call volume;

22.4.1.4. Provide a message that notifies callers that the call may be monitored for

quality control purposes;

22.4.1.5. Measure the number of calls in the queue;

22.4.1.6. Measure the length of time callers are on hold;

22.4.1.7. Measure the total number of calls and average calls handled per day/week/month;

22.4.1.8. Measure the average hours of use per day;

22.4.1.9. Assess the busiest times and days by number of calls;

22.4.1.10. Record calls to assess whether answered accurately;

22.4.1.11. Provide a backup telephone system that shall operate in the event of line trouble, emergency situations including natural disasters, or other problems so that access to the telephone lines is not disrupted;

22.4.1.12. Provide interactive voice response (IVR) options that are user-friendly to Members and include a decision tree illustrating IVR system; and

22.4.1.13. Inform the Enrollee to dial 911 if there is an emergency.

22.5. Call Center Performance Standards

22.5.1. The Contractor shall implement a Telecommunication Relay Service (TRS) system to, in part, evaluate the Call Center's performance using the criteria outlined in this Section. The Contractor shall report on the following performance metrics to EOHHS on or before the last Day of each month.

22.5.1.1. Answer at least ninety-five percent (95%) of incoming Member information telephone line calls within thirty (30) seconds.

22.5.1.2. Daily average Hold Time shall be two (2) minutes or less during regular business hours as defined in Section 22.3.2, above. For purposes of this Agreement, a Member is considered on hold when they are waiting for a call center representative after navigating the interactive voice response (IVR) system and when a customer service representative places the Member on hold.

22.5.1.3. Maintain call abandonment rate of less than five percent (5%).

22.5.2. If the Contractor fails to meet one (1) or more of its performance standards, the Contactor shall promptly notify the EOHHS Contract Officer and Compliance Officer.

22.5.3. In the event of a service outage or other operational failure, the Contractor shall notify EOHHS no later than thirty (30) minutes of becoming aware of the issue, including the root cause of the issue and the Contractor's mitigation plan.

22.5.4. EOHHS reserves the right to impose contractual remedies, the including Liquidated Damages described in Attachment F-6, if the Contractor fails to meet the performance standards described above or fails to provide timely notification of service outages or other operational failures.

22.6. Interpreter and Translation Services

22.6.1. The Contractor shall offer oral and written translation and interpreter services, including auxiliary aids such as TTY/TDD and American Sign Language, at no cost to the Member or the Member Representative. The Contractor may use in- person, telephone-based, or TRS for the oral translation and interpreter services.

22.6.2. The Contractor shall make available interpreter services to Contracted Providers treating Members with Limited English Proficiency at no charge to the Provider or Member. The Contractor may coordinate with Rhode Island Commission for the Deaf and Hard of Hearing for interpretation services.

22.6.3. The Contractor shall ensure that written Marketing Materials and Member Materials are readily available in, at a minimum, English, Spanish, and Portuguese. If EOHHS provides the Contractor with notice of an additional prevalent non-English language in Rhode Island, the Contractor shall provide a translation of its Marketing Materials and Member Materials within forty-five (45) Days of receiving notification from EOHHS.

22.6.4. The Contractor shall provide translated Marketing Materials and Member Materials to Potential Members and Members.

22.6.4.1. If a Member requests translated Marketing Materials or Member Materials in Spanish or Portuguese, the Contractor shall send the translated Member Materials in the format the requested to the Member within five (5) Business Days of the request, and at no cost to the Member.

22.6.4.2. If the Member requests translated Marketing Materials or Member Materials in other languages, the Contractor shall translate and distribute the materials in a format requested within seven (7) Business Days of the request, and at no cost to the Member.

22.6.5. In delivering translation and interpreter services, the Contractor shall comply with all applicable guidelines and requirements under Title VI of the Civil Rights Act and under the Americans with Disabilities Act. This includes offering in-person interpreter services

22.7. Auxiliary Aids

22.7.1. In accordance with 42 C.F.R. § 438.10(d) and Section 22.6, "Interpreter and Translation Services," the Contractor shall:

22.7.1.1. Notify Members that Auxiliary Aids and Services are available upon request to Members with disabilities at no cost.

22.7.1.2. Make written Member Materials available through Auxiliary Aids and Services in a manner that considers the special needs of Members with disabilities.

22.7.1.3. Include information on the Contractors website and in all written Member Materials, including the Member Handbook, on how to request and access Auxiliary Aids and Services, including materials in alternative formats.

22.7.1.4. As described in Article 23, "Grievances and Appeals," the Contractor shall provide Members with any reasonable assistance needed to complete forms and other procedural steps related to the Grievance and Appeals process. This includes providing Auxiliary Aids and Services and interpreter services upon request.

22.8. Member Advisory Committee

22.8.1. The Contractor shall establish a Member Advisory Committee where Members discuss and evaluate their experiences at the Health Plan. The Member Advisory Committee shall include a reasonable representative sample of those individuals served by the Contractor in terms of race or ethnicity, gender, education or income, disability, geographic location (e.g., rural or urban), or sexual orientation, and including LTSS populations. Additionally, the Contractor shall identify at minimum two (2) members of their Member Advisory Committee to participant in the EOHHS state consumer committee. The Contractor may elect to combine the Medicaid Member Advisory Committee with the FIDE-SNP Member Advisory Committee, if applicable.

22.8.2. The Member Advisory Committee shall meet at least on a quarterly basis. To call a meeting to order, the Member Advisory Committee shall have at least five (5) currently enrolled Members or Member Representatives in attendance, plus representation from the Contractor. Meeting attendees may participate either virtually or in-person. Advocacy organization staff or Member advocates may attend meetings, but the Member Advisory Committee may not consider their attendance for purposes of establishing a meeting quorum.

22.8.3. Participating in the Member Advisory Committee is not a paid position; however, the Contractor may offer compensation to Members as it relates to attending a meeting. This can include reimbursement for transportation to and from an in-person meeting or food at in-person meetings. The Contractor is not required to compensate advocacy organization representatives or other non-Member participants.

22.8.4. The Contractor recognizes the importance of getting a well-rounded understanding of the Member experience and shall make an effort to engage a diverse representation of Members to participate in the Member Advisory Committee. The Contractor shall provide interpreter services at a meeting if requested by a Member, provided the Member requests the interpreter reasonably in advance of the designated meeting time. The Contractor shall also provide virtual connectivity options (including assistance with accessibility if needed) if requested.

22.8.5. The Contractor shall ensure the Member Advisory Committee creates and maintains the following documents:

22.8.5.1. A Member Advisory Committee charter.

22.8.5.2. Meeting minutes for each meeting.

22.8.5.3. A reporting structure under which the Member Advisory Committee shares an annual report with Contractor leadership and escalates significant Member issues as soon as reasonably possible.

22.8.6. The Contractor shall make a good faith effort to publicize Member Advisory Committee meetings in advance, including social media, direct consumer outreach, and sharing updates on Contractor website of methods to participate in Committee.

22.8.7. The Member Advisory Committee shall review and provide input on Member materials, including educational materials and the Contractor's Health Equity Plan.

22.9. Member Education

22.9.1. The Contractor agrees to maintain an ongoing support system program. The program shall cover topics including proper utilization of benefits and services, with an emphasis on screenings and preventative services, Behavioral Health Benefits, appropriate prescription drug use, health education, Fraud, Waste, Abuse, and other topics the Contractor deems appropriate.

22.10. Member Portal

22.10.1. The Contractor shall provide a secure Member portal, at no cost to Members, which shall be mobile-responsive.

22.10.2. Access to the Member portal shall be available to Members within one (1) Business Day of Contractor receiving notification from EOHHS of the Member's enrollment

22.10.3. The Member portal shall allow Members to perform the following functions:

22.10.3.1. Submit questions, comments, grievances, and appeals; and receive a response, giving the Member the option of requesting a response by return email or phone call;

22.10.3.2. Submit changes of Member name, address, and phone number for the Contractor to provide that information to EOHHS; and

22.10.3.3. Request a change in PCP.

22.10.4. The Contractor shall respond to questions or comments received from Members within one (1) Business Day from receipt.

22.10.5. The Contractor shall offer Members the option to "opt in" to receive information from the Contractor via email or text message.

22.10.6. The portal shall allow Members to access the following information:

22.10.6.1. The Member's redetermination date;

22.10.6.2. Authorized services;

22.10.6.3. The Member's current PCP;

22.10.6.4. Explanation of benefits for claims;

22.10.6.5. Community resources;

22.10.6.6. A copy of the Member's ID Card; and

22.10.6.7. Other Information that the Contractor determines would be helpful to encourage the Member to engage in their own health care.

22.11. Member Satisfaction Report

22.11.1. The Contractor shall collect Member satisfaction data for all lines of business through an annual survey of a representative sample of its Members, in accordance with NCQA standards, and provide copies of the results to EOHHS in accordance with the Managed Care Manual.

22.12. Welcome Calls

22.12.1. The Contractor shall make welcome calls to new Members within fourteen (14) Business Days of the date the Contractor sends the welcome packet.

22.12.2. The Contractor shall review PCP assignment if a PCP Automatic Assignment was made and assist the Member in changing the PCP if requested by the Enrollee.

22.12.3. The Contractor shall develop and submit to EOHHS for approval a script(s), for all covered populations during the welcome call to discuss the following information with the Enrollee:

22.12.3.1. A brief explanation of the program;

22.12.3.2. Statement that all Enrollee PHI shall be handled in accordance with Federal and State privacy laws;

22.12.3.3. The availability of oral interpretation and written translation services and how to obtain them free of charge;

22.12.3.4. The concept of the patient-centered medical home, including the importance of the Enrollee(s) making a first appointment with his or her PCP for preventive care before the Enrollee requires care due to an illness or condition and instructions about changing PCPs; and

22.12.3.5. Administration of the Health Needs Assessment with a focus on criteria to establish the appropriate tier of case management as described in the Care Management section.

22.12.4. The Contractor shall make three (3) attempts to contact the Enrollee. If the Contractor discovers that the Enrollee lost or never received the welcome packet, the Contractor shall resend the packet.

Article 23. Grievances and Appeals

23.1. General Requirements

23.1.1. In accordance with 42 C.F.R. § 438.402(c)(2)(i), Members have a right to file a Grievance with the Contractor at any time. The Contractor shall also extend that same right to Providers and Authorized Representatives acting on behalf of a Member.

23.1.2. The Contractor shall have an internal Grievance and Appeals Procedure in place that complies with relevant sections of the Social Security Act, 42 U.S.C. § 1396a, 42 C.F.R. § 438 Subpart F, and NCQA accreditation standards. Components of the Grievance and Appeals Procedure shall include:

23.1.2.1. A Grievance process.

23.1.2.2. An Appeal process that includes only one (1) level (i.e., does not require multiple levels of Appeal).

23.1.2.3. A process to access the State's Fair Hearing process.

23.1.3. The Grievance and Appeals Procedure shall include the following criteria:

23.1.3.1. The right to a State Fair Hearing, how to obtain a hearing, and the right to representation at a hearing.

23.1.3.2. The right to file Grievances and Appeals and their requirements and timeframes for filing.

23.1.3.3. The availability of assistance in the filing process, including auxiliary aids and services (upon Member request) such as interpreter services and toll-free numbers with TTY/TTD and interpreter capabilities.

23.1.3.4. The toll-free numbers that Members can use to file a Grievance or Appeal by phone.

23.1.3.5. All notices provided to Members shall be provided in formats and languages that, at a minimum, meet applicable notification standards in 42 C.F.R. § 438.10.

23.1.3.6. The Member's right to request continuation of Covered Benefits during an Appeal or State Fair Hearing within the timeframes specified for filing; and the Member may be liable for the cost of any continued benefits while the Appeal is pending if the final decision is adverse to the Member.

23.1.4. The Contractor shall create written materials to educate Members, Providers, and Subcontractors of the Grievance and Appeals processes, including applicable forms for Grievances, Appeals, and State Fair Hearings. The Contractor shall post these materials alongside Member Materials on its website and provide alternate versions to the Member upon request, at no cost to the Member. All written materials and associated auxiliary aids shall meet the requirements of 42 C.F.R. § 438.10(d)(3)-(4).

23.1.5. The Contractor shall ensure that any decision makers in the Grievance and Appeals processes are not:

23.1.5.1. Involved in any previous level of review or decision-making; or

23.1.5.2. Subordinates of any individual who was involved in a previous level of review or decision-making.

23.1.6. Further, the Contractor shall ensure that the decision makers are individuals with appropriate clinical expertise, as determined by EOHHS, in treating the Member's condition or disease if the decision involves:

23.1.6.1. An Appeal of a denial based on lack of Medical Necessity;

23.1.6.2. A denial of an Expedited Appeal; or

23.1.6.3. A Grievance or Appeal involving clinical issues.

23.1.7. For dual eligible Members, the Member's FIDE SNP will be responsible for integrated Grievance and Appeals. Contractor shall cooperate with this process.

23.1.8. EOHHS and their designees, may at any time, inspect and audit any records or documents of the Contractor, or its Subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted.

23.2. Grievances

23.2.1. A Member, or Provider or Authorized Representative acting on behalf of the Member, may file a Grievance at any time with the Contractor either orally or in writing. The right to file a Grievance only applies to filing with the Contractor and does not extend to filing a Grievance directly with EOHHS.

23.2.2. The Contractor shall acknowledge receipt of each Grievance filed within five (5) Business Days of receipt.

23.2.3. The Contractor shall resolve each Grievance and provide written notice of the resolution as expeditiously as the Member's health condition requires but not to exceed ninety (90) Days from the date it received the Grievance.

23.2.4. Notwithstanding the foregoing, the Contractor may extend the timeframe for resolution of a Grievance by fourteen (14) Days if the Member, the Member's representative, or the Provider request an extension or the Contractor can show (to the satisfaction of EOHHS, upon EOHHS' request) that there is need for additional information and that the extension is in the Member's interest. If the Contractor extends the timeframes not at the request of the Member, it shall:

23.2.4.1. Make reasonable efforts to give the Member prompt oral notice of the delay; and

23.2.4.2. Within two (2) Days, give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if they disagree with that decision. The notification shall be provided in a format and language that, at a minimum, meets the standards at 42 C.F.R. § 438.10.

23.3. Appeals

23.3.1. A Member or Provider or Authorized Representative acting on behalf of the Member, may file an Appeal with the Contractor either orally or in writing, within sixty (60) Days from the date of the notice of Adverse Benefit Determination.

23.3.1.1. For oral requests, the date the Contractor received the oral request shall be considered as the filing date. An oral request for an Appeal shall be followed by a written, signed request, unless the Member, Provider, or Authorized Representative requests an Expedited Appeal.

23.3.1.2. If any party other than the Member or the Member's guardian is filing the Appeal on the Member's behalf, the Member shall provide written or oral consent of the Appeal filing. The Contractor shall complete an Authorized Representative Consent Form.

23.3.1.3. The Contractor shall issue a written acknowledgement of an Appeal within five (5) Business Days of receipt.

23.3.2. For resolution of each standard Appeal, the Contractor shall provide written notice of the disposition within thirty (30) Days from the time the Contractor receives the Appeal. If the Contractor does not provide notice within thirty (30) Days, the Member is deemed to have exhausted the Appeal process and may initiate a State Fair Hearing.

23.4. Resolving a Standard Appeal

23.4.1. Parties to an Appeal may include the Member, the Member's Authorized Representative, or the legal representative of a deceased Member's estate, as appropriate.

23.4.2. The Contractor shall provide the Member with a reasonable opportunity, both in person and in writing, to present evidence and testimony and make legal and factual arguments. The Contractor shall inform the Member of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals as specified in 42 C.F.R. §§ 438.408(b) and 408(c) in the case of expedited resolution.

23.4.3. Additionally, the Contractor shall provide the Member and their representative with a copy of the Member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor (or at the direction of the Contractor) in connection with the Appeal of the Adverse Benefit Determination. This information shall be provided free of charge and sufficiently in advance of the resolution timeframe for Appeals as specified in 42 C.F.R.§§ 438.408(b) and 408(c).

23.4.4. Each written notice of determination shall be provided in a format and language that, at minimum meets the standards at 42 C.F.R. § 438.10 and shall include the following:

23.4.4.1. The results of the resolution process and the date it was completed.

23.4.4.2. For Appeals not resolved wholly in favor of the Members, the right to an external Appeal at no cost to the Member; the right to request a State Fair Hearing, and how to do so; the right to request to receive benefits while

the hearing is pending, and how to make such a request; and that the Member may not be held liable for the cost of those benefits if the hearing decision upholds the Contractor's notice of Adverse Benefit Determination.

23.4.4.3. Information on how to contact the Contractor either in writing or telephone regarding the Appeal process.

23.4.5. In resolution of an expedited Appeal, the Contractor shall make a reasonable effort to provide oral notice of the resolution in addition to the written notice outlined in this Section.

23.5. Timeliness for Resolving an Expedited Appeal

23.5.1. An expedited review is permitted when the Contractor determines (for a request from a Member) or the Provider indicates (in making the request on the Member's behalf or supporting the Member's request) that taking time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

23.5.1.1. The Contractor shall ensure that punitive action is not taken against a Provider who requests an expedited resolution or who supports a Member's request.

23.5.2. The Member may submit a verbal request for an expedited resolution of Appeal. The Member does not need to follow an oral request for an expedited resolution of Appeal with a written request. The Contractor shall inform the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person and in writing, in the case of an expedited resolution.

23.5.3. Expedited appeals shall be resolved within seventy-two (72) hours of receipt.

23.5.4. If the Contractor denies the request for an Expedited Appeal, it shall transfer the appeal to the timeframe for standard resolution, make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two (2) Days with a written notice.

23.6. Extending a Standard or Expedited Appeal

23.6.1. Notwithstanding the resolution timelines outlined in this Section, the Contractor may extend the timeframe for resolution of a standard or expedited Appeal by fourteen (14) Days if the Member, the Member's Authorized Representative, or the Provider request an extension or the Contractor can show (to the satisfaction of EOHHS, upon EOHHS' request) that there is need for additional information and that the extension is in the Member's interest. If the Contractor extends the timeframes not at the request of the Member, it shall:

23.6.1.1. Make reasonable efforts to give the Member prompt oral notice of the delay.

23.6.1.2. Within two (2) Days give the Member's written notice of the reason for the decision to extend the timeframe and inform the Member of the right

to file a Grievance if he or she disagrees with that decision.

23.6.1.3. Resolve the Appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.

23.7. Adverse Benefit Determination

23.7.1. Notice of Adverse Benefit Determination

23.7.1.1. The notice of Adverse Benefit Determination shall include all of the following:

a) An explanation of the Adverse Benefit Determination the Contractor has made or intends to make.

b) The reasons for the Adverse Benefit Determination, including the right of the Member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Member's Adverse Benefit Determination.

c) The Member's right to request an Appeal of the Contractor's Adverse Benefit Determination, including information on exhausting the Contractor's one (1) level of appeal as described at 42 C.F.R. § 438.402(b) and the Member's right to request a State Fair Hearing consistent with 42 C.F.R. § 438.402(c).

d) The procedures for exercising the right to file an Appeal or request a State Fair Hearing under 210-RICR-10-05-2.

e) The circumstances under which an expedited resolution of the Adverse Benefit Determination is permitted and how to request it.

f) The Member's right to have benefits continue pending resolution of the Appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the Member may be required to pay the costs of these services provided during the pendency of the Appeal.

g) The toll-free number to file oral Grievances and Appeals.

23.7.1.2. If the Contractor does not reach a service authorization decision within the applicable timeframes, as outlined in Article 19, "Utilization Management", it shall provide notice to the Member that a decision has not been reached.

23.7.2. Timelines for a Notice of Adverse Benefit Determination

23.7.2.1. The Contractor shall mail a Notice of Adverse Benefit Determination termination, suspension, or reduction of previously authorized Medicaid-Covered Services, at least ten (10) Days before the date of Action as specified in 42 C.F.R. § 431.211.

23.7.2.2. Notwithstanding the foregoing, the Contractor may shorten the period of Notice of Adverse Benefit Determination to five (5) Days before the date of Action if:

a) The Contractor has facts demonstrating that Action should be taken because of probable Fraud by the Member, and

b) The facts have been verified, if possible, through secondary sources.

23.7.2.3. In accordance with the requirements contained in 42 C.F.R. § 438.210(d)(1), the Contactor may have one (1) possible extension of up to fourteen (14) additional Days if:

a) The Member or the Provider requests an extension; or

b) With the agreement of the Member the Contractor provides justification to EOHHS upon request upon request a of the need for additional information and that the extension is in the Member's best interests.

23.7.2.4. If the Contractor exercises its option to extend the Notice of Adverse Benefit Determination, it shall provide the Member with a written notice of the reason for the extension and inform the Member of the right to file a Grievance if he or she disagrees with the Contractor's decision.

23.7.2.5. Under the extended timeframe, the Contractor still shall carry out its determination as expeditiously as possible as the Member's health condition requires and no later than the date the extension expires.

23.7.3. Expedited Notice of Adverse Benefit Determination

23.7.3.1. In accordance with 42 C.F.R. § 438.210(d)(2), if a provider indicates following the standard timeframe for authorization decisions will seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision. The Contractor shall provide notice as expeditiously as the Member's health conditions requires but no later than seventy-two (72) hours after the receipt of the request for services. The Contractor may extend the seventy-two (72) hour response time by up to fourteen (14) Days if the Member requests an extension or the Contractor justifies to the EOHHS a need for additional information and how the extension is in the Member's best interest.

23.7.4. Special Circumstances for Mailing a Notice of Adverse Benefit Determination on the Date of Action

23.7.4.1. The Contractor may mail the notice of Adverse Benefit Determination on the date of Action only under the following circumstances:

a) The Contractor has factual information confirming the Member's death.

b) The Contractor receives a clear written statement signed by a Member that:

(i) They no longer want to receive services; or

(ii) The Member has provided information that requires termination or reduction of services and indicates he or she understands the

Adverse Benefit Determination is the result of supplying this information.

c) The Member has been admitted to an institution and is ineligible under the Managed Care Program for further services.

d) The Member's whereabouts are unknown and the post office returns Contractor mail directed to them indicating no forwarding address.

e) A change in the level of medical care is prescribed by the Member's physician.

f) The notice involves an Adverse Benefit Determination with regard to preadmission screening requirements under Section 19-19I(7) of the Social Security Act.

g) The transfer or discharge from a facility will occur in an expedited fashion.

23.7.4.2. The Contractor shall give notice of the Adverse Benefit Determination on the date of the determination when the Action is a denial of payment.

23.8. Continuation of Benefits

23.8.1. Under the following circumstances, the Contractor shall continue covering benefits for a Member while an Appeal is in process:

23.8.1.1. The Member files a request for an Appeal within sixty (60) Calendar Days following the date of the Notice of Adverse Benefit Determination.

23.8.1.2. The Appeal involves the termination, suspension, or reduction of a previously authorized, but unexpired, service as ordered by an authorized provider.

23.8.1.3. The request for the continuation of benefits is filed on or before the later of the following:

a) Within ten (10) Days of the Contractor sending a Notice of Adverse Benefit Determination; or

b) The intended effective date of the Contractor's proposed Adverse Benefit Determination.

23.8.1.4. If the Contractor either elects to continue a Member's benefits or provides continued benefits, the benefits shall continue until:

a) The Member withdraws the Appeal or request for a State Fair Hearing;

b) The Member does not request a State Fair Hearing and continuation of benefits within ten (10) Days from the date the Contractor sent the notice of an adverse Appeal resolution; or

c) EOHHS issues an adverse State Fair Hearing determination.

23.8.2. Payment for Continued Services

23.8.2.1. In the event of a reversed Adverse Benefit Determination, the Contractor

shall pay for the continued services provided during a pending Appeal or State Fair Hearing, unless Rhode Island law or regulation requires EOHHS to cover the costs.

23.8.2.2. In the event of an affirmed Adverse Benefit Determination, The Contractor may recover the cost of continued services provided during a pending Appeal or State Fair Hearing, so long as the Contractor recovers costs consistent with Rhode Island policy.

23.9. Restoring Benefits

23.9.1. The Contractor shall authorize the continued services as promptly and expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours from the date it reverses or receives notice of a reversed Adverse Benefit Determination if the services were not furnished during a pending Appeal or State Fair Hearing.

23.10. External Medical Review

23.10.1. Members may seek an external Appeal (external medical review), which is offered by the Contractor through a contracted independent external medical reviewer under the external Appeal procedural requirements pursuant to R.I. Gen. Laws § 27-18.9-8 of the Benefit Determination and Utilization Review Act.

23.11. Grievances and Appeals Reporting

23.11.1. The Contractor shall submit quarterly Grievances and Appeals reports in accordance with the Managed Care Manual. The Contractor will be required to submit an aggregate analysis of Grievances and Appeals activity, identification of systemic issues (e.g., access, equity), Grievances and Appeals trends, and corrective action plans where needed. More details on the content of the quarterly report can be found in the Managed Care Manual.

23.11.2. Each record of a Grievance or Appeal shall include:

23.11.2.1. The Member's name.

23.11.2.2. A general description of the reason for the Grievance or Appeal.

23.11.2.3. The date received.

23.11.2.4. The date of each review or, if applicable, review meeting.

23.11.2.5. Resolution information for each level of the Grievance or Appeal, if applicable; and

23.11.2.6. The date of resolution at each level, if applicable.

23.11.3. The Contractor is subject to contractual remedies, including liquidated damages, if it fails to meet the following performance standards:

23.11.3.1. Ninety-eight percent (98%) of Grievances resolved within ninety (90) Days of receipt.

23.11.3.2. Ninety-eight (98%) of Appeals resolved within thirty (30) Days of receipt.

23.12. Grievance and Appeals Records Retention

23.12.1. The Contractor shall maintain a complete and accurate record of all Grievances and Appeals for ten (10) years.

23.12.2. The Contractor shall maintain and make Grievance and Appeal records available upon request by EOHHS and CMS. The record of each Grievance and Appeal shall contain, at a minimum:

23.12.2.1. A General description of the reason for the Grievance or Appeal and the date the Grievance or Appeal was received.

23.12.2.2. The date of each review, or if applicable, review meeting.

23.12.2.3. Resolution information for each level of the Grievance or Appeal, if applicable, including the date of the resolution.

23.12.2.4. The name of the Member for whom the Grievance or Appeal was filed.

23.12.3. The Contractor shall log, track, and trend all Grievances, regardless of the degree of seriousness or whether the Member expressly requests filing the concern.

Article 24. Program Integrity and Compliance

24.1. General Requirements

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

24.2. Compliance Program

24.2.1. The Contractor and any subcontractors delegated responsibility for coverage of services or payment of claims under this Contract, shall implement and maintain a compliance program, as described in 42 C.F.R. § 438.608 and EOHHS' policies and procedures, that includes, at a minimum:

24.2.1.1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the Contract, and all applicable Federal and State requirements.

24.2.1.2. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the board of directors. Effective lines of communication between the Compliance Officer and the Contractor's employees.

24.2.1.3. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the Contract. For existing employees, such training shall be conducted at least annually, and new hire training shall be conducted within thirty (30) Days of the date of hire. The Compliance Plan shall also include a description of how the Contractor monitors and audits Provider and Subcontractor training.

24.2.1.4. Effective lines of communication between the Contractor's compliance officer and the organization's employees.

24.2.1.5. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the compliance program and its compliance with the requirements under the Contract.

24.2.1.6. Enforcement of standards through well-publicized disciplinary guidelines.

24.2.1.7. A system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract.

24.2.1.8. Assistance to EOHHS in any investigation or prosecution of fraud by providing the following:

a) Access to and free copies of computerized data stored by the Contractor;

b) Direct computer access to computerized data stored by the Contractor that is supplied without charge and in the form requested EOHHS; and

c) Access to any information possessed or maintained by any Provider of service(s) under the Medicaid State Plan to which EOHHS and the Contractor are authorized to access.

24.2.1.9. Provision for prompt reporting of all Overpayments identified or recovered, specifying the Overpayments due to potential fraud to the State.

24.2.1.10. Provisions for prompt notification to the State when it receives information about changes in a Member's circumstances that may affect the Member's eligibility including all of the following:

a) Changes in the Member's residence;

b) The death of a Member.

24.2.1.11. Provision for notification to the State when it receives information about a change in a Network Provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor.

24.2.1.12. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by Network Providers were received by Members and the application of such verification processes on a regular basis.

24.2.1.13. In the case of Contractor that make or receive annual payments under the contract of at least $5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in Section 1902(a)(68) of the Social Security Act,

including information about rights of employees to be protected as whistleblowers.

24.2.1.14. Provision for the prompt referral of any potential fraud, waste, or abuse that the Contractor identifies to the EOHHS Program Integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit (MFCU).

24.2.1.15. Provision for the Contractor's suspension of payments to a Network Provider for which the State determines there is a credible allegation of fraud in accordance with 42 C.F.R. § 455.23.

24.3. Engagement with EOHHS' Office of Program Integrity

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

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

24.4. Compliance Staff

24.4.1. In addition to the Compliance Officer, the Contractor shall employ at least two (2) additional employees dedicated staff in a Special Investigations Unit (SIU) and/or auditing unit.

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

24.4.3. As required by Section 1.5, "Contractor's Key Personnel," the Contractor shall provide EOHHS and the EOHHS Office of Program Integrity the name and contact information of the designated individual within their SIU with whom EOHHS and its Office of Program Integrity shall:

24.4.3.1. Communicate directly, and

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

24.5. Provider Site Audits

24.5.1. The Contractor shall complete a minimum of three (3) EOHHS acceptable provider site audits per Contract year. EOHHS, at its sole discretion, may waive the minimum requirement.

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

24.5.3. In the event that audit liabilities arising from any discrepancies in payment are discovered during the course of such audits, the net effect of which resulted in an overpayment to the Contractor, EOHHS may either:

24.5.3.1. Make a demand for the repayment of Overpayment among within thirty (30) days.

24.5.3.2. Offset the amount of Overpayment payments.

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

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

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

24.6. Cooperation with Other Agencies

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

24.7. Fraud, Waste and Abuse Compliance Plan

24.7.1. The Contractor must have a written Fraud Waste and Abuse compliance plan for Rhode Island Medicaid. The plan, including fraud, waste and abuse policies and procedures, must be provided to the EOHHS, Office of Program Integrity for written approval within ninety (90) calendar days of execution of this Contract and annually thereafter. EOHHS will provide notice of approval, denial, or modification to the Contractor within sixty (60) calendar days of receipt. Revisions to an approved compliance plan or fraud and abuse policies and procedures must be submitted to the Office of Program Integrity for written approval at least sixty (60) calendar days prior to the planned implementation of those revisions.

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

24.8. Plan Requirements

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

24.8.1.1. Require reporting of fraud, waste, and abuse comply with the requirements of this Contract.

24.8.1.2. Include a risk assessment of the Contractor's various fraud, waste, and abuse and program integrity processes.

a) A risk assessment must also be submitted when requested by EOHHS and immediately after a program integrity related action, including financial-related actions (such as overpayment, repayment, and fines), is issued on a provider with concerns of fraud, waste, and abuse. The Contractor must inform EOHHS of such action and provide details of such financial action. The assessment shall also include a listing of the Contractor top three (3) vulnerable areas and shall outline action plans in mitigating such risks.

24.8.1.3. Outline unique policy and procedures, including specific instruments to be used.

24.8.1.4. Include procedures designed to prevent and detect abuse and fraud in the administration of delivery of services under this Contract.

24.8.1.5. Describe of the specific controls in place for prevention and detection of potential or suspected fraud, waste, and abuse, including but not limited to:

a) A list of automated pre-payment claims edits.

b) A list of automated post-payment claims edits.

c) A list of desk audits on post-processing review of claims.

d) A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services.

24.8.1.6. Include a list of provisions for the investigation and follow-up of any suspected or confirmed fraud, waste, and abuse, even if already reported, and/or compliance plan reports.

24.8.1.7. Ensure that the identities of individuals reporting violations of the Contractor are protected and that there is no retaliation against such persons.

24.8.1.8. Contain specific and detailed internal procedures for officers, directors, managers, and employees for detecting, reporting, and investigating fraud, waste, and abuse compliance plan violations.

24.8.1.9. Contain specific and detailed internal procedures on how information received from the State regarding providers already under investigation or review is disseminated internally to the appropriate group(s). Specifically,

outline the steps that are in place to ensure providers under review or investigation are not contacted or investigated unless approval has been received from the Office of Program Integrity.

24.8.1.10. Require any confirmed or suspected provider fraud, waste, and abuse under state or federal law be reported to the Medicaid Fraud Control Unit as well as EOHHS' Office of Program Integrity.

24.8.1.11. Include work plans for conducting both announced and unannounced site visits and field audits to providers defined as high risk (providers with cycle/auto billing activities, providers offering DME, home health, mental health, and transportation services) to ensure services are rendered and billed correctly.

24.8.1.12. Include provisions about conducting monthly comparison of the Contractor's provider files against the Social Security Master Death File, the General Services Administration (GSA) System for Award Management (SAM) and the HHS-OIG List of Excluded Individuals/Entities (LEIE) and provide a report of the result of comparison to EOHHS each month. The Contractor must establish an electronic database to capture identifiable information on the owners, agents and managing employees listed on providers' Disclosure information as provided by EOHHS;

24.8.1.13. Include provisions about performing a monthly check for exclusions of their owners, agents and managing employees. The Contractor must establish an electronic database to capture identifiable information on its owners, agents and managing employees and perform monthly exclusion checking. The Contractor must provide the Division with such database and a monthly report of the exclusion check; and

24.8.1.14. Include details regarding prompt terminations of inactive providers due to inactivity in the past twelve (12) months, unless EOHHS provides prior approval for a provider type to remain contracted or as otherwise required by EOHHS.

24.8.1.15. Effective implementation of a well-publicized email address for the dedicated purpose of reporting Fraud. This email address must be made available to Enrollees, providers, Contractor employees and the public on the Contractor's website required under this Contract. The Contractor shall implement procedures to review complaints filed in the Fraud reporting email account at least weekly, and investigate and act on such complaints as warranted. The Contractor shall submit to EOHHS or its designee the Fraud, Waste, and Abuse Compliance Plan as part of Readiness Review, annually thereafter, and upon updates or modifications for written approval at least thirty (30) Calendar Days in advance of making them effective.

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

24.9. Investigation and Reporting of Fraud, Waste and Abuse

24.9.1. Duty to Report to the Division

24.9.1.1. The Contractor must report Subcontractor, Member, or Provider fraud and/or abuse that it has reasonable cause to suspect, or should have had reasonable cause to suspect, immediately to EOHHS. The Contractor must cooperate with EOHHS regarding the investigation. Failure to report and/or cooperate with EOHHS to investigate fraud could result in criminal and/or civil penalties for the Contractor. The Contractor must report Member or Provider Fraud or Abuse in a format to be specified by EOHHS. The Contractor must use the most current version of the Program Integrity Fraud and Abuse Standard Operating Procedure for referrals and reporting to EOHHS' Office of Program Integrity

24.9.2. Investigations

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

24.9.3. Division Authorization Required

24.9.3.1. Fraud Reported to the Division.

a) The Contractor must not take any of the following actions once the suspected fraud is substantiated and reported to EOHHS without prior written approval from EOHHS:

(i) Contact the subject of the investigation about any matters related to suspected and/or confirmed fraud or abuse;

(ii) Enter into or attempt to negotiate any settlement or agreement regarding incidents of suspected or confirmed fraud or abuse; or

(iii) Accept any monetary or other thing of valuable consideration offered by the subject(s) of the investigation in connection with incidents of suspected or confirmed fraud or abuse.

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

24.9.3.2. Retrospective Reviews

a) All retrospective reviews must be pre-approved by the Office of Program Integrity. This includes investigations of claims initiated by the Contractor and/or its Subcontractor. The Contractor is allowed a look-back period of a minimum of eighteen (18) months and a maximum of thirty-six (36) months based on the date of service of the claim. The

Contractor must submit a written request to the Office of Program Integrity to retrospectively audit a provider.

24.9.3.3. Prepayment Reviews

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

b) All prepayment reviews must be completed within twelve (12) months of case initiation. The Contractor must re-evaluate the case after the twelve (12) months to determine if the provider's billing practices have changed and a continuation of the prepayment review is necessary to prevent future improper payments or refer the case as a credible allegation of fraud. The Contractor must submit a new written request to the Office of Program Integrity for the new prepayment review.

c) The Contractor cannot use prepayment review to hold claims for an indefinite period.

24.9.3.4. Overpayments

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

b) When recovering funds on behalf of EOHHS, the Contractor will retain any overpayments identified and collected because of the audit if EOHHS approves the investigation. The Contractor will be responsible for collecting the overpayment for any provider audited. If it is determined that the Office of Program Integrity will conduct an investigation, EOHHS will be responsible for collecting the overpayments of providers audited.

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

24.9.3.5. Recoupment

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

(i) The improperly paid funds have already been recovered by the State of Rhode Island, either directly by EOHHS or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to False Claims Act cases; or

(ii) The improperly paid funds have already been identified by the

State's Recovery Audit Contractor (RAC); or

(iii) When the issues, services, or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Rhode Island, are the subject of pending Federal or State litigation or investigation, or are being audited by the Rhode Island RAC. This prohibition is limited to a specific provider, for specific dates, and for specific issues, services, or claims. The Contractor must confer with the Office of Program Integrity before initiating any recoupment or withhold of any program integrity related funds to ensure that the recovery recoupment or withhold is permissible. If the Contractor obtains funds in cases where recovery or withhold is prohibited under this section, the Contractor will return the funds to EOHHS.

24.9.3.6. Suspension of Payment

a) The rules governing payment suspensions based upon pending investigations of credible allegations of fraud apply to Rhode Island MCOs. Each Contractor must cooperate with EOHHS when the Office of Program Integrity imposes payment suspensions or lifts a payment suspension. In accordance with 42 C.F.R. § 455.23, the Contractor must also suspend payments to the Provider within twenty-four (24) hours of receipt of notification from EOHHS that payments to a provider have been suspended and immediately inform EOHHS of that action. Such suspension shall include any claims that may be ready for payment, unless otherwise stated by EOHHS. The Contractor must lift a payment suspension within twenty-four (24) hours of receipt of notification from EOHHS of a payment suspension lift and immediately inform the Division of that action. The Contractor shall require its Subcontractors, when applicable, to suspend payments to Providers for all claims the Subcontractor has or may have against any entity that directly or indirectly receives funds under this Contract. The Contractor is responsible for the return of any money paid in error for services provided to a suspended Provider. If the Contractor does not suspend payments to the Provider, or if the Contractor does not correctly report the amount of adjudicated payments on hold, EOHHS may impose contractual or other remedies.

24.9.3.7. Credible Allegation of Fraud

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

determine if a referral is made to EOHHS.

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

c) If the Contractor does not suspend payments to the Provider, or the Contractor does not correctly report the amount of the payments held, EOHHS may impose contractual or other remedies in accordance with Attachment F-2, Article 7, "Performance Standards, Remedies, and Disputes."

24.9.3.8. Provider Terminations

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

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

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

d) The Contractor must review the Rhode Island Sanctioned Provider List at least monthly.

Article 25. Records Retention, Audits, and Inspections

25.1. Records Retention

25.1.1. The Contractor shall maintain all records relating to the administration of this Agreement, including documents and electronically stored information (collectively "Contract Records"). Contract Records include:

25.1.1.1. All financial statements and records relating to expenditures or transactions made pursuant to this Agreement.

25.1.1.2. Reports to EOHHS and source information used to prepare the reports.

25.1.1.3. Medical records.

25.1.1.4. Member and Provider materials.

25.1.1.5. Records relating to claims adjudication, payments, disputes, and appeals.

25.1.1.6. Records relating to Prior Authorization, clinical reviews, and other UM activities.

25.1.1.7. Records relating to quality of care.

25.1.1.8. Records relating to Member Grievances and Appeals.

25.1.1.9. MLR records.

25.1.1.10. Subcontracts and purchase orders.

25.1.1.11. Prescription files.

25.1.2. The Contractor shall have written policies and procedures for storing Contract Records.

25.1.3. The Contractor shall comply with all State and Federal standards for record keeping, including:

25.1.3.1. 42 C.F.R. § 438.5(c), regarding base rate data.

25.1.3.2. 42 C.F.R. § 438.8(k), regarding MLR reports.

25.1.3.3. 42 C.F.R. § 438.416, regarding Member Grievance and Appeals records.

25.1.3.4. 42 C.F.R. §§ 438.604 through 438.610, regarding program integrity safeguards.

25.1.4. In accordance with 42 C.F.R. § 438.3(h), the Contractor shall preserve, maintain, and provide EOHHS and the entities described in Section 25.2 access to all Contract Records until ten years after the later:

25.1.4.1. The termination or expiration of this Agreement, or

25.1.4.2. The resolution of all litigation, claims, financial management reviews, or audits relating to the Agreement.

25.2. Access to Information

25.2.1. Upon reasonable notice, the Contractor shall provide prompt, reasonable, and adequate

access to all Contract Records. Requests may be for any purpose, including examination, audit, investigation, inspection, contract administration, or the making of copies, excerpts, or transcripts.

25.2.2. Access to Contract Records shall be provided to EOHHS or the following officials or entities, or their designees, at any time:

25.2.2.1. DHHS and the DHHS Inspector General;

25.2.2.2. Government Accountability Office;

25.2.2.3. CMS;

25.2.2.4. Comptroller General of the United States;

25.2.2.5. State Department of Health;

25.2.2.6. MFCU of the Rhode Island Department of Attorney General;

25.2.2.7. EOHHS Office of Program Integrity and Medicaid Compliance Unit;

25.2.2.8. A State or Federal Law Enforcement Agency;

25.2.2.9. The Auditor General of Rhode Island;

25.2.2.10. A special or general investigative committee of the Rhode Island Legislature; and

25.2.2.11. Any other entity identified in writing by EOHHS.

25.2.3. The Contractor shall provide access to Contract Records wherever they are maintained and in reasonable comfort. The Contractor shall provide furnishings, equipment, and other conveniences EOHHS deems reasonably necessary to fulfill the purposes described in this Section.

25.2.4. The Contractor shall provide the entities described in this Section access to and copies of Contract Records free of charge.

25.2.5. Upon request by a Member, the Contractor shall make available any reports provided to EOHHS or other agencies regarding transactions between the Contractor and parties in interest.

25.3. Inspections

25.3.1. The officials and entities described in Section 24.2 or their designees shall, during normal business hours, have the right to enter the Contractor's premises, physical facilities, or any place where duties under this Agreement are being performed, to audit, inspect, monitor, or otherwise evaluate the work being performed.

25.3.2. Inspections may include CMS or state-mandated operational and financial Health Plan reviews, determinations of compliance with this Agreement, and CMS or state-mandated independent evaluations. All inspections and evaluations will be performed in a manner that does not unduly interfere with or delay work.

25.4. Audit of Services and Deliverables

25.4.1. Upon reasonable notice from EOHHS, the Contractor shall provide the officials and

entities described in Section 25.2 access to:

25.4.1.1. Service locations, facilities, or installations.

25.4.1.2. Contract Records, including the records of all Representatives.

25.4.1.3. Computers, electronic systems, software, and equipment.

25.4.2. The access described in this Section will be for the purpose of examining, auditing, investigating, or inspecting:

25.4.2.1. Contractor's capacity to bear the risk of potential financial losses.

25.4.2.2. The services and deliverables provided by Contractor.

25.4.2.3. Information relating to the Contractor's Members.

25.4.2.4. A determination of the amounts payable under this Agreement.

25.4.2.5. A determination of whether the costs reported under this Agreement are allowable.

25.4.2.6. An examination of Subcontract terms or transactions

25.4.2.7. An assessment of financial results under this Agreement.

25.4.2.8. Detection of Fraud, Waste, or Abuse.

25.4.2.9. Other purposes EOHHS deems necessary to perform its oversight function or enforce this Agreement.

25.4.3. The Contractor shall provide any assistance such officials and entities require to complete examinations, audits, investigations, or inspections.

25.4.4. EOHHS will notify the Contractor of payment errors and overcharges and is entitled to offset payments to the Contractor or to collect such funds directly from the Contractor.

25.4.5. Contractor shall return funds owed to EOHHS within thirty (30) Days after receiving notice of an error or overcharge, or interest will accrue on the amount due.

25.4.6. EOHHS will calculate interest at twelve percent (12%) per annum, compounded daily. If the interest rate stipulated hereunder is found by a court of competent jurisdiction to be outside the range deemed legal and enforceable, then the rate hereunder will be adjusted as little as possible so as to be deemed legal and enforceable.

25.4.7. If an audit reveals that errors in reporting by the Contractor have resulted in errors in payments to the Contractor, the Contractor shall indemnify EOHHS for any losses resulting from such errors, including the cost of audit.

25.5. Compliance with Audit Findings

25.5.1. The Contractor shall take corrective action with respect to any finding of noncompliance or deficiency contained in any audit, review, or inspection conducted under this Section. This action shall include Contractor's delivery to EOHHS, for EOHHS' approval, of a Corrective Action Plan that addresses noncompliance or

deficiency findings within thirty (30) Days of the close of the audit, review, or inspection.

25.5.2. The Contractor shall bear the expense of noncompliance or deficiency findings and corrective actions, including the cost of additional audit, review, or inspection activities EOHHS determines are necessary due to the noncompliance or deficiency.

25.5.3. The Contractor shall provide EOHHS a copy of the portions of the Contractor's and its Representative's internal audit reports relating to the services and deliverables provided under this Agreement no later than five (5) Business Days after the reports are complete.

25.6. Application to Representatives and Network Providers

25.6.1. The Contractor shall require Representatives and Network Providers to comply with this Article and include appropriate flow-down provisions in Subcontracts and Network Provider Agreements.

25.6.2. Contracts between the Contractor and Representatives shall provide that EOHHS and the entities described in Section 25.2 may inspect, evaluate, or audit the Representative at any time.

25.6.3. Contracts between the Contractor and any Subcontractor or other Representative shall require that if EOHHS, CMS or the DHHS Inspector General determines there is a reasonable possibility of Fraud or similar risk, EOHHS, CMS, or the DHHS Inspector General may inspect, evaluate, or audit the Subcontractor or Representative at any time.

Article 26. Claims Processing and Management Information Systems (MIS)

The obligations outlined in this Section will survive the termination of the Agreement.

26.1. General Requirements

26.1.1. The Contractor shall have a claims processing system and management information system (MIS) that collects, analyzes, integrates, and reports data. The system shall be sufficient to meet all Provider payment and reporting requirements described in this Agreement.

26.1.2. The Contractor shall ensure that all data received from Provider is screened for completeness, logic, and consistency.

26.1.3. The Contractor shall make all collected data available to EOHHS, and to CMS and upon request.

26.1.4. The Contractor shall ensure all data collected from providers is collected in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies used for EOHHS Medicaid quality improvement and Care Coordination efforts.

26.1.5. EOHHS will own the exclusive rights to all data produced or collected by the Contractor's claims processing and MIS system.

26.1.6. The Contractor shall ensure all Subcontractors performing claims or MIS system functions or related activities comply with the requirements in this Section.

26.2. Claims System Functionality

26.2.1. The Contractor shall maintain an electronic claims management system that shall:

26.2.1.1. Uniquely identify the attending and billing provider of each service;

26.2.1.2. Identify the date of receipt of the claim by the Contractor as indicated by the date stamp on the claim;

26.2.1.3. Identify real-time accurate history with dates of adjudication results of each claim such as paid, denied, pended, adjusted, voided, appealed, etc., and follow up information on disputed claims;

26.2.1.4. Identify the date of payment as indicated on the check or other form of payment, and the number of the check or electronic funds transfer (EFT);

26.2.1.5. Identify all data elements as required by EOHHS for encounter data submission as stipulated in this Section of the Contract and the MCO System Companion Guide;

26.2.1.6. Accept submission of paper-based claims and electronic claims by Network Providers, and Out-of-Network Providers;

26.2.1.7. Accept submission of paper-based and electronic adjustments and void transactions;

26.2.1.8. Have capability to pay claims at $0.00; and

26.2.1.9. For the purpose of this Section, identify means to capture, edit, and retain.

26.2.2. The Contractor shall not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the Contractor or a third party. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable transaction fees and/or charges.

26.2.3. The Contractor shall assume all costs associated with claims processing, including costs for processing and/or reprocessing encounters.

26.2.4. Contractor shall bear the costs associated with claims reprocessing due to errors in processing by the Contractor to EOHHS' MMIS System. Reprocessing shall be deducted from the Contractor's monthly capitation payment. Errors due to an EOHHS error shall be waived by EOHHS.

26.2.5. The Contractor shall provide online and phone-based capabilities to providers to obtain claim processing status information.

26.2.6. The Contractor shall support a CAQH/CORE compliant interface to the automated clearinghouse (ACH) that allows providers to request and receive electronic funds transfer (EFT) of claims payments.

26.2.7. The Contractor shall have procedures, which shall be submitted and approved by EOHHS in writing prior to implementation, available to providers in written and web form for the acceptance of claim submissions which include:

26.2.7.1. The process for documenting the date of actual receipt of non-electronic claims and date and time of receipt of electronic claims;

26.2.7.2. The process for reviewing claims for accuracy and acceptability in accordance with 42 C.F.R. § 438.242(b)(3);

26.2.7.3. The process for prevention of loss of such claims; and

26.2.7.4. The process for reviewing claims for determination as to whether claims are accepted as clean claims.

26.2.8. The Contractor shall not employ off-system or gross adjustments when processing corrections for payment errors, unless the Contractor requests and receives prior written approval from EOHHS.

26.2.9. For purposes of network management, the Contractor shall notify all Network Providers to file claims associated with covered services for its Members directly with the Contractor.

26.2.10. The Contractor shall modify its claims billing and processing procedures to be consistent with industry norms within thirty (30) Calendar Days of receipt of a request from EOHHS.

26.3. Key Business Processes

26.3.1. The Contractor's MIS shall include key business processing functions and/or features, which shall apply across all subsystems.

26.3.2. Key business functions shall include:

26.3.2.1. Collecting, analyzing, integrating, and reporting data, including data pertaining to utilization, claims, Grievances and Appeals, and disenrollment for reasons other than loss of Medicaid eligibility.

26.3.2.2. Operating claims processing and retrieval systems that are able to collect data elements necessary to enable mechanized claims processing and informed retrieval systems, as required by Section 6504(a) of the ACA and 42 C.F.R. § 438.242(b)(1). Electronic transmission of claims data shall be consistent with the Transformed Medicaid Statistical Information System (T-MSIS), including detailed individual Member Encounter Data and other information necessary for program integrity, program oversight and administration.

26.3.2.3. Processing electronic data transmission or media to add, delete or modify membership records with accurate begin and end dates.

26.3.2.4. Capturing and reporting Member data by race, ethnicity, language, sexual orientation, gender identity, and other demographic characteristics as specified by EOHHS.

26.3.2.5. Tracking Covered Services received by Members through the system, and accurately and fully maintaining those Covered Services as HIPAA-compliant encounter transactions.

26.3.2.6. Transmitting or transferring Encounter Data transactions on electronic media in the HIPAA format to EOHHS or its agent.

26.3.2.7. Maintaining a history of changes and adjustments and audit trails for current and retroactive data.

26.3.2.8. Maintaining procedures and processes for accumulating, archiving, and restoring data in the event of a system or subsystem failure.

26.3.2.9. Employing industry-standard medical billing taxonomies (procedure codes, diagnosis codes, NDC) to describe services delivered and encounter transactions produced.

26.3.2.10. Supporting the coordination of benefits and recoveries from responsible third- parties.

26.3.2.11. Producing standard EOBs for Providers.

26.3.2.12. Supporting mechanized claims processing and paying financial transactions to Subcontractors, Network Providers, and Out-of-Network Providers in compliance with Governing Requirements.

26.3.2.13. Ensuring all financial transactions are auditable according to GAAP guidelines.

26.3.2.14. Relating and extracting data elements to produce reports required by CMS or EOHHS.

26.3.2.15. Ensuring written process and procedures manuals document and describe all manual and automated system procedures and processes for the MIS.

26.3.2.16. Maintaining and cross-referencing all Member-related information with the most current Medicaid Provider number.

26.4. Electronic Visit Verification

26.4.1. In accordance with Section 1903(l) of the Social Security Act, Section 12006(a) of the 21st Century Cures Act (P.L. 114-255), and the State's electronic visit verification (EVV) requirements, the Contractor shall comply with the following:

26.4.1.1. Sending Member authorization data for services subject to EVV to the State's EVV system;

26.4.1.2. Require all personal care and home health service providers to utilize the EVV system;

26.4.1.3. Receive and pay claims submitted by the State's or third-party EVV system on behalf of providers; and

26.4.1.4. Integrate and use any EVV data from the State's EVV system for care coordination, case management, service monitoring, pre-payment claims review and post-payment claims review.

26.4.1.5. Comply with EOHHS claims edits and claims management system requirements.

26.4.2. The Contractor shall ensure the following terms and conditions are met related to EVV System requirements under this Agreement:

26.4.2.1. Compliance with Federal and State Regulations: The EVV system must comply with all applicable federal and state regulations, including the 21st Century Cures Act, which mandates EVV for Medicaid-funded home health and personal care services.

26.4.2.2. Service Verification Features: The EVV system should accurately capture and record key data elements such as the date of service, type of service, individual providing the service, location of service delivery, and time the service begins and ends.

26.4.2.3. User Authentication: The system should ensure that the person providing the service is the same individual who is scheduled and authorized to provide the service.

26.4.2.4. Data Security and Privacy: Adequate measures must be in place to protect the privacy and security of patient and provider data in compliance with HIPAA and other relevant privacy laws.

26.4.2.5. Reliability and Accessibility: The EVV system should be reliable and easily accessible by providers. It should also accommodate different methods of electronic verification, such as mobile applications, telephonic systems, and fixed devices, depending on the service setting.

26.4.2.6. Training and Support: The Contractor must provide adequate training and support to providers and beneficiaries on how to use the EVV system.

26.4.2.7. Integration with State Systems: The EVV system should be capable of integrating with state Medicaid management information systems (MMIS) and other relevant state systems for seamless data exchange and reporting.

26.4.2.8. Flexibility and Adaptability: The system should be adaptable to accommodate changes in service models, regulatory requirements, and technological advancements.

26.4.2.9. Reporting Capabilities: The EVV system should have robust reporting features to facilitate monitoring, billing, and compliance verification.

26.4.2.10. Stakeholder Engagement: The contract may require the MCO to engage with stakeholders, including patients, caregivers, and providers, to ensure the EVV system meets their needs and addresses any concerns.

26.4.2.11. Audit, Compliance and Program Integrity Monitoring and Oversight: Provisions for regular audits and compliance monitoring of the EVV system to ensure adherence to contract requirements and regulations.

26.4.2.12. Exception Handling: The system should have a mechanism for handling and documenting exceptions or anomalies in service delivery.

26.4.3. The Contract must aim to ensure that EVV systems not only comply with legal mandates, but also enhance the efficiency, transparency, and quality of home health and personal care services provided to Members.

26.5. Provider Preventable Conditions

26.5.1. The Contractor shall require all Providers to report Provider Preventable Conditions associated with claims for payment or Member treatments for which payment would otherwise be made.

26.5.2. See Attachment F-1, “Definitions and Acronyms” for a description of Provider Preventable Conditions, including the criteria for and Health Care Acquired Conditions and Other Provider Preventable Conditions.

26.6. HIPPA Compliance

26.6.1. The Contractor’s MIS system shall comply with operational and information system requirements of HIPAA, including data specification and reporting requirements; issuing applicable certificates of creditable coverage when coverage is terminated; and reporting requested data to EOHHS or its designee.

26.6.2. All transactions and code sets exchange with EOHHS or its designee shall comply with the appropriate standard formats specified under HIPAA.

26.7. Claims Processing

26.7.1. The Contractor shall administer an effective, accurate, and efficient claims payment process that complies with this Agreement and Governing Requirements.

26.7.2. The Contractor shall process all claims in accordance with the benefit limits and exclusions set forth in the Rhode Island Medicaid State Plan and the terms of this Agreement.

26.7.3. The Contractor cannot directly or indirectly charge or hold a Member or Provider for claims adjudication or transaction fees.

26.7.4. The Contractor may pend claims submitted by providers that are the subject of a payment suspension due to a credible allegation of Fraud in accordance with 42 C.F.R. § 455.23 for the duration of the payment suspension. Once the suspension period has ended, the Contractor shall Adjudicate any previously pended claims in accordance with the timeframes above.

26.7.5. The Contractor shall not automatically adjust, down-code, or pay claims at a lower level of service than what was submitted by the provider.

26.7.6. In accordance with 42 CFR § 455.440, all claims for payment for items and services that were ordered or referred shall contain the National Provider Identifier (NPI) of the provider who ordered or referred such items or services.

26.7.7. For Dually Eligible Members, the Contractor shall adjudicate the claims in a manner that determines the Medicare payment amount separately from the Medicaid payment amount.

26.7.8. For Dually Eligible Members, the Contractor shall process the claim through the aligned integrated D-SNPs claims processing system for Medicare prior to the Contractor processing the claim for Medicaid.

26.7.9. For LTSS eligible Members who are determined by EOHHS to have a monthly patient share, the Contractor shall reduce reimbursements to the LTSS provider(s) equal to the Patient Share amount each month reported by EOHHS.

26.8. Timely Payment

26.8.1. The Contractor shall pay all claims timely in accordance with the following standards:

26.8.2. Clean Claims shall be paid within thirty (30) Days of receipt.

26.8.2.1. Timely payment is judged by the date that the Contractor receives the claim as indicated by its date stamped on the claim. The date of payment is the date of the check or other form of payment.

26.8.2.2. The Contractor is subject to contractual remedies, including liquidated damages, if it fails to meet the following performance standards:

a) Ninety percent (90%) of all Clean Claims shall be paid within thirty (30) Days of the date of receipt.

b) Ninety-nine percent (99%) of all Clean Claims shall be paid within ninety (90) Days of the date of receipt.

26.8.2.3. The Contractor shall report to EOHHS on Timely Payments. The Contractor's report shall include separate reporting containing all relevant information from Subcontractors and shall be conducted quarterly and

shall include, at minimum, data on the following, and any other requirements per the Managed Care Manual:

a) The average time to pay clean claims from the date of receipt;

b) The average time to pay clean claims based on provider type;

c) The number and rate of claims that are rejected;

d) The number and rate of claims that are clean;

e) The number and rate of pended claims;

f) The number and rate of denied claims;

g) The average time for claims to remain pended.

26.9. Date of Receipt and Payment

26.9.1. The Contractor shall ensure that the date of receipt is the date the Contractor receives the claim, as indicated by its date stamp on the claim; and that the date of payment is the date of the check or other form of payment.

26.10. Timely Filing

26.10.1. The Contractor shall establish a written policy regarding timely filing of Subcontractor and Provider claims for payment. The timeframe for timely filing a claim shall not be greater than ninety (90) Days from the date of service.

26.11. Denial of Payment

26.11.1. The Contractor may deny a claim submitted by a Provider for failure to file in a timely manner in accordance with the Contractor's written policy.

26.12. Payments Withholds

26.12.1. The Contractor shall withhold all or part of payment for any claim submitted by a Provider:

26.12.1.1. Debarred, suspended, or otherwise excluded from the Medicare, Medicaid, or CHIP programs for Fraud, Waste, or Abuse.

26.12.1.2. On payment hold under the authority of EOHHS or its authorized agents.

26.12.1.3. With debts, settlements, or pending payments due to EOHHS, or the State or Federal government.

26.13. Penalties

26.13.1. The Contractor is subject to contractual remedies, including liquidated damages and interest, if the Contractor does not process and adjudicate claims in accordance with the procedures and the timeframes listed in this Agreement.

26.14. Electronic Data Interchange

26.14.1. The Contractor shall offer its Providers and Subcontractors the option of submitting and receiving claims information through an electronic data interchange (EDI) that allows for automated processing and adjudication of claims. EDI processing shall be offered as an alternative to the filing of paper claims; however, the Contractor may not

require electronic submission. Electronic claims shall use HIPAA-compliant electronic formats. The Contractor shall only utilize an EDI approved by EOHHS. The Contractor shall utilize a single claims submission process for all Medicare and Medicaid claims, regardless of the type of claim. EOHHS will add requirements to the final negotiated contract.

26.15. Electronic Funds Transfers

26.15.1. The Contractor shall make an electronic funds transfer payment process for direct deposit available to Network Providers.

26.16. Provider Portal

26.16.1. The Contractor shall provide a Provider portal, at no cost to Providers, that supports functionality to reduce administrative burden on Network Providers. To the greatest extent possible, the Provider portal functionality should support both online and batch processing as applicable to the information being exchanged. To facilitate the exchange of clinical data and other relevant documentation, the Provider Portal shall provide a secure exchange of information between the Provider and Contractor, including, as applicable, a Subcontractor. The Provider Portal shall also provide one-stop access to information for the Contractor's affiliated D-SNP.

26.17. Audits

26.17.1. The Contractor shall conduct periodic audits of Provider claims in accordance with its Compliance Plan described in Section 24.2.

26.18. Claims System Changes

26.18.1. The Contractor shall notify EOHHS of major claim system changes in writing no later than one hundred eighty (180) Days prior to implementation. The Contractor shall provide an implementation plan and schedule of proposed changes. EOHHS reserves the right to require a desk or onsite Readiness Review of the changes and to approve go-live of the system changes based on the results of the Readiness Review.

26.19. Policies Affecting Claims Adjudication

26.19.1. The Contractor shall make any policies affecting claims adjudication and claims coding and processing guidelines available to Providers for the applicable Provider type. Providers shall receive ninety (90) Calendar Days' notice prior to the Contractor's implementation of changes to these claims policies and guidelines.

26.20. Inappropriate Payment Denials or Recoupments

26.20.1. If the Contractor has a pattern, as determined by EOHHS, of inappropriately denying, delaying, or recouping Provider payments for services, the Contractor may be subject to contractual remedies, including:

26.20.1.1. Suspension of new enrollments;

26.20.1.2. Monetary penalties equal to one hundred fifty percent (150%) of the value of the claims; inappropriately denied, delayed, or recouped;

26.20.1.3. Termination of this Agreement; and

26.20.1.4. Disqualification from future contract awards.

26.20.2. This Section applies not only to situations where EOHHS has ordered payment after a provider's claims payment appeal but also to situations where no appeal has been made (i.e., EOHHS is knowledgeable about the documented abuse from other sources).

26.21. Rejected Claims

26.21.1. The Contractor may reject claims because of missing or incomplete information required for adjudication. Paper claims that are received by the Contractor that are screened and rejected prior to scanning shall be returned to the provider with a letter notifying them of the rejection. Paper claims received by the Contractor that are scanned prior to screening and then rejected are not required to accompany the rejection letter.

26.21.2. The Contractor shall not include a rejected claim on the Remittance Advice (RA) because it will not have entered the claims processing system (except for pharmacy RAs).

26.21.3. In the claims rejection letter, the Contractor shall indicate why the claim is being returned, including all defects or reasons known at the time the determination is made and at a minimum, must include the following:

26.21.3.1. The date the letter was generated;

26.21.3.2. The Enrollee's name;

26.21.3.3. Provider identification, if available, such as provider ID number, TIN or NPI;

26.21.3.4. The date of each service;

26.21.3.5. The patient account number assigned by the provider;

26.21.3.6. The total billed charges;

26.21.3.7. The date the claim was received; and

26.21.3.8. The reasons for rejection.

26.22. Pended Claims

26.22.1. If a claim is received, but additional information is required for adjudication, the Contractor may pend the claim and request in writing all necessary information in order for the claim to be Adjudicated within the timeframes described above.

26.22.2. Claims should not be pended solely based on predictive modeling algorithm tools.

26.23. Payment to Providers

26.23.1. At a minimum, the Contractor shall run one (1) provider payment cycle per week, on the same day each week.

26.23.2. The Contractor shall encourage that its providers, as an alternative to the filing of paper-based claims, submit and receive claims information through electronic data interchange (EDI).

26.23.3. Interest owed to the provider shall be paid the same date that the claim is Adjudicated. Any interest payment should be reported on the applicable encounter submissions to the FI as defined in the MCO System Companion Guide.

26.23.4. The Contractor shall notify providers and EOHHS within five (5) Business Days of discovery of a system error or "glitch" that impacts reimbursement.

26.23.5. The notification must outline the process of resolution, including time frames, and be posted on the provider portal on the Contractor's web page and sent to providers via email and/or fax blast.

26.23.6. The Contractor should provide its provider call center staff with the relevant information immediately after discovery of the system error or "glitch" in order to ensure that staff will be able to properly answer provider questions.

26.24. Claims Reprocessing

26.24.1. If the Contractor or EOHHS or its subcontractors or Providers discover errors made by the Contractor when a claim was Adjudicated, the Contractor shall make corrections and reprocess the claim within fifteen (15) Calendar Days of discovery or notification, or if circumstances exist that prevent the Contractor from meeting this time frame, by a specified date subject to EOHHS written approval.

26.24.2. The Contractor shall pay providers interest at twelve percent (12%) per annum, calculated daily for the full period in which a payable clean claim remains unpaid beyond either the fifteen (15) Calendar Day claims reprocessing deadline or the specified deadline approved by EOHHS in writing, whichever is later.

26.24.3. The Contractor shall automatically recycle all impacted claims for all providers and shall not require the provider to resubmit the impacted claims.

26.25. Adjustments and Voids

26.25.1. The Contractor may adjust or void incorrect claims payments in accordance with the MCO Manual.

26.26. Claim System Edits

26.26.1. The Contractor shall perform system edits including, but not limited to:

26.26.1.1. Confirming eligibility on each Member;

26.26.1.2. Validating Member name;

26.26.1.3. Validating unique Member identification number;

26.26.1.4. Validating date of service – Perform system edits for valid dates of service, and ensure that dates of services are valid dates, e.g., not dates in the future or outside of an Enrollee's Rhode Island Medicaid eligibility span;

26.26.1.5. Determination of medical necessity – By a staff of qualified, medically trained and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity;

26.26.1.6. Covered Services – Ensure that the system verifies that a service is a covered service and is eligible for payment;

26.26.1.7. Prior Authorization – The system shall determine whether a covered service required prior authorization and if so, whether the Contractor granted such authorization;

26.26.1.8. Duplicate Claims – The system shall in an automated manner, flag a claim as being exactly the same as a previously submitted claim or a possible duplicate and either deny or pend the claim as needed;

26.26.1.9. Provider Validation – Ensure that the system shall approve for payment only those claims received from qualified providers eligible to render the service for which the claim was submitted and that the provider has not been excluded from receiving Medicaid payments as stipulated in the Provider Network, Contracts, and Related Responsibilities section; and

26.26.1.10. Quantity of Service – Ensure that the system shall evaluate claims for services provided to ensure that any applicable benefit limits are applied.

26.26.1.11. The Contractor shall perform post-payment review on a statistically valid sample of claims to ensure services provided were medically necessary.

26.26.1.12. The Contractor shall notify EOHHS and providers as to when system updates will be in production and of the Contractor's process for the recycling of denied claims that are due to system update delays. The recycling of these denied claims shall be completed no later than fifteen (15) Calendar Days after the system update.

26.26.1.13. Except as otherwise specified by EOHHS in writing, the Contractor shall use only national standard code sets such as CPT/HCPCS, ICD-10-CM, etc. The Contractor shall also comply with deadlines for communication, testing and implementation of code sets established by CMS and/or EOHHS.

26.26.1.14. The Contractor shall have the ability to update national standard code sets such as CPT/HCPCS, ICD-10-CM, and move to future versions as required by CMS or EOHHS. Updates to code sets are to be complete no later than thirty (30) Calendar Days after notification, unless otherwise directed by EOHHS in writing. This includes annual and other fee schedule updates.

26.26.1.15. In addition to CPT, ICD-10-CM, ICD-10-PCS and other national coding standards, the Contractor shall use applicable HCPCS Level II and Category II CPT codes to aid both the Contractor and EOHHS in evaluating performance measures.

26.26.1.16. The Contractor shall perform internal audit reviews at least annually to confirm claim edits are functioning properly and provide EOHHS with confirmation of this process. EOHHS shall be provided the results of

internal audit reviews upon request.

26.26.1.17. The Contractor shall employ CMS mandated edits for Rhode Island Medicaid Program and nationally recognized clinical editing standards as outlined below:

26.26.1.18. At a minimum, these edits shall be maintained and updated annually unless otherwise appropriate and apply to practitioners, outpatient hospitals, and DME services.

26.26.1.19. Edits shall be based on current industry benchmarks and best practices including, but not limited to, specialty society criteria, American Medical Association CPT coding guidelines, and CMS mandated edits for Rhode Island Medicaid Program, which include the quarterly National Correct Coding Initiative (NCCI) edits or its successor.

26.26.1.20. These edits include, but are not limited to, units of service, unbundling, mutually exclusive and incidental procedures, pre/post-op surgical periods, modifier usage, multiple surgery reduction, add-on codes, cosmetic, and assistant surgeon. Editing shall include the ability to apply edits to the current claim as well as paid history claims when applicable.

26.26.1.21. The Contractor shall provide a written attestation to EOHHS annually stating that they are adhering to these requirements and are subject to periodic requests from EOHHS for validation of the edits.

26.26.1.22. The Contractor shall implement CMS mandated edits and NCCI edits quarterly as directed by CMS and adhere to EOHHS timelines for the updates.

26.27. National Correct Coding Initiatives

26.27.1. The Contractor shall comply with the requirements of Section 6507 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), regarding "Mandatory State Use of National Correct Coding Initiatives," to control improper coding, including all applicable rules, regulations, and methodologies, as amended or modified, in accordance with EOHHS policy, unless otherwise directed, in writing, by EOHHS.

26.27.2. Any Contractor requested exceptions to NCCI policies must in writing and be reviewed and approved by EOHHS.

26.27.3. The Contractor must incorporate compatible NCCI methodologies in its payment systems for processing Medicaid claims.

26.27.4. The NCCI editing should occur in addition to current procedure code review and editing by the Contractor's claims payment systems.

26.27.5. For codes with a Medically Unlikely Edit Adjudication Indicator (MAI) of "1" or "3," the Contractor must allow a provider appeal process to perform case by case evaluation for exceptions based on medical necessity.

26.27.6. EOHHS will share the non-public Medicaid NCCI edit files received from CMS with the Contractor, when available.

26.27.7. The Contractor shall not:

26.27.7.1. Disclose, publish, or share with any part not involved in the implementation of the quarterly state Medicaid NCCI methodologies covered by this Contract, the non-public Medicaid NCCI edit files;

26.27.7.2. Use any non-public information from the non-public Medicaid NCCI edit files for any business purposes unrelated to the implementation of the Medicaid NCCI methodologies in the State;

26.27.7.3. Implement new, revised, or deleted non-public Medicaid NCCI edits prior to the first calendar day of the quarter;

26.27.7.4. Allow use of new, revised, or deleted Medicaid NCCI edits by reviewers in non-Medicaid programs prior to the posting of the public Medicaid NCCI edit files on the Medicaid NCCI webpage;

26.27.7.5. Release to the public any non-public Medicaid NCCI edit file, at any time; and,

26.27.7.6. Use the non-public Medicaid NCCI edit files for any non-Medicaid purpose, at any time.

26.27.8. Contractor and their Subcontractor shall only disclose general confidential information that is available that is also available to the general public about the Medicaid NCCI edit files on the Medicaid NCCI webpage.

26.27.8.1. EOHHS shall impose sanctions in accordance with the Sanctions section of this Contract, up to and including termination of this Agreement, for violations of this section.

26.28. Remittance Advices

26.28.1. In conjunction with its payment cycles, the Contractor shall provide that:

26.28.1.1. Adjustments and Voids shall appear on the remittance advice under "Adjusted or Voided Claims" either as Approved or Denied.

26.28.1.2. In accordance with 42 C.F.R. §§ 455.18 and 455.19, the following statements shall be included on each remittance advice sent to providers:

26.28.1.3. "This is to certify that the foregoing information is true, accurate, and complete."

26.28.1.4. "I understand that payment of this claim will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws."

26.28.2. Pharmacy remittance advice from the PBM must be issued as a standalone remittance advice, specific to the Rhode Island Medicaid Program and separate from other lines of business at the request of the pharmacy.

26.28.2.1. The Contractor shall submit a sample of remittance advices that were sent to independent, chain and specialty pharmacies by the PBM to EOHHS pharmacy staff quarterly. This sample shall include at least ten (10) remittance advices from different pharmacies from each pharmacy type (independent, chain, and specialty). Each quarter shall have samples from different pharmacies.

26.29. Sampling of Paid Claims

26.29.1. On a monthly basis, the Contractor shall provide individual explanation of benefits (EOB) notices to a sample group of Members, not more than forty-five (45) Calendar Days from the date of payment, in a manner that complies with 42 C.F.R. §§ 455.20 and 433.116(e). In easily understood language, the required notice shall specify:

26.29.1.1. Description of the service furnished;

26.29.1.2. The name of the provider furnishing the service;

26.29.1.3. The date on which the service was furnished;

26.29.1.4. The amount of the payment made for the service; and

26.29.1.5. The method for notifying the Contractor of services not rendered.

26.29.2. The Contractor shall stratify the paid claims sample to ensure that all provider types (or specialties) and all claim types are proportionally represented in the sample pool from the entire range of services available under the Contract. To the extent that the Contractor or EOHHS considers a particular specialty (or provider) to warrant closer scrutiny, the Contractor may over sample the group. The paid claims sample shall be a minimum of two percent (2%) of paid claims per month to be reported to EOHHS on a quarterly basis.

26.29.3. The notices may be provided by mail, telephonically, or in person (e.g., case management on-site visits).

26.29.4. The Contractor shall track any responses received from Enrollees and resolve the responses according to its established policies and procedures. The resolution may be affected through Enrollee education, provider education, payment recovery, or referral to EOHHS. The Contractor shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.

26.29.5. Within three (3) Business Days of receipt of a response from an Members, results indicating that paid services may not have been received shall be referred to the Contractor's Fraud and Abuse department for review and to the EOHHS Office of Program Integrity.

26.29.6. Reporting shall include, at a minimum, the total number of notices sent to Enrollees, total number of services sent for validation, total number of responses completed, total services requested for validation, number of services validated, analysis of interventions related to resolution, and number of responses referred to EOHHS for further review.

26.30. Claims Dispute Management

26.30.1. The Contractor shall develop an internal claims dispute process for those claims or group of claims that have been denied or underpaid. The process shall be submitted as part of Readiness Review to EOHHS or its designee for approval.

26.30.2. The Contractor's Claims Dispute process shall allow providers the option to request binding arbitration for claims that have denied or underpaid claims or a group of claims bundled, by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If the Contractor and the provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this Section shall be binding on all parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) Calendar Days of being selected, unless the Contractor and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorney fees, shall be shared equally by the parties.

26.30.3. The Contractor shall systematically capture the status and resolution of all claim disputes as well as all associated documentation.

26.30.4. The Contractor shall Adjudicate all disputed claims to a paid or denied status within thirty (30) Business Days of receipt of the disputed claim.

26.30.5. The provider shall have one hundred eighty (180) Calendar Days from the date of denial to dispute the denied claim.

26.31. Payment Recoupments

26.31.1. The Contractor shall provide written prior notification to a provider of its intent to recoup any payment.

26.31.2. The notification shall include:

26.31.2.1. The Enrollee's name, date of birth, and Medicaid identification number;

26.31.2.2. The date(s) of health care services rendered;

26.31.2.3. A complete listing of the specific claims and amounts subject to the recoupment;

26.31.2.4. The specific reasons for making the recoupment for each of the claims subject to the recoupment;

26.31.2.5. The date the recoupment is proposed to be executed;

26.31.2.6. The mailing address or electronic mail address where a provider may submit a written response;

26.31.2.7. When applicable, the date EOHHS notified the Contractor of the Enrollee's Disenrollment via the ASC X12N 834 Benefit Enrollment and Maintenance Transaction; and

26.31.2.8. When applicable, the effective date of Disenrollment.

26.31.3. Before the recoupment is executed, the provider shall have sixty (60) Calendar Days from receipt of written notification of recoupment to submit a written response to the Contractor as to why the recoupment should not be put into effect on the date specified in the notice. If the provider fails to submit a written response within the time period provided, the Contractor may execute the recoupment on the date specified in the notice.

26.31.4. Upon receipt by the Contractor of a written response as to why the recoupment should not be put into effect, the Contractor shall, within thirty (30) Calendar Days from the date the written response is received, consider the statement, including any pertinent additional information submitted by the provider or otherwise available to the Contractor, determine whether the facts justify recoupment, and provide a written notice of determination to each written response that includes the rationale for the determination.

26.31.5. If the Contractor determines that the recoupment is valid, the provider shall remit the amount to the Contractor or permit the Contractor to deduct the amount from future payments due to the provider.

26.31.6. EOHHS reserves the right to review and prohibit any recoupment.

26.31.7. The Contractor must complete all reviews and/or audits of a provider claim no later than one (1) year after receipt of a clean claim, regardless of whether the provider participates in the Contractor's network. This includes an “automated” review, which is one for which an analysis of the paid claim is sufficient to determine the existence of an overpayment, whereas no additional documentation is required to be submitted from the provider to determine the existence of an overpayment.

26.31.8. This limitation does not apply in cases of provider Fraud, Waste, or Abuse that the Contractor did not discover within the one- (1)-year period following receipt of a claim via “complex” review. (Additional information regarding automated and complex reviews may be found in the Fraud, Waste and Abuse Prevention section.)

26.31.9. This limitation also does not apply when CMS, OIG, HHS, OIG, the Rhode Island Attorney General, the Department of Justice, the Government Accountability Office (GAO), EOHHS, and/or any of their designees conclude an examination, audit, or inspection of a provider more than one (1) year after the Contractor received the claim.

26.31.10. For Enrollees disenrolled due to the invalidation of a duplicate Medicaid ID, the Contractor shall not recover claim payments under the retroactively dis-enrolled member’s ID if the remaining, valid ID is also linked to the same Contractor for the retroactive Disenrollment period. The Contractor shall identify these duplicate Medicaid IDs for a single Enrollee and resolve the duplication so that histories of the duplicate records are linked or merged.

26.31.11. The Contractor shall develop and implement a safeguard for automated reviews to prevent subsequent reviews on a claim when the denial or exception reason is the same as a previous denial or exception reason. The Contractor and its subcontractors shall

not recover from a provider via automated review for a claim for which an automated denial was reversed subsequent to provider dispute, when the denials are for the same reason. For such claims, the Contractor shall ensure a complex review and consideration of the claim history or audit trail.

26.31.12. At the provider's request, the Contractor shall provide an independent review of claims that are the subject of an adverse determination by the Contractor.

26.31.13. The Contractor shall not recoup simply on the basis of an encounter being denied.

26.32. Claims Payment Accuracy Report

26.32.1. On a monthly basis, the Contractor shall submit a claims payment accuracy percentage report to EOHHS. The report shall be based on an audit conducted by the Contractor.

26.32.2. The audit shall be conducted by an entity or staff independent of claims management, and shall utilize a randomly selected sample of all processed and paid claims upon initial submission in each month. A minimum sample consisting of two hundred (200) to two hundred-fifty (250) claims per month, based on financial stratification, shall be selected from the entire population of electronic and paper claims processed or paid upon initial submission.

26.32.3. The minimum attributes to be tested for each claim selected shall include:

26.32.3.1. Claim data is correctly entered into the claims processing system;

26.32.3.2. Claim is associated with the correct provider;

26.32.3.3. Proper authorization was obtained for the service;

26.32.3.4. Enrollee eligibility at processing date was correctly applied;

26.32.3.5. Allowed payment amount agrees with contracted rate;

26.32.3.6. Duplicate payment of the same claim has not occurred;

26.32.3.7. Denial reason is applied appropriately;

26.32.3.8. Co-payments are considered and applied, if applicable;

26.32.3.9. Effect of modifier codes were correctly applied; and

26.32.3.10. Proper coding.

26.32.4. The results of testing at a minimum should be documented to include:

26.32.4.1. Results for each attribute tested for each claim selected;

26.32.4.2. Amount of overpayment or underpayment for each claim processed or paid in error;

26.32.4.3. Explanation of the erroneous processing for each claim processed or paid in error;

26.32.4.4. Determination if the error is the result of a keying error or the result of error in the configuration or table maintenance of the claims processing system; and

26.32.4.5. Claims processed or paid in error have been corrected.

26.32.5. If the Contractor subcontracted for the provision of any covered services, and the subcontractor is responsible for processing claims, then the Contractor shall submit a claims payment accuracy percentage report for the claims processed by the subcontractor.

26.33. Claims Summary Report

26.33.1. The Contractor shall submit monthly Claims Summary Reports of paid and denied claims to EOHHS by claim type. Instructions are provided in the MCO System Companion Guide.

26.34. Pharmacy Claims Processing

26.34.1. System Requirements

26.34.1.1. The Contractor shall have an automated claims and encounter processing system for pharmacy claims that will support the requirements of this Contract and ensure the accurate and Timely processing of claims and encounters. The Contractor shall allow pharmacies to back bill electronically (reversals and resubmissions) for three hundred sixty-five (365) Calendar Days from the date of the original submission of the claim.

26.34.1.2. The Contractor shall support electronic submission of claims using the most current HIPAA compliant transaction standard.

26.34.1.3. Pharmacy claim edits shall include eligibility, drug coverage, benefit limitations, prescriber and prospective/concurrent drug utilization review edits.

26.34.1.4. The system shall provide for an automated update to the National Drug Code file including all product, packaging, prescription and pricing information. The system shall provide online access to reference file information. The system shall maintain a history of the pricing schedules and other significant reference data. The drug file for both retail and specialty drugs, including price, shall be updated within three (3) Business Days of receipt of the drug file.

26.34.1.5. The Contractor shall comply with the claims history requirements in this Section.

26.34.1.6. The Contractor shall ensure that the manufacturer number, product number, and package number for the drug dispensed shall be listed on all claims. This information shall be taken from the actual package from which the drug is usually purchased by a provider, from a supplier whose products are generally available to all pharmacies and reported in one or more national compendia.

26.34.1.7. Provisions shall be made to maintain permanent history by service date for those services identified as “once-in-a-lifetime.”

26.35. Pharmacy Rebates

26.35.1. The Contractor shall submit all drug encounters, with the exception of inpatient hospital drug encounters, to EOHHS or its subcontractor pursuant to the requirements of this section. EOHHS or its subcontractor shall submit these encounters for federal or supplemental pharmacy rebates from manufacturers under the authority of the EOHHS Secretary pursuant to the Section 2501 of the Patient Protection and Affordable Care Act (ACA).

26.36. Pharmacy Encounters Claims Submission

26.36.1. The Contractor shall submit a weekly claim-level detail file of pharmacy encounters to EOHHS which includes individual claim-level detail information on each pharmacy claim dispensed to a Member including, but not limited to, the total number of metric units, dosage form, strength and package size, and National Drug Code of each covered outpatient drug dispensed to Enrollees. This weekly submission must comply with encounter data requirements of this section.

26.36.2. At the request of EOHHS or the FI, the Contractor shall submit pharmacy claims information in an electronic format that is suited to allow for integration with the State's pharmacy rebate program according to the schedule established by EOHHS in writing.

26.36.3. The pharmacy rebate process is a quarterly process, and claims information is usually required before the end of the month that follows the end of the quarter.

26.36.4. The Contractor shall require that Network Providers who are covered entities, as defined by Section 340B of the Public Health Services Act, utilize the same carve-in or carve-out designation for the Contractor's Members as for FFS. If a covered entity appears on the Medicaid Exclusion File, EOHHS will exclude that provider's FFS and MCO claims from rebate invoicing. Claims for FFS and Members are treated identically in regards to exclusion from rebate invoicing.

26.36.5. The Contractor shall utilize a unique Processor Control Number (PCN) or Group Number for the Rhode Island Medicaid Program. This unique PCN or group number shall be submitted to EOHHS before processing any pharmacy claims.

26.36.6. Contract pharmacies are not permitted to bill the Rhode Island Medicaid Program for drugs purchased at 340B pricing. This includes both FFS and the MCOs.

26.36.7. The Contractor shall include billing instructions on how to identify 340B claims/encounters in their contracts with 340B providers.

26.37. Disputed Pharmacy Encounter Submissions

26.37.1. At least quarterly, EOHHS may review the Contractor's pharmacy encounter claims and send a file back to the Contractor of disputed encounters that were identified through the drug rebate invoicing process.

26.37.2. Within sixty (60) Calendar Days of receipt of the disputed encounter file from EOHHS, the Contractor shall, if needed, correct and resubmit any disputed encounters and send a response file to EOHHS or its designee that includes:

26.37.2.1. Corrected and resubmitted encounters as described in the Rebate Section of the MCO System Companion Guide; and/or,

26.37.2.2. A detailed explanation of why the disputed encounters could not be corrected including documentation of all attempts to correct the disputed encounters at an encounter claim level detail, as described in the Rebate Section of the MCO System Companion Guide.

26.37.3. The Contractor may be subject to Monetary Penalties in accordance with Attachment F-6, "Liquidated Damages", for failure to submit weekly pharmacy encounter claims files and/or a response file to the disputed encounters file within sixty (60) Calendar Days as detailed above for each disputed encounter.

26.38. Encounter Data Reporting

26.38.1. In accordance with 42 C.F.R. § 438.242(c), the Contractor shall submit complete, accurate, and timely Encounter Data for all services for which the Contractor has incurred any financial liability, whether directly or through Subcontracts or other arrangement.

26.38.2. The Contractor shall:

26.38.2.1. Collect and maintain sufficient Member Encounter Data to identify:

26.38.2.2. Any items or services provided to Members and the identity of the Provider who furnished them;

26.38.2.3. The allowed amount and paid amount;

26.38.2.4. Member and Provider characteristics; and

26.38.2.5. Any other data as specified by EOHHS or CMS based on program administration, oversight and program integrity needs or that EOHHS is required to report to CMS under 42 C.F.R. § 438.818.

26.38.2.6. Collect data from Providers in standardized formats to the extent feasible and appropriate.

26.38.2.7. Submit encounter data in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format, as appropriate.

26.38.2.8. Collect and submit all Subcontractor Encounter Data.

26.38.2.9. Comply with the procedures and requirements for data reporting, submission, and accuracy in the EOHHS guidance document "Rhode Island Medicaid Managed Care Encounter Data Quality, Thresholds and Penalties for Non-Compliance" (the "EOHHS Encounter Data Guidance") in the Managed Care Manual.

26.38.2.10. Make all collected data available to EOHHS and upon request, to CMS.

26.38.3. EOHHS reserves the right to make changes to the EOHHS Encounter Data Guidance at any time, and the Contractor shall implement those changes within the time specified by EOHHS.

26.39. Timeliness and Frequency Requirements

26.39.1. The Contractor shall submit all specified Encounter Data at an agreed upon cadence with EOHHS.

26.39.2. Encounter Data shall be submitted within forty-five (45) Days of the claim's paid date. If an encounter is initially rejected, the Contractor shall correct and resubmit the encounter claim within the forty-five (45) Calendar Day timeframe.

26.39.3. The Contractor is required to ensure that its submitted encounters are submitted timely. Timeliness of initial encounter submissions will be monitored monthly by the MMIS Vendor and the EOHHS Data Quality Team. The MMIS Vendor will calculate the difference between the Contractor's paid date and the date the encounter was accepted into the MMIS.

26.39.4. The MMIS Vendor will prepare a monthly report to summarize the data on the Contractor's timely submission of Encounter Data. If more than two percent (2%) of the Contractor's encounters are untimely (e.g., submitted and accepted more than forty five (45) Days after the payment date shown on the accepted encounter), the Contractor will be subject to penalties for non-compliance as outlined in Attachment F-6 "Liquidated Damages Matrix".

26.40. Office of Management and Budget Standards for Collecting and Reporting Demographic Data

26.40.1. In accordance with 42 U.S.C. § 300kk, the Contractor shall be able to collect and report data on race, ethnicity, sex, primary language, and disability status.

26.40.2. The Contractor shall develop procedures to collect this information from Members or their legally Authorized Representatives.

26.40.3. The Contractor shall comply with the Office of Management and Budget (OMB) standards for data collection for race and ethnicity.

26.41. Accuracy

26.41.1. The Contractor shall ensure that the Encounter Data received from Subcontractors and Providers is accurate and complete by:

26.41.1.1. Verifying the accuracy and timeliness of reports date, including data from Network Providers who the Contractor is compensating on the basis of capitation or APM payments.

26.41.1.2. Screening for completeness, logic, and consistency.

26.41.1.3. Attesting to the accuracy of each submission to the State.

26.41.2. The Contractor is required to ensure that its submitted encounters are accepted as accurate upon initial submission. Accuracy of initial encounter submissions will be monitored monthly by the MMIS Vendor and the EOHHS Data Quality Team. The MMIS Vendor will calculate the number of rejected encounters upon initial submission and the number of total encounters submitted for each encounter file submitted by the Contractor. The MMIS Vendor will prepare a report that summarizes the number of

total encounters submitted and rejected for the Contractor each month.

26.41.3. The number of rejected encounters will be the numerator and the total number of submitted encounters will be the denominator of the calculation for accuracy. If the ratio of the rejected encounters for the month over the total number of encounters submitted for the month is greater than two percent (2%), the Contractor will be subject to the penalties for non-compliance as outlined in Attachment F-6 "Liquidated Damages Matrix".

26.41.4. Annually, EOHHS will develop a diagnosis code distribution report by file type (institutional, professional, dental and pharmacy) and state fiscal year for accepted Encounter Data in the MMIS. The diagnosis code distribution will illustrate the percentage of claims, as shown in the Encounter Data, with a given number of diagnoses [e.g., forty percent (40%) of claims have one (1) diagnosis, twenty percent (20%) of claims have two (2) diagnoses, etc.]. The Contractor shall attest within thirty (30) Days of receipt of the file from EOHHS that the diagnosis code distribution for each file type matches the diagnosis codes on the paid claims associated with the accepted Encounter Data.

26.41.5. Failure to attest to any diagnosis code distribution report will result in penalties for non-compliance as outlined in Attachment F-6 "Liquidated Damages Matrix".

26.41.6. If EOHHS determines there are material errors in the accuracy of the submitted Encounter Data that interrupt EOHHS business operations, including but not limited to such activities as capitation rate development, risk adjustment, and fiscal analyses, EOHHS may enforce the penalty for non-compliance in Encounter Data accuracy as outlined in Attachment F-6 "Liquidated Damages Matrix".

26.41.7. Additional accuracy measures may be established by EOHHS in response to identified encounter data issues.

26.41.8. The Contractor shall comply with standards for Encounter Data completeness, accuracy, and timeliness in the EOHHS Encounter Data Guidance.

26.41.9. The Contractor is responsible for reconciling Financial Data Cost Report cost allocations and the File Submission Report in accordance with the standards and requirements set forth in the EOHHS Encounter Data Guidance.

26.41.10. The Contractor shall cooperate and assist EOHHS to validate that the Contractor's Encounter Data is a complete and accurate representation of the services provided to Members under this Agreement by producing records, including samples of medical records and claims data upon request.

26.41.11. The Contractor is solely responsible for ensuring that its Subcontractors are in compliance with EOHHS' data submission and reporting requirements as described in this Agreement and the EOHHS Encounter Data Guidance.

26.42. Completeness

26.42.1. The Contractor is required to ensure that its submitted encounters are complete. The File Submission Report (FSR) templates will be used in the evaluation of Contractor's

Encounter Data submission completeness. The FSR will include summarized file submission information status by vendor, line of business and state fiscal year in a format specified by EOHHS. The ratio of Encounter Data accepted into the MMIS over the claims incurred as reported in the FSR template shall meet or exceed an accepted rate of ninety-nine percent (99%) and will be evaluated on a quarterly basis by EOHHS.

26.42.1.1. EOHHS reserves the right to require the Contractor to be at one-hundred percent (100%) completeness by Base Year 2 of this Agreement.

26.42.2. The Contractor will submit an attestation that the amounts reported in the FSR are an accurate representation of the claim payment financial liability and encounter submission activity of the Contractor. Failure to provide attestation will result the penalties for non-compliance as outlined in Attachment F-6 "Liquidated Damages Matrix".

26.42.3. The reported incurred expenditures submitted in the FSR shall align with the sum of the Direct Paid, Non-State Plan Paid, and Subcapitated Proxy Paid expenditures submitted in the Financial Data Cost Report (FDCR) for each state fiscal year within a point zero one percent (0.1%) threshold for each quarter the FDCR is submitted. The File Submission Report and FDCR used for this comparison will include the same paid run-out period. The format of the reconciliation will be specified by EOHHS. Failure to meet threshold will result the penalties for non-compliance as outlined in Attachment F-6 "Liquidated Damages Matrix".

26.43. All Payer Claims Database

26.43.1. The Rhode Island All Payer Claims Database (RI-APCD), is a repository of healthcare insurance payment information for people living in Rhode Island. The data will come from the major health insurance companies doing business in Rhode Island, including fully insured and self-funded commercial plans, Medicare, and Medicaid. The development of the RI-APCD is a collaborative effort amongst the Rhode Island Department of Health, the Office of the Health Insurance Commissioner, the Health Benefits Exchanges, and the Executive Office of Health and Human Services.

26.43.2. Pursuant to R.I. Gen. Laws § 23-17.17-10, the Contractor shall submit timely data exchange files to the RI-APCD according to the schedule established by the RI-APCD.

26.44. Penalties for Non-Compliance

26.44.1. At the discretion of EOHHS, the Contractor may be subject to penalties as set forth in the "Rhode Island Medicaid Managed Care Encounter Data Quality Measurement, Thresholds and Penalties for Non-Compliance" document.

26.44.2. For non-compliance with the standards for encounter data completeness, accuracy and timeliness that are incorporated by reference into this contract at Section 26.32, penalties shall be imposed in accordance with the procedures set forth in the EOHHS Encounter Data Guidance.

26.44.3. Failure of a Health Care Provider or Subcontractor to provide the Contractor with necessary Encounter Data will not excuse the Contractor's noncompliance with the

encounter data requirements.

26.45. Financial Sanctions

26.45.1. EOHHS will require the Contractor to submit a Corrective Action Plan when areas of noncompliance are identified. EOHHS may assess financial sanctions as provided in EOHHS Encounter Data Guidance based on the identification of instances of non-compliance.

26.46. Encounter Data Meetings

26.46.1. The Contractor shall participate in regular meetings with the State concerning Encounter Data reporting and submission and shall submit reports to the State as requested.

26.47. RIte Share Reporting

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

26.48. Coordination with Medicare

26.48.1. The Contractor is responsible for providing medically necessary covered services to Members who are also eligible for Medicare if the service is not covered by Medicare.

26.48.2. The Contractor shall ensure that services covered and provided pursuant to this Agreement are delivered without charge to Members who are Dually Eligible for Medicare and Medicaid services.

26.48.3. The Contractor shall coordinate with the aligned Medicare Advantage plan and Medicare providers as appropriate to coordinate the care and benefits of Members who are also eligible for Medicare.

26.48.4. The Contractor shall be responsible for processing, paying, and reporting all Medicare crossover claims in accordance with provisions described by EOHHS.

26.48.5. The Contractor shall maintain Medicare eligibility information for assigned Members in a format approved by EOHHS in order to identify Medicare crossover claims.

26.48.6. The Contractor shall be responsible for processing, paying, and reporting all Medicare crossover claims, including out-of-network providers.

26.48.7. The Contractor shall require out-of-network providers to execute an Out-of-Network Provider Agreement with the Contractor prior to payment for Medicare crossover claims.

26.48.8. The Contractor shall maintain HIPAA compliance and follow state policies and processes which shall include at a minimum, coordination of benefits, sending explanation of benefits, applicable audit trail, reporting, data to support audits (including PERM) and submitting post-adjudicated encounter data to EOHHS which shall represent claims received and processed.

26.48.9. The Contractor shall be responsible for responding to inquiries related to claims (e.g., claim status inquiries, appeals).

26.48.10. The Contractor shall provide EOHHS with encounter data that includes details of financial liability for both Medicare and Medicaid on each respective claim.

26.49. Independent Audits of Systems

26.49.1. The Contractor shall submit an independent SOC 2 Type II system audit. The audit shall review system security, system availability, system confidentiality and processing integrity for the Rhode Island Medicaid Program line of business. The audit period shall be twelve (12) consecutive months, aligning with the Contractor's fiscal year, with no breaks between subsequent audit periods.

26.49.2. The Contractor shall supply EOHHS with an exact copy of the SOC 2 Type II independent audit no later than six (6) months after the close of the Contractor's fiscal year.

26.49.3. The Contractor shall deliver to EOHHS a Corrective Action Plan to address deficiencies identified during the audit within thirty (30) Business Days of the Contractor's receipt of the final audit report.

26.49.4. These audit requirements are also applicable to any subcontractors or vendors delegated the responsibility of adjudicating claims on behalf of the Contractor. The cost of the audit shall be borne by the Contractor or subcontractor.

26.50. Audit Coordination and Claims Reviews

26.50.1. The Contractor shall coordinate audits with EOHHS as directed by EOHHS.

26.50.2. EOHHS reserves the right to review any claim paid by the Contractor or designee. The Contractor has the right to collect or recoup any overpayments identified by the Contractor from providers of service in accordance with applicable Federal and State laws, regulations, rules, policies, and procedures. If an overpayment is identified by the State or its designee and the provider fails to remit payment to the State, EOHHS may require the Contractor to collect and remit the overpayment to EOHHS. Failure by the Contractor to collect from the provider does not relieve the Contractor from remitting the identified overpayment to EOHHS.

26.50.3. The Contractor must complete all reviews and/or audits of a provider claim no later than one (1) year after receipt of a clean claim, regardless of whether the provider participates in the Contractor's network. This includes an "automated" review, which is one for which an analysis of the paid claim is sufficient to determine the existence of an overpayment, whereas no additional documentation is required to be submitted from the provider to determine the existence of an overpayment.

26.50.4. This limitation does not apply in cases of provider Fraud, Waste, or Abuse that the Contractor did not discover within the one (1)-year period following receipt of a claim via "complex" review. (Additional information regarding automated and complex reviews may be found in the Fraud, Waste and Abuse Prevention section.)

26.50.5. This limitation also does not apply when CMS, OIG, HHS, MFCU, the Rhode Island

Attorney General, GAO, EOHHS, and/or any of their designees conclude an examination, audit, or inspection of a provider more than one (1) year after the Contractor received the claim.

Article 27. Financial Requirements

27.1. Third-Party Liability

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

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

27.1.3. Under Section 1902(a)(25) of the Social Security Act, EOHHS and the Contractor are required to take all reasonable measures to identify legally liable third-parties and treat verified TPL as a resource of the Medicaid recipient.

27.1.4. The Contractor agrees to take primary responsibility for identifying, collecting, and reporting TPL coverage and collection information to EOHHS on a weekly basis. As TPL information is a component of Capitation Rate development, the Contractor shall maintain records regarding TPL collections and shall report these collections to EOHHS in the timeframe and format determined by EOHHS, in accordance with Section 27.14, "Financial Data Reporting."

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

27.1.6. The Contractor shall designate one (1) contact person for TPL matters.

27.1.7. The Contractor shall develop and maintain a TPL Policy. In accordance with, Section 27.1, "Third-Party Liability," the Contractor shall submit the TPL Policy for EOHHS review and approval within ninety (90) Days of the execution of this Agreement. The Contractor shall submit the TLP annually thereafter and upon EOHHS' request. In the event of modification of the TPL Policy, the Contractor shall submit TPL Policy amendments to EOHHS for review and approval at least ninety (90) Days before the proposed effective date.

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

27.1.9. The Contractor shall collect and retain all TPL collections. The Contractor shall document cost recovery and cost adjustment through the encounter data reporting process, including denials. All claims subject to "pay and chase" shall be reported to EOHHS on a monthly basis in accordance with Section 27.14, "Financial Data Reporting," and shall include current recovery efforts.

27.1.10. The Contractor shall obtain recovery of payment from a liable third-party and not from

the provider unless the provider received payment from both the Contractor and the liable third-party.

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

27.1.12. The Contractor shall cooperate with EOHHS in the implementation of R.I. Gen. Laws § 40-6-9.1 by participating in the matching of data available to EOHHS and to the Contractor through an electronic file match. The matching of such data is critical to the integrity of the Medicaid program and the use of public funds. Requests made of the Contractor by EOHHS will be made at such intervals as deemed necessary by EOHHS to participate in the data matching.

27.1.13. The Contractor shall respond with the requested data within five (5) Business Days.

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

27.2. Cost Avoidance and Pay and Chase

27.2.1. The Contractor shall cost-avoid a claim if it establishes the probable existence of a liable third party other health insurance at the time the claim is filed, except for the "pay and chase" claims identified in the Managed Care Manual.

27.2.2. The Contractor shall "pay and chase" the full amount allowed under its payment schedule for the claim and then seek reimbursement from the TPL insurer. The Contractor shall, within sixty (60) Calendar Days after the end of the calendar month in which the payment was made (or within sixty (60) Calendar Days after the end of the calendar month the Contractor learns of the existence of a liable third party), pursue recovery from said third party for any legal liability.

27.2.3. The Contractor shall "wait and see" on claims for a service that is provided to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D agency. "Wait and see" is defined as payment of a claim only after documentation is submitted to the Contractor demonstrating that one hundred (100) Calendar Days have elapsed since the provider billed the responsible third party and the provider has not received payment for such services.

27.3. Post-Payment Recoveries

27.3.1. Post-payment recovery is necessary in cases where the Contractor has not established the probable existence of TPL at the time services were rendered or paid for. The Contractor shall adhere to the following requirements for post-payment recovery:

27.3.2. Initiate recovery of reimbursement within sixty (60) Calendar Days after the end of the calendar month in which it learns of the existence of the liable third party.

27.3.3. Not perform post-payment recovery for TPL from providers for claims with dates of service (DOS) older than ten (10) months, except when the primary carrier is

traditional Medicare or Tricare.

27.3.4. If the liable third party is traditional Medicare or Tricare, and more than ten (10) months have passed since the DOS, the Contractor shall recover from the provider.

27.3.5. Allow providers sixty (60) Calendar Days from the date stamp of the recovery letter to refute the recovery with a one-time thirty (30) Calendar Day extension at the provider's request.

27.3.6. Refer pay and chase claims directly to the liable third parties.

27.3.7. Refer Point of Sale (POS) pharmacy claims directly to the carrier.

27.3.8. The Contractor shall initiate an automatic recoupment at the expiration of the sixty (60) Calendar Day time period if an extension request is not received from the provider and at the expiration of the ninety (90) Calendar Day time period if an extension is requested by the provider if the provider has not remitted the payment to the Contractor

27.3.9. The Contractor shall void encounters for claims for which the full Rhode Island Medicaid Program paid amount is being recouped. For recoupments for which the full Rhode Island Medicaid Program paid amount is not being recouped, the Contractor shall submit adjusted encounters for the claims.

27.3.10. The Contractor shall identify the existence of potential TPL to pay for Covered Services through the use of trauma code edits in accordance with 42 C.F.R. § 433.138(e).

27.3.11. The Contractor shall be required to seek reimbursement in accident/trauma related cases when claims in the aggregate equal or exceed five hundred dollars ($500.00) as required by the State Plan and Federal Medicaid guidelines and may seek reimbursement when claims in the aggregate are less than five hundred dollars ($500.00).

27.3.12. The Contractor shall notify EOHHS when subpoenas duces tecum are received and report the resulting recoveries to EOHHS.

27.3.13. The amount of any recoveries collected by the Contractor outside of the claims processing system shall be treated by the Contractor as offsets to medical expenses for the purposes of reporting.

27.3.14. Prior to accepting a TPL settlement on accident/trauma-related claims equal to or greater than twenty-five thousand dollars ($25,000.00), the Contractor shall obtain approval from EOHHS in writing.

27.3.15. Upon receipt of a subpoena duces tecum, the Contractor shall produce documents responsive to said subpoena by the date of return indicated therein (or shall contact the party who caused issuance of the subpoena, in order to request additional time to respond). Upon receipt of a request for records not sent via subpoena, the Contractor shall release PHI or a response explaining why PHI cannot be released to the individual or entity making the request, within fifteen (15) Calendar Days of receipt of the request and a written authorization. The Contractor is solely responsible for any sanctions and

costs imposed by a court of competent jurisdiction for failure to comply with the requirements for failure to respond Timely to a subpoena duces tecum. Additionally, EOHHS may impose sanctions against the Contractor for failure to properly or Timely respond to requests for PHI.

27.3.16. All records requests received by the Contractor shall be investigated by the Contractor (or its vendor) for possible TPL recoveries, resulting in issuance of a lien statement (or notice of lack thereof) to the requesting party.

27.3.17. When the Contractor has actual knowledge that an insurer or other risk bearing entity of an Member has filed for bankruptcy and the provider files a claim for reimbursement with the Contractor with dates of service prior to the date the insurer or other risk bearing entity filed bankruptcy, the Contractor shall reimburse the provider with the Rhode Island Medicaid Program as the primary insurer only if the Member was enrolled with the Contractor at the time the service was provided and the provider has not been paid. The Contractor shall seek reimbursement as a creditor in the bankruptcy proceeding or from a liable third party. If the provider files a claim for reimbursement with the Contractor with dates of service after the date the insurer or other risk bearing entity filed for Chapter 11 bankruptcy, the insurer or other risk bearing entity shall continue to be the primary insurer. If the provider files a claim for reimbursement with the Contractor with dates of service after the date the insurer or other risk bearing entity filed for Chapter 7 bankruptcy, the Rhode Island Medicaid Program shall be the primary insurer.

27.4. Distribution of TPL Recoveries

27.4.1. The Contractor may retain up to one hundred (100%) of its TPL recoveries if all of the following conditions exist:

27.4.1.1. Total TPL recoveries received do not exceed the total amount of the Contractor's financial liability for the Enrollee.

27.4.1.2. There are no payments made by EOHHS related to FFS, reinsurance, or administrative costs (e.g., lien filing) for the Enrollee.

27.4.1.3. Such recovery is not prohibited by State or Federal law.

27.4.2. EOHHS shall utilize the TPL recovery data in calculating future Capitation Rates.

27.5. TPL Reporting Requirements

27.5.1. The Contractor shall provide TPL information to EOHHS in a format and medium described in the Managed Care Manual and shall cooperate in any manner necessary, as requested by EOHHS, with EOHHS and/or its designee.

27.5.2. The Contractor shall include the TPL recoveries and claims information in the encounter data submitted to EOHHS, including any retrospective findings via encounter adjustments or voids.

27.5.3. Upon the request of EOHHS, the Contractor shall provide information not included in encounter data submissions that may be necessary for the administration of TPL activity. The information shall be provided within thirty (30) Calendar Days of

EOHHS' request. Such information may include, but is not limited to, Members Medical Records for the express purpose of a liable third party to determine liability for the services rendered.

27.5.4. Upon the request of EOHHS, the Contractor shall demonstrate that reasonable effort has been made to seek, collect, and/or report TPL and recoveries. EOHHS shall have the sole responsibility for determining whether or not reasonable efforts have been demonstrated. Said determination shall consider reasonable industry standards and practices.

27.5.5. The Contractor shall submit an annual report of all health insurance collections for Enrollees plus copies of any Form 1099s received from health insurance companies for that period of time.

27.6. EOHHS Right to Conduct Identification and Pursuit of TPL

27.6.1. EOHHS may invoke its right to pursue TPL recoveries if the Contractor fails to recover reimbursement from the liable third party to the limit of legal liability within three hundred sixty-five (365) Calendar Days from date(s) of service of the claims(s).

27.6.2. If EOHHS determines that the Contractor is not actively engaged in cost avoidance activities, the Contractor may be subject to a CAP and liquidated damages under this Agreement.

27.7. Reinsurance

27.7.1. The Contractor shall obtain reinsurance coverage from a source other than EOHHS. Proof of such reinsurance is a condition of contract award. The Contractor shall purchase reinsurance to protect against the financial risk of high-cost individuals and shall submit to EOHHS a complete copy of the reinsurance agreement. The Contractor shall submit new policies and insurance certificates, renewals, or amendments to EOHHS for review and approval at least ninety (90) Days before becoming effective. The submitted copy shall include the following specifications and parameters:

27.7.1.1. Name of reinsurance carrier.

27.7.1.2. Services covered under reinsurance contract.

27.7.1.3. Specific stop loss threshold (deductible/retained liability).

27.7.1.4. Aggregate stop loss threshold (if applicable).

27.7.1.5. Coinsurance after stop loss threshold (if applicable).

27.7.1.6. Reinsurance maximum (if applicable).

27.7.1.7. Experience refund provisions (if applicable).

27.7.1.8. Coverage period.

27.7.1.9. Reinsurance premium amounts and structure.

27.7.2. The Contractor shall maintain the following set of minimum specifications and parameters for specific stop loss reinsurance unless otherwise approved by EOHHS:

27.7.2.1. The deductible shall be no more than $500,000.

27.7.2.2. The coinsurance after the deductible is no more than twenty percent (20%).

27.7.2.3. The reinsurance maximum shall be at least $2,000,000.

27.7.2.4. At a minimum, the reinsurance contract shall cover inpatient services.

27.7.3. For purposes of this Section, "coinsurance" means the percentage the Contractor shall pay for covered losses after the Contractor's deductible has been paid. Coinsurance payments will not exceed the maximum reinsurance set forth in this Agreement.

27.7.4. EOHHS reserves the right to require changes to a reinsurance arrangement.

27.7.5. The Contractor shall maintain the reinsurance arrangement and submit any proposed changes to EOHHS for review and approval. EOHHS may require additional protections and documentation at any time.

27.7.6. EOHHS reserves the right to revisit reinsurance requirements annually and to modify the reinsurance specification and parameters required if a change is deemed warranted by EOHHS. The Contractor may not change the thresholds from those in the Contractor's approved insurance certificates without the prior written consent of EOHHS.

27.7.7. Reinsurance agreements will transfer risk from the Contractor to the reinsurer. The Contractor may request alternative reinsurance arrangements; however, EOHHS will maintain the sole discretion to determine if other forms of reinsurance are acceptable. EOHHS also may require other forms of security in addition to reinsurance. These other security tools may include parent company guarantees, letters of credit, or performance bonds. In determining whether the request will be approved, EOHHS may consider any or all of the following:

27.7.7.1. Whether the Contractor has sufficient reserves available to pay unexpected claims.

27.7.7.2. The Contractor's history in complying with financial indicators as specified in this Agreement.

27.7.7.3. The number of Members covered by the Contractor.

27.7.7.4. How long the Contractor has provided coverage for Medicaid Members (separately for Rhode Island and other contracts).

27.7.7.5. Financial metrics, such as risk-based capital ratios, from financial statements submitted to EOHHS.

27.7.7.6. Review of historical and projected claims distributions relative to the current and proposed reinsurance parameters.

27.8. Financial Benchmarks

27.8.1. The success of the Rhode Island Medicaid Managed Care program is contingent on the financial stability of participating Health Plans. As part of its oversight activities,

the State has established financial viability criteria, or benchmarks, to be used in measuring and tracking the fiscal status of Health Plans.

27.8.2. In accordance with Section 27.14, "Financial Data Reporting," the Contractor shall provide documentation on a regular basis that it is financially solvent and has the capital, financial resources, and management capability to operate under this risk-based contract and comply with the terms outlined in this Agreement.

27.8.3. The Contractor shall demonstrate to EOHHS that it is able to meet the solvency requirements set forth by OHIC. EOHHS will not grant exceptions to minimum OHIC standards.

27.8.4. The Contractor shall provide all the information necessary for calculating financial benchmark levels. EOHHS may impose contractual remedies, including corrective action plans and liquidated damages, if the Contractor fails to meet financial benchmarks.

27.9. Financial Disclosures

27.9.1. Upon EOHHS' request, the Contractor shall disclose all financial terms and arrangements for payment of any kind that apply between the Contractor or the Subcontractor and any provider of a Medicaid service, except where Federal or State law restricts disclosing the terms and arrangements. EOHHS acknowledges such information may be considered confidential and proprietary and thus will be held confidential by EOHHS to the extent allowed under Rhode Island law.

27.9.2. If applicable, the Contractor and Subcontractor shall narrowly designate portions of any agreement as proprietary information that should not be otherwise disclosed, except to EOHHS and its designees. Portions of any agreement designated as proprietary information will be limited to the portions that consist of unique business or pricing structures that a competitor may or would likely use to gain an unfair market advantage over the Contractor or Subcontractor. Proprietary designations in every agreement shall be limited consistent with the foregoing. Every portion of an agreement that is not designated as proprietary will be deemed to be a public record.

27.10. Limits on Payments to Associated Providers and Subcontractors

27.10.1. For any provider or Subcontractor associated with the Contractor, the Contractor shall not pay more for services rendered by the associated entity than it pays for similar services rendered by providers and Subcontractors not associated with the Contractor. For purposes of this Section, "associated with" means providers or Subcontractors that have an indirect ownership interest or ownership or control interest in the Contractor, an affiliate of the Contractor, or the Contractor's management company. The term "associated with" also includes providers or Subcontractors that the Contractor, an Affiliate of the Contractor, or the Contractor's management company has an indirect ownership interest or ownership or control interest in. The standards and criteria for determining indirect ownership interest, an ownership interest or a control interest are set out at 42 C.F.R. Part 455, Subpart B.

27.10.2. Any payments made by the Contractor that exceed the limitations set forth in this

Section are considered non-allowable payments and shall be excluded from medical expenses and administrative expenses reported in the MLR report. This restriction does not apply to Value-Added Service or cost-effective alternatives to Covered Services, which may be considered medical expenses.

27.10.3. In accordance with financial reporting requirements described below, the Contractor shall submit information on payments to related providers and Subcontractors. This information shall include claims and administrative expenses paid to the provider or Subcontractor.

27.11. Restriction on Payments to Related Entities or Downstream Entities

27.11.1. With the exception of payment of a claim, the Contractor shall not pay money or transfer any assets for any reason to a Related Entity or Downstream Entity without prior approval from EOHHS, if any of the following criteria apply:

27.11.1.1. The Contractor's risk-based capital (RBC) ratio was below the requirement in Section 27.7 as of December 31 of the most recent year for which the due date for filing the annual financial report has passed.

27.11.1.2. Subsequent adjustments are made to the Contractor's financial statement as the result of an audit, or are otherwise modified, such that after the transaction took place, a final determination is made that the Contractor was not in compliance with the RBC standards in Section 27.7. In this event, EOHHS may require repayment of amounts involved in the transaction.

27.12. Related Entity Affiliations

27.12.1. The Contractor may not include a Related Entity hospital, FQHC, or other provider in its Network unless the Related Entity and all provider sites and clinics owned or controlled by the Related Entity are included in the network of another Health Plan contracted with EOHHS.

27.12.2. EOHHS may waive this requirement if it determines sufficient number of Health Plans are unwilling to contract with the provider at reasonable terms.

27.12.3. By way of example, this prohibition applies when the Related Entity arrangement is carried out through one (1) or more unrelated parties.

27.13. Disclosure of Changes in Circumstances

27.13.1. The Contractor shall notify EOHHS and OHIC of any change in circumstances that may have a material adverse effect upon financial or operational conditions of the Contractor or a Related Entity. The Contractor shall provide the notice within ten (10) Business Days of an event triggering the change in circumstance. By way of example, notice is required for the following events related to the Contractor or its parent company, or any Related Entity of either:

27.13.1.1. Suspension, debarment, or exclusion by any State or the Federal Government.

27.13.1.2. Suspension, debarment. or exclusion of a director, officer, partner, or

person with beneficial ownership of more than five percent (5%) of the Contractor's equity.

27.13.1.3. Notice of a State or Federal Government's intent to suspend, debar, or exclude. In addition the Contractor, Contractor's parent, and any Related

27.13.1.4. Entity of either, this requirement applies to notices relating to any individuals with employment, consulting, or other arrangements that are material and significant.

27.13.1.5. Any new or previously undisclosed lawsuits or investigations by any Federal or State Agency that may have a material impact upon the Contractor's financial condition or ability to perform under this Agreement.

27.14. Financial Data Reporting

27.14.1. The Contractor shall comply with all reporting requirements set forth in this Section, as well as the detailed requirements set forth in the Managed Care Manual. The Contractor shall submit all reports and required data completely and accurately within the specified timeframes established in the Managed Care Manual. Such compliance includes submitting the following reports:

27.14.1.1. National Association of Insurance Commissioners (NAIC) Financial Statements, including Risk Based Capital Reports;

27.14.1.2. The Contractor's Audited Financial Statements;

27.14.1.3. The Contractor shall submit audited financial reports specific to the Managed Care Program on an annual basis. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

27.14.1.4. The Contractor's Report to Owners, Shareholders, Members, and Others;

27.14.1.5. Company's General Liability and Director's' and Officer's Insurance Coverages;

27.14.1.6. Claims Reinsurance Coverage and attachment points;

27.14.1.7. Where applicable, evidence that the parent company provides one-hundred percent (100%) of subsidiary's financial backing;

27.14.1.8. Medical Loss Ratio Statement using the MLR template provided by EOHHS;

27.14.1.9. Financial Data Cost Reports, including both Medicaid and Medicare payment information;

27.14.1.10. Annual MCO Rate Setting Survey;

27.14.1.11. Identification of Third-Party Liability;

27.14.1.12. Third-Party Liability collections, cost recoveries, and cost adjustments;

27.14.1.13. Accountable Entity Shared Savings Financial Performance Report;

27.14.1.14. Accountable Entity Total Cost of Care Historical Base Data Reports;

27.14.1.15. Accountable Entity Total Cost of Care Quarterly Performance Year Reports; and

27.14.1.16. Any other additional reports required due to special circumstances, studies, analyses, audits, and significant changes in the Contractor's financial position or performance.

27.14.2. The Contractor agrees to comply in a timely and complete manner with all financial reporting requirements associated with the Accountable Entity Initiative as described in Section 2.5.

27.14.3. The Contractor shall submit annual reports on total medical expenses, primary care spending, and quality performance spending across all lines of health insurance business for Medicaid, Medicare, and commercial insurance in the State of Rhode Island in accordance with guidance from EOHHS and OHIC

27.15. Medical Loss Ratio Reporting

27.15.1. The Contractor shall submit an analysis of its compliance with parity in Mental Health and Substance Use Disorder benefits that documents how the Contractor is in compliance with 42 C.F.R. § 438.900 et seq. The Contractor shall submit this report annually in accordance with the Managed Care Manual.

27.15.2. The Contractor shall submit annual consolidated Medical Loss Ratio (MLR) reports in accordance with the Managed Care Manual.

27.15.3. The Contractor shall comply with the MLR reporting standards described in 42 C.F.R. § 438.8 and any EOHHS directives required to satisfy the MLR requirements outlined in 42 C.F.R. § 438.74. EOHHS directives may include additional state-specific criteria or adjustments to the MLR calculation methodology or reporting instructions.

27.15.4. The Contractor shall submit MLR Reports by March 1 of each year, for the contract period ending the preceding June 30. EOHHS may also require interim reporting on a more frequent basis.

27.15.5. The MLR report shall include the following items:

27.15.5.1. Total incurred claims;

27.15.5.2. Expenditures on quality improving activities;

27.15.5.3. Fraud prevention activities as defined in 42 C.F.R. § 438.8(e)(4).

27.15.5.4. Expenditures related to activities compliant with program integrity requirements;

27.15.5.5. Non-claims costs;

27.15.5.6. Premium revenue;

27.15.5.7. Taxes, Licensing and Regulatory Fees;

27.15.5.8. Methodology(ies) for allocation of expenditures;

27.15.5.9. Any credibility adjustment applied;

27.15.5.10. The calculated MLR;

27.15.5.11. Any remittance owed to the state, if applicable;

27.15.5.12. A comparison of the information reported with the audited financial report required under 42 C.F.R. § 438.3(m);

27.15.5.13. A description of the aggregation method used to calculate total incurred claims under 42 C.F.R. § 438.8(i); and

27.15.5.14. The number of Member months.

27.15.6. Following submission of each MLR Report, EOHHS will provide either an acceptance or a request for additional information or reconciliation. The Contractor shall submit a good faith response in the timeframe specified in the EOHHS request. Failure to respond to these requests or to make required corrections within the timeline requested may result in contractual remedies, including corrective action or liquidated damages. EOHHS has the authority to determine when the MLR Report is final for purposes of submission to CMS and the calculation of any remittance payments. In the event the Contractor's response takes longer to be submitted than the timeframe specified by EOHHS, EOHHS may, at its discretion, move forward to a final settlement of the Contractor's MLR reports without regard to any additional data the Contractor provides.

27.15.7. The Contractor is responsible for complete and accurate MLR reporting as specified in 42 C.F.R. § 438.8 and should rely on their own consultants and advisors to ensure compliance with these requirements. The acceptance of an MLR Report as final by EOHHS does not constitute a waiver of this requirement.

27.16. Minimum Medical Loss Ratio Remittance

27.16.1. EOHHS requires an MLR remittance, as outlined in 42 C.F.R. § 438.8(j), for Contractors with an MLR as calculated in the MLR Report accepted by EOHHS of less than eighty-five percent (85%). The MLR used for purposes of calculating a remittance will be calculated separately for the two populations outlined below.

27.16.1.1. For the adult aged, blind, and disabled population authorized for LTSS, if the Contractor has an MLR below eighty-seven percent (87%), the Contractor shall remit the amount by which the eighty-seven percent (87%) threshold exceeds the Contractor's actual MLR multiplied by the total Capitation Payment revenue of the Contract. In addition to this remittance, if the calculated MLR is below ninety percent (90%), the Contractor will remit fifty percent (50%) of the difference between its MLR and ninety percent (90%) multiplied by the total Capitation Payment revenue (if the Contractor's MLR is above the threshold eighty-seven percent (87%) or one point five percent (1.5%) multiplied by the total Capitation Payment revenue if the Contractor's MLR is at or below the

threshold eighty-seven percent (87%).

27.16.1.2. For the remaining eligible populations, if the Contractor has an MLR below eighty-five percent (85%), the Contractor shall remit the amount by which the eighty-five percent (85%) threshold exceeds the Contractor's actual MLR multiplied by the total Capitation Payment revenue of the Contract. In addition to this remittance, if the calculated MLR is below eighty-seven percent (87%), the Contractor will remit fifty percent (50%) of the difference between its MLR and eighty-seven percent (87%) multiplied by the total Capitation Payment revenue (if the Contractor's MLR is above the threshold of eighty-five percent (85%) or one percent (1.0%) multiplied by the total Capitation Payment revenue (if the Contractor's MLR is at or below the threshold of eighty-five percent (85%).

27.16.2. EOHHS retains the right to make the final determination on which rate cells used in the rate development process will be aligned with each minimum MLR threshold.

27.16.3. The remittance amount shall be returned to EOHHS. The Contractor shall pay the remittance to EOHHS within sixty (60) Days after EOHHS accepts the submitted MLR.

27.17. Calculating the Medical Loss Ratio

27.17.1. The MLR calculation for the Contractor is the ratio of the numerator (as defined in accordance with 42 C.F.R. § 438.8(e)) to the denominator (as defined in accordance with 42 C.F.R. § 438.8(f)).

27.17.2. Each Contractor expense shall be included under only one (1) type of expense, unless a portion of the expense fits under the definition of, or criteria for, one (1) type of expense and the remainder fits into a different type of expense, in which case the expense shall be prorated between types of expenses.

27.17.2.1. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, shall be reported on pro rata basis.

27.17.2.2. The Contractor's expense allocation shall be based on a generally accepted accounting method that is expected to yield the most accurate results.

27.17.2.3. Shared expenses, including expenses under the terms of a management contract, shall be apportioned pro rata to the contract incurring the expense.

27.17.2.4. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, shall be borne solely by the reporting entity and are not to be apportioned to the other entities.

27.17.3. The Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible.

27.17.3.1. The credibility adjustment is added to the reported MLR calculation

before calculating any remittances, if required by the state.

27.17.3.2. The Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

27.17.3.3. If the Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

27.17.4. The Contractor shall aggregate data for all Medicaid eligibility groups covered under this Agreement unless otherwise indicated by EOHHS.

27.17.5. The Contractor shall require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within one hundred eighty (180) Days of the end of the MLR reporting year or within thirty (30) Days of being requested by EOHHS or the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

27.17.6. If EOHHS makes a retroactive change to the Capitation Payments for a MLR reporting year where the MLR report has already been submitted to EOHHS, the Contractor shall:

27.17.6.1. Recalculate the MLR for all MLR reporting years affected by the change; and

27.17.6.2. Submit a new MLR report meeting the applicable requirements.

27.17.7. The Contractor shall attest to the accuracy of the MLR calculation in accordance with the MLR standards when submitting the required MLR reports.

27.18. Certified Community Behavioral Health Clinics (CCBHCs) Risk Mitigation

27.18.1. For future Rating Periods, Contractor acknowledges and agrees that the State may implement a targeted one hundred percent (100%) risk share/gain share arrangement for Prospective Payment System (PPS) for eligible services rendered at CCBHCs. This targeted risk share/gain share arrangement will be fully incorporated into the managed care rates.

27.18.2. This Contract will include funding, on a PMPM basis, for CCBHC services and isolate the total amount of funding by rate cell included in the medical component of the rate certification for CCBHC services. This funding amount will be used to calculate the total CCBHC revenues received by each Health Plan for the purposes of determining the targeted CCBHC risk share settlements. Any CCBHC expenditures above or below one hundred percent (100%) of the medical baseline will be reimbursed or /recouped by the State.

Risk/Gain Share Corridors for CCBHC Separate Risk Arrangement		
Risk Sharing Provisions	**Plan Share of Excess**	**EOHHS Share of Excess**
Risk Share when CCBHC expenses exceed 100% of Baseline CCBHC Revenue	0%	100%
Gain Sharing Provisions	**Plan Share of Gains**	**EOHHS Share of Gains**
Gain Share when CCBHC expenses are less than 100% of Baseline CCBHC Revenue	0%	100%

27.18.3. The table below illustrates how total CCBHC revenue and expenses will be used to determine the amount due to/from the Health Plans. The values illustrated in the below table do not represent actual funding amounts and are solely used for illustrative purposes.

Step 1. Calculation of CCBHC Medical Component Revenue				
Total Member Months	*multiplied by*	CCBHC Revenue included in Medical Component of Premium (PMPM	*equals*	Baseline CCBHC Revenue
1,000,000	x	$10	=	$10,000,000
Step 2. Calculation of CCBHC Medical Expenses				
CCBHC Attributed Member Months	*multiplied by*	PPS Rate for each CCBHC for each attributed Member with a qualifying visit by month	*equals*	CCBHC PPS Medical Expenses Paid
25,000	x	Varies by CCBHC [1]	=	$12,500,000
Step 3. Calculation of Gain/Risk Share Basis				
Baseline CCBHC Revenue	*minus*	CCBHC PPS- Payments	*equals*	Gain/(Risk) Share Basis
$10,000,000	-	$12,500,000	=	$(2,500,000)

Notes:

[1] Each CCBHC will have its own approved PPS Rate. Contractor shall reimburse the CCBHCs the full PPS payment for each month when an attributed Health Plan Member has at least one (1) qualifying service rendered by the CCBHC. Contractor shall pay this rate in full each month.

27.18.4. The table below provides illustrative examples of implementation impact under two (2) scenarios: (i) a plan gain on the CCBHC component, and (ii) a plan loss on the CCBHC component.

MCO	EXAMPLE	EXAMPLE
PRODUCT	**CCBHC EXP > REV**	**CCBHC EXP < REV**
FTE Member Months	1,000,000	1,000,000
CCBHC Risk Corridor Reconciliation		
CCBHC PMPM	$10.00	$10.00
CCBHC PPS Revenue to Plan	*$ 10,000,000.00*	*$ 10,000,000.00*
CCBHC PPS Expenses Paid by Plan	*$ 12,500,000.00*	*$ 7,500,000.00*
Due to / (From Plan) CCBHC Risk Corridor	***$ 2,500,000.00***	***$ (2,500,000.00)***

27.19. SOBRA Reporting

27.19.1. SOBRA related expenses are to be reported using the format specified in the Managed Care Manual.

27.20. State Directed Payments

27.20.1. The Contractor shall fully participate in and faithfully execute all directed payment programs established by EOHHS, and as approved by CMS.

27.20.2. EOHHS will establish criteria for each directed payment program, including the timeframe for the directed payment; providers who will participate in the directed payment; and the mechanism for the calculation and delivery of the amounts to be paid to the selected Providers.

27.20.3. The Contractor shall collect and provide EOHHS with such information as is required to support all directed payment programs.

27.20.4. Directed payment programs shall be established in accordance with all applicable CMS requirements, including 42 C.F..R § 438.6(c).

27.20.5. EOHHS may require the Contractor to adopt a minimum fee schedule for Network Providers, provide a uniform dollar or percentage increase for Network Providers, or adopt a maximum fee schedule so long as the Contractor retains ability to reasonably manage risk.

27.20.6. EOHHS will require the Contractor to implement the following state directed payments in accordance with CMS approval and as summarized below:

Directed Payment	State Directed Payment Requirement[1]	Effective Date	End Date
Children's Therapeutic	Pay no less than the Medicaid fee-for-service fee schedule Payment Arrangement: Separate Payment Term: Additional reporting requirements:	7/1/2022	6/30/23
CTC payment	$0.77 PMPM paid to the Care Transformation Collaborative for administration of the program, for each Member attributed to providers that meet the OHIC definition of PCMH. Administration includes such activities as: practice facilitation, technical assistance, coaching, and learning collaboratives to support practices in achieving the necessary requirements to become NCQA and OHIC recognized as a PCMH upon completion of the program. Payment Arrangement: Separate Payment Term: Additional reporting requirements:	7/1/2022	6/30/23
Early Intervention	Pay no less than the Medicaid fee-for-service fee schedule. Payment Arrangement: Separate Payment Term: Additional reporting requirements:	7/1/2022	6/30/23
Home Care	Pay no less than the Medicaid fee-for-service fee schedule Payment Arrangement: Separate Payment Term: Additional reporting requirements:	7/1/2022	6/30/23
Home Delivered Meals	Pay no less than the Medicaid fee-for-service fee schedule Payment Arrangement: Separate Payment Term: Additional reporting requirements:	7/1/2022	6/30/23

Directed Payment	State Directed Payment Requirement[1]	Effective Date	End Date
Hospital Inpatient and Outpatient Rates	Five percent (5%) increase over prior year rates, including Level IV alcohol and drug detoxification program rates as described in the preprint. Payment Arrangement: Separate Payment Term: Additional reporting requirements:	7/1/2022	6/30/23
Labor and Delivery to hospitals	Twenty percent (20%) increase to prior year rates as described in pre-print Payment Arrangement: Separate Payment Term: Additional reporting requirements:	7/1/2022	6/30/23
Nursing Home Rates	Four percent (4%) increase over prior year rates, of which one percent (1%) is attributable to the provisions of 40-8-19(vi) related to minimum staffing, as described in the preprint. Payment Arrangement: Separate Payment Term: Additional reporting requirements:	10/1/2022	9/30/23
PCMH PMPM	$3.00 PMPM for each Member attributed to providers that meet the OHIC definition of PCMH as stated here. Payment Arrangement: Separate Payment Term: Additional reporting requirements:	7/1/2022	6/30/23
Pediatric Services	Pay no less than the Medicaid fee-for-service fee schedule. Payment Arrangement: Separate Payment Term: Additional reporting requirements:	7/1/2022	6/30/23

Directed Payment	State Directed Payment Requirement[1]	Effective Date	End Date
Personal Care Behavioral Health Certification Enhancement	Pay no less than the Medicaid fee-for-service fee schedule Payment Arrangement: Separate Payment Term: Additional reporting requirements:	7/1/2022	6/30/23
Personal Care Shift Differential	Pay no less than the FY22 value of the differential; in FY22 the MCO was directed to increase shift differential modifier from FY21 levels by $0.19 per 15 mins, as described in the pre-print Payment Arrangement: Separate Payment Term: Additional reporting requirements:	7/1/2022	6/30/23

27.21. Nonpayment

27.21.1. The Contractor shall not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):

27.21.1.1. With any prohibited funds under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.

27.21.1.2. With any funds expended for roads, bridges, stadiums, or any other item or service not covered under the Rhode Island Medicaid State Plan.

27.22. Reporting Transactions

27.22.1. The Contractor shall report to EOHHS and, upon request, to the Secretary of DHHS, the Inspector General of DHHS, and the Comptroller General a description of transactions between the Contractor and a party in interest (as defined under 1306(b) of the Social Security Act) including the following transactions:

27.22.1.1. Any sale or exchange, or leasing of any property between the MCP and such a party;

27.22.1.2. Any furnishing for consideration of goods, services (including management services), or facilities between the Contractor and a party of interest, but not including salaries paid to employees for services provided in the normal course of employment; and

27.22.1.3. Any lending of money or other extension of credit between the Contractor and the party.

27.23. Reserving

27.23.1. The Contractor shall establish an actuarially sound process for estimating and tracking incurred but not reported claims (IBNRs). The Contractor also shall reserve funds by major categories of service (e.g., hospital inpatient; hospital outpatient) to cover both IBNRs and reported but unpaid claims. As part of its reserving methodology, the Contractor shall conduct "look backs" at least annually to assess its reserving methodology and make adjustments as necessary.

27.24. Disproportionate Share Payments to Hospitals

27.24.1. EOHHS will retain responsibility for disproportionate share payments to hospitals, if any. The Contractor will not be responsible for these payments.

Article 28. Contractor System Performance Requirements and Standards

28.1. Contractor System Technology Requirements

28.1.1. Contractor will be required to provide an architectural diagram of their system network during Contract Readiness. Architectural diagram shall be updated upon any changes related to network systems.

28.1.2. The Contractor shall maintain in sufficient computer hardware and software to support automated call intake, eligibility verification, needs assessment, well as meet monthly reporting requirements under this Agreement.

28.1.3. The Contractor shall obtain maintenance contracts sufficient to ensure the efficient operation of the system, in compliance with this Contract, with equipment and software suppliers for the duration of the contract. The maintenance contracts shall provide upgrades, enhancements, and bug fixes.

28.1.4. All data stored electronically using the Contractor's computer system shall be backed up on a daily basis.

28.1.5. The Contractor shall maintain an automated Management Information System (MIS), hereinafter referred to as System, which accepts and processes provider claims, verifies eligibility, collects and reports encounter data, and validates prior authorization and pre-certification that complies with EOHHS and federal reporting requirements. The Contractor shall ensure that its System meets the requirements of the Contract, the Managed Care Manual, and all applicable Federal and State laws, regulations, rules, and policies, including, but not limited to, Medicaid confidentiality, HIPAA, and American Recovery and Reinvestment Act (ARRA) privacy and security requirements.

28.1.6. The System shall provide information on areas including, but not limited to, utilization, claims, Grievances and Appeals, and Disenrollment for reasons other than loss of Rhode Island Medicaid Program eligibility [42 C.F.R. § 438.242(a)].

28.1.7. The Contractor shall comply with Section 6504(a) of the PPACA, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of Section 1903(r)(1)(F) of the Act [42 C.F.R. § 438.242(b)(1); Section 6504(a) of the ACA; Section 1903(r)(1)(F) of the Act].

28.1.8. The Contractor's application systems foundation shall employ a relational data model in its database architecture, which would entail the utilization of a relational database management system (RDBMS). The Contractor's application systems shall support query access using Structured Query Language (SQL). Other standard connector technologies, such as Open Database Connectivity (ODBC) and/or Object Linking and Embedding (OLE), are desirable.

28.1.9. The Contractor shall comply with the health IT standards referenced in 45 C.F.R. Part 170, Subpart B and the Interoperability Standards Advisory (ISA) as set forth by the

Office of the National Coordinator for Health IT (ONC).

28.1.10. The Contractor shall comply with the CMS Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issues of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers (referred to as the "CMS Interoperability and Patient Access final rule") in accordance with timelines established by CMS and as directed by EOHHS through the EOHHS MCE Interoperability Compliance Plan.

28.1.11. All Contractor applications, operating software, middleware, and networking hardware and software shall be able to interoperate as needed with EOHHS' systems and shall conform to applicable standards and specifications set by EOHHS.

28.1.12. If the Contractor uses different Management Systems for physical health services and behavioral health services, these systems shall be interoperable. In addition, the Contractor shall have the capability to integrate data from the different systems.

28.1.13. The Contractor's System shall have, and maintain, capacity sufficient to handle the workload projected for the Operational Start Date and shall be scalable and flexible so that it can be adapted as needed, within negotiated timeframes, in response to changes in the Contract requirements.

28.1.14. The Contractor shall be capable of transmitting all data, which is relevant for analytical purposes, to EOHHS on a regular schedule in XML format. Final determination of relevant data will be made by EOHHS based on collaboration between both parties. The schedule for transmission of the data will be established by EOHHS and dependent on the needs of EOHHS related to the data being transmitted. XML files for this purpose shall be transmitted via Secure File Transfer Protocol (SFTP) to EOHHS. Any other data or method of transmission used for this purpose shall be via written agreement by both parties.

28.1.15. The Contractor is responsible for procuring and maintaining hardware and software resources which are sufficient to successfully perform the services detailed in this Agreement.

28.1.16. The Contractor shall adhere to Federal and State laws, regulations, rules, policies, procedures, and guidelines as well as industry standards and best practices for systems or functions required to support the requirements of this Contract.

28.1.17. Unless explicitly stated to the contrary, the Contractor is responsible for all expenses required to obtain access to EOHHS systems—including systems maintained by other Contractors including, but not limited to, FI and Enrollment Broker resources that are relevant to successful completion of the requirements of this Contract. The Contractor is also responsible for expenses required for EOHHS to obtain access to the Contractor's systems or resources which are relevant to the successful completion of the requirements of this Agreement. Such expenses are inclusive of hardware, software, network infrastructure and any licensing costs.

28.1.18. Contractor's interface connections with the State shall be established, monitored, and

maintained in compliance with the State's Information security policies and procedures.

28.1.19. The Contractor or its designated subcontractor shall take all steps necessary, as determined by EOHHS, to ensure that the Contractor's systems are always able to interface with EOHHS IT applications, including the State's Enterprise Architecture.

28.1.20. Any confidential information shall be encrypted to FIPS 140-2 standards when at rest or in transit.

28.1.21. Contractor owned resources shall be compliant with industry standard physical and procedural safeguards (NIST SP 800-114, NIST SP 800-66, NIST 800-53A, ISO 17788, etc.) for confidential information (HITECH, HIPAA Part 164).

28.1.22. Any Contractor use of flash drives or external hard drives for storage of Rhode Island Medicaid Program data shall first receive written approval from EOHHS and upon such approval shall adhere to FIPS 140-2 hardware level encryption standards.

28.1.23. The Contractor shall comply with EOHHS electronic visit verification (EVV) requirements for personal care services (PCS) and home health care services.

28.1.24. All Contractor utilized computers and devices shall:

28.1.24.1. Be protected by industry standard virus protection software which is automatically updated on a regular schedule;

28.1.24.2. Have installed all security patches which are relevant to the applicable operating system and any other system software; and

28.1.24.3. Have encryption protection enabled at the Operating System level.

28.1.25. The Contractor shall have:

28.1.25.1. Capabilities of interagency electronic transfer to and from the participating State agencies as needed to support the operations as determined by EOHHS;

28.1.25.2. Electronic storage and retrieval of individualized Plans of Care (POC), treatment plans, crisis plans, and Advance Directives;

28.1.25.3. An MCO Data Warehouse that supports the Timely submission of valid data, including, but not limited to, encounter data;

28.1.25.4. A secure online web-based portal that allows providers and state agencies to submit and receive responses to referrals and prior authorizations for services; and,

28.1.25.5. An MIS that regularly (e.g., bi-weekly) electronically transfers client/episode-level recipient, assessment, service, and provider data as directed by EOHHS for purposes of state and federal reporting (e.g., SAMHSA National Outcome Measures [NOM]S, Treatment Episode Data Sets [TEDS])-, Government Performance Reporting and Results Act [GPRA]), and for ad hoc reporting as needed by the State for service

quality monitoring and performance accountability.

28.2. HIPAA Standards and Code Sets

28.2.1. The System shall be able to transmit, receive and process data in current HIPAA-compliant or EOHHS specific formats and/or methods, including, but not limited to, Secure File Transfer Protocol (SFTP) over a secure connection such as a Virtual Private Network (VPN), that are in use at the start of Systems Readiness Review activities. Data elements and file format requirements may be found in the MCO System Companion Guide.

28.2.2. All HIPAA-conforming exchanges of data between EOHHS, its contractors, and the Contractor shall be subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker.

28.2.3. The System shall conform to the following HIPAA-compliant standards for information exchange. Batch transaction types include, but are not limited to, the following:

28.2.3.1. ASC X12N 834 Benefit Enrollment and Maintenance;

28.2.3.2. ASC X12N 835 Claims Payment Remittance Advice Transaction;

28.2.3.3. ASC X12N 837I Institutional Claim/Encounter Transaction;

28.2.3.4. ASC X12N 837P Professional Claim/Encounter Transaction;

28.2.3.5. ASC X12N 837D Dental Claim/Encounter Transaction;

28.2.3.6. ASC X12N 270/271 Eligibility/Benefit Inquiry/Response;

28.2.3.7. ASC X12N 276 Claims Status Inquiry;

28.2.3.8. ASC X12N 277 Claims Status Response;

28.2.3.9. ASC X12N 278 Utilization Review Inquiry/Response;

28.2.3.10. ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products; and

28.2.3.11. NCPDP Pharmacy Claims.

28.2.4. The Contractor shall not revise or modify standardized forms or formats.

28.2.5. Transaction types are subject to change, and the Contractor shall comply with applicable Federal and HIPAA standards and regulations as they occur.

28.2.6. The Contractor shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms that are developed jointly with EOHHS. These shall include, but not be limited to, HIPAA based standards and Federal safeguard requirements including signature requirements described in the CMS State Medicaid Manual.

28.3. Connectivity

28.3.1. The Contractor shall interface with EOHHS, the FI, the Enrollment Broker, and its trading partners. The Contractor shall have capacity for real time connectivity to all

EOHHS approved systems. The Contractor shall have the capability to allow and enable authorized EOHHS personnel to have real-time connectivity to the Contractor's system as remote connections from EOHHS offices.

28.3.2. The System shall conform and adhere to the data and document management standards of EOHHS and the FI, inclusive of standard transaction code sets as outlined in the MCO System Companion Guide.

28.3.3. The MCO's Systems shall utilize mailing address standards in accordance with the United States Postal Service.

28.3.4. The Contractor shall encourage all hospitals, physicians, and other providers in its network to adopt certified electronic health record technology (CEHRT) and comply and attest with its corresponding meaningful use requirements and deadlines as outlined by CMS and the Office of the National Coordinator (ONC).

28.3.5. The Contractor shall require all EDs in its network to exchange admit discharge transfer (ADT) data with a Health Information Exchange (HIE) ED visit registry to aid in identification of and creation of policies around high utilizers, drug seeking behavior, and Care Management. The visit registry shall consist of three (3) basic attributes: 1) the ability to capture and match patients based on demographics information, 2) the ability to identify the facility at which care is being sought, and 3) at minimum, the chief complaint of the visit. These three (3) pieces of information are commonly available through the Health Level Seven (HL7) ADT message standard and in use by most ED admission systems in use today across the country. This data shall be available in real-time in order to assist providers and systems with up-to-date information for treating patients appropriately.

28.3.6. All information, whether data or documentation and reports that contain references to that information involving or arising out of the Contract, is owned by EOHHS. The Contractor is expressly prohibited from sharing or publishing EOHHS' information and reports without the prior written consent of EOHHS. In the event of a dispute regarding the sharing or publishing of information and reports, EOHHS decision on this matter shall be final.

28.3.7. The Medicaid Management Information System (MMIS) processes claims and payments for Medicaid Covered Services for FFS. EOHHS shall require the Contractor to comply with all transitional requirements as necessary if EOHHS contracts with a new FI during the Contract term at no cost to EOHHS or the FI.

28.3.8. The Contractor shall be responsible for all initial and recurring costs required for access to EOHHS system(s), as well as EOHHS access to the Contractor's system(s). These costs include, but are not limited to, hardware, software, licensing, and authority/permission to utilize any patents, annual maintenance, support, and connectivity with EOHHS, the FI, and the Enrollment Broker.

28.3.9. EOHHS may require the Contractor to complete an Information Systems Capabilities Assessment (ISCA), which shall be provided by EOHHS. The ISCA shall be completed and returned to EOHHS as part of Readiness Review and upon request

thereafter.

28.4. Hardware and Software

28.4.1. The Contractor shall maintain hardware and software compatible with current EOHHS requirements in accordance with the Managed Care Manual.

28.5. Network and Back-up Capabilities

28.5.1. The Contractor shall have network and back-up capabilities in accordance with the Managed Care Manual**.**

28.6. Resource Availability and Systems Changes

28.6.1. Resource Availability

28.6.1.1. The Contractor shall provide Systems Help Desk services to EOHHS, its FI, and Enrollment Broker staff that have direct access to the data in the MCO's Systems.

28.6.1.2. The Systems Help Desk shall:

28.6.1.3. Be available via local and toll-free telephone service, and via e-mail on Business Days from 7:00 a.m. to 7:00 p.m., Eastern Standard Time. Upon request by EOHHS, the Contractor shall be required to staff the Systems Help Desk on a State-designated holiday, Saturday, or Sunday;

28.6.1.4. Answer questions regarding the Contractor's System functions and capabilities; report recurring programmatic and operation problems to appropriate staff for follow-up; redirect problems or queries that are not supported by the Systems Help Desk, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate EOHHS staff;

28.6.1.5. Ensure individuals who place calls after hours have the option to leave a message. The Contractor's staff shall respond to messages left between the hours of 6:00 p.m. and 7:00 a.m. by noon the next Business Day;

28.6.1.6. Ensure recurring problems not specific to Systems unavailability identified by the Systems Help Desk are documented and reported to MCO management within one (1) Business Day of recognition so that deficiencies are promptly corrected; and

28.6.1.7. Have a service management system that provides an automated method to record, track and report all questions and/or problems reported to the Systems Help Desk.

28.7. Systems Quality Assurance Plan

28.7.1. The Contractor shall ensure that written Systems process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems. The Systems Quality Assurance Plan information systems documentation requirements must be submitted

to EOHHS or its designee as part of Readiness Review for approval. At a minimum, the Systems Quality Assurance Plan must address the following:

28.7.1.1. The Contractor shall develop, prepare, print, maintain, produce, and distribute to EOHHS distinct Systems design and management manuals, user manuals and quick reference guides, and any updates.

28.7.1.2. The Contractor shall ensure the Systems user manuals contain information about, and instruction for, using applicable Systems functions and accessing applicable system data.

28.7.1.3. The Contractor shall ensure when a System change is subject to EOHHS prior written approval, the Contractor will submit any necessary revision(s) to the appropriate manuals before implementing said Systems changes.

28.7.1.4. The Contractor shall ensure all aforementioned manuals and reference guides are available in printed form and online; and

28.7.1.5. The Contractor shall update the electronic version of these manuals immediately, and update printed versions within ten (10) Business Days of the update taking effect.

28.7.2. The Contractor shall provide to EOHHS documentation describing its Systems Quality Assurance Plan.

28.8. Systems Changes

28.8.1. The MCO's Systems shall conform to future federal and/or EOHHS specific standards for encounter data exchange prior to the standard's effective date, unless otherwise directed by CMS or EOHHS.

28.8.2. If a system update and/or change is necessary, the Contractor shall draft appropriate revisions for the documentation or manuals, and present to EOHHS thirty (30) Calendar Days prior to implementation, for EOHHS review and approval. Documentation revisions shall be accomplished electronically and shall be made available for Department review in an easily accessible, near real-time method. Printed manual revisions shall occur within ten (10) Business Days of the actual revision.

28.8.3. The Contractor shall notify EOHHS staff of the following changes to its System within its span of control upon the earlier of beginning work on the changes or at least ninety (90) Calendar Days prior to the projected date of the change, unless otherwise directed by EOHHS:

28.8.3.1. Major changes, upgrades, modification or updates to application or operating software associated with the following core production Systems:

28.8.3.2. Claims processing;

28.8.3.3. Eligibility and Enrollment processing;

28.8.3.4. Service authorization management;

28.8.3.5. Provider Enrollment and data management; and

28.8.3.6. Conversions of core transaction management Systems.

28.8.4. The Contractor shall respond to EOHHS notification of System problems not resulting in System unavailability according to the following timeframes:

28.8.4.1. Within five (5) Calendar Days of receiving notification from EOHHS, the Contractor shall respond in writing to notices of system problems.

28.8.4.2. Within fifteen (15) Calendar Days, the correction shall be made or a requirements analysis and specifications document will be due.

28.8.5. The Contractor shall correct the deficiency by an effective date to be determined by EOHHS.

28.8.6. The Contractor's Systems shall have a system-inherent mechanism for recording any change to a software module or subsystem.

28.8.7. The Contractor shall put in place procedures and measures for safeguarding against unauthorized modification to the Contractor's Systems.

28.8.8. Unless otherwise agreed to in advance by EOHHS, the Contractor shall not schedule Systems unavailability to perform system maintenance, repair and/or upgrade activities during hours that can compromise or prevent critical business operations.

28.8.9. The Contractor shall work with EOHHS pertaining to any testing initiative as required by EOHHS and shall provide sufficient system access to allow testing by EOHHS and/or its FI of the Contractor's System**.**

28.9. Systems Refresh Plan

28.9.1. The Contractor shall provide to EOHHS or its designee a Systems Refresh Plan as part of Readiness Review and sixty (60) Calendar Days prior to implementation of revisions. The plan shall outline how Systems within the Contractor's span of control shall be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors.

28.9.2. The systems refresh plan shall also indicate how the Contractor shall ensure that the version and/or release level of all of its Systems components (application software, operating hardware, and operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM and/or SDF to support the Systems component.

28.10. Other Electronic Data Exchange

28.10.1. The Contractor's system shall scan, house, and retain indexed electronic images of documents to be used by Enrollees and providers to transact with the Contractor and shall repose them in appropriate database(s) and document management systems (i.e., Master Patient Index) as to maintain the logical relationships to certain key data such

as Enrollee identification numbers, provider identification numbers and claim identification numbers. The Contractor shall ensure that records associated with a common event, transaction or customer service issue have a common index that shall facilitate search, retrieval and analysis of related activities, such as interactions with a particular Enrollee about a reported problem.

28.10.2. The Contractor shall implement Optical Character Recognition (OCR) technology that minimizes manual indexing and automates the retrieval of scanned documents.

28.11. Electronic Messaging

28.11.1. The Contractor shall provide a continuously available electronic mail communication link (e-mail system) to facilitate communication with EOHHS. This e-mail system shall be capable of attaching and sending documents created using software compatible with EOHHS' installed version of Microsoft Office (currently 2016) and any subsequent upgrades as adopted. The e-mail system shall also be capable of sending e-mail blasts to providers.

28.11.2. As needed, the Contractor shall be able to communicate with EOHHS over a secure Virtual Private Network (VPN).

28.11.3. The Contractor shall comply with national standards for submitting PHI electronically and shall set up a secure emailing system that is password protected for both sending and receiving any PHI.

28.12. Eligibility and Enrollment Data Exchange

28.12.1. The Contractor shall:

28.12.1.1. Receive, process and update Enrollment files sent by the Enrollment Broker, and update eligibility and Enrollment databases within the following timelines:

28.12.1.2. Daily files – within twenty-four (24) hours of receipt;

28.12.1.3. Weekly reconciliation files – within three (3) Business Days of receipt;

28.12.1.4. Quarterly or monthly reconciliation files – within five (5) Business Days of receipt; and

28.12.1.5. Special corrections files – within seven (7) Business Days of receipt;

28.12.1.6. Be capable of uniquely identifying (i.e., Master Patient Index) a distinct Enrollee across multiple populations and Systems within its span of control; and

28.12.1.7. Be able to identify potential duplicate records for a single Enrollee and, upon confirmation of said duplicate record by EOHHS, resolve the duplication within five (5) Business Days after receipt of manual correction, such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.

28.13. Information Systems Availability

28.13.1. The Contractor shall:

28.13.1.1. Not be responsible for the availability and performance of systems and IT infrastructure technologies outside of the Contractor's span of control;

28.13.1.2. Allow EOHHS personnel, agents of the Rhode Island Attorney General's Office, individuals authorized by EOHHS in writing, and CMS direct, real-time, read-only access to its data for the purpose of data mining and review. Access shall be granted within thirty (30) Calendar Days of EOHHS request. Direct, real-time, read-only access can be provided through a SQL based production-like reporting environment to be updated no less than weekly with the ability to query using Microsoft SQL Server Management Studio©, or similar enterprise-grade technology which shall be subject to EOHHS approval. This reporting environment shall include all data from the systems referenced in the Contract or any additional data upon EOHHS request.

28.13.1.3. Access shall be provided to the following Contractor (including subcontractors) systems (this is not an exclusive list):

28.13.1.4. Prior authorization;

28.13.1.5. Claims processing;

28.13.1.6. Provider portal;

28.13.1.7. Third party liability;

28.13.1.8. Fraud, Waste, and Abuse;

28.13.1.9. Pharmacy benefits manager point of sale;

28.13.1.10. Pharmacy benefits manager prior authorization; and

28.13.1.11. Provider contracting and credentialing.

28.13.2. The Contractor's satisfaction of the requirements to provide the direct, real-time access to EOHHS personnel shall not constitute constructive compliance with nor relieve the Contractor of any duty to satisfy any other provision of this Contract, including, but not limited to, the Contractor's obligation to provide information at the request of EOHHS.

28.13.3. Provide training EOHHS staff on how to use the Contractor's Systems and data on-site at the Contractor's location upon request by EOHHS;

28.13.4. Ensure that critical Enrollee and provider internet and/or telephone-based IVR functions and information functions are available to the applicable System users twenty-four (24) hours a day, seven (7) days a week except during periods of scheduled System unavailability agreed upon by EOHHS and the Contractor. Unavailability caused by events outside of the Contractor's span of control is outside of the scope of this requirement;

28.13.5. Ensure that, at a minimum, all other System functions and information are available

to the applicable system users between the hours of 7:00 a.m. and 7:00 p.m., Central Time, Monday through Friday;

28.13.6. Ensure that the systems and processes within its span of control associated with its data exchanges with the FI and/or Enrollment Broker and its contractors are available and operational;

28.13.7. Ensure that in the event of a pandemic, natural disaster or man-made emergency including, but not limited to, localized acts of nature, accidents, and technological and/or attack-related emergencies, or other events which leads to a significant disruption in operations due to staff absence and/or loss of utilities, the Contractor's core eligibility/Enrollment and claims processing system shall be back on line within seventy-two (72) hours of the failure's or disaster's occurrence;

28.13.8. Notify designated EPJJS staff via phone and electronic mail within sixty (60) minutes of discovery of a problem within or outside the Contractor's span of control that may jeopardize or is jeopardizing availability and performance of critical systems functions and the availability of critical information as defined in this Section, including any problems impacting scheduled exchanges of data between the Contractor and EOHHS, EOHHS's FI, or any other state vendors or systems. In its notification, the Contractor shall explain in detail the impact to critical path processes such as Enrollment management and encounter submission processes;

28.13.9. Notify designated EOHHS staff via phone and electronic mail within fifteen (15) minutes of discovery of a problem that results in delays in report distribution or problems in online access to critical systems functions and information, in order for the applicable work activities to be rescheduled or handled based on System unavailability protocol;

28.13.10. Provide information on System unavailability events, as well as status updates on problem resolution, to appropriate EOHHS staff. At a minimum, these updates shall be provided on an hourly basis until resolution and made available via phone and/or electronic mail;

28.13.11. Resolve and implement system restoration within sixty (60) minutes of official declaration of unscheduled System unavailability of critical functions caused by the failure of system and telecommunications technologies within the Contractor's span of control. Unscheduled System unavailability to all other System functions caused by system and telecommunications technologies within the Contractor's span of control shall be resolved, and the restoration of services implemented, within eight (8) hours of the official declaration of System unavailability;

28.13.12. Cumulative Systems unavailability caused by systems and/or IS infrastructure technologies within the Contractor's span of control shall not exceed twelve (12) hours during any continuous twenty (20) Business Day period; and

28.13.13. Within five (5) Business Days of the occurrence of a problem with system availability, the Contractor shall provide EOHHS with full written documentation that includes a Corrective Action Plan describing how the Contractor shall prevent the problem from

reoccurring.

28.14. Off Site Storage and Remote Back-up

28.14.1. The Contractor shall provide for off-site storage and a remote back-up of operating instructions, procedures, reference files, system documentation, and operational files.

28.14.2. The data back-up policy and procedures shall include, but not be limited to:

28.14.2.1. Descriptions of the controls for back-up processing, including how frequently back-ups occur;

28.14.2.2. Documented back-up procedures;

28.14.2.3. The location of data that has been backed up (off-site and on-site, as applicable);

28.14.2.4. Identification and description of what is being backed up as part of the back-up plan;

28.14.2.5. Any change in back-up procedures in relation to the Contractor's technology changes; and

28.14.2.6. A list of all back-up files to be stored at remote locations and the frequency with which these files are updated.

28.15. Technology Systems Planned Downtime

28.15.1. Contractor shall notify EOHHS, in writing, at least thirty (30) days before any planned maintenance where the Contractor's staff, members and Providers will not have access to any technology system. Planned maintenance should not occur during any peak hours of traffic that would impact normal business operations and functions.

28.15.2. Contractor notification shall describe what is being maintained and if there will be any impacts on business operations.

28.15.3. Contractor shall provide EOHHS a Systems Maintenance Policy and Procedure during Contract Readiness.

28.15.4. Failure to provide EOHHS notice will result in a liquidated damage as described in Attachment F-6, "Liquidated Damages Matrix."

28.16. Unplanned Technology Systems Downtime

28.16.1. The Contractor shall notify EOHHS immediately if there are any system failures, unplanned systems downtime that impact business operations.

28.16.2. Contractor shall provide EOHHS a root cause analysis.

28.16.3. In the event of power failure or natural disaster, the Contractor shall have a back-up system capable of operating the telephone system at full capacity, with no interruption of services or data collection. The Contractor shall notify EOHHS when its phone system is on a back-up system or is inoperative.

28.16.4. The Contractor shall have a manual back up procedure to allow requests to continue being processed if the system is down. An error report and root cause analysis shall be

provided to EOHHS upon request of any outage and root cause associated with the findings for non-natural disasters in conformance with Section 27.4, "Disaster Recovery Plan' policy and procedures.

28.16.5. Failure to notify EOHHS immediately will result in a liquidated damage under Attachment F-6, "Liquidated Damages Matrix." of this Agreement.

28.17. Disaster Recovery Plan

28.17.1. The Contractor shall develop and maintain a Disaster Recovery Plan designed to minimize the any disruption to services caused by a natural disaster, pandemic, man-made event at the Contractor's central business office or other facility that provides operational supports under this Agreement.

28.17.2. It is sole responsibility of the Contractor to maintain adequate backup to ensure continued scheduled and transportation capability.

28.17.3. The Disaster Recovery Plan shall include the following components:

28.17.3.1. A call center contingency plan that maintains sufficient call center capacity to meet call center performance standards at all times.

28.17.4. The Disaster Recovery Plan shall be submitted to EOHHS for review and approval during Contract Readiness.

28.17.5. Modifications required by EOHHS shall be incorporated by the Contractor within ten (10) Calendar Days of notification.

28.17.6. The Contractor will be required to provide updated Disaster Recovery Plan annually to EOHHS.

28.17.7. The Disaster Recovery Plan shall address the following scenarios, at a minimum:

28.17.7.1. The hardware or software is destroyed or damaged;

28.17.7.2. The system interruption or failure resulting from network, operating hardware, software, or operations errors that compromise the integrity of transactions that are active in a live system at the time of the outage;

28.17.7.3. System interruption or failure resulting from network, operating hardware, software or operations errors that compromise the integrity of data maintained in a live or archival system; and,

28.17.7.4. System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system, but does prevent access to the System, such that it causes unscheduled System unavailability.

28.17.8. Contractor shall develop a Systems Contingency Plan within the Disaster Recovery Plan that shall specify projected data unavailability and recovery times for mission-critical Systems in the event of a declared disaster.

28.17.9. The Contractor shall test annually its plan through simulated disasters and lower level

failures in order to demonstrate to EOHHS that it can restore system functions. The Contractor shall report documentation of this testing in a manner determined by EOHHS.

28.17.9.1. In the event that the Contractor fails to demonstrate through these simulation tests that it can restore systems functions, the Contractor shall be required to submit a Corrective Action Plan to EOHHS describing the failure within ten (10) Business Days of the conclusion of the test.

28.17.10. The Contractor shall immediately inform EOHHS, in writing, when invoking its Disaster Recovery Plan. If the nature of the triggering event renders written notification impossible, the Contractor shall notify EOHHS of the invocation of the Disaster Recovery Plan through the best available means. If the nature of triggering event renders immediate notification impossible, the Contractor shall inform EOHHS of the invocation of the Disaster Recovery Plan as soon as possible.

28.17.11. The Contractor shall follow all EOHHS directives during a pandemic, natural disaster, or man-made event.

28.18. Computer and Information Interchange Standards

28.18.1. The Contractor shall be responsible for ensuring that all services, products and deliverables furnished pursuant to this Contract comply with the standards promulgated by the Rhode Island Department of Information Technology (DoIT) and as modified from time to time by DoIT during the term of this Contract.

28.18.2. If any service, product or deliverable furnished pursuant to this Contract does not conform with DoIT standards, the Contractor shall, at its expense and option either:

28.18.2.1. Replace it with a conforming equivalent; or,

28.18.2.2. Modify it to conform with DoIT standards.

28.18.3. The Contractor shall be and remain liable in accordance with the terms of this Contract and applicable law for all damages to the State caused by the Contractor's failure to ensure compliance with DoIT standards.

28.18.4. The Contractor shall have adequate personnel and resources in place to meet the following standards regarding receipt, processing, and transmission of program information.

28.18.5. All Contract staff shall have access to equipment, software and training necessary to accomplish their stated duties in a timely and efficient manner.

28.18.6. The Contractor shall supply all hardware, software, communication, and other equipment necessary to perform the duties described below:

28.18.6.1. The Contractor will receive daily and monthly via electronic media a file for all newly eligible Medicaid or. Final defemination of the exact method of transmission and file specification will be made jointly by the State and Contractor after contract award.

28.18.6.2. The Contractor shall provide the State agency on a weekly basis, updates

on TPL information as collected pursuant to requirements described in this Agreement.

28.18.7. The Contractor shall implement adequate security provisions and procedures in order to maintain client confidentiality. The Contractor shall also adhere to all application State agency procedures and restrictions associated with access and update capabilities of State maintained information and systems databases.

28.18.8. The Contractor's systems will be HIPPA complaint in the areas of privacy and security and shall support all other HIPPA regulations, e.g. Code Transaction Sets.

28.18.9. The Contractor shall transmit to and receive from the State all transactions and code sets in the appropriate standard formats as specified under applicable State or Federal law and as directed by the State, as long as the State direction does not conflict with State or Federal law.

28.18.10. The Contractor's systems shall conform to future Federal and/or State specific standards for data exchange within the timeframe stipulated by Federal authorities or the State. The Contractor shall partner with the State in the management of current and future data exchange formats and methods and in the development and implementation planning of future data exchange methods not specific to HIPPA or other Federal effort.

28.18.11. Furthermore, the Contractor shall conform to these standards as stipulated in the plan to implement such standards. The Contractor shall ensure that written system process and procedure manuals document and describe all manual and automated system procedures for its information management processes and Information Systems and shall provide these documents to the State upon request.

28.18.12. The Contractor shall implement proprietary file exchanges and interfaces as required to transfer data to and from the States' FI and modify these as necessary to meet future changes to those requirements. Information about these interfaces is available from EOHHS.

28.18.13. In addition to the requirements in this Contract, the Contractor's Information Systems shall meet all State technical requirements and standards for Information Systems.

28.19. System and Information Security and Access Management Requirements

28.19.1. The Contractor's systems shall employ an access management function that restricts access to varying hierarchical levels of system functionality and information.

28.19.2. The access management function shall:

28.19.2.1. Restrict access to information on a 'least privilege' basis (e.g., users permitted inquiry privileges only will not be permitted to modify information); and,

28.19.2.2. Restrict access to specific system functions and information based on an individual profile, including inquiry only capabilities; global access to all functions shall be restricted to specified appropriate staff.

28.19.3. The Contractor's systems shall contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The Contractor shall test these controls in periodic and spot audits and make the results of these tests available to EOHHS upon request.

28.19.4. The Contractor shall provide for the physical safeguarding of its data processing facilities and systems and information housed therein. The Contractor shall provide EOHHS with access to data facilities upon request.

28.19.5. The Contractor shall restrict perimeter access to equipment sites, processing areas and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.

28.19.6. The Contractor shall comply with recognized industry standards governing security of State and Federal automated data processing systems and information processing. At a minimum, the Contractor shall conduct a security risk assessment and communicate the results in an information security plan provided to EOHHS prior to Operational Start Date. The risk assessment shall also be made available to appropriate State and Federal agencies upon request.

Article 29. EOHHS and Contractor Oversight Requirements

29.1. EOHHS Oversight

29.1.1. EOHHS will oversee the Rhode Island Medicaid Managed Care Program, including overall program management, determination of policy and monitoring of service.

29.1.2. EOHHS will work in partnership with Contractor in developing a quality program.

29.1.3. The following are the primary responsibilities of EOHHS to provide oversight of the Rhode Island Medicaid Managed Care Program:

29.1.3.1. Policy Interpretation—EOHHS will make final decisions regarding all policy issues;

29.1.3.2. On-going project oversight and management to include announced and unannounced visits to ensure regulatory compliance;

29.1.3.3. Provide the Contractor with all up to date member eligibility information;

29.1.3.4. Review and approve any Contractor written policy or procedural communications to members, and other prior to release.

29.1.3.5. Ensure compliance with all aspects of this Agreement.

29.2. Contractor Administrative Oversight

29.2.1. Contractor is responsible for the management of overall day-to-day operations necessary for the delivery of Medicaid Managed Care services and the maintenance of appropriate records and systems of accountability to report to EOHHS and respond to the terms of this Contract.

29.2.2. Contractor shall ensure that all oversight safeguards before Operational Start Date and through the entirety of the Contract.

29.3. Performance Monitoring of Contractor

29.3.1. EOHHS reserves the right to conduct a review of Contractors' records or to conduct an onsite review at any time to ensure compliance with Contract requirements.

29.3.2. The Contractor agrees to make all records related to services available for such reviews by EOHHS or its agents.

29.3.3. EOHHS reserves the right to audit the Contractor's records, reports and other information.

29.3.4. EOHHS staff or its official agent will review reports of grievances from members, providers, or any individual or group who contact the Contractor regarding the delivery of services under this Contract.

29.3.5. The Contractor agrees EOHHS may assess liquidated damages for failure to meet the performance standards specified in this Contract.

29.3.6. EOHHS, in its daily activities, shall monitor the Contractor for compliance with the provisions of this Contract.

29.4. EOHHS Oversight Meetings and Active Contract Management

29.4.1. The Contractor shall meet with EOHHS representatives at the EOHHS Office in Cranston, Rhode Island at least monthly and upon request by EOHHS to discuss the Rhode Island Medicaid Managed Care Program and to answer pertinent inquiries regarding the Program, its implementation and its operation.

29.4.2. The Contractor shall attend regular performance review meetings held by EOHHS at EOHHS offices, or at another location determined by EOHHS in writing, each month or more frequently at EOHHS' discretion.

29.4.3. The Contractor shall ensure that key personnel and other staff with appropriate expertise are present in person at such meetings, as requested by EOHHS. Contractor shall be prepared for EOHHS Oversight Meetings and shall have relevant data and participate in Active Contract Management to improve service quality or other requested oversight item by EOHHS.

29.4.4. The Contractor shall prepare materials and information for such meetings as further directed by EOHHS, including, but not limited to, materials and information such as:

29.4.4.1. Reports, in a form and format approved by EOHHS in writing, on Contractor's performance under this Contract, including, but not limited to, measures such as:

29.4.4.2. Costs of care for Enrollees by program and category of service;

29.4.4.3. Performance reporting information;

29.4.4.4. Quality measure performance;

29.4.4.5. Measures of Enrollee utilization across categories of service and other indicators of changes in patterns of care;

29.4.4.6. Variation and trends in any such performance measures at the level of individual PCPs;

29.4.4.7. Completeness and validity of any data submissions made to EOHHS;

29.4.4.8. Opportunities the Contractor identifies to improve performance and plans to improve such performance, including plans proposed to be implemented by the Contractor for PCPs or other Network Providers;

29.4.4.9. Changes in Contractor's staffing and organizational development;

29.4.4.10. Performance of Material Subcontractors, including, but not limited to, any changes in or additions to Material Subcontractor relationships; and

29.4.4.11. Any other measures deemed relevant by Contractor or requested by EOHHS;

29.4.4.12. Updates and analytic findings from any reviews requested by EOHHS, such as reviews of data irregularities; and

29.4.4.13. Updates on any action items and requested follow-ups from prior meetings or communications with EOHHS.

29.4.5. The Contractor shall, within two (2) Business Days following each performance review meeting, prepare and submit to EOHHS for review and approval a list of any action items, requested follow-ups for the next meeting, and estimated timelines for delivery, in a form and format specified by EOHHS.

29.4.6. The Contractor may be required to attend other meetings as requested by EOHHS.

Article 30. Contract Transition and Readiness Review

30.1. Introduction

30.1.1. This Section includes the Scope of Work for the Readiness Review phases of the Agreement, which shall be completed before the Operational Start Date in accordance with 42 C.F.R. § 438.66(d).

30.1.2. The Contractor shall have completed the Readiness Review one-hundred eighty (180) Days prior to the Operational Go-Live Date for each phase described in Section 30.2.1.

30.1.2.1. EOHHS reserves the right to amend or delay the date of this Readiness Review requirement.

30.1.3. During Readiness Review, EOHHS will assess the Contractor's adherence to Readiness Review requirements and capability to assume all functions required under this Agreement.

30.1.4. To complete the Readiness assessment, EOHHS will consider the Contractor's assurance of readiness, information contained in the Contractor's proposal, systems testing, network adequacy, and documentation supplied during Readiness Review.

30.1.5. The Contractor is responsible for all implementation and start-up costs associated with this Agreement.

30.1.6. If the Contractor does not fully meet the Readiness Review prior to the Operational Start Date, EOHHS may impose a Liquidated Damage for each Calendar Day beyond the Operational Start Date that the Contractor is not operational.

30.1.7. The Contractor is accountable for providing sufficient personnel to meet the goals and objectives of the Readiness Review and implementation in a timely and accurate manner.

30.2. Phases of Readiness Review

30.2.1. The Readiness Review Schedule includes three (3) phases for Contractor to be approved for accepting enrollment.

30.2.1.1. Transition Phase I: Enrollment of core populations and bringing LTSS services in-plan for Medicaid Managed Care Plans for Medicaid only Members on July 1, 2025, or another later date established by EOHHS.

30.2.1.2. Transition Phase II: Enrollment of current Full Benefit Dual Eligible (FBDE) Members into Medicaid Managed Care Plans on January 1, 2026, or another later date established by EOHHS.

30.2.1.3. Transition Phase III: Begin implementation of default enrollment for new dual eligible Members who become newly eligible for Medicare on January 1, 2027, or another later date established by EOHHS.

30.2.2. EOHHS will have sole discretion to adjust the Transition Phase dates to a later date if needed for any reason.

30.3. Transition Phase Work Plan and Protocols for Contractor

30.3.1. The Contractor shall submit to EOHHS, or its designee as requested, for its review and approval, a Transition Work Plan that demonstrates how it will accomplish required tasks set forth in this Agreement before the Operational Start Date for Each Transition Phase and provide documentation of the following:

30.3.1.1. Contractor's Project management structure;

30.3.1.2. Communication protocols between EOHHS and the Contractor;

30.3.1.3. Contractor's contacts for Readiness activities;

30.3.1.4. Schedule of key activities and milestones related to the implementation; and,

30.3.1.5. Process for ensuring continuity of care for Members during the transition with a focus on health and safety.

30.4. Designation of a Readiness Project Manager for the Rhode Island Medicaid Managed Care Program

30.4.1. The Contractor is required to assign a Project Management Professional (PMP) certified individual who will be responsible for the development and supervision of all activities in the Transition Work Plan. This Readiness Project Manager shall not be the same person supervising the daily operations for an incumbent Contractor or managing another business line for a New Entrant. The assigned individual's sole focus should be on implementing all Phases of the Readiness Review and execution.

30.4.2. The Readiness Project Manager shall possess comprehensive knowledge of the Contractor's business processes and the capacity to meet all specifications and respond to feedback from EOHHS.

30.4.3. The Readiness Project Manager should be granted the authority to adjust or modify the Contractor's business practices promptly, adhering to the EOHHS timeframes.

30.4.4. The Readiness Project Manager shall promptly respond to EOHHS requests and provide timely updates regarding the status of the Readiness Review.

30.4.5. The Readiness Project Manager should stay assigned to the Rhode Island Medicaid Managed Care Program for at least one (1) year after the end of Transition Phase III to ensure the achievement of steady state operations.

30.5. EOHHS Readiness Review Schedule

30.5.1. EOHHS will provide the Contractor with a Readiness Review Schedule with timelines for completing all Readiness Review activities.

30.5.2. The Contractor shall complete all Readiness Review activities to the satisfaction of EOHHS within requested timeframes.

30.6. General Readiness Review Requirements

30.6.1. Deficiencies Identified During Readiness Review

30.6.1.1. If the Contractor or EOHHS identify a deficiency during Readiness

Review, the Contractor shall either:

a) Correct the deficiency within ten (10) Calendar Days of discovering or receiving written notice of the deficiency; or

b) If the deficiency requires more than ten (10) Calendar Days to correct, provide a Corrective Action Plan or Risk Mitigation Plan within the timeframe directed by EOHHS.

c) EOHHS may postpone the Contractor's Operational Start Date up to one (1) year and assess contractual remedies, including termination of the Agreement or liquidated damages if the Contractor fails to correct all Readiness Review deficiencies within required timeframes. EOHHS will make all final decisions regarding the Contractor's operational readiness.

30.6.2. Desk and Onsite Reviews

30.6.2.1. EOHHS may conduct Readiness Review activities via desk reviews and onsite reviews, as well as thorough systems testing and file exchanges. A portion of the Readiness Review will be performed onsite at the Contractor's administrative office or other locations identified by EOHHS.

30.6.2.2. If the Contractor fails to provide pre-onsite materials as requested, EOHHS may choose to delay the onsite review and contractual remedies, including liquidated damages, may apply.

30.6.2.3. The Contractor shall be responsible for all travel costs incurred by EOHHS staff or designees participating in onsite Readiness Reviews.

30.6.2.4. The results of the Readiness Review will be submitted to CMS by EOHHS for CMS to make a determination that the Agreement or associated amendment is approved under 42 C.F.R. § 438.3(a).

30.6.3. Readiness Review Activities

30.6.3.1. If the Contractor identifies information needed from EOHHS to complete Readiness Review activities, the Contractor shall submit a written request for information in a manner that does not delay the schedule or work to be performed.

30.6.3.2. The Parties will work together during Readiness Review to:

a) Establish communication protocols and regular check-ins and monitoring to assess Contractor's performance.

b) Establish contacts with EOHHS staff and other contractors.

c) Clarify expectations for the content and format of deliverables.

30.6.3.3. The Contractor shall submit a Transition Plan and monthly progress reports by the dates identified in the Readiness Review Schedule. At a minimum, the Transition Plan shall include:

a) Staffing patterns and key personnel for all major Agreement functions identified in Article 1, "Contractor Management and Administration."

b) Proposed schedules for Readiness Review demonstrations.

c) Other requirements identified by EOHHS

30.6.3.4. The Contractor is required to:

a) Meet all Readiness Review timelines.

b) Be responsive to EOHHS questions and requests within designated timeframes.

c) Provide adequate space and facilities for onsite reviews.

d) Include all staff and Subcontractors responsible for the functions described in this Agreement in Readiness Review activities.

30.6.4. Changes to Key Personnel and Organization During Readiness Review

30.6.4.1. The Contractor shall submit a report identifying:

a) Key Personnel meeting the requirements of Article 1, "Contractor Management and Administration," including current resumes. Changes to Key Personnel identified in the Contractor's Proposal shall be approved by EOHHS.

b) Job descriptions, organizational charts, and other organizational information that has changed since proposal submission.

30.6.5. Financial Readiness Review

30.6.5.1. The Contractor shall submit a Financial Report that:

a) Identifies whether the Contractor or its ultimate parent organization has experienced a material financial deterioration or change following proposal submission. The report shall describe any changes to financial statements, including changes to net worth; cash flow; loss of contracts; credit, audit, regulatory or legal issues; and major contingencies. In addition, the report shall describe any issues regarding changes in ownership or control.

b) Includes the most recently updated financial statements for the Contractor and ultimate parent organization (internal financial statements, annual statements, and audited statements). Except for internal financial statements, the financial statements should generally include the notes, management discussion, and where appropriate, the audit letter.

c) Includes the most recent financial reports to and registration statements with the Rhode Island Department of Business Regulation; IRS Form 990; and bond or debt rating analysis. It is not necessary to submit updated SEC 10-K or 10-Q filings with the report.

30.6.5.2. The Contractor shall submit documentation demonstrating it has secured all required bonds.

30.6.5.3. If the Contractor intends to include employee bonuses or incentive payments as allowable administrative expenses in financial reports, it shall furnish an Employee Bonus or Incentive Plan. The plan shall include the:

a) Criteria for establishing bonus or incentive payments.

b) Methodology to calculate payments.

c) Timing of payments.

30.6.5.4. EOHHS shall approve all substantive revisions to the Employee Bonus or Incentive Plan at least thirty (30) Calendar Days before revisions take effect.

30.6.5.5. EOHHS reserves the right to disallow all or part of the Employee Bonus or Incentive Plan that it deems inappropriate. All bonus or incentive payments are subject to audit and shall conform with the cost reporting and financial requirements in this Agreement.

30.6.5.6. The Contractor shall submit a Third-Party Liability (TPL) Policy describing how the Contractor shall conduct the following activities:

a) Cost avoidance activities;

b) Payment reductions based on third-party payments for any part of a Covered Service;

c) Payment recovery activities;

d) Identification of other forms of insurance processes and procedures;

e) Subrogation, including the analysis of the State motor vehicle accident report file data exchange required under 42 C.F.R. § 433.138(d)(4)(ii) to identify potential subrogation claims and identify Members with a legal liable third-party; and

f) The analysis of the State motor vehicle accident report file data exchange required under 42 C.F.R. §433.138(d)(4)(ii) to identify potential subrogation claims and identify Members with a legal liable third-party and methods for conducting diagnosis and trauma code editing to identify potential subrogation claims.

30.6.6. Systems Readiness Review

30.6.6.1. The Contractor shall submit descriptions of interface and data and process flow for each key business processes described in Article 26, "Claims Processing and Management Information System (MIS)."

30.6.6.2. The Contractor shall have clearly defined policies and procedures to support day-to-day MIS activities. During Readiness Review, the Contractor shall submit the following plans:

a) Disaster Recovery Plan.

b) Business Continuity Plan.

c) Security Plan.

d) Joint Interface Plan.

e) Risk Management Plan.

f) Systems Quality Assurance Plan.

30.6.6.3. The Business Continuity Plan and the Disaster Recovery Plan may be combined into one (1) document. The documents shall address processes and procedures in the event of a cyberattack.

30.6.6.4. During Readiness Review, the Contractor shall demonstrate Information Systems (IS) capabilities and adherence to Agreement specifications, including requirements relating to claims management, encounter data submission, and Member information. EOHHS will provide the Contractor with a test plan outlining activities the Contractor shall perform prior to the Operational Start Date.

30.6.6.5. The Contractor shall have hardware, software, network and communications systems with the capability and capacity to handle and operate all IS systems and subsystems (collectively "systems") identified in Article 26, "Claims Processing and MIS." For example, the MCO's MIS system shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

30.6.6.6. During Readiness Review testing:

a) The Contractor's systems shall accept all data files and information provided by EOHHS or its contractors.

b) The Contractor shall install and test all hardware, software, and telecommunications required to support the Agreement.

c) The Contractor shall identify and test systems' modifications needed to support the business functions of the Agreement.

d) The Contractor shall produce data extracts and receive all electronic data transfers and transmissions.

e) Provide test data files for systems and interface testing for all external interfaces (e.g., Member hotline, provider support line, EOHHS administrative contractors).

f) The Contractor shall execute all systems readiness testing cycles required by EOHHS.

30.6.6.7. The Contractor shall provide documentation demonstrating its systems and facilities comply with HIPAA security requirements.

30.6.6.8. EOHHS may independently test whether the Contractor's systems have the capacity to administer the Rhode Island Medicaid Managed Care Program. EOHHS may perform desk reviews or on-site reviews of the Contractor's systems.

30.6.6.9. The Contractor is responsible for all costs incurred by EOHHS due to system errors, regardless of whether these errors were discovered during Readiness Review testing.

30.6.6.10. The Contractor shall provide EOHHS with a summary of all recent external audit reports, including findings and corrective actions, relating to the Contractor's proposed systems, including any SSAE16 audits conducted in the prior three (3) years.

30.6.6.11. The Contractor shall make additional information regarding the details of such system audits available to EOHHS upon request.

30.6.6.12. The Contractor is required to demonstrate sufficient IT infrastructure and data analytics capacity to support EOHHS's vision and goals for quality improvement, measurement, and evaluation during the readiness review process and through routine reporting requirements, as outlined in the Managed Care Manual. The Contractor shall also demonstrate continued compliance via ongoing documentation. EOHHS reserves the right to request any policies, procedures, algorithms, workflows, or report templates that document the Contractor's IT infrastructure and data analytics capabilities.

30.6.6.13. Contractor will be required to provide an architectural diagram of their system network during Contract Readiness. Architectural diagram shall be updated upon any changes related to IS.

30.6.7. Operational Readiness Review

30.6.7.1. Within twenty (20) Calendar Days of the Agreement Effective Date, EOHHS will provide to the Contractor a readiness review tool outlining the evidence of readiness the Contractor shall provide for each element of the Operational Readiness Review.

30.6.7.2. The Contractor shall clearly define and document the policies and procedures it will follow to support day-to-day business operations, including coordination with Subcontractors and EOHHS contractors. EOHHS may perform interviews with the Contractor's staff to gauge operational preparedness.

30.6.7.3. At a minimum, the Contractor shall submit the following documents for EOHHS review and approval during Readiness Review. The documents shall meet the Managed Care Manual specifications, where applicable:

a) Network Adequacy Plan, including a list of all contracted and credentialed providers and a description of contracting and credentialing activities to be completed before the Operational Start Date.

b) Training curriculum for Member Services staff and Network Providers.

c) Oversight and Coordination Plan documenting how the Contractor shall oversee subcontracted functions and coordinate its business activities

with those performed by Subcontractors and EOHHS contractors.

d) Pre-delegation audit of subcontracted functions, including an evaluation of each Subcontractor's readiness to perform the delegated functions. The audit shall encompass all duties and responsibilities that have been delegated to Subcontractors and include a risk evaluation.

e) Draft Member and Provider materials, including the Contractor's Member Handbook, Provider Manual, Provider Directory (hard copy and online format), Member Identification (ID) card, website content, hotline scripts and messaging, and other Member and Provider materials identified by EOHHS.

f) Member Grievance and Appeals policies and procedures.

g) Program Integrity and Fraud, Waste, and Abuse Compliance Plan.

h) Utilization Management Plan and Drug Utilization Review Program policies and procedures.

i) Health Equity, Diversity, and Inclusion Plan (to be updated annually during the Operations Phase).

j) Care Program Plan, including the Care Plan Strategy for AEs and Members receiving HCBS and CFCM.

k) Quality Improvement Plan.

l) Value-Based Payment (VBP) Implementation Plan.

m) Copies of all Subcontracts and results of delegation oversight, including Accountable Entity (AE) oversight reviews.

n) Documentation showing the Contactor has secured all required insurance coverage.

o) Proof of licensure or approval with the Rhode Island Department of Business Regulation.

p) Proof of NCQA accreditation and certification.

q) Proof of integrated D-SNP certification by CMS.

30.6.7.4. The Contractor shall demonstrate toll-free telephone systems and reporting capabilities for the Member Services and provider hotlines.

30.6.7.5. The Contractor shall supply copies of the Provider Directory and other materials requested by EOHHS for purposes of Member enrollment.

30.6.7.6. To the extent any Readiness Review topics or documentation relate to services provided by a Subcontractor of the Contractor, Contractor shall assure that Subcontractor staff fully comply with and participate in Readiness Review activities.

30.6.7.7. During Readiness Review, EOHHS shall provide the Contractor with one (1) opportunity to enhance proposed Value-added Services or add new Value-added Services. EOHHS will not allow the Contractor to delete,

limit, or restrict any Value-added Services included in its Proposal.

30.6.7.8. At EOHHS' discretion, the Contractor may not be eligible for payment prior to meeting all Readiness Review criteria.

30.6.7.9. If the Contractor fails to obtain FIDE-SNP certification by CMS before the go-live date, the Contractor shall have twelve (12) additional months to obtain certification. During the twelve (12) month period following go-live, the Contractor shall not be eligible for new Member assignments or enrollments until the Contractor obtains certification from CMS. If after the twelve (12) month period the Contractor still has not obtained certification from CMS, the Contractor shall be terminated for failure to meet all Readiness requirements.

30.6.7.10. The Contractor shall be required to operate on a statewide basis and establish an adequate network throughout Rhode Island pursuant to Article 18 of this Agreement.

30.6.8. Operational Readiness Testing

30.6.8.1. Approximately ninety (90) Days before the Operational Start Date, the Contractor shall pass an operational readiness-testing program. Representatives from EOHHS will visit the Contractor's facility and determine whether all systems are operational and ready for full-time service.

30.6.8.2. During the test, the Contractor will ensure that:

a) Telephone systems are fully functional;

b) IS are fully operational;

c) Staffing follows the Solicitation and the Contractor's proposal; and,

d) All deliverables required in this RFQ are available for review and approval.

30.6.8.3. The Contractor will be required to demonstrate readiness for the following systems and processes:

a) Member Services;

b) After-hours coverage arrangements;

c) Grievance and Appeals Process;

d) Quality assurance and Provider monitoring;

e) Critical Incident Reporting Protocols;

f) Provided service agreements and Network Adequacy;

g) Encounter data submission procedure;

h) Reporting procedures; and,

i) Any other items or functions as deemed necessary by EOHHS.

30.6.8.4. The Contractor will have an opportunity to make corrections and will be required, upon request by EOHHS, to submit proof to EOHHS that the corrections were made. The Contractor will not begin operating until the operational readiness test is complete and the Contractor is fully ready to provide service.

30.6.8.5. Funding will be withheld until the Contractor passes the Operational Readiness Tests.

30.6.8.6. EOHHS shall decide if the Contract has passed Operational Readiness Testing.

30.6.9. Additional Assurances

30.6.9.1. In addition to the deliverables described in this Section, the Contractor shall implement all processes, IS systems, and staffed functions prior to the Operational Start Date, and the Contractor shall successfully assume all contractual responsibilities prior to the Operational Start Date.

30.6.9.2. The Contractor shall complete the following prior to the Operational Start Date:

a) Key MCO personnel, staff, and Subcontractors are hired and trained.

b) IS systems and interfaces are in place and functioning properly.

c) Communications procedures are in place.

d) Provider Manuals have been distributed.

e) Provider training sessions have occurred according to an EOHHS-approved schedule.

30.6.9.3. EOHHS reserves the right to request additional information, including more detailed or up-to-date information regarding the Contractor's operating procedures and documentation.

30.6.10. Waiver or Amendment of Readiness Review Requirements

30.6.10.1. EOHHS reserves the right to waive or amend one (1) or more Readiness Review requirements in writing, and to allow incumbent vendors to modify previously approved materials.

30.6.11. Additional Readiness Review Activities

30.6.11.1. Notwithstanding its right to terminate the Agreement, EOHHS may require the Contractor to complete all or some of the Readiness Review activities described in this Section at any time during the term of the Contract, including the option for a targeted annual compliance review, if the Contractor:

a) Exhibits evidence where it is found to be less than fully compliant regarding elements under this Contract.

b) Begins providing a new service or benefit.

c) Expands operations to new managed care programs.

d) Makes a change to its Major Subcontractor.

e) Makes a significant change to the Contractor's Provider Network.

f) Implements a major system change after the Operational Start Date.

g) Other programmatic changes made by the Contractor that impacts the performance or oversight of EOHHS to assure contract compliance with all terms and conditions in this Agreement.

ATTACHMENT F-4.1

Schedule of In-Plan Benefits

Schedule of In-Plan Benefits

Note: *For Members who are Dually Eligible or who have other Third-Party Liability or Coordination of Benefits, this list of benefits only applies insofar as Medicaid is the payor of last resort.*

Service	Referral Necessary (Yes/No)	Benefit Detail	Reference Coverage Document
Adult Day Health	Yes	Day programs for other adults who need supervision and health services during the daytime. Adult Day Health programs offer nursing care, therapies, personal care assistance, social and recreational activities, meals, and other services in a community group setting. Adult Day Health programs are for adults who return to their homes and caregivers at the end of the day.	Provider Manual: Adult Day Health
AIDS Medical Case Management	No	It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to- face, phone contact, and any other form of communication	Provider Manual: AIDS / HIV Case Management
Ambulance Services	Yes	Emergency and non-emergent medical transportation for patients who cannot sit, stand, or walk. Only ground transportation is covered. Wheelchair or air transportation is not a covered service. The type of trip (emergency/non-emergent) must be consistent with the diagnosis of the patient transported (e.g., a trip billed as emergency transport would not be covered if the patient had a non-emergent diagnosis)	Provider Manual: Ambulance
Behavioral Health (Outpatient& Inpatient)	No	Include a full continuum of Mental Health and Substance Use Disorder treatment, including but not limited to, community- based narcotic treatment, methadone, community detox, substance use residential, intensive outpatient services and crisis intervention services. Includes both Adults and Children. This also includes Psychiatric Residential Treatment Facilities and Acute Residential Treatment Services. CCBHC Services are covered and detailed further in the CCBHC Manual.	Medicaid Managed Care Manual Services Provider Manual: BH Services

Service	Referral Necessary (Yes/No)	Benefit Detail	Reference Coverage Document
Court-Ordered Mental Health and Substance Use Treatment – Civil Court	Yes	All Civil Mental Health Court Ordered Treatment must be provided in totality as an in-plan benefit. All regulations in the following State of Rhode Island General Laws must be followed: R.I.G.L. Title 40.1, Behavioral Healthcare, Developmental Disabilities and Hospitals R.I.G.L. Chapter 40.1- 5, Mental Health Law, R.I.G.L. § 40.1-5-5, Admission of patients generally, et. al. If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. Note the following are facilities where treatment may be ordered: • The Eleanor Slater Hospital • Our Lady of Fatima Hospital • Rhode Island Hospital (including Hasbro) • Landmark Medical Center • Newport Hospital • Roger Williams Medical Center • Butler Hospital (including the Kent Unit) • Bradley Hospital • Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than seven (7) Calendar Days, will be dis-enrolled from the Health Plan at the end of the month, and be re- assigned into Medicaid FFS. Civil Court Ordered Treatment can be from the result of: • Voluntary Admission • Emergency Certification • Civil Court Certification Court-ordered treatment that is not an in-plan benefit or to a non-network provider, is not the responsibility of the Contractor. Court ordered treatment is exempt from the fourteen (14) Day prior authorization requirement for residential treatment.	Provider Manual: BH and SUD Services Managed Care Manual

Service	Referral Necessary (Yes/No)	Benefit Detail	Reference Coverage Document
Court-Ordered Mental Health and Substance Use Services – Criminal Court	Yes	Covered for all members. Treatment must be provided in totality, as directed by the Court or other State official or body (i.e., a Probation Officer, The Rhode Island State Parole Board). If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. The Health Plans must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. The following are examples of Criminal Court Ordered Benefits that must be provided in totality as an in-plan benefit: • *Bail Ordered:* Treatment is prescribed as a condition of bail/bond by the court. • *Condition of Parole:* Treatment is prescribed as a condition of parole by the Parole Board. • *Condition of Probation*: Treatment is prescribed as a condition of probation. • *Recommendation by a Probation State Official:* Treatment is recommended by a State official (Probation Officer, Clinical social worker, etc.). • *Condition of Medical Parole:* Person is released to treatment as a condition of their parole, by the Parole Board.	Provider Manual: BH and SUD Services Managed Care Manual
Court Ordered Treatment for Children	Yes	All Court Ordered Treatment must be provided in totality as an in-plan benefit including treatments which are ordered by the court to be provided by a non-network provider. If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. The Health Plans must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires.	Provider Manual: BH and SUD Services Managed Care Manual

Service	Referral Necessary (Yes/No)	Benefit Detail	Reference Coverage Document
Dental Services *(Limited Benefit. – See Out-of- Plan Benefits)*	Yes	*Inpatient:* The Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid Member in an inpatient setting. *Outpatient:* The Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid Member in an outpatient hospital setting. *Oral Surgery:* Treatment covered as medically necessary.	Provider Manual: Dental Managed Care Manual
Diagnostic Services	Yes	N/A	Provider Manual: Diagnostic Services
Doula Services	No	Services are covered during the prenatal period, during delivery, and up to twelve (12) months post-partum.	State Plan Pages: Doula (TN No: 21-0013)
Durable Medical Equipment	Yes	A guide to covered DME Items can be found in the provider manual.	Provider Manual: Durable Medical Equipment
Early Intervention	Yes	Covered for RIte Care members as included within the Individual Family Service Plan (IFSP), consistent with R.I Gen. Laws § 27-19-55.	Provider Manual: Early Intervention
Emergency Room Services and Emergency Transportation Services	No	N/A	Provider Manual: Emergency Room Transportation

Service	Referral Necessary (Yes/No)	Benefit Detail	Reference Coverage Document
EPSDT Services	No	Provided to all children, pregnant individuals, unborn children, and young adults up to age twenty-one (21). See Section 3.2.2. Home Based Therapeutic Services (HBTS) are services available to children and families with varying degrees of intensity based on the individual health needs. HBTS services include: • Applied Behavioral Analysis (ABA) • Personal Assistance Services and Supports (PASS) • Respite Services	Provider Manual: EPSDT Services
Family Planning Services	No	As further described in the Medicaid Managed Care Manual	Managed Care Manual

Health Homes for Children	Yes	Cedar services are established as EPSDT- based Medicaid children under the age of twenty-one (21), including children enrolled in RIte Care or RIte Share.
		Eligibility Criteria:
		• Suspected of having a severe mental illness, or severe emotional disturbance
		• Suspected of having two (2) or more chronic conditions as listed below:
		  ○ Mental Health Condition
		  ○ Asthma
		  ○ Diabetes
		  ○ Intellectual and Developmental Disabilities
		  ○ Down Syndrome
		• Seizure Disorders
		Has one (1) chronic condition listed above and is at risk of developing a second.
			Provider Manual: CEDARR Services

Service	Referral Necessary (Yes/No)	Benefit Detail	Reference Coverage Document
HIV/AIDS Non-Medical Targeted Case Management For People Living with HIV/AIDS and those at High Risk for acquiring HIV	No	N/A	Provider Manual: HIV/AIDS Providers
Home and Community Based Services	No	Medically necessary Home and Community Based Services and Long-Term Services and Supports must be provided by the Contractor based on the state eligibility determination for LTSS. **Assisted Living:** The Rhode Island Medicaid program covers assisted living services in State-licensed Assisted Living Residences (ALRs) that are certified to participate in the LTSS program. Covered services include on-site, twenty-four (24) hour personal care assistance, homemaker and chore services, medication management, therapeutic, social and recreational activities, and health-related transportation. **Member Community Transition Services:** Community transition services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the individual is directly responsible for their own living expenses. Allowable expenses are those necessary to enable an individual to establish a basic household that does not constitute room and board and may include security deposits that are required to obtain a lease on an apartment or home; essential household furnishings and moving expense; set-up fees or deposits for utility or service access; and services necessary for the individual's health and safety and activities to assess need arrange for and procure needed resources. Community transition services are furnished only to the extent that they are reasonable	Managed Care Manual

Service	Referral Necessary (Yes/No)	Benefit Detail	Reference Coverage Document
		and necessary as determined through the Community Transition Plan development process and clearly identified in the Community Transition Plan and the individual is unable to meet such expense or when the services cannot be obtained from other sources. They do not include ongoing shelter expenses, food, regular utility charges, household appliances, or items intended for recreational purposes. **Member Homemaker:** Services that consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for their self or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities. **Home Delivered Meals:** The delivery of hot meals and shelf staples to the individual's residence. Meals are available to individuals unable to care for their nutritional needs because of a functional dependency/disability and who require this assistance to live in the community. Meals provided under this service will not constitute a full daily nutritional requirement. Meals must provide a minimum of one-third of the current recommended dietary allowance. Provision of home delivered meals will result in less assistance being authorized for meal preparation for individual participants, if applicable. **Personal Care Services:** Provide direct support in the home or community to Member in performing tasks they are functionally unable to complete independently due to disability, based on the LTSS Care Plan and/or the self-directed care plan. Services include: • Member assistance with ADLs, such as grooming, personal hygiene, toileting bathing, and dressing. • Assistance with monitoring health status and physical condition. • Assistance with preparation and eating of meals (not the cost of the meals itself). • Assistance with housekeeping activities (e.g., bed making, dusting, vacuuming,	

Service	Referral Necessary (Yes/No)	Benefit Detail	Reference Coverage Document
		laundry, grocery shopping, cleaning). • Assistance with transferring, ambulation, and use of special mobility devices. • Assisting the Member by directly providing or arranging transportation (If providing transportation, the personal care assistant must be verified as having a valid driver's license and liability coverage). **Respite:** Respite can be defined as a service provided to individuals unable to care for themselves that is furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the person. Federal financial participation is not claimed for the cost of room and board as respite services are provided in a private home setting, which may be in the person's home or occasionally in the respite provider's private residence, depending on Family preference and case-specific circumstances. When an individual is referred to a RI EOHHS-certified respite agency, a respite agency staff person works with the Family to assure they have the requisite information and/or tools to participate and manage the respite services, The Individual/Family will already have an allocation of hours that has been recommended and approved by RI EOHHS. These hours will be released in six (6) month increments. The Individual/Family will determine how they wish to use these hours. Patterns of potential usage might include intermittent or occasional use; routine use of a few hours each week; planned weekends away; a single block of hours that might allow the rest of the Family to spend a few Days together; or some combination of the above. The Individual's/Family's plan will be incorporated into a written document that will also outline whether the Member/Family wants help with recruitment, the training needed by the respite worker, the expectations of the Individual/Family relative to specific training and orientation to the home, and expectations relative to documenting the respite worker's time. Each eligible person may receive up to one hundred (100) hours of respite services in a year. **Shared Living:** Personal care and services, homemaker, chore, attendant care, companion services, and medication oversight (to the extent permitted under State law) provided in a private home by a principal care provider who lives in the home. Supported living arrangements are furnished to	

Service	Referral Necessary (Yes/No)	Benefit Detail	Reference Coverage Document
		individuals who receive these services in conjunction with residing in the home. Separate payment will not be made for homemaker or chore services furnished to an individual receiving supported living arrangements, since these services are integral to and inherent in the provision of adult foster care services. **Self-Directed Services:** Focuses on empowering individuals to define and direct their own personal assistance needs and services; guides and supports, rather than directs and manages, the individual through the Service Planning and delivery process. The facilitator counsels, facilitates, and assists in the development of a self-directed care plan which includes both paid and unpaid services and supports designed to allow the individual to live in the home and participate in the community. A back-up plan is also developed to assure that the needed assistance will be provided if regular services identified in the self-directed care plan are temporarily unavailable. **Financial Management Services (Fiscal Intermediary):** Payroll services for the self-directed care program individuals responsible for all taxes, fees, and insurances required for the self-directed care program. The individual is to act as an employer of record; manage all non-labor related payments for goods and services authorized in the participant's approved spending plan; assure that all payments made comply with the person's approved spending plan and conduct criminal background and abuse registry screens of all Member's employees. **Self-Directed Goods and Services (Self-Directed Care):** Self-directed goods and services are services, equipment or supplies not otherwise provided through LTSS or through the Medicaid State Plan that address an identified need and are in the approved self-directed care plan (including improving and maintaining the individual's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services and/or promote inclusion in the community; and/or the item or service would increase the individual's ability to perform ADLs or IADLs and/or increase the person's safety in the home environment; and, alternative funding sources are not available. Individual goods and services are purchased from the person's self-directed budget through the fiscal intermediary when approved as part of the self-directed care	

Service	Referral Necessary (Yes/No)	Benefit Detail	Reference Coverage Document
		plan. Examples include a laundry service for a person unable to launder and fold clothes or a microwave for a person unable to use a stove due to their disability. This will not include any good/service that would be restrictive to the individual or strictly experimental in nature.	
Home Care Services	Yes	Include laboratory services and private duty nursing for a patient whose medical condition requires more skilled nursing than intermittent visiting nursing care. Home care services include personal care services, such as assisting the client with personal hygiene, dressing, feeding, transfer, and ambulatory needs. Home care services also include homemaking services that are incidental to the client's health needs such as making the client's bed, cleaning the client's living areas such as bedroom and bathroom, and doing the client's laundry and shopping.	Provider Manual: Home Care
Hospice Services	Yes	Available to individuals who require palliative and end-of-life care.	Provider Manual: Hospice
Inpatient Hospital Care	No	The Contractor will be responsible for inpatient admissions or authorizations, even after the Member has been disenrolled from the Contractor's Health Plan and enrolled in another Health Plan or re- enrolled into Medicaid fee- for-service, until the management of the Member's care is formally transferred to the care of another Health Plan, another program option, or fee-for-service Medicaid.	Provider Manual: Inpatient
Laboratory Services	Yes	Includes urine drug screens	Provider Manual: Clinical Laboratory
PCA & Homemaker		Services includes help with general household tasks such as meal preparation and routine household care. These services may be available when a person can no longer do these tasks on their own and has no other person available to help. Limited personal care may also be available. Maximum hours available are six (6) hours per week for an individual or ten (10) hours per week for a household with two (2) or more eligible individuals.	

Service	Referral Necessary (Yes/No)	Benefit Detail	Reference Coverage Document
Medication Assisted Therapy	No	All Federally qualified therapies are covered.	
MHPRR	No	The BHDDH regulates and monitors access to these therapeutic residences as a part of the Medicaid State plan.	
Non-Prescription Drugs	Yes	As described in the *Medicaid Managed Care Pharmacy Benefit Plan Protocols.* • Includes nicotine cessation supplies ordered by a Health Plan physician. • Includes medically necessary nutritional supplements ordered by a Health Plan physician.	Provider Manual: Pharmacy
Nursing Home Care and Skilled Nursing Facility Care	Yes	All skilled and custodial care covered, up to three-hundred sixty-five (365) days a year.	Provider Manual: Nursing Home Care and Skilled Nursing Facility Care
Nutrition Services	Yes	Provided by a registered or licensed dietitian for applicable medical conditions as defined in Medicaid Managed Care Manual	Managed Care Manual
Optometry Services	No	*For children under twenty-one (21)*: Covered as medically necessary with no other limits. *For adults twenty-one (21) and older:* Benefit is limited to examinations that include refractions and provision of eyeglasses if needed once every two (2) years. Eyeglass lenses are covered more than once in two (2) years only if medically necessary. Eyeglass frames are covered only every two (2) years. Annual eye exams are covered for members who have diabetes. Other medically necessary treatment visits for illness or injury to the eye are covered.	Provider Manual: Vision

Service	Referral Necessary (Yes/No)	Benefit Detail	Reference Coverage Document
Outpatient Hospital Services	No	Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting.	Provider Manual: Outpatient
Personal Care Services	Yes	Personal Care Services provide direct support in the home or community to an individual in performing activities of daily living (ADL) tasks (e.g., bathing, dressing, eating, grooming, mobility, toileting, and transferring) that he/she is functionally unable to complete independently due to disability. Personal care services may be provided by: • A Certified Nursing Assistant who is employed under a state licensed home care/ home health agency and meets such standards of education and training as are established by the State for the provision of these activities. • A Personal Care Attendant via Employer Authority under the Self Direction option.	Provider Manual: Personal Care
Physician Services	No	Includes primary care, specialty care, obstetric and newborn care.	Provider Manual: Physician Services
Podiatry Services	Yes	Routine foot care, such as debridement of nails and treatment for ingrown toenails.	Provider Manual: Podiatry
Prescription Drugs	Yes	Generic substitution only unless provided for otherwise as described in the *Managed Care Pharmacy Benefit Plan Protocols.*	Provider Manual: Pharmacy
Radiology Services	Yes	N/A	Provider Manual: Radiology Services
Specialty Care Services	No	Includes –advanced medically necessary care and treatment of specifical physical, behavioral health conditions or those health conditions provided by a specialist, preferable in coordinate with a primary care professional or other health care professional.	Provider Manual: Provider Services

Service	Referral Necessary (Yes/No)	Benefit Detail	Reference Coverage Document
Therapies	No	Includes physical therapy, occupational therapy, speech therapy, hearing therapy, respiratory therapy, and other related therapies. All therapy services must be prescribed by a physician and Speech Therapy performed by a licensed therapist. Therapy services must be Services directly related to an active plan of care designed by the prescribing physician and of such a level of complexity and sophistication that the judgment, knowledge, and skills of a qualified therapist are required. All therapies must be medically necessary under accepted standards of medical practice to the treatment of the patient's condition.	Provider Manual: Physical, Occupational, and Speech Therapy
Tobacco Cessation Services	Yes	Covers over the counter and prescription cessation products, as well as counseling.	Tobacco Cessation Benefits
Transplant Services	Yes	N/A	N/A
Treatment for Gender Dysphoria	Yes	Gender Nonconformity - extent to which a person's gender identity, role or expression differs from cultural norms prescribed for people of a particular sex and Gender Dysphoria - discomfort or distress that is caused by a discrepancy between the person's identity and that person's sex at birth. Covered services for members aged eighteen (18) and older: • Behavioral Health • Hormonal therapy • Laboratory testing required to monitor hormonal therapy • Surgical procedures included in the list below. Covered services for members aged seventeen (17) or younger: • Behavioral Health • Pharmacological and hormonal therapy to delay physical changes of puberty to masculinize or feminize. • Non-reversible hormonal therapy.	Provider Manual: Gender Dysphoria PDF Version of Coverage Guidelines

ATTACHMENT F-4.2

Schedule of Out-of-Plan Benefits

Schedule of Out-of-Plan Benefits

Service	Service Details
BH Link	The Contractor is expected to coordinate with BH Link for qualifying members.
Centers of Excellence Programs	The Contractor is expected to coordinate with COE Programs for qualifying members.
Dental Services	**Adults ages 21 and over:** • **Preventive Services:** Two (2) cleanings per calendar year. Fluoride varnish allowed for adults if high caries risk per caries risk assessment. • **Diagnostic & Radiology Services: Two (2) oral exams per calendar year.** Bitewing and full series X-rays, biopsies of oral tissue, all medically necessary diagnostic evaluations and radiographic/diagnostic images. • **Endodontic Services** Complete root canal therapy for anterior teeth, intraoperative radiographs, , and limited other medically necessary endodontic services. • **Restorative Services** Limited restorative services, including amalgams, resins, and other medically necessary restorative services. • **Periodontal Services** Gingival curettage, gingivectomy, when medically necessary, scaling and root planning with prior authorizations, and limited other periodontal procedures. • **Prosthodontic Services** Partial or full dentures**, r**elines and adjustments, partial or full dentures, and limited other medically necessary prosthodontic procedures. • **Emergency and Palliative Services** Medically necessary emergency dental services, all palliative services, including routine and surgical extractions, incisions, and drainage of abscesses. • **Oral Surgery:** Covered when medically necessary. **Children under age 21[1]:** • **Preventive Services:** o **Cleanings:** Every six (6) months o **Fluoride Varnish**: Every six (6) months o **Sealants:** Covered only for permanent molars; one (1) treatment per tooth every five (5) years. • **Diagnostic & Radiographs[2] Services:**

[1] Treatment for children born after May 1, 2000. Managed through the RIteSmiles Program.

[2] Regarding radiographs, Medicaid believes it is the dentist's responsibility to follow the ALARA Principle (As Low as Reasonably Achievable) to minimize the patient's radiation exposure and follows the recommendations developed by the American Dental Association and the Food and Drug Administration. For new patient adults or adolescents, recommendation is for individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized oral disease or a history of extensive dental treatment. Medicaid will not reimburse for both a full mouth series and panoramic radiographic in the same year.

Service	Service Details
	○ **Routine Dental Exams:** Every six (6) months ○ **Intraoral/complete series:** Every four (4) years; ○ **Bitewing:** Once every calendar year; ○ **Panoramic Film:** Every four (4) years; • **Restorative Services** ○ **Fillings** ○ **Crowns** ○ **Dentures, partial or complete** • **Other Services** ○ **Space Maintainers:** ○ Removable space maintainers will not be replaced. Medicaid will only pay once for re-cementation of any space maintainer. ○ **Oral Surgery:** Extractions (removing a tooth) or other mouth surgery; as medically necessary. ○ **Emergency Dental Care Services:** As medically necessary • **Other Services, *Requires Prior Authorization*** ○ **Orthodontics**: To correct a handicapping malocclusion
Department of Children, Youth and Families/Department of Health/Rhode Island Executive Office of Health and Human Services Special Program	The Contractor is required to coordinate with DCYF for those members accessing services that are provided by DCYF as out-of-plan services.
I/DD Waiver Services	The Contractor is required to coordinate with BHDDH for those members accessing services through the 1115 Waiver.
Lead Program home assessment and non-medical case management provided by Department of Health or Lead Centers for lead poisoned children	The Contractor will assist in the coordination of Lead Program home assessment and non-medical case management provided by the RI Department of Health and/or Lead Centers for lead poisoned children.

Service	Service Details
Non-Emergency Medical Transportation	The Contractor is required to coordinate with NEMT for those members to access NEMT services.

ATTACHMENT F-4.3

Schedule of Non-Covered Benefits

Schedule of Non-Covered Benefits

- Any service (medication, device, procedure, or equipment) that is not medically necessary.
- Cosmetic medications, devices, procedures, or equipment.
- Experimental/investigational medications, devices, procedures, or equipment.
- Medications for sexual or erectile dysfunction, pursuant to Public Law No. 109-91, § 104.
- Private rooms in hospital and nursing facilities, except when medically necessary.
- Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, related office visits (medical or clinic), drugs, laboratory services, radiological and diagnostic services, and surgical procedures.
    - Any services or items furnished for which the provider does not normally charge.
- Services or items furnished for any condition or accidental injury arising out of and in the course of employment for which any benefits are available under the provisions of any workers' compensation law, temporary disability benefits law, occupational disease law, or similar legislation, whether or not the Medicaid Member claims or receives benefits there under, and whether or not any recovery is obtained from a third-party for resulting damages.
    - Services or items furnished for any sickness or injury occurring while the covered person is on active duty in the military.
    - Payments to outside the United States and territories pursuant to § 6505 of the Affordable Care Act which amends section 1902(a) of the Social Security Act.
    - All claims arising directly from services provided by or in institutions owned or operated by the federal government such as Veterans Administration hospitals.

ATTACHMENT F-4.4

Schedule of In Lieu of Services

Schedule of Approved In Lieu of Services (ILOS)

EOHHS Approved ILOS	State Plan Covered Service or Setting Substitute	Definition of ILOS	Target Population(s)	Billing Code
Asthma Remediation	Asthma-related primary care and specialty visits Emergency Department Services Home Health Aide Home Health Agency Inpatient Stay Outpatient Hospital Services Personal Care Services	Environmental Asthma Trigger Remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization. Also includes home-based asthma services and self-management education by a Certified Asthma Educator as offered by programs like HARP	Individuals with poorly controlled asthma (as determined by an emergency department visit or hospitalization or two sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test)	*Pending*
Chronic Disease Self-Management Education Programs - Alternative Setting	Patient self-management and education	Diabetes prevention programs, Ready for Health, Wise Woman, HEAL, Walk with Ease Program, Stepping On: Falls Prevention Program, Tai Ji Quan: Moving for Better Balance, Matter of Balance, Otago Exercise Program, and other cultural, linguistic, or physically accessible adaptations of these programs.	Individuals with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, chronic lung disorders, human immunodeficiency virus (HIV), or disabling mental/behavioral health disorders.	*Pending* (Potential codes include: 98961-2, S9445-6, S9451)

EOHHS Approved ILOS	State Plan Covered Service or Setting Substitute	Definition of ILOS	Target Population(s)	Billing Code
Complimentary Alternative Medicine (in current core contract)	Medications for treating pain or anxiety. Invasive procedures including surgical procedures.	Chiropractic Services Acupuncture Massage Therapy Yoga Meditation	Based on medical necessity	Codes reported by MCOs: 97124 97810 97811 97813 97814 98940 98941 98942 98943 S9454
Home Care	Long Term Care placements	Home care hours greater than 6 hours to prevent increases in level of care or institutionalization	Individuals at risk for hospitalization, or institutionalization in a nursing facility; or • Individuals with functional deficits and no other adequate support system	Codes reported by MCOs: T1000, G0299, G0300

EOHHS Approved ILOS	State Plan Covered Service or Setting Substitute	Definition of ILOS	Target Population(s)	Billing Code
Housing Supports and Services	Emergency Department Services Emergency Transport Services Inpatient Services Outpatient Hospital Services Post-Acute Care Skilled Nursing Facility Services	Recuperative Care (Medical Respite)**	Unsheltered, unhoused or at high-risk of homelessness OR staying in a setting that is inappropriate for pre or post hospitalization or recovery; and 2. Have a health need that requires a safe and supportive environment.	*Pending*
Lactation Consultation – Alternative Settings	Lactation support services, including education and counseling, provided by a clinician in a clinical setting.	Lactation support services, including education and counseling, by a qualified provider or postpartum doula in a community setting.	Postpartum individuals and their infants from marginalized populations at higher risk of failure to breast/chest feed, Cesarean births, prenatal substance use, first time parents, individuals recommended for lactation consultations by birth attendant or care team, pediatrician, Women and Infant Children staff, maternal home visitor or other case management program.	*Pending* (Potential codes include: 99202, 99212, 99401-404)

*Recuperative Care (Medical Respite) services are pending 1115 waiver approval from CMS

EOHHS Approved ILOS	State Plan Covered Service or Setting Substitute	Definition of ILOS	Target Population(s)	Billing Code
Medication Management	Extended Skilled Nursing Services	Medication management services which include: Ensuring compliance with medication regime Prepacking medication boxes Creating reference guide describing medications and dosages.	Individuals identified as needing support to manage medications and enhance compliance with medication regiment	*Pending*
Nutrition Supports	Gastric By-pass Surgery Weight Reduction Medications prescribed by a licensed provider	Nutritional Programs which include: Weight Reduction Programs for Obesity Therapeutic counseling Group support programs	Individuals who meet medical necessity for weight reduction services and supports	Codes reported by MCOs: 97802-04, S9470, S9452
	Preventive homecare services. Homemaking services up to 6 hours/week	Home-delivered meals for persons who are in danger of malnutrition and/or have limited mobility or access to transportation.	Individuals who are in danger of malnutrition and/or have limited mobility or access to transportation.	Codes reported by MCOs: S5170

EOHHS Approved ILOS	State Plan Covered Service or Setting Substitute	Definition of ILOS	Target Population(s)	Billing Code
	Emergency Department Services Emergency Transport Services Home Health Agency Services Home Health Aide Services Inpatient Services Outpatient Hospital Services	Medically supportive food and nutrition services, including medically tailored groceries, healthy food vouchers, and food pharmacies	Individuals who lack the capacity to shop and cook for themselves as well as adequate supports to meet these needs. Beneficiaries must also be diagnosed with a chronic disease, including any of the following: failure to thrive, slowed/faltering growth pattern, gestational diabetes, pre-eclampsia, HIV/AIDS, kidney disease, diabetes/pre-diabetes, cardiovascular disease, COPD, stroke, celiac disease, severe food allergies, or cancer.	*Pending* (Potential code: S5170)
Therapeutic Light Boxes	Antidepressant medication management for seasonal depression	Therapeutic Light Boxes are used for treatment of Seasonal Affective Disorder (SAD). Only tabletop therapeutic light boxes approved by the Food and Drug Administration (FDA) are covered.	Individuals with a history of winter depressive episodes with seasonal onset that substantially outnumber any non-seasonal depressive episodes.	Codes reported by MCOs: E0203

ATTACHMENT F-5

Capitation Rates and Fiscal Assurances

Will be Added to Final Executed Contract

ATTACHMENT F-6

Liquidated Damages Matrix

Liquidated Damages Matrix

Contract Reference	Description	Damages
Attachment F-2 – General Terms and Conditions		
Article 3 – Amendments, Modifications, and Implementation Timeframes		
3.13	Failure to comply with tiered implementation timeframes described in Section 3.13 "Amendment Implementation Timeframes by Contractor".	**$10,000** per Day.
Article 5 – Assurances, Certifications, Guarantees and Warranties		
5.6	Failure to comply with conflict-of- interest requirements described in Section 5.6 "Conflict of Interest".	**$10,000** per occurrence.
5.6 F-3 - 23.19	Failure to timely provide conflict of interest or criminal conviction disclosures as required by Section 5.6 "Conflict of Interest" and Attachment F-3 Section 23.19 "Required Disclosures".	**$1,000** per Day.
5.5	Failure to obtain and/or maintain NCQA accreditation within the timeframes specified in Section 5.5 "Certification of Licensure and Accreditation".	**$100,000** per month for every month beyond the month NCQA accreditation must be obtained.
Article 7 – Performance Standards and Remedies		
7.2 F-3 25.4	Failure to provide a corrective action plan in a timely manner or failure to receive EOHHS approval for a submitted corrective action plan in accordance with Section 7.2 "Corrective Action Plans" and Attachment F-3 Section 25.4 "Audits of Services and Deliverables."	**$500** per Day for each Day the corrective action plan is not submitted and approved by EOHHS.
7.2 F-3 25.4	Failure to comply with a corrective action plan as required by EOHHS in accordance with Section 7.2 "Corrective Action Plans" and Attachment F-3 Section 24.4 "Audits of Services and Deliverables".	**$1,500** per Day for each Day the Contractor fails to comply with an approved corrective action plan.

Contract Reference	Description	Damages
Article 10 – Security and Confidentiality		
10.4 10.6 DOA GC Addendum F. Par. 10.	Failure by the Contractor or its Subcontractor to ensure that all data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable, and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of EOHHS Member's PHI as described in Section 10.4 "Privacy and Security Safeguards and Obligations," Section 10.6 "Compliance with Applicable Laws, Regulations, Policies, and Standards," and DOA GC Addendum F. Par. 10.	**$500** per Member per occurrence
10.6	Failure to comply with Applicable Laws, Regulations, Policies, and Standards	**$10,000** per occurrence.
10.7 DOA GC Addendum F. Par. 10.	Failure by the Contractor to timely report violations in the access, use and disclosure of PHI or timely report a security Incident or timely make a notification of Breach or notification of provisional Breach as described in Section 10.7 "Breach/Incident Reporting" and DOA GC Addendum F. Par.10.	**$500** per Member per occurrence, not to exceed $10,000,000.
10.4 10.6 10.8 DOA GC Addendum F. Par. 10.	Failure by the Contractor to execute the appropriate agreements to effectuate transfer and exchanged of Member PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, Business Associate Agreement or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to the Contract as described in Sections 10.4 "Privacy and Security Safeguards and Obligations," 10.6 "Compliance with Applicable Laws, Regulations, Policies, and Standards," and 10.8 "Other," and DOA GC Addendum F. Par. 10.	**$500** per Member per occurrence.
10.5	Failure to abide by the State's confidentiality policy or the required signed Business Associate Agreement ("BAA").	**$20,000** per occurrence.
Attachment F-3 – Scope of Work		

Contract Reference	Description	Damages
Article 1 – Contractor Management and Administrative Requirements		
1.2.4	Failure to respond to or comply with any formal written requests for information or a directive made by EOHHS within the timeframe provided by EOHHS.	**$500** per Day that EOHHS determines the Contractor is not in compliance.
1.6	Failure to establish or participate on any committee as required under the Contract, by EOHHS, or pursuant to Rhode Island or federal law or regulation.	**$1,000** per occurrence per committee that EOHHS determines the Contractor is not in compliance.
Article 2 – Subcontractual Relationships and Delegation		
2.1.3	Failure to obtain written EOHHS approval for Subcontractors and corresponding contracts.	**$15,000** per occurrence.
Article 3 – Covered Populations, Enrollment, and Disenrollment		
Article 3	Failure to comply with Member enrollment and disenrollment processing timeframes as described in Article 3	**$1,000** per occurrence per Member.
3.15.7	Acts to discriminate among members on the basis of their health status or need for health care services.	**$15,000** for each Member EOHHS determines was either not enrolled or disenrolled due to a discriminatory practice.
Article 4 – Covered Benefits, Service Requirements, and Limitations		
4.2.1	Failure to provide any Medically Necessary Covered Services, or approved In-Lieu of Services, as outlined by this Agreement.	**$25,000** per incidence.
Article 5 – Behavioral Health Benefits		
5.1.10	Failure to report on or meet performance targets regarding behavioral health quality metrics and outcomes.	**$10,000** per missed quality target.
2.5.13	Failure to report on or complete plan activities describing Behavioral Health Innovation Plan activities and outcomes. .	**$2,000** per Day.
Article 6 – Pharmacy Services		
Article 6	Failure to timely update pharmacy reimbursement schedules.	**$2,500** per Day per occurrence.

Contract Reference	Description	Damages
6.14	Failure to implement and maintain a Pharmacy Lock-In Program.	**$2,000** per Day for each Day EOHHS determines the contractor is not in compliance.
Article 8 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)		
8.8.1.1	Failure to achieve annual well child visits for at least seventy-five percent (75%) of Members under age twenty-one (21).	**$15,000** per year deficient
8.8.1.2	Failure to achieve annual immunization standards of one-hundred percent (100%) for children in DCYF substitute care and seventy-five percent (75%) of other Members under age twenty-one (21).	**$15,000** per deficient metric.
8.8.1.3	Failure to achieve annual blood lead testing standards of at least sixty-five percent (65%) of Members under age twenty-one (21).	**$15,000** per deficient metric.
Article 13 – Population Health		
13.3	Failure to make at least three (3) documented attempts to conduct a Health Risk Assessment for one hundred percent (100%) of the Contractor's Members.	**$20,000** per month that the Contractor's performance is less than one hundred percent (100%).
13.3	Failure to successfully conduct a Health Risk Assessment for at least forty percent (40%) of the Contractor's Members.	**$20,000** per month that the Contractor's performance is less than forty percent (40%) of the membership.
Article 14 – Care Program and Continuity of Care		
Article 14	Failure to comply with Transition of Care requirements within this Article.	**$250** per Day per Member.
14.2	Failure to develop a Care Plan for a Member that includes all required elements.	**$500** per deficient/missing plan.
14.3	Failure to timely develop and furnish to EOHHS the Care Program Plan.	**$250** per Day.

Contract Reference	Description	Damages
14.4	Failure to delegate specified duties to Accountable Entities as required for Care Management functions.	**$10,000** for each instance EOHHS finds the Contractor failed to delegate required duties and functions.
Article 15 – General Reporting Requirements		
Article 15	Failure to timely submit complete and accurate reports and statements to EOHHS pursuant to the Managed Care Reporting Calendar.	**$2,000** per Day.
Article 15	For each report that is late for two (2) consecutive reporting periods or more than three (3) times within a calendar year.	**$5,000** per Day
Article 15	For each report returned to the Contractor for resubmission due to missing information or EOHHS identified errors in data reported for two (2) consecutive reporting periods or more than three (3) times within the calendar year.	**$5,000** per Day
15.1.6	Failure to comply with reporting requirements.	**$500** per incident per report.
Article 16 – Quality Assurance		
Article 16	Failure to submit quality measures including audited HEDIS and CAHPS results within the timeframes specified.	**$5,000** per Day.
16.7	Failure to timely submit appropriate PIPs to EOHHS.	**$1,000** per Day.
16.9	Failure to timely submit QAPI to EOHHS.	**$1,000** per Day.
16.9	Failure to take corrective action regarding the reporting of accurate, complete, and timely performance measures to EOHHS.	**$2,500** per occurrence.
Article 17 – Value Based Payment and Alternative Payment Methodologies		
Article17.	Failure to provide required data to Accountable Entities as required	**$500** for each Member EOHHS finds the Contractor failed to provide required data to the Accountable Entity.

Contract Reference	Description	Damages
17.4	Failure to properly monitor and oversee Accountable Entities on an ongoing basis to assess performance, deficiencies, or areas for improvement.	**$25,000** for each instance EOHHS finds the Contractor failed to properly monitor or oversee the Accountable Entities.
Article 18 – Provider Networks and Requirements, Access to Care		
18.1	Failure to timely provide notice to EOHHS of capacity to serve the Contractor's expected enrollment.	**$2,500** per Day.
18.11	Failure to report notice of Provider termination from participation in the Contractor's Provider network (includes terminations initiated by the Provider or by the Contractor) to EOHHS or to the affected Members within the timeframes required.	**$100** per Day per Member for failure to timely notify the affected Member.
18.32	Failure to provide Covered Services within the timely access, distance, and appointment availability standard (excludes Department approved exceptions to the network adequacy standards).	**$2,500** per month for failure to meet a time or distance standard or appointment availability standard.
18.42	Failure to allow a Member to obtain a second medical opinion at no expense and regardless of whether the provider is a network Provider as specified.	**$5,000** per occurrence.
Article 19 – Utilization Management		
Article 19	Failure to comply with Member notice requirements for denials, reductions, terminations, or suspensions of services.	**$1,000** per occurrence.
19.2	Failure to follow Department required Clinical Coverage Policies.	**$2,500** per occurrence.
19.8	Failure to confer a timely response to a service authorization request in accordance with 42 C.F.R. § 438.404 (c)	**$5,000** per standard authorization request OR **$7,500** per expedited authorization request.

Contract Reference	Description	Damages
19.9	Imposing arbitrary utilization guidelines, prior authorization restrictions, or other quantitative coverage limits on a Member as prohibited under the Agreement or not in accordance with an approved Utilization Management Program Plan policy and protocols.	**$5,000** per occurrence per Member.
Article 20 – Marketing		
20.1	Misrepresents or falsifies information that it furnishes to a Member, potential Member, or health care Provider.	**$25,000** for each instance of misrepresentation.
20.4	Failure to ensure Provider compliance with Marketing guidelines.	**$10,000** per incident.
20.7	Distribution of Marketing Materials that have not been approved by EOHHS or that contain false or misleading information, either directly or indirectly through any Representative.	**$25,000** per distribution or reported incident.
20.7	Engaging in prohibited marketing activities or discriminatory practices or failure to market in the entire state.	**$25,000** per occurrence of prohibited activity.
20.7	Failure to obtain approval of any agreements or materials requiring review and approval by EOHHS prior to distribution as specified in the Contract.	**$500** per Day the unapproved agreement or materials are in use.
Article 21 – Member Materials		
21.4 21.5	Failure to comply with timeframes for providing Member Welcome Packets, handbooks, identification cards, and Provider Directories	**$250** per occurrence, per Member.
21.7	Failure to update online and printed Provider Directory	**$1,000** per monthly occurrence.
21.7	Failure to provide a Member a printed, braille, or oral Provider Directory within thirty (30) Days of request.	**$2,500** per occurrence.
21.7	Failure to maintain accurate Provider Directory information.	**$100** per confirmed incident.

Contract Reference	Description	Damages
Article 22 – Member Services		
22.2	Contractor's Helpline one hundred percent (100%) of operating hours must be properly equipped to accept calls including, without limitation, calls from members with limited English proficiency and calls from members who are deaf, hearing impaired or have other special needs.	**$1,000** for each instance EOHHS finds the Contractor failed to meet a metric in a given month.
22.3	Answer at least ninety five percent (95%) of incoming Member information telephone calls within 30 seconds.	**$500** for each instance EOHHS finds the Contractor failed to meet a metric in a given month.
22.3	Daily average Hold Time must be two (2) minutes or less during regular business hours. A Member is considered on hold when they are waiting for a call center representative after navigating the interactive voice response (IVR) system and when a customer service representative places the Member on hold.	**$500** for each instance EOHHS finds the Contractor failed to meet a metric in a given month.
22.3	Maintain a call abandonment rate of less than five percent (5%).	**$1,000** for each instance EOHHS finds the Contractor failed to meet a metric in a given month.
22.3	Failure to provide notification within the thirty (30) minute timeframe of service outage or operational failure of the Call Center.	**$1,500** for each instance EOHHS finds the Contractor failed to notify EOHHS within timeframe.
Article 23 – Grievances and Appeals		
Article 23	Failure to attend mediations and hearings as scheduled	**$2,500** for each mediation or hearing that the Contractor fails to attend as required.
Article 23	Failure to comply with all orders and final decisions relating to claim disputes, Grievances, Appeals and/or State Fair Hearing as issued or as directed by EOHHS.	**$5,000** per occurrence.
23.3.4	Failure to report to EOHHS a denial of an Expedited Appeal request and the reasoning for the denial within twenty four (24) hours of the issuance of the Notice to the Member.	**$1,000** per Day.

Contract Reference	Description	Damages
23.5 23.6	Failure to provide continuation or restoration of services where Member was receiving the service as required by Department rules or regulations, applicable Rhode Island or federal regulations and law, and all court orders governing Appeal procedures as they become effective.	**$500** per Day for each Day the Contractor fails to provide continuation or restoration as required by EOHHS.
23.8.3	Failure to meet the following performance standards: Ninety Eight percent (98%) of Grievances resolved within ninety (90) Days of receipt. Ninety Eight percent (98%) of Appeals resolved within thirty (30) Days of receipt.	**$2,500** for each instance EOHHS finds the Contractor failed to meet a metric in a given month
Article 24 – Program Integrity, and Compliance		
24.2.1	Failure to timely submit on an annual basis the Compliance Program pursuant to 42 C.F.R. § 438.608.	**$1,000** per Day.
24.4	Failure to establish and maintain a Special Investigative Unit	**$5,000** per Day that EOHHS determines the Contractor is not in compliance.
24.6	Failure to cooperate fully with EOHHS and/or any other Rhode Island or federal agency during an investigation of Fraud or Abuse, complaint, or Grievance as described in Section 24.6 "Cooperation with Other Agencies."	**$2,500** per incident for failure to fully cooperate during an investigation**.**
24.7.1	Failure to implement an approved Fraud, Waste, and Abuse Compliance Plan within sixty (60) days of approval may result in liquidated damages or imposition of other available remedies by the Division.	The Division may assess up to **$2,000** per calendar day for each incident of noncompliance. The Office of Program Integrity may reassess the implementation of the Fraud and Abuse compliance plan every sixty (60) days until Program Integrity deems the plan to be in compliance.
24.9.2.6	Contractor does not suspend payments to the Provider, or the Contractor does not correctly report the amount of the payments held.	**$10,000** per occurrence.
24.9.2.7	Failure to timely report, or report all required information, for any credible allegation or confirmed instance of fraud or abuse relating to the Contractor's own conduct, a Provider, or a Member	**$2,000** per Day.

Contract Reference	Description	Damages
24.9	Failure to identify a minimum of two percent (2%) in provider overpayments and prepayment cost avoidance related to Fraud and Abuse of the Annual Premium total as reported.	$100,000 per annual occurrence.
24.9	Failure to require and ensure compliance with ownership and disclosure requirements as required	$2,500 per Provider disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a Provider that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 C.F.R. Part 455, Subpart B.

Contract Reference	Description	Damages
Conflict of Interest	When the Contractor becomes aware of an actual, apparent, or potential conflict of interest but not more than two (2) days, the Contractor must develop and submit a mitigation plan for approval by the Division. Any changes to the approved mitigation plan must be approved in advance by the Division. The Contractor must maintain one hundred percent (100%) compliance with this item at all times throughout the term of the Contract.	The Contractor will be fined **$5,000** per day for each day past two (2) days for each actual, apparent, or potential conflict of interest it fails to disclose. The Contractor shall be fined **$100,000** for the first failure to comply with the mitigation plan developed by the Contractor and approved by the Division. Each subsequent violation of the mitigation plan shall be twice the amount of the immediately preceding violation fine. In addition, such violation will be reported to the State Ethics Commission, Attorney General, and appropriate federal law enforcement officers for review. This Contract may be terminated by the Division if it is determined that a conflict of interest exists.
Article 26 – Claims Processing and Management Information Systems (MIS)		
26.8	Timeliness: Contractor fails to make timely payments to Providers	**$1,000** per Day
26.8.2.2	Failure to meet the following performance standards: Ninety percent (90%) of all Clean Claims must be paid within thirty (30) Days of the date of receipt. Ninety nine percent (99%) of all Clean Claims must be paid within ninety (90) Days of the date of receipt.	**$15,000** per payment deficiency.
26.10	Failure to process and adjudicate Clean Claims in accordance with the procedures and the timeframes listed in this Agreement.	**$500** per incident.

Contract Reference	Description	Damages
26.20	Contractor demonstrates a pattern of inappropriately denying, delaying, or recouping Provider payments for services as determined by EOHHS	Monetary penalties equal to one hundred fifty percent (150%) of the value of the claims; inappropriately denied, delayed, or recouped;
26.21	Failure to comply with standards for encounter data completeness, accuracy and timeliness as described in "Rhode Island Medicaid Managed Care Encounter Data Quality Measurement, Thresholds and Penalties for Non- Compliance" and noted below.	See individual damages per incidence of noncompliance below
26.22	***Timely File Submission*** Failure of the MCO to submit at least one (1) file for each file type in the agreed upon cadence with EOHHS.	**$1,000** per Day late fee.
26.22	***Timely Submission*** Failure to submit and have encounters accepted into the MMIS within forty-five (45) Calendar Days of the claim payment date.	**$15,000** per month where the timeliness submission rate is greater than two percent (2%).
26.24	***Acceptance Rate*** Failure to maintain a rejection rate for encounter claim submission that is less than or equal to two percent (2%).	**$5,000** for each month the encounter rejection rate is above two percent (2%).
26.24	***Diagnosis Code Accuracy*** Failure to be able to attest that the diagnosis code distribution matches the diagnosis codes on the paid claims associated with the accepted encounter data for each state fiscal year and file type combination.	**$100,000** for each quarter the attestation is not completed.
26.24	***Data Accuracy for Business Use*** Failure to submit accurate encounter data resulting in interruptions to EOHHS business operations.	**$100,000** per occurrence.
26.25	***Completeness Variance*** Failure of the MCO to reach ninety nine percent (99%) threshold for encounter completeness.	**$100,000** for each quarter the encounter completeness ratio is below ninety nine percent (99%)
26.25	***Completeness Attestation*** Failure of the MCO attest the FSR is an accurate and complete representation of the claim payment financial liability and encounter submission activity of the MCO.	**$10,000** for each quarter the attestation is not submitted with the FSR submission, or within the timeframe specified by EOHHS.

Contract Reference	Description	Damages
26.25	***Completeness Consistency*** Failure of the MCO to report total incurred cost within the point one percent (0.1%) threshold in the FSR and FDCR submissions.	**$100,000** per quarter the FSR and FDCR are not reconciled within point one percent (0.1%)
26.37	***Pharmacy Encounter Data*** Failure to submit the Pharmacy Encounter Claims file and/or the disputed encounter response file in the format and per the specifications outlined in the Contract and the Managed Care Manual. In addition to the above, a quarterly offset equal to the value of the rebate assessed on the disputed encounters may be deducted from the Contractor's Capitation payment.	**$10,000** per Day.
Article 27 – Financial Requirements		
27.1	Failure to timely submit Third-Party Liability identification and collections.	**$2,000** per Day.
27.1	Failure to timely submit a Third-Party Liability Policy.	**$2,000** per Day.
27.1	Failure to submit a Third-Party Liability Policy that fulfills the requirements.	**$2,000** per Day.
27.9.1	Failure to timely submit the Recoveries and Collections from the report(s) described in Section 27.9.1	**$250** per Day.
27.10.5	Failure to respond to requests for additional MLR Report information or reconciliation, or failure to make required corrections within the timeframe requested.	**$250** per Day.
Article 30 – Contract Transition and Readiness Review		
30.5	Failure to meet plan Readiness Review Schedule as set by EOHHS.	**$5,000** per Day.
30.6.1	Failure to correct all Readiness Review deficiencies within required timeframes.	**$500** per Day.
30.6.2	Failure to provide pre-onsite materials as requested.	**$500** per deliverable.

ATTACHMENT F-7

Request for Proposals

On file with the Division of Purchases

ATTACHMENT F-8

Contractor's Proposal

On file with the Division of Purchases

ATTACHMENT F-9

Draft Medicaid Managed Care Manual

Available at the following link:

Draft 2023 Medicaid Managed Care Manual

ATTACHMENT F-10

Contractor's Key Personnel Tables

To be submitted with Bid

Table 1: Contractor's Executive Management Personnel

Title	Name	Years of Experience	Years with Organization	Primary Location
Chief Executive Officer (CEO)				
Chief Financial Officer (CFO)				
Chief Operating Officer (COO)				
RI Medicaid Contract Officer (RIM-CO)				
Long-Term Services Benefit Officer (LTSS-BO)				
Chief Medical Officer (CMO)				
Chief Behavioral Health Officer (CBHO)				
Chief Pharmacy Officer (CPO)				
Chief Technology Officer (CTO)				
Chief Compliance Officer (CCO)				
Chief Diversity, Equity & Inclusion Officer (CDEIO)				
Health Equity Officer (HEO)				

Table 2: Contractor's Non-Executive Key Personnel

Title	Name	Years of Experience	Percent FTE Assigned to Rhode Island
Security Official			
Member Services			
Provider Network Development and Management			
Provider Relations			
Medical Management			
Quality Assurance and Improvement			
Care Management Program			
Benefit Administration			
Utilization Management – for Physical, Behavioral & HCBS Services			
MIS & Claims Processing			
Grievances & Appeals			
Reporting			
HCBS Services Administration			
LTSS Administration			
Program Integrity & Compliance			
EPSDT Coordinator			
Special Investigative Units for Fraud, Waste & Abuse			
Claims Manager(s)			
Internal Audit Director			

ATTACHMENT F-11

Contractor's Executive Management Function Resumes

To be submitted with Bid