

CONTRACT BETWEEN

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

AND

NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND

FOR MEDICAID MANAGED INTEGRATED ADULT CARE SERVICES

IN THE RHODY HEALTH OPTIONS PROGRAM

November 1, 2013

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GENERAL PROVISIONS

This Agreement, including the attachments hereto, is made and entered into effective the 1st day of November 1 2013, between the Rhode Island Executive Office of Health and Human Services (referred to as “EOHHS”, or “Executive Office” in this Agreement) and Neighborhood Health Plan of Rhode Island (the “Contractor”). This Agreement ("Agreement") is entered into in conformity with EOHHS procedures.

ARTICLE I: DEFINITIONS

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

1.01 CAPITATION PAYMENT

Capitation Payment means a payment for each premium rate category EOHHS makes periodically to Contractor on behalf of each member enrolled under a contract for the provision of medical services under the State plan. EOHHS makes the payment regardless of whether the particular member receives services during the period covered by the payment.

1.02 CARE COORDINATION

Care coordination is defined as the delivery organization of member care activities between two or more participants (including the member) involved in a members’ care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all medically necessary member care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

1.03 CARE MANAGEMENT

"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. At a minimum, care management functions must include, but are not limited to: (1) Telephonic Initial Health Screen Assessment, (2) Comprehensive Functional Needs Assessment, (3) Designation of a Lead Care Manager, (4) Development of a Plan of Care, (5) Creation of a Multi-Disciplinary Care Management Team, (6) Conflict Free Case Management, (7) Implementation, Coordination, and Monitoring of Plans of Care, (8) Management of Care Transitions, and (9) Analysis of Care Management Effectiveness, Appropriateness and Patient Outcomes. Care management is driven by quality-based outcomes such as: improved/maintained functional status, improved/maintained clinical status, enhanced quality of life, member satisfaction, adherence to the care plan, improved enrollee safety, cost savings, and enrollee autonomy.

1.04 CASE MANAGEMENT

Case management, a component of care management, is a set of activities tailored to meet a member's situational health-related needs. Situational health needs can be defined as time-limited episodes of instability. Case managers will facilitate access to services, both clinical and non-clinical, by connecting the member to resources that support him/her in playing an active role in the self-direction of his/her health care needs.

As in care management, *case* management activities also 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.

1.05 CMS

CMS means the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

1.06 CROSSOVER CLAIMS

Medicare crossover claims are those claims that include primary payment from Medicare.

1.07 COLD CALL MARKETING

Cold call marketing means any unsolicited personal contact by the Contractor with a potential enrollee for the purpose of marketing as defined in 42 CFR 438.104.

1.08 COMPREHENSIVE FUNCTIONAL NEEDS ASSESSMENT

Comprehensive Functional Needs Assessment to be conducted on all Rhody Health Options members receiving long-term services and supports (LTSS includes institutional as well as home and community-based services- HCBS) and on those members not receiving LTSS but are identified in an initial screen who are "at-risk" of requiring and will benefit from care management. The Comprehensive Functional Needs Assessment identifies the multi-disciplinary member conditions and needs of members including but not limited to: physical health, behavioral health, functional condition, long-term care, social services, informal support system, housing conditions and other conditions and needs to assure that members maximize their health, functional capabilities, well-being and independence.

1.09 COMPREHENSIVE RISK CONTRACT

Comprehensive Risk Contract means a risk agreement that covers comprehensive services, that is, inpatient hospital services and the other services in Attachment A hereto.

1.10 CONFLICT FREE CARE MANAGEMENT

Conflict-free case management has the following characteristics: (1) There is separation of case management from direct services provision, (2) Structurally or operationally, case managers should not be employees of any organization that provides direct services to the individuals, (3) There is separation of eligibility determination from direct services provision, (4) Eligibility for services is established separately from the provision of services, (5) Case managers do not establish funding levels for the individual, and (6) Individuals performing evaluations, assessments, and plans of care cannot be related by blood or marriage to the individual or any of the individual's paid caregivers, financially responsible for the individual, or empowered to make financial or health-related decisions on behalf of the individual.

1.11 CONTRACTOR

Contractor means Neighborhood Health Plan of Rhode Island that has executed this Agreement with the State to enroll and serve members under the conditions specified in this Agreement

1.12 CONTRACT SERVICES

Contract Services mean the services to be delivered by the Contractor, which are so designated in Article II of this Agreement.

1.13 COVERED SERVICES

Covered Services mean the medical (primary and acute), behavioral healthcare service, long-term care services and supports and benefits packages described in Article III of this Agreement and set forth in Attachments A.

1.14 DAYS

Days mean calendar days unless otherwise specified.

1.15 DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment (DME) is equipment that can stand repeated use that helps people after an illness or accident. Examples of DME include, but not limited to a: hospital bed, crutches, cane, wheel chair, walker, circulatory aid, scooter and lift chair.

1.16 DEPARTMENT

Department shall mean the Rhode Island Executive Office of Health and Human Services (EOHHS).

1.17 EMERGENCY DENTAL CONDITION

Emergency Dental Condition means a dental condition requiring immediate treatment to control hemorrhage, relieve acute pain, and eliminate acute infection, pulpal death, or loss of teeth.

1.18 EMERGENCY SERVICES

Emergency Services means covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services under this title and (2) needed to evaluate or stabilize an emergency medical condition. An emergency medical condition means 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, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

1.19 ENROLLEE

A Medicaid beneficiary currently enrolled in Rhody Health Options.

1.20 FAMILY

Family means the adult head of household, his or her spouse and all minors in the household for whom the adult has parent or guardian status.

1.21 GRIEVANCE

An expression of dissatisfaction about any matter other than the appeal of actions, a formal complaint (refer to section 2.15.01).

1.22 HEALTH CARE PROFESSIONAL

Health Care Professional means a physician or any of the following: a podiatrist, optometrist, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy assistant.

1.23 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, protects health insurance coverage of workers and their families when they change or lose their jobs. HIPAA also requires the Secretary of the U.S. Department of Health and Human Services to adopt national electronic standards for automated transfer of certain health care data between health care payers, plans, and providers.

1.24 HEALTH PLAN, PLAN, OR HMO

Health Plan, Plan, or HMO means any organization that is licensed as a health maintenance organization ("HMO") by the Rhode Island Department of Business Regulation, or otherwise meets the requirements of Section 2.02 of this Agreement, and contracts with the State to provide services pursuant to Title XIX of the Social Security Act to members.

1.25 HOMEMAKER

Services that consist of the performance of general household tasks (such as: 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 him or herself or others in the home.

1.26 HOME MODIFICATIONS

Home Modifications or Environmental Modifications are those physical adaptations to the private residence and/or vehicle of the participant or participant's family to improve access and provide greater independence and to ensure the health, welfare and safety of a participant (such as: installation of ramps and grab rails, widening doorways, modifying bathroom facilities, installation of specialized plumbing or electric that are necessary for the welfare of the member.

1.27 HOME CARE SERVICES

Home Care Services means those services provided under a home care plan authorized by a physician including full-time, part-time, or intermittent care by a licensed nurse or home health aide (certified nursing assistant) for patient care and including, as authorized by a physician, physical therapy, occupational therapy, respiratory therapy, and speech therapy. Home care services 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 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.

1.28 HOME HEALTH SERVICES

Home Health Services means those services provided under a home care plan authorized by a physician including full-time, part-time, or intermittent skilled nursing care and home health aide services as well as physical therapy, occupational therapy and speech-language pathology, as ordered by a health plan physician and provided by a Medicare-certified home health agency. This service also includes medical social services, other services, durable medical equipment and medical supplies for use at home. Home health services do not include respite care, relief care, or day care.

1.29 IBNR (Incurred But Not Reported)

IBNR means liability for services rendered for which claims have not been received.

1.30 INTEGRATED CARE INITIATIVE

Integrated Care Initiative (ICI) integrates the provision of primary care, acute care, behavioral health care, and long-term care services and supports through care management strategies focused on the person's needs. The State has developed three models for integrating care: (1) an Enhanced Primary Care Management model (PCCM) which is based on a fee-for-service reimbursement approach, (2) a Managed Care Capitated Model, and (3) the PACE Model, if there is available capacity to serve new members. Two populations are covered by the ICI and this contract: (1) those enrolled in the Medicaid program (Medicaid-only), and (2) those individuals who are dually eligible for both Medicaid and Medicare. The latter group is commonly referred to as "dual eligible". This contract also refers to the dual eligible population as "Medicaid and Medicare Eligible (MME)".

1.31 INITIAL TELEPHONIC HEALTH SCREEN

An initial screen is conducted to identify and prioritize all Rhody Health Options members not receiving long-term care services to identify members who are "at risk" and may benefit from care management services. The telephonic health screen explores the member's condition and need for care management.

1.32 MARKETING

Marketing means any communication, from the Contractor to a Medicaid recipient who is not enrolled in Rhody Health Options that can reasonably be interpreted as intended to influence the recipient to enroll in Rhody Health Options.

1.33 MARKETING MATERIALS

Marketing materials means materials that are produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended to market to Potential Enrollees or Enrollees to change Health Plans.

1.34 MEDICARE/MEDICAID ELIGIBLE (MME)

Individuals who are eligible for the Medicaid and Medicare programs, commonly referred to as "dual eligible". The "dual eligible" in this contract are referred to a Medicaid and Medicare eligible (MME). In this contract only those Medicare beneficiaries are currently eligible to participate in the Rhody Health Options programs.

1.35 MEDICAL NECESSITY, MEDICALLY NECESSARY, OR MEDICALLY NECESSARY SERVICE

The term “medical necessity”, “medically necessary”, or “medically necessary service” means medical, surgical, or other services required for the prevention, diagnosis, cure, or treatment of a health related condition including such services necessary to prevent a decremental change in either medical or mental health status. Medically necessary services must be provided in the most cost effective and appropriate setting and shall not be provided solely for the convenience of the member or service provider.

1.36 MEMBER

Member means a State determined eligible Rhody Health Options Rhode Island resident who is enrolled with a Contractor.

1.37 MID-LEVEL PRACTITIONERS

Mid-level Practitioners include 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 these regulations.

1.38 MINOR ASSISTIVE DEVICES

Specialized medical equipment and supplies that may include devices, controls or appliances that enable an individual to increase their ability to perform activities of daily living; or to enable the individual to perceive control or communicate with the with the environment in which they live, including such other durable and non-durable not available under the State Plan.

1.39 NON-PARTICIPATING PHYSICIAN

Non-participating Physician means a physician licensed to practice that has not contracted with or is not employed by the Contractor to participate in the network of providers under this Agreement.

1.40 OPTIONS COUNSELING

An interactive decision-support process whereby consumers, family members and/or significant others are supported in their deliberations to determine appropriate longer services and supports choices in the context of the consumers’ needs, preferences, values and individual circumstances.

1.41 PARTY

Party means either the State of Rhode Island or the Contractor in its capacity as a contracting party to this Agreement.

1.42 PATIENT CENTERED MEDICAL HOME

A Patient-Centered Medical Homes (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. PCMH are certified by NCQA and the State requires the inclusion of PCMH's as primary care providers in this procurement.

1.43 PERSONAL CARE ASSISTANCE SERVICES

Direct support in the home or community in performing tasks that individuals are functionally unable to complete independently due to disability (e.g. assistance with activities of daily living, monitoring health care status, assistance with housekeeping activities and meals preparation, assistance with transferring and use of mobile devices, and in providing and arranging for transportation.

1.44 PHASE I

Phase I includes the provision of all Medicaid covered benefits to the Medicaid only adults who receive long-term services and supports (LTSS) and to all full benefit MMEs population, except for those individuals who are specifically excluded from this initiative as described in the Model Contract appended to this LOI. Services for individuals with developmental disabilities and individuals with severe and persistent mental illness (SPMI) will continue to be funded and managed by the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH). In Phase I, Rhody Health Partners program includes those individuals who are eligible for Medicaid only services, exclusive of long-term care services and supports. In Phase I, Rhody Health Options program includes those Medicaid recipients who are eligible for long-term care benefits and those individuals who are Medicare/Medicaid beneficiaries who are eligible for full Medicaid benefits. In Phase I only Medicaid benefits are covered. The contract in Phase I shall be between the State and the Contractor.

1.45 PHASE II

Phase II includes the provision of all Medicaid benefits and Medicare benefits to the Medicaid only and Medicaid and Medicare individuals eligible for full Medicare benefits covered in Phase I. Services for SPMI and developmentally disabled individuals may become in-plan services in Phase II as designed by new State requirements. The conduct of Phase II shall be governed through a three way agreement with CMS, EOHHS and the MCO. MCOs shall receive prospective payments to provide the comprehensive, coordinated care to Rhode Island Medicaid only ABD and MME individuals.

1.46 PLAN OF CARE

For Rhody Health Options members, the Care Management Plan referred to in this Contract as the Plan of Care is 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.

1.47 PLAN PHYSICIAN OR PARTICIPATING PHYSICIAN

Plan physician or participating physician means a physician licensed to practice in Rhode Island who has contracted with or is employed by the Contractor to furnish services covered in this Agreement.

1.48 POST-STABILIZATION CARE SERVICES

Post-stabilization care services means covered services, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 CFR 422.113(c).

1.49 POTENTIAL ENROLLEE

A person who is a Medicaid-eligible beneficiary but has not yet enrolled with the Contractor.

1.50 PREPAID BENEFIT PACKAGE

Prepaid Benefit Package means the set of health care-related services for which Health Plans will be responsible to provide and for which the Health Plan will receive reimbursement through a per member per month pre-determined capitation rate.

1.51 PRIMARY CARE

Primary care means all health care services and laboratory services customarily furnished by or through a general practitioner, family practitioner, internal medicine physician, gynecologist, geriatric physician or other medical specialists as provided for in Section 1.50 of this Agreement, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

1.52 PRIMARY CARE PROVIDER (PCP)

Primary Care Provider means the individual Plan Physician or team selected by, or assigned to the member to provide and coordinate all of the member's health care needs and to initiate and monitor referrals for specialized services when required. Primary Care Providers shall be Medical Doctors or Doctors of Osteopathy in the following specialties: family and general practice, gynecology, internal medicine geriatrics, or other medical specialists who have a demonstrated clinical relationship as the principal coordinators of care for adults and who are prepared to undertake the responsibilities of serving as a PCP as stipulated in the Contractor's primary care agreements. Primary Care Providers also shall meet the credentialing criteria established by the Contractor and approved by the State. NCQA certified Patient Centered Medical Homes shall be included in the Contractor's network as a primary care provider. The Primary Care Provider may designate other participating plan clinicians who can provide or

authorize a Member's care. Mid-level practitioners may function as Primary Care Providers under certain circumstances.

1.53 PRIVATE DUTY NURSING

Private Duty Nursing means those skilled nursing services authorized by a physician when the physical or mental condition of the patient requires more skilled nursing than intermittent visiting nursing care and takes into account family strengths and other family obligations.

1.54 PROVIDER PREVENTABLE CONDITIONS

Provider-preventable condition means a condition that meets the definition of a "health care-acquired condition" or an "other provider-preventable condition" as defined in this section. *Health care-acquired condition* means a condition occurring in any inpatient hospital setting, identified as a HAC in the 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. *Other provider-preventable condition* means a condition occurring in any health care setting that meets the following criteria: (1) is identified in the State plan, (2) has been found by the State, 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 beneficiary, (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 .

1.55 RHODY HEALTH OPTIONS

Rhody Health Options (RHO) is the name of the comprehensive Medicaid managed care delivery system covered by this procurement who meet the specified eligibility criteria as designated by the State for those adults who are Medicare beneficiaries and entitled to full Medicaid benefits; and those Medicaid only recipients eligible for long-term care services and supports.

1.56 RHODY HEALTH OPTIONS ELIGIBLES

Rhody Health Options Eligibles means Title XIX eligible groups describe in Section 2.04.who are also Medicare beneficiaries and are eligible for full Medicaid benefits and persons who are eligible for long-term services and supports during Phase I.

1.57 RISK CONTRACT

Risk contract means an agreement under which the Contractor assumes financial risk for the cost of the services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the agreement.

1.58 RITE @ HOME

RIte @ Home provides a home like setting for individual who cannot live alone but who want to continue to live in the community as long as possible. There are two components of this service: (1) a RIte Home agency who helps individuals find an appropriate host home/caregiver, and (2) the caregiver who agrees to allow the person to move in with them and provide the personal, homemaker, chore services, meals, socialization, transportation services required by the member on a twenty- four (24) hours and seven (7) days a week basis

1.59 SELF DIRECTED SERVICES

The core feature of Self-Directed Services is the choice and control that members have in regard to the paid personnel who provide personal assistance services. In the traditional service delivery model, decision making and managerial authority is vested in professionals who may be either State employees/contractors or service providers. Self-direction transfers much (though not all) of this authority to participants and their families (when chosen or required to represent them). Self directed models may enable individuals (1) to hire, dismiss, and supervise individual workers (e.g., personal care attendants and homemakers), or (2) allow individuals to have a flexible budget to purchase a range of goods and services to meet their needs. The State's Personal Choice Program allows participants both with the assistance of a service advisement agency and a fiscal agent to assist in making informed decisions that are consistent with their needs and that reflect their individual circumstances.

1.60 SHORT-TERM CARE MANAGEMENT

Short-Term Care Management represents those actions taken by Contractor necessary to address the needs for continuity and access to services that have been identified for the member in the Initial Health Screen or in the course of a member's enrollment with Contractor.

1.61 SIBLING

Sibling includes sisters, brothers, half-sisters, half-brothers, adoptive sisters, adoptive brothers, step-sisters and step-brothers living in the same household.

1.62 SSI

SSI means Supplemental Security Income, or Title XVI of the Social Security Act.

1.63 SPMI AND DD POPULATIONS

Individuals with Developmental Disabilities (DD) and individuals with severe and persistent mental illness (SPMI) will continue to be funded and managed by the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) in Phase I. Services to the DD and SPMI populations become an in-plan benefit in Phase II based on the Health Plan's capacity to provide services to these two populations.

1.64 STABILIZED

The attending emergency physician, or the medical provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge.

1.65 STATE

State means the State of Rhode Island, acting by and through the Executive Office of Health and Human Services, or its designee.

1.66 UNINSURED

Uninsured means any individual who has no coverage for payment of health care costs either through a private organization or public program.

1.67 URGENT MEDICAL CONDITION

Urgent Medical Condition means 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:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

ARTICLE II: HEALTH PLAN PROGRAM STANDARDS

2.01 GENERAL

This article describes the operational and financial standards with which Contractor must comply in full. The standards have been set to allow plans flexibility in their approach to meeting Rhody Health Options program objectives, while ensuring that the special needs of these populations are addressed. EOHHS and the Contractor will work collaboratively to build a successful program that will achieve the state goals and requirements of EOHHS. EOHHS and the Contractor will engage in a planning period initiating at the start of this contract to address opportunities for program improvements.

EOHHS agrees to purchase, and Contractor agrees to fulfill all requirements and to furnish or arrange for the delivery of the scope of services as specified in this Article.

In return for Capitation Payments (as defined in Sections 1.01 and 2.16 of this Agreement), the Contractor agrees to provide eligible members with the medical care and services described in this Article II and Attachment A hereto.

Contractor shall furnish or arrange for the personnel, facilities, equipment, supplies, pharmaceuticals, and other items and expertise necessary for, or incidental to, the provision of medical care services specified below, at locations including, but not limited to, the entire State of Rhode Island, to Rhody Health Options members enrolled with Contractor.

In accordance with 42 CFR 438.6, Contractor will provide or arrange for the provision of Covered Services under this Comprehensive Risk Contract. Contractor's legal responsibility to EOHHS is to assure that all activities specified in this contract are carried out and will not be altered if a service is arranged by Contractor or provided by a subcontractor.

2.02 LICENSURE, ACCREDITATION, CERTIFICATION

2.02.01 Phase I

Contractor certifies that it is licensed in Rhode Island as an HMO under the provisions of Chapter 27-41, "the HMO Act" or that it shall become licensed as a Health Maintenance Organization (HMO) or Health Plan (HP) in the State of Rhode Island by the Rhode Island Department of Health and the Rhode Island Department of Business Regulation prior to signing an Agreement with the State. If Contractor is not a licensed HMO in Rhode Island, Contractor certifies that it is either a nonprofit hospital service corporation that is licensed by the Rhode Island Department of Business Regulation ("DBR") under Chapter 27-19 of the Rhode Island General Laws, a nonprofit medical service corporation that is licensed by DBR under Chapter 27-20 of the Rhode Island General Laws, or another health insurance entity licensed by DBR, and that it meets the following requirements:

- Is certified by the Rhode Island Department of Health as a Health Plan under R23-17.13-CHP; and

- Meets the requirements of Sections 3.4, 5.2, 6.1.4, and 6.4.7 under R23-17.13-CHP; and
- Meets the requirements under R23-17.12: *Rules and Regulations for the Utilization Review of Health Care Services*
- Is accredited by the National Committee for Quality Assurance (“NCQA”) as a Medicaid managed care organization or otherwise for a newly entering plan:
 - The Contractor must submit a PDF copy of its current NCQA accreditation certificate for a Medicaid managed care organization in another State and;
 - The Contractor must submit a specific timeline outlining the Contractor’s plan to achieve full accreditation within twelve months of the execution of the contract and;
 - Failure to obtain accreditation by the date specified will result in the suspension of enrollment.

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 State’s Agreement with the Contractor. In the event that NCQA were to deny accreditation to the Contractor, the State shall consider this to be cause for termination of the Agreement.

Contractor agrees to forward to EOHHS any complaints received from the DBR, the Rhode Island Department of Health, or NCQA concerning its licensure, certification, and/or accreditation within thirty (30) days of Contractor’s receipt of a complaint. Contractor also agrees to forward to the State a copy of any correspondence sent by the Contractor to the Rhode Island Department of Business Regulation or the Rhode Island Department of Health which pertains to the Contractor’s licensure or its contract status with any institution or provider group.

Contractor agrees to provide to the State, or its designees, any information requested pertaining to its licensure, certification, and/or accreditation including communication to and from the NCQA. Such information shall include any communications pertaining to Contractor’s accreditation by NCQA as well as actual HEDIS[®] and CAHPS[®] data, transmittals, and reports.

Contractor shall notify the State of any person or corporation that has five percent (5%) or more ownership or controlling interest in Contractor. Contractor agrees to provide the State with financial statements for any person or corporation with five percent (5%) or more ownership or controlling interest.

Contractor shall inform the State about the status of receiving CMS approval to operate as a Medicaid Advantage Organization or a Special Needs Plan with authority to provide Medicare Part D services and to serve the dual eligible or MME population, on a quarterly basis, or more frequently when situations arise that affect the status of the Contractor’s application to be an approved Medicare Plan. The failure to obtain CMS approval prior to Phase I will result in the Contractor not being able to participate in any phase of the program.

2.02.02 Phase II

The following are the conditions for Phase II:

- Contractor shall be licensed to serve Medicare beneficiaries in Rhode Island
- Contractor shall be accredited by the National Committee for Quality Assurance (“NCQA”) as a Medicare managed care organization or a newly entering plan in Phase II.
- Contractor provides evidence to the State that it is certified as an Medicare Advantage Plan or Special Needs Plan,
- Contractor demonstrates ability to meet all program requirements members with developmental disabilities and members with Severe and Persistent Mental Illness (SPMI)

Contractor shall not be allowed to commence with Phase II unless they can demonstrate that they meet all the Federal requirements. Contained in Attachment P is a copy of the CMS ‘Readiness Checklist’ and CMS requirements. Contractor shall recognize that The Readiness Checklist is not an exhaustive compilation of all Federal requirements. Contractor shall provide the State and CMS with all the necessary information and data that demonstrates the Contractors “readiness” to commence with Phase II as described in, but not limited to, Attachment P.

2.03 HEALTH PLAN ADMINISTRATION

Contractor agrees to maintain sufficient administrative staff and organizational components to comply with all program standards described herein. At a minimum, Contractor agrees to include each of the functions noted in Sections 2.03.01 and 2.03.02 below. Contractor agrees to staff qualified persons in numbers appropriate to its size of enrollment.

Contractor may combine functions or split the responsibility for a function across multiple departments, as long as it can demonstrate that the duties of the function are being carried out. Similarly, Contractor may contract with a third party (subcontractor) to perform one or more of these functions, subject to the subcontractor conditions described in Section 3.05.05 of the Agreement.

2.03.01 Executive Management

Contractor agrees to have an executive management function with clear authority over all of the administrative functions noted in Section 2.03.02 below.

2.03.02 Other Administrative Components

Contractor must include each of the administrative functions listed below, with the duties of these functions conforming to the program standards described in this chapter. The required functions are:

- Medical Director's Office
- Accounting and Budgeting Function
- Member Services Function
- Provider Services Function
- Medical Management Function, including quality assurance, prior authorization, concurrent medical review/discharge planning, and retrospective medical review
- Grievance and Appeals Function
- Claims Processing Function
- Management Information System
- Program Integrity and Compliance

2.03.03 RI Works Participants

The State operates a worker training and employment assistance program known as the RI Works. As part of its hiring practices, Contractor agrees to consider qualified RI Works individuals for openings. For its part, the State is prepared to design and implement training programs for RI Works individuals to provide them with the skill sets required by Rhode Island employers, particularly those with government contracts. Contractor agrees to make good faith efforts to fill at least fifty percent (50%) of their new or open, Rhody Health Options-related positions with RI Works participants, providing they are qualified for the positions.

2.04 ELIGIBILITY AND PROGRAM ENROLLMENT

2.04.01 Rhody Health Options (RHO) Eligible Groups

Eligibility for enrollment in RHO is based on EOHHS determination of individuals who are: (1) eligible for the Medicaid program only (based on age of 21 or older and categorical eligibility including 65 or older, disabled or blind) and: (2) Medicare and Medicaid Eligible (MME) individuals who are eligible for full Medicaid benefits. The two eligible populations fall into four groups: (1) MMEs living in the community receiving no long-term care services or supports-LTSS, (2) MMEs living in the community receiving long term care services and supports, (3) MMEs living in an institutional care setting, (4) Medicaid only adults who receive LTSS in a nursing home or in the community. Only Rhode Island residents are eligible under this contract. Services for individuals with developmental disabilities and individuals with severe and persistent mental illness (SPMI) will continue to be funded and managed by the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) in Phase I. Enrollment in Rhody Health Options shall be based on the State's sole determination of eligibility.

2.04.02 Rhody Health Options Exempt Populations

The following individuals are exempt from enrolling in a Managed Health Plan:

- Medicare beneficiaries who are not eligible for full Medicaid benefits i.e. Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Beneficiaries (SLMBs), and Qualified Individuals (QIs)
- Individuals who are eligible for “partial Medicare: benefits (Part A only or Part B/D only)
- Individuals residing at Tavares, Eleanor Slater or out-of state hospitals
- Individuals who are incarcerated (adjudicated and in prison)
- Individuals who are in hospice/end-of-life care on the enrollment start date. An enrolled member who needs hospice/end-of-life care shall remain in the MCO

2.04.03 Rhody Health Options (RHO) New Eligibility Groups

The State reserves the right to add new eligibility groups to RHO at any time. The State’s intent to add any new eligibility group and the terms upon which any new eligibility would be covered under this Agreement shall be made according to the notice provisions in Section 3.01.09 of the Agreement. Contractor shall have forty-five (45) days from the date of receipt of such notice to either accept or reject in writing the addition of the new eligibility group(s) and the terms proposed. Acceptance shall be formalized through an amendment to this Agreement, as provided in Article III, Section 3.03 of this Agreement.

2.04.04 Rhody Health Options (RHO) Eligibility Determination

The State shall have sole authority for determining whether individuals meet the eligibility criteria specified in Section 2.04.10 and therefore are eligible to enroll in a RHO Health Plan.

2.04.05 Rhody Health Options Eligibility Determination

The State shall have sole authority for determining whether individuals meet the financial eligibility criteria for Long-Term Care services and supports. The Contractor shall comply with the State procedures for identifying and notifying the State of information needed to assess whether individuals meet financial eligibility criteria and to determine cost-sharing responsibilities of an individual. The State will notify the Contract within thirty (30) days regarding an individual’s financial eligibility and cost-sharing responsibilities.

The Contractor shall have authority to conduct a clinical assessment to determine whether individuals meet the level of care need for Long-Term Services and Supports. The Contractor shall comply with State requirements for determining the programmatic need for Long-Term Services and Supports. The clinical assessment form used by the Contactor shall be approved by the State.

2.04.06 Rhody Health Options (RHO) Guaranteed Eligibility

There are no eligibility guarantees for RHO members.

2.04.07 Rhody Health Options (RHO) Non-Biased Enrollment Counseling

At the time of initial eligibility determination or re-certification, the State shall make available non-biased enrollment counseling to RHO eligible persons who are not already enrolled in a Health Plan. Responsibilities of the counselors include the following:

- Educating the Potential Enrollee and his or her family, guardian or adult caregiver about managed care in general, including: the option to enroll in a Rhody Health Options Health Plan; the way services typically are accessed under managed care; the role of the Primary Care Provider (PCP); and the responsibilities of the Health Plan member.
- Educating the Potential Enrollee and his or her family, guardian or adult caregiver about benefits available through RHO, both in-plan and out-of-plan.
- Informing the Potential Enrollee and his or her family, guardian or adult caregiver of available Health Plans and outlining 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.
- Educating the Potential Enrollee and his or her family, guardian or adult caregiver about premium and copayment requirements (if applicable).

Contractor will provide updated materials to EOHHS annually to facilitate enrollment counseling. All informational materials related to members and potential members must be written at no higher than a sixth-grade level, in a format and manner that is easily understood.

2.04.08 Voluntary Selection of Health Plan by Rhody Health Options (RHO) Members

At the time of application or at other times determined in its sole discretion by EOHHS, RHO applicants or beneficiaries shall be offered the opportunity to select a Health Plan or another program option. If an eligible member does not select a Health Plan or does not select another program option, he or she shall automatically be assigned to a Health Plan.

2.04.09 Rhody Health Options (RHO) Member Automatic Assignment to Health Plans

The State will employ a formula, or algorithm, that may include quality metrics and Health Plan financial performance to assign any RHO eligibles that do not make a voluntary selection.

2.04.10 Rhody Health Options (RHO) Automatic Re-Assignment Following Resumption of Eligibility

RHO members who are disenrolled from a Health Plan due to loss of eligibility shall automatically be re-enrolled, or assigned, into the same Health Plan should they regain eligibility

within sixty (60) calendar days. If more than sixty (60) days have elapsed, the member shall be permitted to select a Health Plan or automatically assigned to a Health Plan.

2.05 MEMBER ENROLLMENT AND DISENROLLMENT

2.05.01 Health Plan Marketing

Contractor may conduct marketing campaigns for members, subject to the restrictions noted in *Marketing and Approval of Written Materials Protocols for Medicaid Managed Care Programs*, issued by the State.

Contractor agrees not to display or distribute marketing materials, nor to solicit members in any other manner, within fifty feet of Rhody Health Options eligibility and enrollment offices, unless it has received permission to do so from the State.

Contractor agrees to submit all marketing materials to the State for approval prior to use. All marketing materials must be written at no higher than a sixth-grade level, in a format and a manner that is easily understood. The State will determine whether Contractor's marketing plans, procedures, and materials are accurate, and do not mislead, confuse, or defraud either recipients or the State, pursuant to 42 CFR 438.104.

The Contractor, through members of its provider network, is encouraged to identify uninsured patients who may Rhody Health Options eligible and to make appropriate referrals to the State for eligibility determination.

When engaged in marketing its Rhody Health Options programs or in marketing targeted to Rhody Health Options members, the Contractor: (1) shall not distribute marketing materials to less than the entire service area; (2) shall not distribute marketing materials without the approval of EOHHS (3) will not seek to influence enrollment in Rhody Health Options in conjunction with the sale or offering of private insurance; and (4) will not, directly or indirectly, engage in unsolicited door-to-door, telephone, or other cold call marketing activities.

2.05.02 Health Plan Enrollment Procedures for Rhody Health Options Eligibles

The State shall conduct enrollment activities for Rhody Health Options eligibles. The State will conduct an annual open enrollment.

The State shall supply the Contractor with a list of members newly enrolled into the Health Plan, as discussed in Section 2.05.04 below.

The State will supply the Contractor on a monthly basis with a list of members newly enrolled into the Health Plan, as discussed in Section 2.05.04 below. Contractor agrees to accept enrollment information in the data format submitted by the State.

Contractor agrees to have written policies and procedures for enrolling these members effective on the first day of the following month after receiving notification from the State (e.g., if

Contractor is informed of a new member on December 15, it must enroll the member effective January 1). Members must be mailed notification of Rhody Health Options enrollment including effective date and how to access care within ten (10) calendar days after receiving notification from the State of their enrollment.

Contractor agrees to enroll, in the order in which he or she applies or is assigned, any eligible Rhody Health Options beneficiary who selects it or is assigned to it, regardless of the beneficiary's age, sex, sexual orientation, ethnicity, language needs, health status, or need for health services. The only exceptions will be if the member was previously disenrolled from the Health Plan as the result of a grievance filed by the Contractor, as described later in this section.

Contractor agrees to have written policies and procedures for enrolling Rhody Health Options members, which specifically address the requirements for these members as set forth in this Agreement. These policies and procedures must reflect the requirements set forth in the *Rhode Island EOHHS Care Management Protocols for Adults Enrolled in Rhody Health Options (Attachment M)*.

2.05.03 Change in Status

Contractor agrees to report any changes in the status of individual members within five (5) days of their becoming known, including but not limited to changes in address or telephone number, out-of-State residence, deaths, household composition (such as birth of a child or change in legal guardianship of a minor), and sources of third-party liability.

2.05.04 Enrollment and Disenrollment Updates

The State shall provide the Contractor with a monthly full roster of all members enrolled into Rhody Health Options. EOHHS will send the roster to the Contractor during the first financial cycle of each month. Contractor agrees to have written policies and procedures for receiving these updates and incorporating them into its management information system.

2.05.05 Services For New Members

Contractor agrees to make available the full scope of benefits to which a member is entitled immediately upon his or her enrollment.

2.05.06 New Member Orientation

Contractor shall have written policies and procedures for orienting new members to their benefits, the role of the PCP, what to do in an emergency or urgent medical situation, how to utilize services in other circumstances, how to register a complaint or file a grievance and advance directives in accordance with 42 CFR 489.100 and 489.102 and Chapter 23-4.10 of the RI General Laws—HEALTH CARE POWER OF ATTORNEY and Chapter 23-4.11 of the RI General Laws—RIGHTS OF TERMINALLY ILL ACT. These policies and procedures shall take into account the multi-lingual, multi-cultural nature of the population. All enrollment notices, informational materials and instructional materials relating to members should be written at no higher than a sixth-grade level, presented in a manner and format that may be easily understood. All written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who are visually limited or have limited reading proficiency. All enrollees must be informed that information is available in alternative formats and how to access those formats.

Contractor shall make at least four attempts, on different days, to make a welcome call to all new members within thirty (30) days of enrollment to provide the same information as in the paragraph above. Welcome call scripts shall also solicit whether members have new or existing health care needs, including pregnancy or any chronic disease, such as asthma, diabetes, or a behavioral health need. In the event that a welcome call identifies any new members who have existing health care needs immediate steps will be taken (e.g. referral to the Contractor's Care Management Department) to ensure the member's needs are met. Any scripts developed or used by the Contractor for these purposes shall be subject to review by EOHHS.

Orientation Process for Rhody Health Options shall include a direct face-to-face contact to acquaint the member to the Contractor, to confirm, select or change the member's PCP, and to conduct or begin the process for the Initial Health Screen and care management as appropriate for the member's needs. Any script or other materials developed by the Contractor for this purpose is subject to the review and prior approval by EOHHS.

2.05.07 Assignment of Primary Care Providers (PCPs)

Contractor shall have written policies and procedures for assigning each of its Medicaid-only members who have not selected a primary care provider (PCP) at the time of enrollment to a PCP. The process must include at least the following features:

- Contractor shall make at least four attempts, not counting four on the same day, to contact the member within ten (10) days of notification of enrollment to provide information on options for selecting a PCP. Contractor shall offer freedom of choice within the PCP network of participating providers to members in making a selection. Leaving a voicemail message does not constitute an offering of freedom of choice of a PCP.
- The Contractor must allow each enrollee to choose his or her health professional to the extent possible and appropriate.

- If a Medicaid-only member does not select a PCP during enrollment, Contractor shall make an automatic assignment, taking into consideration such factors as current provider relationships, language needs (to the extent they are known), member's area of residence and the relative proximity of the PCP to the member's area of residence. Contractor then must notify the member in a timely manner by telephone or in writing of his/her PCP's name, location, and office telephone number, and how to change PCPs if desired. Contractor shall auto assign members to a NCQA recognized patient centered medical home, where possible.
- Contractor shall notify PCPs of newly assigned members in a timely manner.
- If a Medicaid-only member requests a change in his or her PCP, Contractor agrees to grant the request to the extent reasonable and practical and in accordance with its policies for other enrolled groups. It is the State's preference that a member's reasonable request to change his or her PCP be effective the next business day.

Contractor shall make every effort to ensure a PCP is selected during the period between the notification to the Contractor by EOHHS and the effective date of the enrollee's enrollment in the Contractor's Health Plan. If a PCP has not been selected by the enrollee's effective date of enrollment, the Contractor will assign a PCP. In doing so, Contractor will review its records to determine whether the enrollee has a family member enrolled in the Contractor's Health Plan and, if so and appropriate, the family's members PCP will be assigned to the enrollee. If the enrollee does not have a family member enrolled in the Health Plan but the enrollee was previously a member of the Health Plan, the enrollee's previous PCP will be assigned by the Contractor to the enrollee, if appropriate.

2.05.08 Changing PCPs

Contractor shall have written policies and procedures for allowing members to select or be assigned to a new PCP including when a PCP is terminated from the Health Plan, or when a PCP change is ordered as part of the resolution to a formal grievance proceeding. In cases where a PCP has been terminated, Contractor must allow members to select another PCP or make a re-assignment within ten (10) days of the termination effective date.

2.05.09 Identification Cards

The State shall issue a Medicaid identification card to members for their use when obtaining care for out-of-plan services.

Contractor also agrees to issue an identification card for its members to use when obtaining Covered Services. The card may identify the holder as a Rhody Health Options member and as a Rhody Health Option member through an alpha or numeric indicator, but should not be overtly different in design from the card issued to other enrolled groups.

Contractor agrees to issue all Rhody Health Option members a permanent identification card within ten (10) days after receiving notification from the State of their enrollment. The card must include at least the following information:

- Health Plan name
- Twenty-four hour Health Plan telephone number for use in urgent or emergent medical situations
- Telephone number for Member Services function (if different)
- PCP, or PCP practice, name and office telephone number (can be affixed by sticker to card)

2.05.10 Member Handbook

Contractor agrees to mail a Member Handbook to all members within ten (10) days of being notified of their enrollment. Contractor agrees to publish a revised Member Handbook within six (6) months of the effective date of this Agreement, and to update the handbook thereafter when there are material changes needed as determined by EOHHS. Contractor is strongly encouraged to use the *Guidelines for Health Plan Consumer-Friendly Materials* developed by the Consumer Advisory Committee in preparing this handbook.

Written material must use easily understood language and format. All written material must be written at no higher than a sixth-grade level. Written material must be available in alternative formats (e.g. tape or compact disc) and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All enrollees must be informed that information is available in alternative formats and how to access those formats. However, such alternative media shall not substitute for the above requirement to provide all members with a written Member Handbook except for those members with special needs that warrant an alternative format shall be offered.

2.05.10.01 Required Information

The Member handbook shall be written at no higher than a sixth-grade level and contain at least the following:

- Information on Member Services.
- Information on how to choose a PCP. Each member may choose his or her PCP to the extent possible and appropriate.
- Information on what to do when family size changes.
- Provider network listing (may be included as an insert). The information must include their names, locations, telephone numbers, and non-English languages spoken by

current providers in the member's service area, including identification of providers that are not accepting new patients. This includes, at a minimum, information of primary care physicians, specialists, and hospitals.

- Any restrictions on the member's freedom of choice among network providers.
- Information that enrollment in Rhody Health Options does not restrict the choice of the provider from whom the member may receive family planning services and supplies.
- Information on member's right to change PCP.
- Information on amount, duration, and scope of Covered Services, including how to access Covered Services including behavioral health and long-term services and supports. This information must include sufficient detail to ensure that the Member understands the benefits to which they are entitled.
- Procedures for obtaining benefits, including authorization requirements.
- Right to a second surgical opinion.
- Members may obtain benefits, including family planning services, from out-of-network providers.
- The extent to which, and how, after-hours and emergency coverage are provided, including:
 - What constitutes an emergency medical condition, emergency services, and Post-Stabilization Care Services, with references to the definitions in 42 CFR 438.114(a).
 - The fact that prior authorization is not required for Emergency Services.
 - The process and procedures for obtaining Emergency Services, including use of the 911-telephone system or its local equivalent.
 - The locations of any Emergency Services and Post-Stabilization Care Services covered under the Agreement.
 - The fact that, subject to the provisions of this section, the member has a right to use any hospital or other setting for emergency care.
- Information on the post-stabilization care services rules set forth in 42 CFR 422.113(c).

- Policy on referrals for specialty care and other benefits not furnished by the Member's Primary Care Provider.
- Information on Advance Directives, as set forth in 42 CFR 438.6 (i) (1).
- Information on out-of-plan or out-of-network benefits
- Information on member's rights and responsibilities, including, in conformance with State and Federal law, the rights of mothers and newborns with respect to the duration of hospital stays.
- Information on member's rights and protections, as specified in 42 CFR 438.100.
- Information on formal grievance, appeal and fair hearing procedures, and the information specified in 42 CFR 438.10(g) (1) and described in Section 2.15 of this Agreement.
- Information that a member may request disenrollment at any time from the Health Plan
- Information on cost-sharing responsibilities (if applicable; may be included as an insert)
- Information on non-covered services. How and where to access any benefits that are available under the State plan but are not covered under this Agreement, including any cost sharing, and how transportation is provided.
- Fraud and abuse
 - Provide examples of possible Medicaid fraud and abuse which might be undertaken by providers, vendors and enrollees
 - Inform enrollees about how to report suspected Medicaid fraud and abuse, including any dedicated toll-free number established by the Contractor for reporting possible fraud and abuse
 - Instruct enrollees about how to contact EOHHS's Fraud Unit
- Information on grievance, appeal and fair hearing procedures and timeframes, as provided in 42 CFR 438.400 through 438.424, in a State-developed or State approved description that must include the following:
 - The member's right to a State Fair Hearing, how to obtain a hearing, and the right to representation at a hearing
 - The member's right to file grievances and appeals and their requirements and timeframes for filing

- The availability of assistance in the filing process
- The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone
- The member's right to request continuation of Covered Benefits during an appeal or State Fair Hearing; 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 enrollee (as defined in 42 CFR 438.420).
- Additional information that is available upon request, including the following:
 - Information on the structure and operation of the Contractor
 - Information on any physician incentive plans as set forth in 42 CFR 438.6(h)

Also to be included are the following required by the Health Care Accessibility and Quality Assurance Act (may be included as an insert):

- How does the Health Plan review and approve Covered Services?
- What if I refuse referral to a participating provider?
- Does the Health Plan require that I get a second opinion for any services?
- How does the Health Plan make sure that my personal health information is protected and kept confidential?
- How am I protected from discrimination?
- If I refuse treatment, will it affect my future treatment?
- How does the Health Plan pay providers?
- If I am covered by two or more Health Plans, what do I do?

The Contractor must have written policies regarding enrollee rights that cover:

- Each enrollee is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
- Each enrollee is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.

- Each enrollee is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
- Each enrollee is guaranteed the right to be free from and form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Each enrollee is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR Part 164.

2.05.10.02 State Approval

Contractor agrees to submit all member materials to the State for approval prior to its use. This includes any changes made to language previously approved by the State. Contractor also agrees to make modifications in Member materials if required by the State.

2.05.10.03 Languages Other Than English

Contractor agrees to make available Member Handbooks in languages other than English consistent with interpreter service requirements described in 2.06.03.02 for Rhody Health Options members, and to distribute them to members needing them, whether new or established members. Contractor agrees to publish a revised member handbook within six (6) months of the effective date of this Agreement in all required languages, according to the non-English language enrollment profile of the Contractor on the effective date of this Agreement. Contractor agrees to designate non-English language capability in its provider listings (including mental health and substance abuse providers) distributed to members.

2.05.11 Transitioning Members between Plans

It may be necessary to transition a member between Health Plans for a variety of reasons, including if the member changes Health Plans or if a change is ordered as part of a grievance resolution. Contractor shall have written policies and procedures for transferring relevant patient information in an efficient manner, including medical records and other pertinent materials, when transitioning a member to or from another Health Plan. Contractor also shall transfer this information at no cost to the member. Contractor shall also transfer this information at no cost to the member in instances where the member had received Covered Services from a participating network provider who becomes is no longer in the provider network and become a non-participating provider. Contractor may make a reasonable charge to a member who requests his or her own personal copy of a medical record, not to exceed limits established in RI General Law 5-37-22 and the RI Department of Health Rules and Regulations for the Licensure and Discipline of Physician (R5-37-MD/DO).

2.05.12 Member Disenrollment

2.05.12.01 General Authority

The State has sole authority for disenrolling members from Health Plans, subject to the conditions described below. The Contractor may not disenroll a member. The Contractor must refer the request to the State for disenrollment determination.

2.05.12.02 Reasons For Disenrollment

The State shall disenroll members from a Health Plan for any of the following reasons:

- Loss of Medicaid eligibility or medically needy
- Loss of program eligibility
- Transfer to another Health Plan
- For Rhody Health Options, members who opt for another Medical Assistance managed care option
- Death
- Relocation out-of-State
- Adjudicative actions
- Change of eligibility status
- Placement in Eleanor Slater, Tavares or an out-of- town hospital
- Eligibility determination error
- Just cause (as determined by the State on an individual basis)
- The enrollees service needs (e.g. cesarean section and a tubal ligation) are not available within the network and that the enrollee's primary care provider or another provider determines that not receiving the services will subject the enrollee to unnecessary risk.
- Other reasons for disenrollment include but are not limited to: poor quality of care, lack of access to providers experienced in dealing with the enrollee's health needs.

A member may request disenrollment without cause during the 90 days following the date of the recipient's initial enrollment with the MCO. A member may request disenrollment without cause at least once every twelve (12) months thereafter. A member may request disenrollment upon

automatic reenrollment under Section 438.56 (g) if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.

The Contractor cannot refuse to cover services because of moral or religious objections.

EOHHS reserves the right to disenroll members whom the Contractor is unable to contact within contractual timeframes or members for whom the Contractor cannot produce evidence of services provided within contractual timeframes, as set forth herein.

In accordance with 42 CFR 438.56(b)(2), 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). The Contractor may request in writing that a member be disenrolled for the foregoing exception. All disenrollments are subject to approval by the State, and Contractor shall submit written disenrollment policies and procedures to the State for approval.

A member is permitted to disenroll without cause during the 90 days following the effective date of the individual's initial enrollment with the Health Plan and when the State imposes the intermediate sanction in 42 CFR 438.702(a) (3).

2.05.12.03 Disenrollment Effective Dates

Rhody Health Options member disenrollments will occur monthly, and the Contractor will normally be notified at the first financial cycle (schedule determined by EOHHS), for disenrollments effective at midnight the last day of the month in which the enrollment report was sent. Such disenrollments may be made effective sooner by mutual agreement of the State and Contractor. Contractor agrees to have written policies and procedures for complying with State disenrollment orders. The effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the member files the written request. The disenrollment is considered approved, if the State fails to make a disenrollment determination within the described timeframe.

2.06 IN-PLAN SERVICES

2.06.01 Description of Comprehensive Benefit Package for Rhody Health Options Members

2.06.01.01 General

The Contractor must agree to make available the comprehensive benefit package to Rhody Health Options members eligible for coverage. The comprehensive benefit package includes medically necessary inpatient and outpatient hospital services, physician services, behavioral health services (including mental health and substance abuse services), family planning services,

prescription drugs, laboratory, radiology and other diagnostic services, preventive care, and long-term care services and support (LTSS includes home homes, assisted living, community-based services and supports, Rite @ Home services and adult day services).

The defining core values driving service delivery are:

- Consumer-focused services
- A holistic approach to health care and wellness
- Independence in the community
- Access to primary and specialty care when and where needed
- Respect and dignity of the individual

The guiding principles for service delivery are:

- Flexible options that match services with individual needs, both medical and social
- The establishment of a medical home that supports primary and preventive care
- A screening and assessment process that is coordinated and comprehensive
- A focus on consumer self-management through education, community supports, and care coordination
- Maximum, creative, and effective use of existing infrastructure
- Methods for ensuring cost predictability
- Responsible stewardship of public dollars

The comprehensive benefit package does not include services for individuals with SPMI and developmental disabilities provided through the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) to which this group is entitled in Phase I. During Phase II EOHHS in conjunction with BHDDH intends that those specialized services funded and managed by BHDDH for individuals with SPMI and developmental disabilities may become in-plan services as designed by new State requirements. The Contractor agrees to coordinate with the BHDDH providers, but will not be responsible to deliver or to reimburse for services provided through BHDDH in Phase I.

Contractor shall provide three hundred and sixty-five (365) days of nursing home care as medically and/or functionally necessary for the member, inclusive of skilled care, custodial care or any other level of nursing home care including but not limited to emergency placement, hospice and respite care. Contractor shall provide an array of Disease Management Programs and Self-Help Medical Management Programs. Attachment A of this Agreement presents the full schedule of in-plan benefits contained in the comprehensive benefit package. The contractor is authorized to offer alternatives to Medicaid State Plan services where services in an alternative setting would be more cost effective or efficient, and is consistent with the best interests and wishes of the member. Attachment B of this Agreement presents the schedule of out-of-plan benefits. Attachment C of this Agreement presents a schedule of non-covered services.

2.06.01.02 Long-Term Services and Supports

Long-term services and supports, as described in Attachment A, are only available to RHO members who meet certain EOHHS eligibility criteria. EOHHS has sole authority for determining eligibility for LTSS and will communicate eligibility to the Contractor.

2.06.01.03 Preventive Services

Contractor may provide certain LTSS services in a limited fashion to members who do not currently meet the eligibility criteria for LTSS, in order to prevent admission , re-admission or reduce lengths of stay in an institution. These Preventive Services are outlined in Attachment A.

2.06.01.04 Interpreter/Translation Services

During the enrollment process, the State will seek to identify Rhody Health Options enrollees who speak a language other than English as their primary language. The State will notify Contractor when it knows of members who do not speak English as a primary language who have either selected or been assigned to the Health Plan.

If Contractor has more than fifty (50) members who speak a single language other than English as a primary language, Contractor agrees to make available general written materials, such as its Member Handbook, in that language. Contractor agrees to be responsible for a true translation of materials prior-approved in English by the State, subject to State oversight. Contractor will forward all translated materials to applicable members.

Contractor agrees to make available interpreter services. Interpreter services shall be made available as practical and necessary by telephone, and/or in-person to ensure that members are able to communicate with Contractor and its providers and receive all covered benefits in a timely manner. Members shall have the option of in-person interpreter services, if planned sufficiently in advance according to Contractor policies and procedures.

In addition, Contractor agrees to conform with standards outlined in the Americans with Disabilities Act (ADA) for purposes of communicating with, including about out-of-plan services, and providing accessible services to its visually and hearing impaired, and physically disabled members.

2.06.02 Enrollee/Provider Communication

Contractor may not prohibit, or otherwise restrict, a health care professional, acting within the lawful scope of practice, from advising or advocating on behalf of a member about: (1) the member's health status, medical care, or treatment options including any alternative treatment that may be self-administered; (2) any information the member needs in order to decide among all relevant treatment options; (3) the risks, benefits, and consequences of treatment or non-treatment; or (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.

Contractor, which would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service because of the requirement in the paragraph above, is not required to do so if Contractor objects on moral or religious grounds. If Contractor elects this option, Contractor agrees to furnish information about the services it does not cover as follows:

- To EOHHS, upon execution of this Agreement or whenever Contractor adopts the policy during the term of this Agreement.
- To potential members, before and during enrollment.
- To members, within ninety (90) days after adopting the policy with respect to any particular service.

EOHHS reserves the right to adjust Contractor's rates in Attachment G as a consequence of Contractor's policy.

2.06.03 Second Opinion

A member is entitled to a second opinion from a qualified health professional within the network or, if approved by the Contractor, to a second opinion by a non-participating provider outside the network, at no cost to the member.

2.06.04 New In-Plan Services and In-Plan Service Coverage Arrangements

The State reserves the right to add new in-plan services or to move certain services out of plan (e.g. pharmacy) at any time. The State's intent to add any new in-plan service and the terms upon which any new in-plan service would be covered under this Agreement or to move certain services out of plan (e.g. pharmacy) shall be made according to the notice provisions in Section 3.01.09 of the Agreement. Contractor shall have forty-five (45) days from the date of receipt of such notice to either accept or reject in writing the addition of the new in-plan service and the terms proposed. Acceptance shall be formalized through an amendment to this Agreement, as provided in Article III of the Agreement.

The State further reserves the right to modify coverage arrangements for in-plan services. (e.g., establishing co-payments for pharmacy services). Any such changes shall be made according to the notice provisions in Section 3.01.09 of the Agreement and shall be accompanied by actuarially sound adjustment to the capitation rates in Attachment G of this Agreement. This shall be formalized through an amendment to this Agreement as provided in Article III of the Agreement.

2.07 CARE MANAGEMENT AND CARE COORDINATION

2.07.01 Coordination of Care

Contractor shall ensure coordination of care of all covered benefits under this Agreement. Coordination of care includes identification and follow-up of high risk members, ensuring coordination of services and appropriate referral and follow-up. In particular, Contractor shall

ensure coordination between medical services, behavioral health services, long-term care services and supports and other needs required by the members.

To assist new members in the transition from fee-for-service to the Health Plan, the Contractor shall honor all existing EOHHS/Department approved service authorizations for the period of time authorized by EOHHS, and with the provider that received the authorization. The State will provide the Contractor with the necessary information to comply with this requirement. The Contractor shall also honor all existing pharmacy prior authorizations for sixty (60) days. EOHHS will provide all necessary data to assist the Contractor in fulfilling these requirements.

2.07.02 Care Management Program

Contractor shall have a State approved Care Management Plan for Rhody Health Options programs. The Care Management Plan shall be submitted to the State thirty (30) days prior to the contract commencement date. The Care Management Plan shall describe the policies, procedures and practices for the areas noted below.

Contractor shall comply with the required Components of Contractor's care management program are described in Attachment M of this Contract. The Contractor shall have policies, procedures and practices that shall cover the following components of care management: (1) a Person-Centered System of Care, (2) Risk Profiling to identify members at risk (3) Principles of Care Management (4) Telephonic Initial Health Screen, (5) a Comprehensive Functional Needs Assessment, Designated Lead Care Manager, (6) a Plan of Care, (7) A Multi-Disciplinary Care Management Team (8) Conflict Free Case Management, (9) Implementation, Coordination and Monitoring of the Plan of Care, (10) Management of Care Transitions, and (11) Analysis of Care Management Effectiveness, Appropriateness, and Patient Outcomes.

The Contractor shall ensure that monthly telephone contact is required for members receiving care management services. Quarterly home visits are required with one (1) home visit annually to be unannounced. Home visits for RIte @ Home members are conducted monthly.

The Contractor shall establish policies and procedure to establish and use care manager to member ratios that take into consideration the member's level of care, need for interpreters, acute and specialty care services, LTSS needs, travel time and other factors deemed appropriate by the Contractor. The care manager ratios to members shall be approved by EOHHS.

Care management shall be performed by Health Plan staff or agents located in the State of Rhode Island and may be augmented by Health Plan expertise located in other areas. Rhode Island staff will be key for their ability to work closely with local resources and communities including face-to-face meetings where appropriate, to best coordinate the services and supports needed to meet the needs of members, including behavioral health needs and out-of-plan services. The Rhody Health Options Care Managers and all their needed support staff shall be located in Rhode Island.

The State considers interactive communications between PCPs and specialists to be an important program objective to ensure that members receive the right care in the right setting. The

Contractor is encouraged to promote interactive communication methods or systems that enable timely exchange of member information between collaborating physicians.

2.08 COORDINATION WITH OUT-OF-PLAN SERVICES AND OTHER HEALTH/SOCIAL SERVICES AVAILABLE TO MEMBERS

2.08.01 General

The State supports various special service programs targeted to persons who may be covered by Rhody Health Options. The Contractor is not obligated to provide or pay for any non-plan, non-capitated services. However, Contractor shall develop policies and procedures to guide coordination of its in-plan and other service delivery with services delivered outside of the Health Plan. Examples of services with which it must coordinate are described below, but this list is not exhaustive.

Although such services are not Health Plan covered benefits, the State expects that Contractor will promote and coordinate such services to avoid service fragmentation. In addition, these services are significant for the promotion of the health of the Rhody Health Option members and families and to assure optimum outcome of the clinical services.

2.08.02 Mental Health Services For Individuals with Seriously and Persistently Mentally Ill and Developmental Disabilities

The State considers mental health services to be an integral part of the Rhody Health Options program, and therefore, has included them within the Comprehensive Risk Contract. However, the State also has worked with Rhode Island mental health providers over a number of years to develop a delivery system for treatment of adults with serious and persistent mental illnesses (SPMI) and developmental disabilities. The State wishes to preserve this delivery system for adults with SPMI and developmental disabilities mental health care needs are different from the general population.

For those individuals whose SPMI and developmentally disabilities diagnostic and premium rate category status is confirmed by the State and who are enrolled in Rhody Health Options, the State will continue to assume responsibility for providing the required Community Support Program services and will be financially responsible for the associated costs for those benefits described in Attachment B of this Agreement in Phase I. The Health Plans will be responsible for coordinating in-plan services with out-of-plan services for individuals with SPMI and developmental disabilities.

The State has sole authority for making determinations regarding the status for individuals with SPMI and developmental disabilities for enrollment in the Rhody Health Options program.

2.08.03 Dental Services

Contractor agrees to assist a member in obtaining dental services when so requested by a member.

2.08.04 Services of the Rhode Island Division of Elderly Affairs

Contractor agrees to assist members in accessing necessary services provided by the RI Division of Elderly Affairs (DEA). These services include but are not limited to: the RI Pharmaceutical Assistance for the Elderly Program, Rhode Island's aging and disability resource center, known as THE POINT, congregate and home-delivered nutrition programs, the DEA Protective Services Unit, and the Long Term Care Ombudsman.

2.08.05 Services of the Rhode Island Department of Human Services

The Contractor agrees to assist members in accessing necessary services provided by the RI Department of Human Services (DHS). These services include but are not limited to, services of the Office of Rehabilitation Services, and the State Nutrition Assistance Program (SNAP).

2.08.06 Services of the Rhode Island Department of Health

The Contractor agrees to assist members in accessing necessary services provided by the RI Department of Health (DOH). These services include but are not limited to the Disability and Health Program, and the Chronic Conditions Workforce Initiative, and the Chronic Disease Self Management Programs.

2.08.07 Housing

The Contractor agrees to assist members in accessing necessary housing arrangements, and agrees to collaborate with all state and federal housing authorities to accomplish access. These agencies include but are not limited to the Corporation for Supportive Housing, Rhode Island Housing Authority and the RI Office of Housing and Community Development.

2.08.08 CurrentCare

CurrentCare, Rhode Island's Health Information Exchange is a secure and private electronic health network that stores and shares a patient's medical information until a participating medical provider needs access to treat a patient. Enrolling in CurrentCare keeps providers informed, allowing them to coordinate your member's health care easily. The Contractor shall support CurrentCare by providing information and education to members on the benefits of enrolling in CurrentCare.

2.08.09 Non-Emergency Transportation

The Contractor shall coordinate and collaborate with the EOHHS-selected transportation broker to assist members in accessing non-emergency transportation. The requirements for collaboration will be set forth at a future date to be determined by EOHHS. Requirements shall include but will not be limited to supplying provider directories to the broker on a quarterly basis and complying with all EOHHS-established referral policies.

2.09 PROVIDER NETWORKS

2.09.01 Network Composition

Contractor shall establish and maintain a robust geographic network designed to accomplish the following goals: (1) offer an appropriate range of services, including access to preventive care, primary care, acute care, specialty care, behavioral health care, and long-term services and supports (including nursing homes and home and community-based care) services for the anticipated number of enrollees in the services area; (2) maintain providers in sufficient number, mix, and geographic areas; and (3) make available all services in a timely manner.

Contractor agrees to maintain and monitor a network of appropriate providers that is supported by written agreements and can sufficiently demonstrate to EOHHS' satisfaction Contractor's ability to provide Covered Services under this Agreement. Members must have access to services that are at least equal to, or better than community norms. In establishing and maintaining the network, Contractor shall consider the following:

- Anticipated Rhody Health Options enrollment
- Expected utilization of services taking into consideration the characteristics and health care needs of specific Rhody Health Options populations for which Contractor is, or will be, responsible
- Numbers and types (in terms of training, experience, and specialization) of providers, specifically specialty providers, required to furnish the services contracted for herein
- Numbers of providers who are not accepting new Rhody Health Options patients
- 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.
- "Disability Competency" of providers and the physical accessibility of their offices. "Disability Competency" is defined as the capacity of health professionals and health educators to support the health and wellness of people with disabilities through their disability knowledge, experience and expertise.

Contractor shall develop and maintain its network to maximize the availability of primary and specialty care access to reduce utilization of emergency services, preventable hospital admission/re-admissions, and the use of avoidable costly medical procedures.

Contractor shall include in their network current fee-for-service providers as "essential community" providers, unless the Contractor demonstrates a valid reason for not including them. If Contractor declines to include individual or groups of providers in its network, Contractor agrees to give the affected providers written notice of the reason for its decision. These essential community providers include but are not limited to: Rite@Home agencies and providers, Tri-Town Community Action, PARI, OSCIL; NeuroRestorative RI group homes; Rocky Knoll Group Home in Tiverton; Spurwink habilitation program, Sargent Rehabilitation, United Cerebral Palsy, To LIFE Incomp habilitation program, and other essential providers determined by the State.

Contractor agrees that if the network is unable to provide necessary services, covered under this Agreement, to a particular member, Contractor must adequately and on a timely basis cover these services out of network, for as long as Contractor is unable to provide them.

Contractor agrees to ensure that all in-plan services covered under the Medicaid State Plan and provided for in Attachment A are available and accessible to members, according to 42 CFR 438.206. Refer to Section 2.10 of this Agreement for service accessibility standards.

Contractor agrees to ensure that providers will meet the State standards for timely access to care and services, taking into account the urgency of need for services. Refer to Section 2.10 for service accessibility standards.

Contractor agrees to ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only members.

Nothing in this section may be construed to:

- Require Contractor to contract with providers beyond the number necessary to meet the needs of members;
- Preclude Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty;
- Preclude Contractor from establishing measures that are designed to maintain quality of services control costs and are consistent with its responsibilities to members; or
- Allow Contractor to reimburse FQHCs/RHCs at a rate less than that paid for comparable services provided by non-FQHC/RHC based providers.

For members, with the exception of PCP as defined in this contract, this may require the Contractor's inclusion of providers who practice or are located outside of the State and/or allowing such members to retain established relationships to preserve continuity of care with non-network providers, including traditional Medical Assistance providers. Contractor shall be obligated to offer a provider agreement to become a Participating Provider to any such providers. Contractor may inquire as to member's interest in switching to a closer in-State, in-network provider.

Each physician in the network must have a unique identifier assigned to them.

The Contractor shall have written policies and procedures for the selection and retention of providers that comply with 42 CFR 438.214 and with the State's policy for credentialing and recredentialing.

2.09.02 Primary Care Providers (PCPs)

2.09.02.01 PCP Responsibilities

Contractor agrees to have written policies and procedures for assigning every member to a Primary Care Provider (PCP), who has not chosen one at the time of enrollment. The PCP must serve as the member's initial and most important point of interaction with the Health Plan network. As such, PCP responsibilities must include at a minimum:

- Serving as the member's Primary Care Provider (PCP) and medical home
- Provide overall clinical direction and serve as the central point for the integration and coordination of care
- Making referrals for specialty care and other Medically Necessary services, both in- and out-of-plan
- Maintaining a current medical record for the member
- Serve as the general care manager and refer members for specialized care management services, when appropriate

Although PCPs must be given responsibility for the above activities, Contractor also agrees to retain responsibility for monitoring PCP actions to ensure they comply with Contractor and Rhode Island Medical Assistance managed care program policies.

2.09.02.02 Eligible Specialties

Contractor agrees to limit its PCPs to licensed, board-certified, eligible, or trained Medical Doctors and Doctors of Osteopathy in the following specialties:

- Family and General Practice
- Gynecology
- Geriatric Medicine
- Internal Medicine
- Other medical specialists identified by the Contractor and approved by EOHHS

PCPs may also be Mid-Level Practitioners under certain circumstances as provided for in Section 2.09.02.05,

Contractor shall include NCQA certified Patient-Centered Medical Homes (PCMH) in its network that serve as primary care providers. PCMH's provide and coordinate 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.

Contractor shall have a network of home-based primary care providers.

2.09.02.03 PCP Teams

If Contractor's primary care network includes institutions with accredited primary care residency training programs, it may use PCP teams, comprised of residents and a supervising faculty physician, to serve as a PCP. Contractor shall organize its PCP teams so as to ensure continuity of care to members and must identify a "lead physician" within the team for each member. The "lead physician" must be an attending physician and the physician who is accountable as the PCP. Teams shall be small in size and team members shall be assigned for sufficient duration to maintain patient continuity.

2.09.02.04 PCP Sites

If Contractor's primary care network includes Federally Qualified Health Centers (FQHCs) or Rural Health Centers (RHCs), it may designate either type of site as a PCP. In both instances, Contractor shall organize its PCP sites so as to ensure continuity of care to members and shall identify a "lead physician" within the site for each member and the physician who is accountable as the PCP.

2.09.02.05 Certified Nurse Practitioners as PCPs

The inclusion of the following Mid-Level Practitioners Certified Nurse Practitioners, and/or Physician Assistants - is permitted and encouraged. The State recognizes the ability of Mid-Level Practitioners to provide Primary Care to members. The State also recognizes that some Rhody Health Options members may wish to designate a Mid-Level Practitioner as their PCP. Therefore, Contractor may use Mid-Level Practitioners as PCPs with the following conditions: Mid-Level Practitioners who wish to become PCPs for Rite Care or Rhody Health Partners and Rhody Health Option shall submit to Contractor documentation of evidence of a collaborative relationship with a Primary Care Physician, in which this physician agrees to share responsibility for the care of Rhody Health Options patients, and particularly assume responsibility for components of care which are beyond the scope of practice and/or expertise of the Mid-Level Practitioner. The designated physician shall also agree to collaborate with the Mid-Level Practitioner to ensure that members receive specialty and other referrals as necessary.

2.09.02.06 Member-to-PCP Ratios

Contractor agrees to assign no more than fifteen hundred (1,500) members to any single PCP in its network. For PCP teams and PCP sites, Contractor agrees to assign no more than one thousand (1,000) members per single primary care provider within the team or site, e.g., a PCP team with three (3) providers may be assigned up to 3,000 members.

2.09.02.07 In-Network Self-Referrals

Contractor agrees to have written policies and procedures that permit members at a minimum to self-refer for one annual and up to five (5) GYN/Family Planning visits annually and for sexually-transmitted (STD) services, without obtaining a referral from the Primary Care Provider.

2.09.02.08 Transitioning Between Non-Network and Network Providers for Medical and Behavioral Health

The State recognizes that members upon enrollment in a Health Plan may transition between non-network and network providers to receive needed health care services (medical and behavioral). Contractor may require that non-network providers possess appropriate licensure, certification, or accreditation as required by the NCQA. This can occur when members first enrolls in a Health Plan, when members change Health Plans, or at other times. To ensure continuity of care, Contractor agrees to have written policies and procedures for transitioning between network and non-network providers the following types of members:

- Individuals with developmental disabilities and individuals with serious and persistent mental illness (SPMI),
- Those receiving services through the Rhode Island Department of Behavioral Health, Developmental Disabilities and Hospitals, or
- Individuals receiving Medicare benefits enrolled in Rhody Health Options.

Contractor shall routinely document the frequency of use from non-network to network providers in a format acceptable to EOHHS on an agreed upon schedule. These policies and procedures must contain a provision allowing members to continue seeing out-of-network providers for up to six (6) months after the member's enrollment into the Health Plan. As described in Section 2.07.01, existing prior authorizations may require the Contractor to extend the six (6) month transition period. At the end of such period, in order to require that member transition to an in-network provider, Contractor must offer a provider with comparable or greater expertise in treating the needs of members.

Contractor will ensure there is no cost to the member for the transfer of medical records during the transition period and thereafter, for efficient and seamless transfer of clinical care from one provider to another (in-network or out-of-network, primary or specialty care, including behavioral health).

2.09.03 Mental Health Providers

2.09.03.01 Provider Mix

Contractor agrees to include a mix of mental health providers in its network to ensure that a broad range of treatment options representing a continuum of care is available. The mental health provider network shall at least include Psychiatrists, Clinical Psychologists, Psychiatric Nurses, licensed Social Workers, and providers approved by the Departments of Children, Youth and Families (DCYF); and the Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH).

The network must include providers experienced in serving low income populations, subspecialists or specialty providers experienced in sexual abuse, domestic violence, rape, and dual diagnosis (mental health and substance abuse) in sufficient numbers to meet the needs of the

population to be served in a timely manner. The composition of the network shall also recognize the multi-lingual, multi-cultural nature of the population to be served and include providers in locations where members are concentrated. Contractor shall include Community Mental Health Centers (CMHCs) in its network unless it can demonstrate that it has both adequate capacity and an appropriate range of services for vulnerable populations to serve the expected enrollment in a service area without contracting with CMHCs.

2.09.03.02 In-Network Self Referrals

Contractor agrees to have written policies and procedures that permit members to self-refer for in-network mental health services, rather than obtaining a referral from their Primary Care Provider. Contractor shall establish provisions for the coordination of this care with the PCP that takes into account patient confidentiality requirements.

2.09.03.03 Transitioning between Non-Network and Network Providers

The State recognizes that members may need to, at times, transition between non-network and network providers to continue to receive needed mental health services. This can occur when members first enroll in a Health Plan, when members change Health Plans, or at other times. Contractor agrees to have written policies and procedures for transitioning members between non-network and network providers to assure continuity of care, including paying for one or more transition visits with a non-network provider.

2.09.04 Substance Abuse Providers

2.09.04.01 Provider Composition

Contractor shall include licensed substance abuse treatment programs and licensed substance abuse professionals in its substance abuse provider network. The network shall include providers experienced in serving low-income populations, persons with polypharmacy and dual diagnosis in sufficient numbers to meet the needs of the population to be served in a timely manner. The composition of the network shall also recognize the multi-lingual, multi-cultural nature of the population to be served and include providers in locations where members are concentrated. In order to accomplish this, Contractor may ease customary credentialing standards provided this does not jeopardize Contractor's licensure or accreditation status. Contractor shall assure access to confidential substance abuse treatment services for minors as provided for in Chapter 14-5-4 of the RI General Laws.

2.09.04.02 In-Network Self Referrals

Contractor agrees to have written policies and procedures that permit members to self-refer for in-network substance abuse services, rather than obtaining a referral from their Primary Care Provider. Contractor shall establish provisions for coordination of this care with the PCP that takes into account patient confidentiality requirements.

2.09.04.03 Transitioning between Non-Network and Network Providers

The State recognizes that members may need to, at times, transition between non-network and network providers to continue to receive needed substance abuse services. This can occur when members first enroll in a Health Plan, when members change Health Plans, or at other times. Contractor agrees to have written policies and procedures for transitioning members between non-network and network providers to assure continuity of care, including paying for one or more transition visits with a non-network provider.

2.09.05 Physician Specialists

Because of the large number of physician specialties that exist, Contractor is not required to maintain specific member-to-specialist provider ratios. However, Contractor agrees to provide adequate access to physician specialists for PCP referrals, and to employ or contract with specialists in sufficient numbers and locations to ensure specialty services can be made available in a timely manner. Networks shall include specialists experienced with adult health specialty needs.

2.09.06 Long-Term Care Providers

2.09.06.01 Provider Composition

Contractor shall include a mix of long-term care (LTC) providers in its network to assure that a broad range of long-term care institutional and community-based services representing a continuum of care are available to members who are eligible for long-term care that represent a continuum of care. The network shall provide community-based alternatives to institutional care. The long-term care provider network shall at a minimum include State licensed: nursing home facilities, home nursing agencies, home care agencies, adult day care centers, home health care providers, shared living providers, and assisted living facilities, or Rite@Home agencies approved by EOHHS. LTC providers shall be experienced in serving low income populations with multiple complex and chronic conditions.

Contractor shall be required to develop a long-term care system that provides timely access to quality institutional and home and community-based services and support to meet member needs twenty-four (24) hour per day, seven (7) days a week. Specific access standards are described in Section 2.10.01.

Network home care providers shall not be required to be Medicare certified, but must be affiliated or partnered with a Medicare certified home care provider. Network providers are subject to the rules and regulations of the Department of Health. Home Nursing Home Providers can also be certified to meet Federal Medicare services authorized under the Federal CFR Title 18 regulations. HNCP's are "certified for Medicare" are referred to as Home Health Agencies (HHA).

2.09.06.02 Service Philosophy

Contractor agrees to adhere to the following principles in providing long-term care services:

- Priority shall be placed on allowing members to reside or return to their home, when appropriate and desired by the member.
- Promote a member-centered system through the development of a Plan of Care that is directed to meet the multiple needs of members.
- Involve the member and his/her representative in the development of a Plan of Care, selection of providers, monitoring of services, and in transitional planning
- Support the members informal support system
- Meet the special needs of members who have cognitive impairments, behavioral health needs and other special medical or support needs

The composition of the network shall also recognize the multi-lingual, multi-cultural nature of the population to be served and include providers in locations where members are concentrated.

2.09.06.03 Provider Monitoring

Contractor shall monitor the Long-Term Care providers to ensure that services are provided promptly, are reasonably accessible in terms of the location and hours of services, and meet the quality standards prescribed in the Contractor's agreement with the provider. Member's satisfaction shall be considered in monitoring long-term care providers. Provider practices that endanger the health or safety of members shall be reported to the appropriate State authorities.

2.09.07 FQHCs/RHCs

Contractor shall include FQHCs and RHCs in its network unless it can demonstrate that it has both adequate capacity and an appropriate range of services for vulnerable populations to serve the expected enrollment in a service area without contracting with FQHC's or RHCs (a description of FQHC services is included in Attachment E).

2.09.08 Department of Health Laboratory

The Rhode Island Department of Health ("DOH") operates a reference laboratory and relies on this laboratory to monitor the incidence of lead poisoning and contagious diseases throughout the State. To assist in this monitoring process, Contractor agrees to require its network providers to submit to the Department of Health laboratory all specimens for HIV testing and mycobacteria (TB) analysis. All blood lead screening test samples, including venipuncture samples, should be submitted to DOH laboratory for analysis. All non-screening blood lead samples shall be

considered diagnostic lead testing and may be sent to any lab licensed by the DOH to perform blood lead analysis. Contractor also agrees to submit specimens from suspected cases of measles, mumps, rubella, and pertussis when required by the State to facilitate investigations of outbreaks. Contractor shall negotiate fees directly with the DOH laboratory.

2.09.09 Title X Providers

Contractor is encouraged to include Title X delegate agency providers in its network to serve individuals to provide required non-medical services and supports.

2.09.10 Mainstreaming

The State considers mainstreaming of members into the broader health delivery system to be an important program objective. Contractor agrees that all of its network providers will accept members for treatment. Contractor agrees to have policies and procedures in place such that any provider in its network who refuses to accept a member for treatment cannot accept non-members for treatment and remain in the network. Contractor also agrees to accept responsibility for ensuring that network providers do not intentionally segregate members in any way from other persons receiving services. 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 Section 3.10.

2.09.11 Selective Contracting

Notwithstanding the provisions of Section 2.09.10 Contractor is expected to utilize selective contracting and/or preferred provider initiatives for non-primary care and non-urgent services in order to secure the best price for services while maintaining quality and timely access.

2.09.12 Provider Network Lists

Contractor agrees to provide the State quarterly with a list of all its participating providers, including its mental health and substance abuse providers, with whom regular referral arrangements exist. This list must include a separate list of PCPs who have adequate capacity to accept members. In addition, a list shall be provided quarterly that includes designation of language capability of the provider and physical accessibility of the provider's location, as well as applicable addresses and telephone numbers.

2.09.13 Network Changes

Contractor agrees to notify the State monthly of any changes in its network's composition. Contractor also agrees to notify the State promptly of any changes to the composition of its provider network that materially affects Contractor's ability to make available all capitated services in a timely manner. Contractor agrees to have procedures to address changes in its network that negatively affect the ability of members to access services.

Contractor agrees to make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) business days after receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

Contractors shall notify the State in writing of any actions undertaken to terminate or suspend a practitioner from the Contractor's network due to quality, Medicaid fraud or abuse, or integrity, within ten (10) business days.

2.09.14 Provider Discrimination

Contractor may not discriminate with respect to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.

2.09.15 New Members' Providers

At the time a client transitions into managed care, the Contractor is required to maintain the member's current network of providers, including but not limited to, nursing home providers, assisted living providers, and home care providers for a period of six (6) months after the members start date. Members, who are permanent residents of nursing homes or assisted living facility in which they reside at the time they are enrolled, may remain in that nursing home or assisted living facility, regardless of whether that nursing home or assisted living facility is in-network for the Contractor.

2.10 SERVICE ACCESSIBILITY STANDARDS

2.10.01 Twenty-Four Hour Coverage

Contractor agrees to provide coverage, either directly or through its PCPs, to members on a twenty-four (24) hours per day, seven (7) days per week basis. If PCPs are to provide such coverage, Contractor agrees to have a back-up plan for instances where the PCP is not available. Contractor also agrees to have written policies and procedures describing how members and providers can contact the Contractor to receive instructions for treatment of an emergent or urgent medical problem.

2.10.02 Travel Time

Contractor agrees to make available to every member a PCP, whose office is located within twenty (20) minutes or less driving distance from the member's home. Members may, at their discretion, select PCPs located farther from their homes.

2.10.03 Emergency Medical Services

Pursuant to 42 CFR 438.114, Contractor agrees to provide or ensure access to Emergency Services which are available twenty-four (24) hours a day and seven (7) days a week, either in

Contractor's own facilities or through arrangement, with other providers. Contractor agrees that services shall be made available immediately for an emergent medical condition including a mental health or substance abuse condition. In accordance with 42 CFR 438.114(d)(1)(i), the Contractor may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor, as specified in 42 CFR 438.114(b) as responsible for coverage and payment. The provision of emergency services must also conform to *Rhody Health Partners and Rhody Health Options Program Emergency Medical Services Policy*.

Contractor must cover and pay for Emergency Services, as defined herein, regardless of whether the provider that furnishes the services has a contract with the Health Plan. In accordance with 42 CFR 438.114(d)(1)(ii), Contractor may not refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the member's PCP or Health Plan of the member's screening and treatment within ten (10) calendar days of presentation for emergency services. A member, who has an emergency medical condition, as defined herein, may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. The Contractor may not deny payment for treatment obtained when a representative of the entity instructs the enrollee to seek emergency services. The Federal and State requirements governing emergency services will be provided to members in a clear, accurate and standardized form at the time of enrollment and annually thereafter.

2.10.04 Days to Appointment for Non-Emergency Services

Contractor agrees to make services available within twenty-four (24) hours for treatment of an Urgent Medical Condition including a mental health or substance abuse condition. Contractor agrees to make services available within thirty (30) days for treatment of a non-emergent, non-urgent medical problem. This thirty (30) day standard does not apply to appointments for routine physical examinations, nor for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) days. Contractor agrees to make services available within five (5) business days for diagnosis or treatment of a non-emergent, non-urgent mental health or substance abuse condition.

2.10.05 Post-Stabilization Care Services

Post-Stabilization Care Services will be provided to members in accordance with the definition set forth in Section 1.47. Members have the right to receive Post-Stabilization Care Services after they have been stabilized following an admission for an emergency medical condition; provided, however, that the provider of Post-Stabilization Care Services must request prior authorization for those services in accordance with the provisions of this Agreement and the Contractor. Contractor must pay for Post-Stabilization Care Services if: (1) Contractor pre-approved such services; (2) Contractor authorizes those services in accordance with the provisions of the Health Plan; (3) Contractor did not respond to the request for prior authorization within one hour of the request; (4) Contractor cannot be contacted; or (5) Contractor's representative and the treating physician cannot reach an agreement concerning the enrollee's care and the Contractor's physician is not available for consultation. In this situation,

the Contractor must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with the care of the patient until a plan physician is reached or one of the criteria of 42 CFR 422.133(c) is met. The requirements of Federal and State law governing Post-Stabilization Care Services will be provided to members in clear, accurate, and standardized form at the time of enrollment and annually thereafter.

The Contractor's financial responsibility for Post-Stabilization Care Services it has not pre-approved ends when: (1) a Health Plan physician with privileges at the treating hospital assumes responsibility for the member's care; (2) a Health Plan physician assumes responsibility for the member's care through transfer; (3) Contractor's representative and the treating physician reach an agreement concerning the member's care; or (4) the member is discharged as specified in 42 CFR 438.114(e).

The Contractor must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the Health Plan as indicated in 42 CFR 422.113.

2.10.06 Access for Women

Contractor will allow women direct access to a women's health care specialist within the Contractor's network or outside the network for women's routine and preventive services. A women's health care specialist may include a gynecologist, a certified nurse midwife, or another qualified health care professional. Enrollment in Rhody Health Options does not restrict the choice of the provider from whom the person may receive family planning services and supplies.

2.10.07 Assessment Standards

The Contractor shall conduct an Initial Health Screen on all new members not currently receiving LTSS within forty-five (45) days of enrollment and every one hundred and eighty (180) days thereafter, unless member conditions dictate otherwise.

The Contractor shall be required to conduct an in-person face-to-face Comprehensive Functional Needs Assessment on members. An in-person assessment shall be completed within fifteen (15) days of enrollment and every ninety (90) days thereafter or sooner if required, for members living in the community receiving LTSS. An in-person assessment shall be conducted within thirty (30) days and every one hundred and eighty (180) days thereafter or sooner if required, for members living in long-term care institutions. An in-person Comprehensive Functional Needs Assessment shall be conducted within fifteen (15) days after the Initial Health Screen Comprehensive Functional Needs Assessment and every one hundred and eighty (180) days thereafter or sooner if needed, for members not receiving LTSS but are at risk and may benefit from LTSS. The Contractor has one hundred and eighty (180) days to complete all Comprehensive Functional Needs Assessments during the initial start-up period. Failure to meet this requirement shall result in sanctions to the Contractor.

The Contractor shall provide a consultation and an Initial Health Screen within fifteen (15) days of a member's or caregiver's request.

A home re-assessment shall be conducted and the Plan of Care modified, if necessary within five (5) days after a hospitalization.

2.10.08 Compliance with Service Accessibility Standards

Contractor shall establish mechanisms to assure compliance by providers, monitor providers regularly to determine compliance, and take corrective action if there is a failure to comply.

2.10.09 Access for Rhody Health Options Members with Special Needs

In certain cases, Rhody Health Options members may have an ongoing clinical relationship with a particular specialist who serves as a principal coordinating physician for a member's special health care needs and who plays a critical role in managing that member's care on a regular basis throughout the year. Contractor shall have policies and procedures whereby the member is ensured facilitated and timely access to such principal coordinating physician. Where this is the case, Contractor shall require communication and collaboration between the PCP and the specialist serving as the principal coordinating physician.

For members with special health care needs determined through an assessment by appropriate health care professionals, consistent with 42 CFR 438.208(c) (2), who need a course of treatment or regular care monitoring, Contractor must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.

2.10.10 Access Standards for Long-Term Care Providers

Contractor shall demonstrate that sufficient capacity exists to provide timely access to quality institutional care (e.g. nursing home) and home and community-based services and supports that meet the needs where the Rhody Health Options populations reside. Contractor shall monitor the availability of long-term care providers and shall make the appropriate adjustments to maintain timely access to quality LTC.

Contractor shall ensure that home and community-based services shall be available twenty-four (24) hours a day, seven (7) days a week. The required services must be in place within five (5) days of a member's need is determined. Nursing homes shall be located within ten (10) miles of a member's primary care giver, unless the member selects a nursing home farther than ten (10) miles. Assisted living facilities, Adult Day Care Service Centers and other community-based LTSS agencies shall be located within twenty (20) minutes driving time of the primary caregiver's residence, unless the member selects a provider located more than twenty (20) minutes driving time of a member's residence.

2.10.11 State Affordability Standards

The Contractor shall comply with the Affordability Standards issued by the RI Office of Health Insurance Commissioner (OHIC). The Affordability Standards aim to improve the affordability

of health in the State by requiring companies issuing health insurance to: (1) expand and improve primary care infrastructure, (2) adopt patient centered medical homes, (3) support CurrentCare the State's information exchange, and (4) work toward comprehensive payment reform across the delivery system.

2.11 MEMBER SERVICES

2.11.01 General

Contractor agrees to staff a Member Services function to be operated at least during regular business hours (8 AM to 6 PM including lunch hours) and to be responsible for the following:

- Explaining to members the operation of the Health Plan, including the role of the PCP and what to do in an Emergency or urgent medical situation
- Assisting members in the selection of a PCP
- Assisting members to make appointments and obtain services
- Arranging Medically Necessary transportation for members
- Handling member complaints
- Assisting members with coordination of out-of-plan services

As part of its Member Services function, Contractor shall have an ongoing program of member education that takes into account the multi-lingual, multi-cultural nature of the population.

2.11.02 Toll-Free Telephone Number

Contractor agrees to maintain a toll-free Member Services telephone number. While the full Member Services function will not be required to operate after regular business hour (between 6 PM and 8 AM) this or another toll-free telephone number of the Contractor must be staffed twenty-four (24) hours per day to provide prior authorization of services during evenings and on weekends.

TTY/TDD services and foreign language interpretation are available when needed by a member who called Member Services telephone number.

2.11.03 Annual Notification

Once a year, Contractor must notify members in writing of their rights to request and obtain the information listed below:

- Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the member's services area, including those not

- accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals.
- Any restriction on the member's freedom of choice of network providers
 - Member rights and protections, including those specified in 42 CFR 438.100
 - Notify all members of their disenrollment rights
 - Information on grievance, appeal, and State Fair Hearing procedures, including applicable time frames and the information specified in 42 CFR 438.10(g)(1)
 - The amount, duration, and scope of benefits available under this Agreement in sufficient detail to ensure that members understand the benefits to which they are entitled
 - Procedures for obtaining benefits, including authorization requirements
 - The extent to which, and how, members may obtain benefits, including family planning services from out-of-network providers
 - The extent to which, and how, after-hours and emergency coverage are provided, including:
 - What constitutes emergency medical condition, emergency services, and post-stabilization services, with reference to the definition in 42 CFR 438.114(a)
 - The fact that prior authorization is not required for emergency services.
 - The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent.
 - The locations of any emergency settings and other locations at which providers and hospital furnish emergency services, urgent care and Post-Stabilization Care Services covered under this Agreement.
 - The member has a right to use any hospital or other setting for emergency care.
 - The Post-Stabilization Care Services rules set forth in 42 CFR 422.113(c)
 - Policy on referrals for specialty care and for other benefits not furnished by the Member's PCP
 - Cost-sharing, if applicable
 - How and where to access any benefits that are available under the Medicaid State Plan, but are not covered under this Agreement, including any cost-sharing and how transportation is provided. For a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor need not furnish information on how and where to obtain the service. The State must provide information on how and where to obtain the service.
 - Advance directives, as set forth in 42 CFR 438.6(i)(1)

- Additional information that is available on request, including information on the structure and operation of the Health Plan and physician incentive plans as set forth in 42CFR 438.6(h)

Contractor agrees to submit to EOHHS for prior approval the written materials to be used to fulfill these requirements at least thirty (30) days prior to their use.

2.11.04 Cultural Competency

Contractor must ensure that services are provided in a culturally competent manner to all members. Specifically, Contractor: (1) must give the concerns of members related to their racial and ethnic minority status full attention beginning with the first contact with a member, continuing throughout the care process, and extending to evaluation of care; (2) must make interpreter services available when language barriers exist and are made known to Contractor, including the use of sign interpreters for members with hearing impairments and the use of Braille for members with vision impairments; and (3) as appropriate, should adopt cultural competency projects to address the specific cultural needs of racial and ethnic minorities that comprise a significant percentage of its member population.

2.11.05 Best Practices

Contractor shall adopt nationally recognized best practice to enhance member services that improve the member's health care status, access to preventive and acute medical care, proper use of limited medical resources, linking with available community resources and supports, independence and well-being. Examples of such best practices may include strategies that improve member's health care literacy or the implementation of a Health Care Concierge that assists members navigate the health care delivery system as well as to obtain necessary community and support services

2.12 PROVIDER SERVICES

Contractor agrees to staff a Provider Services function, to be operated at least during regular business hours and to be responsible for the following:

- Assisting providers with questions concerning member eligibility status
- Assisting providers with Health Plan prior authorization and referral procedures
- Assisting providers with claims payment procedures
- Handling provider complaints
- Assisting with care management

As part of its Provider Services function, Contractor shall have an ongoing program of provider education concerning Rhody Health Options benefits and the needs of the member population. The provider education program shall include a quarterly provider newsletter and shall

communicate, at least annually, how to obtain injectable medications and out-of-network benefits.

Contractor shall require providers to report any changes in address or telephone numbers at least thirty (30) days prior to the change occurring.

2.13 MEDICAL MANAGEMENT AND QUALITY ASSURANCE

2.13.01 General

The Rhode Island Department of Health (DOH) regulates the utilization review and quality assurance, or quality management (UR/QA) functions of all licensed Health Plans. Contractor, therefore, agrees to comply with all Department of Health UR/QA standards, in addition to specific standards described in this section. A health care professional who has the appropriated clinical expertise in treating the member's condition or disease may make a decision to deny a service authorization request or to authorize a service on the basis of Medical Necessity in an amount, duration or scope that is less than requested.

2.13.02 Medical Director's Office

Contractor shall designate a Medical Director responsible for the development, implementation, and review of the internal quality assurance program (QAP). The Medical Director shall have adequate and appropriate experience in successful QA programs and be given sufficient time and support staff to carry out the Health Plan's QA functions. The Medical Director shall be full-time employed by the Contractor. Contractor may use assistant or associate Medical Directors to help carry out the responsibilities of this office.

The qualifications and responsibilities shall include, but need not be limited to, what follows below. Specifically, the Medical Director shall:

- Be licensed to practice medicine in the State of Rhode Island and be board-certified, -eligible, or trained in his or her field of specialty
- Be responsible for Contractor's UR and QA Committees, direct the development and implementation of Contractor's internal Quality Assurance Plan, utilization review activities, and monitor the quality of care that members receive
- Be responsible for the development of medical practice standards and protocols for Contractor
- Oversee 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 in accordance with 42 CFR 447,434,438, and 1902(a)(4), 1902(a)(6), and 1903, and possible hospital acquired conditions and recommend development and implementation of corrective action plans.

- Be responsible for the development of Contractor's medical policies
- Be responsible for the Contractor's referral process for specialty and out-of-plan services
- Be involved in the Contractor's recruiting and credentialing activities
- Be involved in the Contractor's process for prior authorizing and denying services
- Be involved in the development and oversight of the Contractor's disease management programs
- Be involved in the Contractor's process for ensuring the confidentiality of medical records/client information
- Be involved in the Contractor's process for ensuring the confidentiality of sexually transmitted infection (STI) appointments and mental health and substance abuse appointments
- Serve as a liaison between the Contractor and its providers and communicate regularly with the Contractor's providers, addressing areas of clinical relevance including but not limited to:
 - Contractor's utilization management functions
 - Contractor's prescription and over the counter drug formulary for Medicaid enrollees
 - Disease management and health promotion programs offered by the Contractor
 - Any prior authorization (PA) requirements
 - Clinical practice guidelines
 - Quality indicators, such as the Contractor's performance on HEDIS® and CAHPS® measures
- Participate in the development of strategies to educate members about health promotion, disease prevention and efficient and effective use of health care benefits
- Be available to the Contractor's medical staff on a daily basis for consultation on referrals, denials, complaints, and problems

2.13.03 Utilization Review and Quality Assurance (UR/QA)

2.13.03.01 General

Contractor agrees to have written policies and procedures to monitor utilization of services by its members and to assure the quality and accessibility of care being provided in its network. Such policies and procedures shall:

- Conform to 42 CFR 438.350
- Assure that the UR and QA Committees meet on a regular schedule
- Provide for regular UR/QA reporting to the Contractor management and Contractor providers, including profiling of provider utilization patterns

2.13.03.02 Utilization Review

Contractor agrees to have written utilization review policies and procedures that include protocols for denial of services, prior approval, hospital discharge planning, physician profiling, and retrospective review of claims. Contractor shall be expected to, at minimum, meet the limits for minor assistive devices and home modifications as described in Attachment A as in-plan services. As part of its utilization review function, Contractor also agrees to have processes to identify utilization problems and undertake corrective action. As part of this function, Contractor shall have a structured process for the approval or denial of covered services. This shall include, in the instance of denials, formal written notification to the member and the requesting or treating provider of the denial, its basis and any applicable appeal rights and procedures including EOHHS/Department-level appeal within fourteen (14) days of the request for authorization. Contractor shall demonstrate to the State that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

The contractor must define service authorization in a manner that at least includes an enrollee's request for the provision of services as required by 42 CFR 431.210

Contractor may engage in direct discussions and/or patient or patient family interviews, as necessary, in order to facilitate discharge planning, consider treatment options or alternatives, and the like for cost-effective, patient-centered medically necessary care. These direct discussions may be used to assess the medical and/or mental health status of a patient.

Contractor must maintain written policies and procedures that cover the language and format of notices of adverse actions:

- Written notice must be translated for individuals who speak prevalent non-English languages, as defined by the State per 42 CFR 438.10 (c).
- Notice must include language clarifying that oral interpretation is available for all languages and how to access it.
- Written material must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration for those with special needs.

- Enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.

2.13.03.03 Quality Assurance

Contractor agrees to have a written quality assurance or quality management plan that monitors, assures, and improves the quality of care delivered over a wide range of clinical and health service delivery areas including all subcontractors. Emphasis shall be placed on, but need not be limited to, clinical areas relating to management of chronic diseases, mental health and substance abuse care, members with special needs, and access to services for members. Contractor agrees to establish a Medicaid Pharmacy Lock-In Program for Medicaid only members whose utilization of prescriptions is documented as being excessive. Members are “locked-in” to a specific pharmacy in order to monitor prescriptions received and reduce unnecessary or inappropriate utilization. The Contractor agrees to provide ample notification to members regarding pharmacy lock-in.

The Contractor’s quality assurance/quality management plan shall focus on clinical and nonclinical areas and involve the following:

- Measurement of performance using objective quality indicators
- Implementation of system interventions to achieve improvement in quality
- Evaluation of the effectiveness of interventions
- Planning and initiation of activities for increasing or sustaining improvement

Contractor agrees to report the status and results of each project to the State, or its designees, as requested, but at least within thirty (30) days following presentation to Contractor’s Quality Improvement Committee. Contractor agrees to cooperate fully with the State or its designees in any efforts to validate performance improvement projects. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

Contractor agrees to support joint quality improvement projects involving Health Plans and EOHHS.

Contractor agrees to provide Medicaid HEDIS[®] and CAHPS[®] results to the State, or its designees, within thirty (30) days, following presentation to Contractor’s Quality Improvement Committee.

For Rhody Health Options members, Contractor shall have defined protocols that require routine reporting on the quality of care (e.g., timeliness for conducting the Initial Health Screen) and access to services (e.g., access barrier analysis).

The Quality Assurance Plan also shall:

- Be developed and implemented by professionals with adequate and appropriate experience in QA
- Detect both underutilization and overutilization of services
- Assess the quality and appropriateness of care furnished to enrollees
- Provide for systematic data collection of performance and patient results
- Provide for interpretation of this data to practitioners
- Provide for making needed changes when problems are found

2.13.03.04 Confidentiality

Contractor must have written policies and procedures for maintaining the confidentiality of data; including medical records/client information and STI appointment records that conform to HIPAA requirements (also see Section 3.09 Confidentiality of Information). Contractor shall have available in its network providers willing to provide confidential family planning and STI services to adolescents.

2.13.03.05 State and Federal Reviews

Contractor agrees to make available to the State and/or its designees on an as needed basis, medical and other records for review of quality of care and access issues.

CMS and/or the State may designate an outside review agency to conduct an evaluation of the Rhode Island Medical Assistance managed care program and its progress toward achieving program goals. Contractor agrees to make available to CMS' and/or the State's outside review agency medical and other records for review as requested.

2.13.03.06 Practice Guidelines

Contractor will develop (or adopt) and disseminate practice guidelines that comply with 42 CFR 438.236 and are based on valid and reliable medical evidence or a consensus of health professionals in the particular field, consider the needs of members, developed in consultation with contracting providers, reviewed and updated periodically as appropriate. The Contractor shall disseminate the guidelines to all affected providers and, upon request, to members and potential members. Decisions for utilization management, member education, coverage of services, and other areas to which the practice guidelines apply must be consistent with the practice guidelines.

2.13.03.07 Service Provision

Contractor will provide services in the amount, duration, and scope of service in a manner that is expected to achieve the purpose for which the services were provided. Contractor may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.

2.13.04 Provider Credentialing

Contractor agrees to have written credentialing and re-credentialing policies and procedures for determining and assuring that all providers under contract to the plan are licensed by the State, or state in which the covered service is furnished, and are qualified to perform their services. Contractor also shall have written policies and procedures for monitoring its providers and for disciplining providers who are found to be out of compliance with Contractor's medical management standards.

Contractor agrees that it will not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. Contractor agrees not to employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.

The Contractor shall have written policies and procedures which pertain to disclosures by providers. In accordance with 42 CFR Section 455.104, disclosures shall be obtained from any provider or disclosing entity at any of the following times:

- Upon the provider or disclosing entity submitting the provider application
- Upon the provider or disclosing entity executing the provider agreement
- Upon request during the re-validation or re-credentialing process
- Within thirty-five (35) days of any change in ownership of the disclosing entity

In accordance with 42 CFR Section 455.106, before the Contractor enters into or renews a provider agreement, or at any time upon written request by EOHHS, the provider must disclose the identity of a person who:

- Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and
- Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Federal Title XX program since the inception of those programs.

An individual is considered to have an ownership or control interest in a provider entity if it has direct or indirect ownership of five (5) percent or more, or is a managing employee (such as a general manager, business manager, administrator or director) who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day

operations of the entity as defined in section 1126(b) of the Social Security Act and under 42 CFR Section 1001.1001(a)(1).

The Contractor should refer to Section 2.19 (Compliance) for further requirements pertaining to disclosures.

The Contractor shall promptly notify EOHHS in writing within ten (10) business days in the event that the Contractor identifies an excluded individual with an ownership or control interest.

The Contractor may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any Federal health care program.

The Contractor may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure as required in this section.

The Contractor must promptly notify EOHHS in writing of any action that it takes to deny a provider's application for enrollment or participation (e.g., a request for initial credentialing or for re-credentialing) when the denial action is based on the Contractor's concern about Medicaid program integrity or quality.

The Contractor must also promptly notify EOHHS in writing of any action that it takes to limit the ability of an individual or entity to participate in its program, regardless of what such an action is called, when this action is based on the Contractor's concern about Medicaid program integrity or quality. This includes, but is not limited to, suspension actions and settlement agreements.

The Contractor may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any Federal health care program.

The Contractor may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure as required in this section.

The Contractor shall have a uniform credentialing and re-credentialing process and comply with that process consistently with State regulations and current NCQA "Standards and Guidelines for Accreditation of Health Plans". For organizational providers including nursing facilities, hospitals, and Medicare certified home health agencies, the Contractor must adopt a uniform credentialing and re-credentialing process and comply with that process consistent with State regulations. Waiver service providers and Personal Care Provider Agencies (PCPAs) are exempt from this requirement.

2.14 OPERATIONAL DATA REPORTING

2.14.01 General

Contractor agrees to provide the State with uniform utilization, quality assurance, and member satisfaction/complaint data on a regular basis, described below, and additional data in a manner acceptable to the State. Record content must be consistent with the utilization control requirement of 42 CFR 456.111. The utilization review plan must provide that each member's record include information needed for the Utilization Review Committee to perform required utilization review activities. Contractor also agrees to cooperate with the State in carrying out data validation activities.

2.14.02 Utilization Data

Contractor agrees to provide, for each member, person-level records that describe the care received by that individual during his or her enrollment period with the Contractor, such as records shall be provided at intervals specified by EOHHS. In addition, Contractor agrees to provide aggregate utilization data for all members at such intervals as required by the State.

2.14.02.01 Person-Level Record

The person-level record shall include, at a minimum, those data elements listed in the *Encounter Data Business Design* and its associated HIPAA companion guides including updates issued by the State's designated Medicaid management information system ("MMIS") contractor.

2.14.02.02 Aggregate Data

The aggregate data submittal shall include, at a minimum, those data elements listed in the *Encounter Data Business Design* including updates.

2.14.02.03 Data Format

Contractor agrees to submit data in an electronic or tape format that conforms to the State's specifications. The precise nature of these specifications is included in the *Encounter Data Business Design* including updates and associated HIPAA companion guides.

2.14.02.04 Timing of Data Submittal

Contractor agrees to submit person-level records at intervals specified by the State and detailed in the *Encounter Data Business Design* including updates

2.14.02.05 Data Validation

Contractor agrees to assist the State in its validation of utilization data by making available a sample of medical records and a sample of its claims data.

2.14.03 Grievance and Appeals Data

Contractor agrees to submit a quarterly grievance and appeals report that conforms to the State's specifications. This report is due no later than thirty (30) days after the end of the reporting quarter. Contractor agrees to report grievance and appeals data separately for Rhody Health Options members.

2.14.04 Quality Assurance Data

Contractor agrees to make available internal quality assurance reports periodically to the State, as the State may specify. Contractor also agrees to perform medical record abstracts in selected quality assurance areas, at a minimum of one (1) such areas related to Rhody Health Options members in any contract year, to be specified by the State, for use in external quality review. The precise methodology for these abstracts will be provided to the Contractor by the State. Contractor agrees to work cooperatively with the State in developing and implementing this methodology.

Contractor shall provide the results of any quality improvement studies/projects and Medicaid HEDIS® and CAHPS® results within thirty (30) days of their presentation to Contractor's Quality Improvement Committee.

2.14.05 Member Satisfaction Report

Contractor agrees to collect member satisfaction data through an annual survey of a representative sample of its Members.

2.14.06 Fraud and Abuse Reports

Contractor agrees to submit a quarterly fraud and abuse report that conforms to the State's specifications. This report is due no later than thirty (30) days after the end of the reporting quarter.

As indicated in 42 CFR 455.17 the report shall indicate at minimum: (1) the number of complaints of fraud and abuse that warranted preliminary investigation, and (2) for each case of suspected provider fraud and abuse that warrants a full investigation. For the latter case, the contractor shall report the following:

- the provider's name and number
- the source of the complaint
- the type of provider
- the nature of the complaint
- the approximate range of dollars involved
- the legal and administrative disposition of the case including actions taken by law enforcement officials to whom the case has been referred.

2.14.07 RItE Share Reporting

If Contractor has an active non-Medicaid product, 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 shall be interpreted to require Contractor to participate in RItE Share.

2.14.08 Presentation of Findings

Contractor agrees to obtain the State's approval prior to publishing or making formal public presentations of statistical or analytical material based on its member enrollment.

2.14.09 Health Insurance Portability and Accountability Act Requirements (HIPAA)

Contractor will comply with the operational and information system requirements of HIPAA, including issuance of applicable certificates of credible coverage when coverage is terminated, and will report requested data to EOHHS or its designee.

2.14.10 Certification Of Data

Contractor agrees to certify the data submitted. Contractor's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, Contractor's CEO or CFO must certify the data. The certification must attest, based on best knowledge, information, and belief, as follows:

- To the accuracy, completeness and truthfulness of the data.
- To the accuracy, completeness and truthfulness of the documents specified by the State.

Contractor must submit the certification concurrently with the certified data.

2.14.11 Patient Protection and Affordable Care Act

The Contractor will comply with all compliance standards and operating rules of the Patient Protection and Affordability Care Act (PPACA) and will report data as requested by EOHHS or its designee on a timely basis.

The Contractor will provide the State with quarterly pharmacy claims information with respect to Drug Rebate Equalization (DRE) in a format that is compliant with CMS published guidelines and approved by EOHHS.

2.15 GRIEVANCE AND APPEALS

2.15.01 General

The State has established a Grievance and Appeals function through which members can seek redress against Health Plans, and through which Health Plans can seek to disenroll members who are habitually non-compliant or who pose a threat to Health Plan employees or other Members. The grievance system includes a grievance process, an appeals process, and access to the State's Fair Hearing system. The function for members seeking redress is described in *Grievance and Appeals Process for Rhody Health Partners and Rhody Health Options Program Applicants/Members* issued by the State. The function for Health Plans is described in Section 0348 of the *Rhode Island Department of Human Services Manual*. For its part, Contractor shall have written policies and procedures conforming to State requirements for resolving member complaints and for processing grievances, when requested by the member or when the time allotted for complaint resolution expires. Such procedures shall not be applicable to any disputes that may arise between Contractor and provider regarding the terms, conditions, or termination or any other matter arising under a participation agreement or regarding any payment or other issues relating to providers. Contractor agrees to participate in EOHHS/Department Fair Hearings upon request.

Contractor's policies and procedures for processing grievances must permit a provider, acting on behalf of the member and with the member's written consent, to file an appeal of an action within 30 days from the date on the Contractor's notice of action. An action means: (1) whether or not a service is a Covered Service; (2) the denial or limited authorization of a requested service, including the type or level of service; (3) the reduction, suspension, or termination of a previously authorized service; (4) the denial, in whole or in part, of payment of a service; (5) the failure to provide or authorize services within a timely manner, as defined Section 2.10 of this Agreement or (6) the failure of the Contractor to act within the timeframes, provided in *Grievance and Appeals Process for Rhody Health Partners and Rhody Health Options Program Applicants/Members* and in Section 2.15.03 of this Agreement.

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

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

The Contractor must meet the requirements specified in 42 CFR 438.10. Contractor must mail the notice of action to the member within the timeframes specified in 42 CFR 438.404. The Contractor shall also meet the requirements in 42. CFR 438.10 regarding information provided to enrollees. Written materials must use easily understood language and that enrollees are informed that alternative formats available for those with special needs who may be visually limited or have limited reading proficiency. Written notices must be translated for enrollees who speak non-English languages and oral interpretations to enrollees are available in all languages.

Contractor agrees to notify the requesting provider in writing of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

In handling grievances and appeals, Contractor must:

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

For appeals, the process must: (a) provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date) and must be confirmed in writing, unless the member or the provider requests expedited resolution; (b) provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing; (c) provide the member and his or her representative opportunity, before and during the appeals process, to examine the case file, including medical records and other documents and records considered during the appeals process; under certain circumstances certain categories of medical records and other documents may not be available to the member based on the type of record including but not limited to mental health records; and (d) include, as parties to the appeal, the member and his or her representative, or the legal representative of a deceased member's estate.

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

- The results of the resolution process and the date it was completed.

- For appeals not resolved wholly in favor of the members, the right to request a State Fair Hearing, and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request; and that the enrollee may not be held liable for the cost of those benefits if the hearing decision upholds the Contractor's action.

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

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

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

If the Contractor takes an action and the member requests a State Fair Hearing, the State must grant the member a State Fair Hearing, after the member has exhausted the Contractor's internal appeals procedures (i.e. having had a denial of both a first and second appeal). The right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the Member by the Contractor. Other information for the beneficiaries and the providers would include:

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

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

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

- The member withdraws the appeal
- The member does not request a State Fair Hearing within ten (10) days from when the Contractor mails an adverse decision.

- A State Fair Hearing decision adverse to the enrollee is made, or
- The authorization expires or authorization service limits are met.

If Contractor or the State Fair Hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, Contractor or the State must pay for those services, in accordance with State policy and regulations.

2.15.02 Complaint Resolution

It is the State's preference that Health Plans resolve member and provider complaints through internal mechanisms whenever possible. Contractor, therefore, agrees to have written policies and procedures for handling complaints registered by its members and providers. As part of the process, Contractor agrees to record and maintain a log of all complaints received, the date of their filing, and their current status and provide reports as requested.

2.15.03 Grievance Process

A grievance is a formal expression of dissatisfaction about any matter other than an "action" a member may file a grievance with the Contractor either orally or in writing. The Contractor must dispose of each grievance and provide notice in writing, as expeditiously as the member's health condition requires, within ninety (90) days from the day the Contractor receives the grievance.

2.15.04 Expedited Resolution Of Appeals

Contractor must establish and maintain an expedited review process for appeals, when 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 or health or ability to attain, maintain, or regain maximum function. The contractor must 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.

Contractor must resolve a request for expedited appeal and notify affected parties of the resolution within three (3) working days after Contractor receives the request. Contractor may extend the timeframe by up to fourteen (14) calendar days, if the member requests the extension, or Contractor can show (to the satisfaction of the State, upon the State's request) that there is need for additional information and how the delay is in the member's interest.

Contractor must ensure that punitive action is not taken against a provider who requests an expedited resolution or who supports a member's request.

If Contractor denies a request for expedited resolution of an appeal, it must transfer the appeal to the timeframe for standard resolution in accordance with *Grievance and Appeals Process for*

Rhody Health Partners and Rhody Health Options Program Applicants/Members and make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with written notice.

Should any of the above timeframes conflict with State regulations under R23-17.12-1-UR, Contractor agrees that the most stringent timeframes shall apply.

2.16 PAYMENTS TO AND FROM PLANS

2.16.01 Acceptance of State Capitation Payments

Contractor shall be capitated for all in-plan services, as described in Section 2.06 in the amount specified in Attachment G, and such reimbursement shall be subject to all conditions specified in this Agreement.

The monthly capitation rates set forth in Attachment G shall not be subject to change during the effective period therein specified except: (1) by Federal or State law; or (2) to cover additional services not currently included in Attachment A or to reflect a reduction in covered services; or (3) unless such change has been negotiated in accordance with Section 3.03 of the Agreement. Such change in rates shall not be effective until agreed in writing by the parties or, in the event of a change due to (1) above, until written notice by the State to the Contractor.

The State shall make Capitation Payments to Contractor on a monthly basis via electronic funds transfer in the following manner:

- For Rhody Health Options members on or before the last day of every month, Contractor shall receive a roster of individuals projected to be enrolled in or assigned to Contractor for the following month.
- For Rhody Health Options members on or before the fifth (5th) calendar day of every month, Contractor shall receive capitation payments for individuals projected to be enrolled or assigned to Contractor for that month, based on the roster provided at the end of the preceding month (see above). These payments shall reimburse Contractor for services rendered to these individuals during that month.

Contractor agrees to accept enrollment information and capitation payments in this manner and shall have written policies and procedures for receiving and processing capitation payments.

2.16.01.01 Transitional Rate

The development the rates included in Attachment G includes a “transitional” component. When a Rhody Health Options member in premium rating group ‘four’ (4) transitions to the community, the Contractor will continue to receive the premium rate ‘four’ (4) for a period of approximately ninety (90) days from the end of the month in which the transition occurs. Conversely, when a RHO member in premium rating group ‘one’ (1), ‘two’ (2) ‘three’ (3) or ‘five’ (5) transitions to a nursing home, the Contractor will continue to receive the premium rate

one (1), two (2), three (3) or five (5) for a period of approximately (90) days from the end of the month in which the transition occurs. In addition, all rates were developed net of patient share liability.

2.16.02 Payments to Providers

2.16.02.01 General

The State believes that one of the advantages of a managed care system is that it permits Health Plans and providers to enter into creative payment arrangements intended to encourage and reward effective utilization management and quality of care. However, Contractor agrees to make timely payments to both its contracted and non-contracted providers, subject to the conditions described below. Contractor also agrees to abide by the special reimbursement provisions for FQHCs and RHCs described below.

Subcontractors and referral providers may not bill enrollees any amount greater than would be owed if the entity provided the services directly (i.e. no balance billing by providers).

2.16.02.02 Retroactive Eligibility Period

Contractor shall not be responsible for any payments owed to providers for services that were rendered prior to a member's enrollment, even if they fell within any applicable period of retroactive eligibility for Medicaid.

2.16.02.03 In-Network (Contracted) Services

Contractor shall be responsible for making timely payment and meet the requirements of 42 CFR 447.45 and 42 CFR 447.46 for Medically Necessary, Covered Services rendered by in-network providers when:

- Services were Emergency Services
- Services were rendered under the terms of the Health Plan's contract with the provider
- Services were prior authorized

A claim means (1) a bill for services, (2) a line item of service, or (3) all services for one enrollee within a bill. A clean claim means one that can be processed without additional information from the provider of service or from a third party. It includes a claim with errors originating in the State's claims system. 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. Timely payment means within thirty (30) days of receipt of a "clean claim" for reimbursement. Timely payment is judged by the date that the contractor receives the claim as indicated by its date stamped on the claim and the date of payment is the date of the check or other form of payment.

Contractor shall make payment for Post-Stabilization Services in conformance with 42 CFR 438.114(e).

Contractor shall process crossover claims (claims that include primary payment from Medicare) in accordance with Section 1902(a)(10)(E) of the Social Security Act and as outlined in the CMS Informational Bulletin CIB 06-07-13.

Providers are strictly prohibited under Section 1902(n)(3) of the Social Security Act from seeking to collect any additional amount from a member for Medicare deductibles or coinsurance, even if the RHO Health Plan's payment is less than the total amount of the Medicare deductibles and coinsurance.

2.16.02.04 Out-of-Network and Out-of-State Providers

Contractor shall be responsible for making timely payments and meet the requirements of 42 CFR 447.45 and 42 CFR 447.46 to out-of-network providers for medically necessary, covered services when:

- Services were Emergency Services
- Services were prior authorized

The same definitions of a claim and a clean claim also apply to out-of-network and out-of-State providers as for in-network providers, as described in the above section 2.16.02.03.

Under these terms, Contractor shall not be financially liable for services rendered to treat a non-emergent condition in a hospital emergency room (except to assess whether a condition warrants treatment as Emergency Services, or as required elsewhere in law), unless the services were prior authorized or otherwise conformed to the terms of Contractor's contract with the provider. The *Rhody Health Partners and Rhody Health Options Program Emergency Medical Services Policy and Procedures*, issued by the State, guide this requirement.

For services provided to eligible and enrolled members, claims for services from a provider may be paid at established Rhode Island Medicaid fees that are in effect at the time of service when the following two conditions are met and the provider does not have an existing agreement with the Contractor:

- a) The provider must be an out-of-State provider, and
- b) The provider must be out-of-network

For services provided to members, claims from out-of-network providers may be paid at established Rhode Island Medicaid fee-for-service rates that are currently in effect at the time of service or at a fee negotiated between the Contractor and the provider of services.

Any provider of Emergency Services that does not have in effect a contract with Contractor must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the enrollee received Medical Assistance other than through enrollment in Rhody Health Options.

Contractor shall make payment for Post-Stabilization Services in conformance with 42 CFR 438.114(e).

2.16.02.05 FQHCs/RHCs

If Contractor includes FQHCs or RHCs in its network, it agrees to address cost issues related to the scope of services rendered by these providers and must reimburse them either on a capitated (risk) basis considering adverse selection factors or on a cost-related basis. Contractor agrees to reimburse FQHCs/RHCs at a rate not less than that paid for comparable services provided by non-FQHC/RHC based providers.

2.16.02.06 Hospital Services

The Contractor shall be required, to implement reforms required by Rhode Island State Legislation (i.e. R.I. General Law Chapter 40-8, Section 40-8-13.4) which stipulates certain requirements for payments to hospitals. Negotiated increases in inpatient hospital payments for the twelve (12) month period beginning January 1, 2012 may not exceed the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price index for the applicable period. All hospitals licensed in Rhode Island shall accept such payment rates as payment in full; and for all such hospitals, compliance with these requirements shall be a condition of participation in the Rhode Island Medicaid program.

The Contractor shall provide quarterly reporting regarding payments as stipulated by R.I. General Law Chapter 40-8, Section 40-8-13.4.

2.16.02.07 Nursing Homes

Contractor shall negotiate the reimbursement rates with nursing home providers. Contractor shall consider establish rates that consider the acuity of care provided to members as well as contain quality indicators. As a condition for payment the contractor must ensure that the Nursing Home has met all federal and state OBRA/PASRR requirements for all individuals seeking admission or readmission to a nursing home, subsequent to the provisions in 42 CFR 483.100-138 and Rhode Island Rules and Regulations for Medical Assistance Section 0378.05. The State shall approve the reimbursement method used to reimburse nursing facilities.

2.16.02.08 Liability during an Active Grievance or Appeal

Contractor shall not be liable to pay claims to providers if the validity of the claim is being challenged by Contractor through a grievance or appeal, unless Contractor is obligated to pay the claim or a portion of the claim through its contract with the provider.

2.16.02.09 Limit On Payment to Other Providers

In accordance with 42 CFR 438.60, no payment shall be made for services furnished by a provider other than Contractor or by one of Contractor's participating providers, if the services were available under the contract.

2.16.02.10 Physician Incentive Plans

Contractor will not place physicians at substantial financial risk for services which avoid costs by limiting referrals to specialty care. Contractor will comply with Federal definitional, operational, and reporting requirements governing physician incentive plans as defined at 42 CFR 422.208 and 210; 434.67, 434.70 and 42 CFR 1003.

2.16.02.11 Actuarial Basis

The actuarial basis for the computation of capitated rates is provided in Attachment L of this Agreement.

2.16.02.12 Prohibition on Restocking and Double Billing of Prescription Drugs

To conform to Section 1903(i) (10) of the Social Security Act (42 U.S.C. 1396b(i)), 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).

2.16.02.13 Payment Adjustment for Provider Preventable Conditions

The Contractor shall meet the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1092(a)(6) , and 1903, with respect to non-payment for provider preventable conditions for Health Care-Acquired Conditions and Other Provider-Preventable Conditions.

2.16.03 Cost Sharing

Any cost sharing imposed on Medicaid enrollees in in accordance with 42 CFR 447.50 through 42 CFR 447.60.

The State shall have sole responsibility for determining the cost-sharing responsibilities for those members in LTSS (nursing homes and community-based services). The State shall notify members of their cost-sharing responsibilities including the amounts of cost-sharing. The State shall notify the Contractor of a member's cost-sharing responsibilities.

The Contractor shall have policies, practices and procedures to ensure that cost-sharing responsibilities are met. Members are required to pay providers monthly of their cost-sharing responsibilities.

2.16.04 Third-Party Liability

Third-Party Liability ("TPL") refers to any individual entity (e.g., insurance company) or program (e.g., Medicare) that may be liable for all or part of Member's health coverage including subrogation. Under Section 1902(a) (25) of the Social Security Act, the State is required to take

all reasonable measures to identify legally liable third parties and treat verified TPL as a resource of the Medicaid recipient.

Contractor agrees to take responsibility for identifying TPL for members and reporting such TPL source to the State within five (5) days of the source becoming known to Contractor, in a format determined by the State. Contractor shall collect and retain all Third-Party Liability collections.

Contractor agrees to cooperate with the State in the implementation of RI General Laws 40-6-9.1 by participating in the matching of data available to the State and to the Contractor through an electronic file match. The matching of such data is critical to the integrity of the Medical Assistance program and the use of public funds. Requests made of the Contractor by the State will be made at such intervals as deemed necessary by the State to participate in the data matching. Contractor shall respond with the requested data within five (5) business days.

2.16.05 Reinsurance

Contractor shall be required to obtain reinsurance coverage from a source other than the State. Proof of such reinsurance is a condition of contract award. However, the State reserves the right to review Contractor reinsurance coverage and to require changes to that coverage in the form of lower thresholds if considered necessary based on the Contractor's overall financial condition. Contractor may not change the thresholds from those in Attachment K of this Agreement without the prior written consent of the State.

2.16.06 Reserving

As part of its accounting and budgeting function, Contractor shall establish an actuarially sound process for estimating and tracking incurred but not reported claims (IBNRs). 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 (RBUCs). 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.

2.16.07 Claims Processing and MIS

Contractor agrees to have claims processing system and Management Information System (MIS) sufficient to support the provider payment and data reporting requirements specified elsewhere in this chapter. Contractor also shall be prepared to document its ability to expand claims processing or MIS capacity should either or both be exceeded through the enrollment of members.

2.16.08 Audits

Pursuant to Section 3.08 of the Agreement, the State, or its designees, maintains the right to conduct with reasonable notice whatever audit functions are necessary to verify proper invoicing by Contractor for provision of services, proper payments by the State to Contractor, and proper identification of TPL in accordance with Section 2.16.04 of this Agreement.

In the event that audit liabilities arising from any discrepancies in payments are discovered during the course of such audits, the net effect of which resulted in an overpayment to Contractor, the State may either:

- Make a demand for repayment of overpayment amount within thirty (30) days
- Offset the amount of overpayment from invoices submitted to provide for payment and/or by the next monthly payment cycle.
- Refer the matter to the Department of Attorney General Medicaid Fraud Unit for investigation and/or seek interest in funds pursuant to RI General Laws Section 40-8.2-22.

In the event that audits discover underpayment to Contractor, the State will process a corrective payment within thirty (30) days.

Any dispute or controversy encountered pursuant to this provision shall be resolved pursuant to the guidelines specified in Section 3.02.05 of the Agreement.

2.16.09 Disproportionate Share Payments to Hospitals

The State will retain responsibility for disproportionate share payments to hospitals, if any. Contractor shall not be responsible for these payments.

2.16.10 Incentive Payments for Attainment of Performance Goals

The State has established a system for incentive payments to Health Plans for attainment of the performance goals listed in Attachment J to this Agreement.

Incentive payments will not exceed limits as described in 42 CFR 438.6 and 42 CFR 438.814.

2.17 HEALTH PLAN FISCAL STANDARDS

2.17.01 General

The Department of Business Regulation regulates the financial stability of all licensed Health Plans in Rhode Island. Contractor, therefore, agrees to comply with all Rhode Island Department of Business Regulation standards in addition to specific Rhody Health Options standards described in this Section.

2.17.02 Financial Benchmarks

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. The areas in which financial benchmarks have been established include the following:

- Current ratio
- Plan equity per enrollee
- Administrative expenses as a percent of capitation
- Net medical costs as a percent of capitation
- IBNR and RBUC levels, including days claims outstanding

Contractor agrees to provide the information necessary for calculating benchmark levels (see the following section). Contractor also agrees to comply with corrective actions ordered by the State to address any identified deficiencies with respect to financial benchmarks.

2.17.03 Financial Data Reporting

Contractor agrees to comply with the *Rhody Health Partners and Rhody Health Options Health Plan Financial Reporting Program and Procedures*.

2.17.04 Audit

In the case where the Agreement amount identified in Section 2.16 is at least twenty-five thousand dollars (\$25,000) in any year, Contractor must submit an acceptable audited financial statement prepared by an independent auditor within nine (9) months of the end of the Contractor's fiscal year. The audit must provide full and frank disclosure of all assets, liabilities, changes in fund balances, and all revenues and expenditures.

2.18 RECORDS RETENTION

2.18.01 General

Contractor agrees to maintain books and records relating to Rhody Health Options services and expenditures, including reports to the State and source information used in preparation of these reports. These records include but are not limited to financial statements, records relating to quality of care, medical records, and prescription files.

Contractor also agrees to comply with all standards for record keeping specified by the State. Operational data and medical record standards are described below. In addition, the Contractor must agree to permit inspection of its records under the terms specified in Section 2.16.07 and in Article III of the Agreement.

2.18.02 Operational Data Reports

Contractor agrees to retain the source records for its data reports for a minimum of ten (10) years and must have written policies and procedures for storing this information. Financial records must be retained for at least ten (10) years.

2.18.03 Medical Records

Contractor agrees to preserve and maintain all medical records for a minimum of ten (10) years from expiration of this Agreement.

If records are related to a case in litigation, then these records should be retained during litigation and for a period of seven (7) years after the disposition of litigation.

2.19 COMPLIANCE

2.19.01 General Requirements

In accordance with 42 CFR 438.608, the Contractor shall have administrative and management arrangements, including a mandatory written compliance plan, which are designed to guard against fraud and abuse. An electronic copy of the Contractor's written compliance plan, including all relevant operating policies, procedures, workflows, and relevant chart of organization must be submitted to the Rhode Island EOHHS for review and approval within 90 days of the execution of this Agreement and then on an annual basis thereafter.

The Contractor's compliance plan must address the following requirements:

- Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards
- The designation of a compliance officer and a compliance committee that are accountable to senior management
- Effective training and education for the compliance officer and the organization's employees
- Effective lines of communication between the compliance officer and the organization's employees
- Enforcement of standards through well-publicized guidelines
- Provision for internal monitoring and auditing
- Provision for prompt response to detected offenses, and for development of corrective action initiatives

2.19.02 Prohibited Affiliations with Individuals Debarred by Federal Agencies

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

- (1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in

non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

- (2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (1) of this section.

The relationships described are as follows:

- (1) A director, officer, or partner of the MCO.
- (2) A person with beneficial ownership of five (5) percent or more of the MCO s equity.
- (3) A person with employment, consulting, or other arrangement with the MCO for the provision of items and services that are significant and material to the MCO s obligations under its contract with the State.

2.19.03 Disclosure of the Contractor's Ownership and Control Interest

In accordance with 42 CFR 455.104, the Contractor must submit completed forms documenting full and complete disclosure of the Contractor's ownership and controlling interest, formatted in conformance with requirements established by EOHHS. Disclosures will be due at any of the following times:

1. Upon the Contractor's submitting the proposal in accordance with the State's procurement process
2. Upon the Contractor's executing the contract with the State
3. Upon renewal or extension of the contract
4. Within thirty-five (35) days after any change in ownership of the Contractor

The following information shall be disclosed by the Contractor, based on 42 CFR 455.104:

- (1)(i) The name and address of any person (individual or corporation) with an ownership or control interest in the Contractor. The address for corporate entities must include as applicable primary business address, every business location, and Post Office (P.O.) Box address.
- (1)(ii) Date of birth and Social Security Number (in the case of an individual).
- (1)(iii) Other tax identification number (in the care of a corporation) with any ownership or control interest in the Contractor or in any subcontractor in which the Contractor has five (5) percent or more interest.
- (2) Whether the person (individual or corporation) with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the Contractor has a five (5) percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
- (3) The name of any other disclosing entity in which an owner of the Contractor has an ownership or control interest.
- (4) The name, address, date of birth, and Social Security Number of any managing employee of the Contractor.

The Contractor must keep copies of all ownership and control interest requests from EOHHS and the Contractor's responses to these disclosure requests. Copies of these requests and the Contractor's responses to them must be made available to the Secretary of the United States Department of Health and Human Services or to the EOHHS upon request. The Contractor must submit copies of the completed disclosure forms to the Secretary of the United States Department of Health and Human Services or to EOHHS within thirty-five (35) days of a written request.

2.19.04 Disclosure by Providers: Information on Ownership and Control

In accordance with 42 CFR Section 455.104, the Contractor must require each disclosing entity to disclose the following information:

- (1)(i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. The address for corporate entities must include as applicable primary business address, every business location, and Post Office (P. O.) Box address.
- (1)(ii) Date of birth and Social Security Number (in the case of an individual).
- (1)(iii) Other tax identification number (in the case of a corporation) with any ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has five (5) percent or more interest.
- (2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a five (5) percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
- (3) The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.
- (4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity.

An individual is considered to have an ownership or control interest in a provider entity if it has direct or indirect ownership of five (5) percent or more, or is a managing employee (such as a general manager, business manager, administrator or director) who exercises operational or managerial control over the entity part thereof, or who directly or indirectly conducts the day-to-day operations of the entity or part thereof, as defined in section 1126(b) of the Social Security Act and under 42 CFR Section 1001.1001(a)(1).

Any disclosing entity that is subject to periodic certification by the Contractor of compliance with Medicaid standards (such as at the time of initial credentialing and re-credentialing by the Contractor) must supply the information as specified in this section in conformance with requirements established by the EOHHS. Any disclosing entity that is not subject to periodic certification of its compliance within the prior 12-month period must submit the information to the Contractor before entering into a contract or agreement with the Contractor.

Disclosures must also be provided by any provider or disclosing entity within thirty-five (35) days after any change in ownership of the disclosing entity.

Updated information must be furnished to the Secretary of the United States Department of Health and Human Services or to EOHHS at intervals between recertification or contract renewals, within thirty-five (35) days of a written request.

The Contractor shall not approve a provider agreement and must terminate an existing provider agreement or contract if the provider fails to disclose ownership or control information as required by this section.

2.19.05 Disclosure by Providers: Information Related to Business Transactions

In accordance with 42 CFR Section 455.105, the Contractor must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary of the United States Department of Health and Human Services or to EOHHS on request full and complete information related to business transactions.

A provider must submit, within thirty-five (35) days of the date of a request by the Secretary of the United States Department of Health and Human Services or to EOHHS, full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than twenty-five thousand (\$25,000) dollars during the 12-month period ending on the date of request; and any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor during the five year period ending on the date of the request.

This information must be submitted by a provider or a subcontractor to the Secretary of the United States Department of Health and Human Services or to the Rhode Island EOHHS within thirty-five (35) days of a written request.

2.19.06 Disclosure by Providers: Information on Persons Convicted of Crimes

In accordance with 42 CFR Section 455.106, before the Contractor enters into or renews a provider agreement, or at any time upon written request by EOHHS, the provider must disclose the identity of any person who:

- (1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and
- (2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Federal Title XX program since the inception of those programs.

An individual is considered to have an ownership or control interest in a provider entity if it has direct or indirect ownership of five (5) percent or more, or is a managing employee (such as a general manager, business manager, administrator or director) who exercises operational or

managerial control over the entity or part thereof, or who directly or indirectly conducts the day-to-day operations of the entity or part thereof, as defined in section 1126(b) of the Social Security Act and under 42 CFR Section 1001.1001(a)(1).

The Contractor shall promptly notify EOHHS in writing within ten (10) business days in the event that the Contractor identifies an excluded individual with an ownership or control interest.

The Contractor may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any Federal health care program.

The Contractor may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure as required in this section.

2.19.07 Disclosures Made by Providers to the Contractor

In accordance with 42 CFR 1002.3 and 42 CFR 1001.1001, before the Contractor enters into or renews a provider agreement, or at any time upon written request by EOHHS, the Contractor shall disclose to EOHHS in writing the identity of any person who:

- (A) Has been convicted of a criminal offense as described in Sections 1128(a) and 1182(b) (1), (2), or (3) of the Social Security Act
- (B) Has had civil money penalties or assessments imposed under Section 1129A of the Social Security Act; or
- (C) Has been excluded from participation in Medicare, Medicaid, or any Federal or State health care programs and such a person has:
 - (1) A direct or indirect ownership interest of five (5) percent or more in the entity;
 - (2) Is the owner of a whole or part interest in any mortgage, deed of trust, note for other obligation secured (in whole or in part) by the entity or any of the property assets thereof, in which whole or part interest is equal to or exceed five (5) percent of the total property and assets of the entity;
 - (3) Is an officer or director of the entity, if the entity is organized as a corporation;
 - (4) Is partner in the entity, if the entity is organized as a partnership;
 - (5) Is an agent of the entity; or
 - (6) Is a managing employee, that is (including a general manager, business manager, administrator or director) who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity or part thereof, or directly or indirectly conducts the day-to-day operations of the entity or part thereof, or
 - (7) Was formerly described in paragraph (a)(1)(ii)(A) of this section, but is no longer so described because of a transfer of ownership or control interest to an immediate family member or a member of the person's household as defined in paragraph (a) (2) of this section, in anticipation of or following a conviction, assessment of a CMP, or imposition of an exclusion.

For the purposes of this section, the following terms (agent, immediate family Member, indirect ownership interest, member of household, and ownership interest) shall have the meaning specified in 42 CFR 1001.1001:

Agent means any person who has express or implied authority to obligate or act on behalf of an entity.

Immediate family member means a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, daughter-in-law, son-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.

Indirect ownership interest includes an ownership interest through any other entities that ultimately have an ownership interest in the entity in issue. (For example, an individual has a ten (10) percent ownership interest in an entity at issue if he or she has a twenty (20) percent ownership interest in a corporation that wholly owns a subsidiary that is a fifty (50) percent owner of the entity in issue.)

Member of household means, with respect to a person, any individual with whom they are sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a Member of household.

Ownership interest means an interest in:

- (i) The capital, the stock, or the profits of the entity, or
- (ii) Any mortgage, deed, trust or note, or other obligation secured in whole or party by the property or assets of the entity.

The Contractor must notify EOHHS in writing within ten (10) business days of the receipt of any disclosures which have been made to the Contractor.

The Contractor must promptly notify EOHHS in writing within ten (10) business days of any action that it takes to deny a provider's application for enrollment or participation (e.g., a request for initial credentialing or for re-credentialing) when the denial action is based on the Contractor's concern about Medicaid program integrity or quality. Provider credentialing requirements are addressed further in Section 2.13.04.

The Contractor must also promptly notify EOHHS of any action that it takes to limit the ability of an individual or entity to participate in its program, regardless of what such an action is called, when this action is based on the Contractor's concern about Medicaid program integrity or quality. This includes, but is not limited to, suspension actions and settlement agreements and situations where an individual or entity voluntarily withdraws from the program to avoid a formal sanction.

The Contractor may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any Federal health care program.

The Contractor may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure as required in this section.

ARTICLE III: CONTRACT TERMS AND CONDITIONS

3.01 GENERAL PROVISIONS

3.01.01 Contract Composition and Order of Precedence

Any submission made by Contractor in response to the State's Letter of Intent (Bid Specifications) Document shall be incorporated into this Agreement by reference. This Agreement shall be in conformity with, and shall be governed by, all applicable laws of the Federal government and the State of Rhode Island.

The component parts of the Agreement between the State of Rhode Island and Contractor shall, in addition to the foregoing, consist of Addenda I-XI and:

- Attachment A:** Schedule of In-Plan Benefits
- Attachment B:** Schedule of Out-of-Plan Benefits
- Attachment C:** Schedule of Non-Covered Services
- Attachment D:** Nutrition Standards for Adults
- Attachment E:** FQHC and RHC Services
- Attachment F:** Contractor's Locations
- Attachment G:** Contractor's Capitation Rates
- Attachment H:** Contractor's Insurance Certificates
- Attachment I:** Rate-Setting
- Attachment J:** Performance Goals
- Attachment K:** Special Terms and Conditions
- Attachment L:** Care Management Protocols
- Attachment M:** Nursing Home Transition including *Rhode to Home* Requirements
- Attachment N:** Quality and Operations Reporting Requirements
- Attachment O:** Medicare Readiness Checklist

3.01.02 Integration Clause

This Agreement shall represent the entire agreement between the parties and will supersede all prior negotiations, representations, or agreements, either written or oral, between the parties relating to the subject matter hereof. This Agreement shall be independent of, and have no effect upon, any other contracts of either party, except as set forth to the contrary within.

3.01.03 Subsequent Conditions

Contractor shall comply with all requirements of this Agreement and the State shall have no obligation to enroll any recipients into the Health Plan until such time as all of said requirements have been met.

3.01.04 Effective Date and Term

All terms and conditions stated herein are subject to final approval from CMS. This Agreement for Phase I shall be effective November 1, 2013. Phase I contract is for three (3) years and ends of June 30, 2016. The Agreement shall be signed by Contractor and the Executive Office of Health and Human Services (EOHHS) and approved by CMS. The contract shall continue in force until June 30, 2016, with three additional one year option periods, unless terminated prior to that date by provisions of this Agreement or extended by mutual agreement of the parties by amendment as provided for in Section 3.03.

Option periods are exercised by a mutual agreement of the parties through a contract amendment.

EOHHS continues to pursue the opportunity to enter into a three-way contract with CMS for the full financial alignment of Medicare and Medicaid. In the event EOHHS issues procurement during the term of this Agreement for new RHO participants, EOHHS would not consider the Contractor's participation in this three-way contract as subject to such procurement. Under such procurement, EOHHS will not auto-assign or reassign Neighborhood's Phase I members and will allow these members the option to remain with the health plan. All related provisions in Section 3.11.04 are still in effect during this contract term.

3.01.05 Contract Administration

This Agreement shall be administered for the State by the Rhode Island Executive Office of Health and Human Services (EOHHS). The EOHHS Director has appointed Deborah J. Florio an Administrator to be responsible for all matters related to this Agreement.

The Administrator, or his or her designee, shall be Contractor's primary liaison in working with other State staff and with the State's private program management contractor. In no instance shall Contractor refer any matter to the EOHHS Director or any other official in Rhode Island unless initial contact, both verbal and in writing, regarding the matter has been presented to the Administrator or designee.

Whenever the State is required by the terms of this Agreement to provide written notice to Contractor, such notice shall be signed by the EOHHS Administrator or designee, or, in that individual's absence or inability to act, such notice shall be signed by the EOHHS Director. All notices regarding the failure to meet performance requirements and any assessments of damages under the provisions set forth in this article shall be issued by the EOHHS Administrator or designee.

3.01.06 Contract Officers

EOHHS will designate a Contract Officer. Such designation may be changed during the period of this Agreement only by written notice. Contractor's Chief Executive Officer shall be authorized and empowered to represent Contractor with respect to all matters within such area of authority related to implementation of this Agreement.

3.01.07 Liaisons

Contractor shall designate an employee of its administrative staff and EOHHS hereby designates its Contract Officer, who shall act as liaisons, between Contractor and EOHHS for the duration of the Agreement. The Contract Officer shall receive all inquiries regarding this Agreement and all required reports. Contractor also shall designate a Member of its senior management who shall act as a liaison between Contractor's senior management and EOHHS when such communication is required.

3.01.08 Notification of Administrative Changes

Contractor shall notify EOHHS of all changes materially affecting the delivery of care or the administration of its program. An example of such a material change would be a change which could affect Contractor's ability to meet performance standards.

3.01.09 Notices

Any notice under this Agreement required to be given by one party to the other party, shall be in writing and given by certified mail, return receipt requested postage pre-paid or overnight carrier which requires a receipt, of delivery in hand with a signed for receipt, and shall be deemed given upon receipt.

Notices shall be addressed as follows:

In case of notice to Contractor: Chief Executive Officer

In case of notice to EOHHS: EOHHS Administrator, 600 New London Avenue,
Hazard Building #74, Cranston, RI 02920

Either party may change its address for notification purposes by mailing a notice stating the change and setting forth the new address.

3.01.10 Authority

Each party has full power and authority to enter into and perform this Agreement, except to the extent noted in Section 3.01.11 below, and by signing this Agreement, each party certifies that the person signing on its behalf has been properly authorized and empowered to enter into this Agreement. Each party further acknowledges that it has read this contract, understands it, and agrees to be bound by it.

3.01.11 Federal Approval of Contract

Under 42 CFR 438.6, CMS has final authority to approve all comprehensive risk contracts between states and contractors in which payment exceeds one-hundred thousand dollars (\$100,000.00). If CMS does not approve a contract entered into under the Terms & Conditions described herein, the Agreement will be considered null and void.

3.02 INTERPRETATIONS AND DISPUTES

3.02.01 Conformance with State and Federal Regulations

Contractor agrees to comply with all State and Federal laws, regulations, and policies as they exist or as amended that are or may be applicable to this Agreement, including those not specifically mentioned in this article. In the event that Contractor may, from time to time, request the State to make policy determinations or to issue operating guidelines required for proper performance of this Agreement, the State shall do so in a timely manner, and Contractor shall be entitled to rely upon and act in accordance with such policy determinations and operating guidelines and shall incur no liability in doing so unless Contractor acts negligently, maliciously, fraudulently, or in bad faith.

3.02.02 Waivers

No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Agreement shall be waived except by the written agreement of the parties and approval of CMS. Forbearance or indulgence in any form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply. Notwithstanding any such forbearance or indulgence, the other party shall have the right to invoke any remedy available under law or equity until complete performance or satisfaction of all such covenants, conditions, duties, obligations, and undertakings.

Waiver of any breach of any term or condition in this Agreement shall not be deemed a waiver of any prior or subsequent breach. No term or condition of this Agreement shall be held to be waived, modified, or deleted except by an instrument, in writing, signed by the parties hereto.

3.02.03 Severability

If any provision of this Agreement (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both the State and Contractor shall be relieved of all obligations arising under such provision; if the remainder of this Agreement is capable of performance, it shall not be affected by such declaration or finding and shall be fully performed. To this end, the terms and conditions defined in this Agreement can be declared severable.

3.02.04 Jurisdiction

This Agreement shall be governed in all respects by the Laws and Regulation of the State of Rhode Island. Contractor agrees to submit to the jurisdiction of the State of Rhode Island should any dispute, disagreement or any controversy of any kind arise or result out of the terms, conditions or interpretation of this Agreement. Contractor, by signing this Agreement, agrees and submits to the jurisdiction of the courts of the State of Rhode Island and agrees that venue for any legal proceeding against the State regarding this Agreement shall be filed in the Superior Court of Providence County.

3.02.05 Disputes

Prior to the institution of arbitration or litigation concerning any dispute arising under this Agreement, the Chief Purchasing Officer of the State of Rhode Island is authorized, subject to any limitations or conditions imposed by regulations, to settle, compromise, pay, or otherwise adjust the dispute by or against or in controversy with, a Contractor relating to a contract entered into by the Department of Administration on behalf of the State or any State agency, including a

claim or controversy based on contract, mistake, misrepresentation, or other cause for contract modification or rescission, but excluding any claim or controversy involving penalties or forfeitures prescribed by statute or regulation where an official other than the Chief Purchasing Officer is specifically authorized to settle or determine such controversy.

A “contract dispute” shall mean a circumstance whereby a Contractor and the State user agency are unable to arrive at a mutual interpretation of the requirements, limitations, or compensation for the performance of a contract.

The Chief Purchasing Officer shall be authorized to resolve contract disputes between Contractors and user agencies upon the submission of a request in writing from either party, which request shall provide:

- A description of the problem, including all appropriate citations and references from the contract in question.
- A clear statement by the party requesting the decision of the Chief Purchasing Officer’s interpretation of the contract.
- A proposed course of action to resolve the dispute.
- The Chief Purchasing Officer shall determine whether:
- The interpretation provided is appropriate.
- The proposed solution is feasible.
- Another solution may be negotiable.

If a dispute or controversy is not resolved by mutual agreement, the Chief Purchasing Officer or his designee shall promptly issue a decision in writing after receipt of a request for dispute resolution. A copy of the decision shall be mailed or otherwise furnished to Contractor. If the Chief Purchasing Officer does not issue a written decision within thirty (30) days after written request for a final decision, or within such longer period as might be established by the parties to the contract in writing, then Contractor may proceed as if an adverse decision had been received.

In the event an adverse decision is rendered, Contractor may proceed to Superior Court and commence litigation against the State in accordance with Section 3.02.04. If damages awarded on any contract claim under this section exceed the original amount of the contract, such excess shall be limited to an amount which is equal to the amount of the original contract. No person, firm, or corporation shall be permitted more than one (1) money recovery upon a claim for the enforcement of or for breach of contract with the State.

In no event, shall the terms of this section apply to disputes between providers and Contractor nor shall the State be entitled to arbitrate such disputes.

Any fraudulent activity may result in criminal prosecution.

3.03 CONTRACT AMENDMENTS

The Executive Office may permit changes in the scope of services, time of performance, or approved budget of the Contractor to be performed hereunder. Such changes, which are mutually agreed upon by the Executive Office and the Contractor, must be in writing and shall be made a part of this agreement by numerically consecutive amendment excluding “Special Projects”, if applicable, and are incorporated by reference into this Agreement.

Special Projects are defined as additional services available to the Executive Office on a time and materials basis with the amounts not to exceed the amounts referenced on the Contractor’s RFP cost proposal or as negotiated by project or activity. The change order will specify the scope of the change and the expected completion date. Any change order shall be subject to the same terms and conditions of this Agreement unless otherwise specified in the change order and agreed upon by the parties. The parties will negotiate in good faith and in a timely manner all aspects of the proposed change order.

An approved contract amendment is required whenever a change affects the payment provisions, the scope of work, or the length of this Agreement. Formal contract amendments will be negotiated by the State with Contractor whenever necessary to address changes to the terms and conditions, the costs of, or the scope of work included under this Agreement. An approved contract amendment means one approved by EOHHS, Contractor, and all other applicable State and Federal agencies prior to the effective date of such change.

An approved contract amendment shall be in writing and shall be signed by EOHHS, Contractor and all other applicable State and Federal agencies prior to the effective date of the Amendment.

The State and Contractor shall use contract amendments to reduce or increase Capitation Payments caused either through changes in the scope of benefits as a result of changes in Federal or State law or regulations or any other reason, scope of benefits otherwise covered by the State, the beneficiaries covered by this Agreement, and/or extension of the term of this Agreement. Annual adjustments in capitation payments shall be made in conformance with actuarial soundness provisions found in 42 CFR 438.6(c) for actuarial soundness, for any applicable period of time, taking into account the budget neutrality limitations placed on Rhode Island Medicaid by CMS.

3.04 PAYMENT

3.04.01 Capitation Payments

Contractor shall receive Capitation Payments in the manner described in Section 2.16 of this Agreement. All payments will be subject to the availability of funds. Adjustments to Capitation Payments due to Member reconciliations will be made in the month following their discovery.

3.04.02 Payments to Subcontractors and Providers

The State shall bear no liability (other than liability for making payments required by this Agreement) for paying the valid claims of Health Plan subcontractors, including providers and suppliers (see also Section 3.05.05, *Subcontracts*).

3.04.03 Liability For Payment

Contractor agrees that members are not held liable for the following:

- Contractor's debts, in the event of Contractor's insolvency,
- Services provided to the member, for which the State does not pay Contractor, or the State, or Contractor, does not pay the individual or the health care provider that furnishes the services under a contractual, referral, or other arrangement, or
- Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the Member would owe if Contractor provided the services directly

3.05 GUARANTEES, WARRANTIES, AND CERTIFICATIONS

3.05.01 Contractor Certification of Truthfulness

By signing this Agreement, Contractor certifies, under penalty of law, that the information provided herein is true, correct, and complete to the best of Contractor's knowledge and belief. Contractor acknowledges that should investigation at any time disclose any misrepresentation or falsification, this Agreement may be terminated by EOHHS upon written notice specifying the misrepresentation or falsification without penalty of further obligation by EOHHS.

3.05.02 Contractor Certification of Legality

Contractor represents, to the best of its knowledge, that it has complied with and is complying with all applicable statutes, orders, and regulation promulgated by any Federal, State, municipal, or other governmental authority relating to its property and the conduct of operations; and, to the best of its knowledge, there are no violations of any statute, order, rule, or regulation existing or threatened.

3.05.03 Contractor Certification of HMO Licensure

Contractor certifies that it meets all the requirements for a State-defined HMO as specified in the laws of Rhode Island and the rules of the Rhode Island Department of Business Regulation. If, at any time during the term of this Agreement, Contractor incurs loss of State approval and/or qualification as a HMO, such loss shall be reported to EOHHS. Such loss may be grounds for termination of the Agreement under the provisions of Section 3.10.

If Contractor is not a State-licensed HMO, Contractor certifies that it meets the other requirements specified in Section 2.02 of this Agreement. If Contractor is not a State-licensed HMO and, at any time during the term of this Agreement, fails to meet the other requirements set forth in Section 2.02 of this Agreement, such failure shall be reported to EOHHS. Such failure may be grounds for termination of this Agreement under the provisions of Section 3.10.

3.05.04 Performance Bond or Substitutes

Contractor shall furnish a performance bond, a cash deposit, or an irrevocable letter of credit. The performance bond shall be in a form acceptable to the State. If a cash deposit is used, it should be placed in different financial institutions to a maximum of one-hundred thousand dollars (\$100,000.00) per deposit. If a letter of credit is used, the letter should be issued by a

bank doing business in the State of Rhode Island and insured by the Federal Deposit Insurance Corporation; a savings and loan institution doing business in the State of Rhode Island and insured by the Federal Savings and Loan Insurance Corporation; or a credit union doing business in the State of Rhode Island and insured by the National Credit Union Administration.

The amount of the performance bond, cash deposit, or letter of credit shall be a minimum of one dollar for each capitation dollar paid in the month, or as determined by the EOHHS Administrator or designee. The total capitation amount shall include projected SOBRA payments. The State shall evaluate the enrollment statistics of Contractor on a monthly basis. If there is an increase in the total capitation payment that exceeds 10 percent (10%) above the previous month's total Capitation Payment, the State may require a commensurate increase in the amount of the performance bond, cash deposit, or letter of credit. Contractor shall have ten (10) business days to comply with any such increase.

The State may, at its discretion, permit Contractor to offer substitute security in lieu of a performance, bond, cash deposit, or letter of credit. In that event, Contractor shall be solely responsible for establishing the credit worthiness of all forms of substitute security. Contractor also shall agree that the State may, after supplying written notice, withdraw its permission for substitute security, in which case Contractor shall provide the State with a form of security as described above. In the event of termination for default, the performance bond, cash deposit, letter of credit or substitute shall become payable to the State for any outstanding damage assessments against Contractor. Up to the full amount of the performance bond or substitute may also be applied to Contractor's liability for any administrative costs and/or excess medical or other costs incurred by EOHHS in obtaining similar services to replace those terminated as a result of the default. The State may seek other remedies under law or equity in addition to this stated liability.

3.05.05 Subcontracts and Delegation of Duty

Contractor may enter into written subcontract(s) for performance of certain of its contract responsibilities listed in Article II of this Agreement. All subcontracts must be in writing and fulfill the requirements of 42 CFR 438.230 that are appropriate to the service or activity delegated under this Agreement. Contractor shall make available all subcontracts for inspection by the State upon request for the State's prior approval.

The prime Contractor shall be wholly responsible for performance of the entire contract whether or not subcontractors are used. Any subcontract which Contractor enters into with respect to performance under this Agreement shall not relieve Contractor in any way of responsibility for performance of its duties. Further, the State will consider Contractor to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from the Agreement (see also Section 3.05.06, *Assignment of the Contract*).

Contractor shall give the State immediate notice in writing, by certified mail, of any action or suit filed and of any claim made against Contractor or subcontractor that, in the opinion of Contractor, may result in litigation related in any way to the Agreement with EOHHS.

Executive Order 92-4 encourages each State agency to meet a goal of ten percent (10%) of the dollar value of all procurement be awarded to small and small disadvantaged and minority and

woman-owned businesses as subcontractors, pursuant to the provisions of Part 19 of Title 48, Federal Acquisition Regulations; 45 CFR 74.161, Attachment G; and Chapter 37-2.5.5.2.

All of the program standards described in Article II shall apply to sub-contractors, to the extent relevant, to the duties they are performing. In addition, the provisions of the following Article III clauses shall apply to subcontractors:

Subsection	3.01.11	Federal Approval of Contract
Subsection	3.02.01	Conformance with State and Federal Regulations
Subsection	3.02.03	Severability
Subsection	3.05.07	Hold Harmless
Subsection	3.05.08	Insurance
Subsection	3.05.10	Patent or Copyright Infringement
Subsection	3.06.01	Employment Practices
Subsection	3.06.03	Independent Capacity of Contractor Personnel
Subsection	3.07.03	Fraud and Abuse
Section	3.08	Inspection of Work Performed
Section	3.09	Confidentiality of Information
Subsection	3.11.02	Ownership of Data and Reports

3.05.06 Assignment of the Contract

Contractor shall not sell, transfer, assign, or otherwise dispose of this Agreement or any portion thereof or of any right, title, or interest therein without the prior written consent of the State. Such consent, if granted, shall not relieve Contractor of its responsibilities under this Agreement. This provision includes reassignment of this Agreement due to change in ownership of the firm. State consent shall not be unreasonably withheld.

3.05.07 Hold Harmless

The Contractor shall indemnify and hold the State of Rhode Island, its Executive Offices, agencies, branches and its or their officers, directors, agents or employees (together the “Indemnities” and their subcontractors) harmless against claims, demands, suits for judgments, losses or reasonable expenses or costs of any nature whatsoever (including actual reasonable attorney’s fees) to the extent arising in whole or part from the Contractor’s willful misconduct, negligence, or omission in provision of services or breach of this Agreement including, but not limited to, injuries of any kind which the staff of the Contractor or its subcontractor may suffer directly or may cause to be suffered by any staff person or persons in the performance of this Agreement, unless caused by the willful misconduct or gross negligence of the Indemnities.

The Contractor shall indemnify and hold the State of Rhode Island, its Executive Offices, agencies, branches and its or their officers, directors, agents or employees (together the “Indemnities” and their subcontractors”) harmless against claims, demands, suits for judgments, losses or reasonable expenses or costs of any nature whatsoever (including actual reasonable attorney’s fees) to the extent arising in whole or part for infringement by the Contractor of any intellectual property right by any product or service provided hereunder.

Nothing in the language contained in this Agreement shall be construed to waive or limit the State or federal sovereign immunity or any other immunity from suit provided by law including,

but not limited to Rhode Island General Law, Title 9, Chapter 31 et al., entitled “Governmental Tort Liability.”

Before delivering services under this Agreement, Contractor shall provide adequate demonstration to the State that insurance protections necessary to address each of these risk areas are in place. Minimum requirements for coverage are defined in Section 3.05.08.

Contractor may elect to self-insure any portion of the risk assumed under the provision of this Agreement based upon Contractor's ability (size and financial reserves included) to survive a series of adverse financial actions, including withholding of payment or imposition of damages by the State.

3.05.08 Insurance

Before delivering services under this Agreement, Contractor shall obtain, from an insurance company duly authorized to do business in Rhode Island, the minimum coverage levels described below for:

- Professional liability insurance
- Workers' compensation
- Comprehensive liability insurance
- Property damage insurance
- Errors and Omissions insurance
- Reinsurance

Attachment H of this Agreement contains Contractor's Certificates of Insurance. Each certificate states the policy, the insured, and the insurance period. Each of Contractor's insurance policies shall contain a clause, which requires the State be notified ten (10) days prior to cancellation.

Contractor shall be in compliance with all applicable insurance laws of the State of Rhode Island and of the Federal Government throughout the duration of this Agreement.

3.05.08.01 Professional Liability Insurance

Contractor shall obtain and maintain, for the duration of this Agreement, professional liability insurance in the amount of at least one-million dollars (\$1,000,000.00) for each occurrence.

3.05.08.02 Workers' Compensation

Contractor shall obtain and maintain, for the duration of this contract, workers' compensation insurance for all of its employees employed in Rhode Island. In the event any work is subcontracted, Contractor shall require the subcontractor similarly to provide workers' compensation insurance for all the latter's employees employed at any site in Rhode Island, unless such subcontractor employees are covered by the workers' compensation protection afforded by Contractor. Any subcontract executed with a firm not having the requisite workers' compensation coverage will be considered void by the State of Rhode Island.

3.05.08.03 Minimum Liability and Property Damage Insurance

Contractor shall obtain, pay for, and keep in force general liability insurance (including automobile and broad form contractual coverage) against bodily injury or death of any person in the amount of one-million dollars (\$1,000,000.00) for any one (1) occurrence; and insurance against liability for property damages, as well as first-party fire insurance, including contents coverage for all records maintained pursuant to this Agreement, in the amount of five-hundred thousand dollars (\$500,000.00) for each occurrence; and such insurance coverage that will protect the State against liability from other types of damages, for up to five-hundred thousand dollars (\$500,000.00) for each occurrence.

3.05.08.04 Errors and Omissions Insurance

Contractor shall obtain, pay for, and keep in force for the duration of the contract Errors and Omissions insurance in the amount of one-million dollars (\$1,000,000.00).

3.05.08.05 Reinsurance

Contractor shall obtain, pay for, and keep in force reinsurance for the reimbursement of excess costs incurred by a Member. The level at which the Contractor establishes reinsurance must be consistent with sound business practices under the financial condition of the Contractor. Contractor may not change the thresholds from those submitted in response to the bid solicitation and incorporated into Attachment H of this Agreement without the prior written consent of the State.

3.05.08.06 Evidence of Coverage

Contractor shall furnish to the State upon request a certificate(s) evidencing that required insurance is in effect, for what amounts, and applicable policy numbers and expiration dates prior to start of work under the contract. In the event of cancellation of any insurance coverage, Contractor shall immediately notify the State of such cancellation. Contractor shall provide the State with written notice at least ten (10) days prior to any change in the insurance required under this subsection.

Contractor shall also require that each of its subcontractors maintain insurance coverage as specified above or provide coverage for each subcontractor's liability and employees. The provisions of this clause shall not be deemed to limit the liability or responsibility of Contractor or any of its subcontractors hereunder.

3.05.09 Force Majeure

Neither Contractor nor the State shall be liable for any damages or excess costs for failure to perform their contract responsibilities if such failure arises from causes beyond the reasonable control and without fault or negligence by Contractor or the State. Such causes may include, but are not restricted to, fires, earthquakes, tornadoes, floods, unusually severe weather, or other catastrophic natural events or acts of God: quarantine restrictions; explosions; subsequent legislation by the State of Rhode Island or the Federal government; strikes other than Contractor's employees; and freight embargoes. In all cases, the failure to perform must be beyond reasonable control of, and without fault or negligence of, either party.

3.05.10 Patent or Copyright Infringement

Contractor shall represent that, to the best of its knowledge, none of the software to be used, developed, or provided pursuant to this Agreement violates or infringes upon any patent, copyright, or any other right of a third party. If any claim or suit is brought against the State for the infringement of such patents or copyrights arising from Contractor's use of any equipment, materials, computer software and products, or information prepared by or on behalf of Contractor, or developed in connection with Contractor's performance of this Agreement, then Contractor shall, at its expense, defend such claim or suit. Contractor shall satisfy any final award for such infringement, through a judgment involving such a claim, suit or by settlement, with Contractor's right of approval.

3.05.11 Clinical Laboratory Improvement Amendments (CLIA) Of 1988

All laboratory testing sites providing services under this Agreement have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests. Contractor shall require all subcontractors and participating providers to conform to this requirement.

3.05.12 Sterilization, Hysterectomy, and Abortion Procedures

Contractor shall follow Rhode Island Medical Assistance policy and consent procedures on sterilizations, hysterectomy, and abortion services for members. Members may self-refer to in-network providers for allowable abortion services.

3.06 PERSONNEL

3.06.01 Employment Practices

By signing this Agreement, the Contractor agrees to comply with the requirements of Title VI of the Civil Rights Act of 1964 (42 USC 2000d et seq.); Section 504 of the Rehabilitation Act of 1973, as amended (29 USC 794); 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, and the Age Discrimination Act of 1975, The United States Department of Health and Human Services Regulations found in 45 CFR, Parts 80 and 84; the United States Department of Education Implementing regulations (34 CFR, Parts 104 and 106; and the United States Department of Agriculture, Food and Nutrition Services (7 CFR 272.6), which prohibit discrimination on the basis of race, color, national origin (limited English proficiency persons), age, sex, disability, religion, political beliefs, in acceptance for or provision of services, employment, or treatment in educational or other programs or activities, or as any of the Acts are amended from time to time.

Pursuant to Title VI and Section 504, as listed above and as referenced in **ADDENDA II AND III**, which are incorporated herein by reference and made part of this Agreement, the Contractor

shall have policies and procedures in effect, including, mandatory written compliance plans, which are designed to assure compliance with Title VI section 504, as referenced above. An electronic copy of the Contractor's written compliance plan, all relevant policies, procedures, workflows, relevant chart of responsible personnel, and/or self-assessments must be available to EOHHS upon request.

The Contractor's written compliance plans and/or self-assessments, referenced above and detailed in **ADDENDA II AND III** of this Agreement must include but are not limited to the requirements detailed in **ADDENDA II AND III** of this Agreement.

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

The Contractor acknowledges receipt of **ADDENDUM II - NOTICE TO EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES' SERVICE PROVIDERS OF THEIR RESPONSIBILITIES UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964** and **ADDENDUM VI - NOTICE TO EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES' SERVICE PROVIDERS OF THEIR RESPONSIBILITIES UNDER SECTION 504 OF THE REHABILITATION ACT OF 1973**, which are incorporated herein by reference and made part of this Agreement.

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

The Contractor also agrees to comply with the requirements of the Executive Office of Health and Human Services for safeguarding of client information as such requirements are made known to the Contractor at the time of this contract. Changes to any of the requirements contained herein shall constitute a change and be handled in accordance with the **MODIFICATION OF AGREEMENT** noted in Section 3.03.

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

Contractor shall agree to comply with all other State and Federal statutes and regulations that are or may be applicable and that are not specifically mentioned above.

3.06.02 Employment of State Personnel

Contractor shall not knowingly engage on a full-time, part-time, or other basis, during the period of this Agreement, any professional or technical personnel who are, or have been at any time during the period of this Agreement, State employees, except those regularly retired individuals, without prior written approval from the EOHHS Administrator or designee. Such approval shall not be unreasonably withheld.

The penalty for violation of the above conditions shall result in a two thousand five hundred dollar (\$2,500.00) penalty per employee, plus an added two thousand five hundred (\$2,500.00) penalty per month, per employee if Contractor or subcontractor fails to terminate the employee

after they have been notified in writing of the violation by the State's designated contract administrator.

3.06.03 Independent Capacity of Contractor Personnel

It is expressly agreed that Contractor or any subcontractor involved in the performance of this Agreement shall act in an independent capacity and not as an agent, officer, employee, partner, or associate of the State of Rhode Island. Contractor staff will not hold themselves out as nor claim to be officers or employees of the State of Rhode Island by reason hereto. It is further expressly agreed that this Agreement shall not be construed as a partnership or joint venture between Contractor or any subcontractor and the State.

3.07 PERFORMANCE STANDARDS AND DAMAGES

3.07.01 Performance Standards for Medicaid Managed Care

The performance standards for Health Plans shall be defined as substantial compliance with the program requirements specified in Article II, Sections 2.04, 2.05, 2.06, and the Attachments of this Agreement. Contractor agrees to cooperate fully with the State in its efforts to monitor and assess compliance with these performance standards. Contractor will cooperate fully with the State or its designees in efforts to validate performance measures.

Failure to comply with the provisions of this section may subject Contractor to intermediate sanctions including: (1) civil monetary penalties, as described in Section 3.07.04; (2) appointment of temporary management of the Health Plan, as provided for in 42 CFR 438.706; (3) granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll; (4) suspension of new enrollment including automatic assignment after the effective date of the sanction; and/or (5) suspension of payment for members enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

3.07.02 Suspension of New Enrollment

Whenever the State determines that Contractor is in material breach of the performance standards described in Section 3.07.01, it may suspend Contractor's right to enroll new Members. The State, when exercising this option, shall notify Contractor in writing of its intent to suspend new enrollment. The suspension period may be for a reasonable length of time specified by the State, depending on the severity and circumstances of the breach. The State also may notify enrollees of Contractor non performance and permit these enrollees to transition to another Health Plan.

3.07.03 Fraud and Abuse

3.07.03.01 General Requirements

The Contractor shall establish and maintain internal controls which are designed and executed to prevent, detect, investigate, and report suspected Medicaid Fraud and Abuse that may be committed by network providers, non-network providers, vendors, subcontractors, employees, members, or other third parties with whom the Contractor contracts. The Contractor shall comply with all Federal and State requirements regarding Medicaid fraud and abuse, including but not limited to Sections 1124, 1126(b)(1), 1126(b)(2), 1126(b)(3), 1128, 1156, 1892, 1902(a)(68), and 1903(i)(2) of the Social Security Act and Section 40-8.2-2 of the General Laws of Rhode Island.

The following terms (abuse, conviction or convicted, exclusion, fraud, furnished, practitioner, and suspension) shall have the meaning specified in 42 CFR 455.2:

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Conviction or convicted means that a judgment of conviction has been entered by a Federal, State, or local court; regardless of whether an appeal from that judgment is pending.

Exclusion means that items or services furnished by a specific provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him self or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Furnished refers to items and services provided directly by, or under the direct supervision of, or ordered by, a practitioner or other individual (either as an employee or in his or her own capacity), a provider, or other supplier of services. (For purposes of denial of reimbursement within this part, it does not refer to services ordered by one party but billed for and provided by or under the supervision of another.)

Practitioner means a physician or other individual licensed under State law to practice his or her profession.

Suspension means that items or services furnished by a specified provider who has been convicted or a program-related offense in a Federal, State, or local court will not be reimbursed under Medicaid.

An electronic copy of the Contractor's written operating policies, procedures, workflows, and relevant chart of organization which focus on the prevention, detection, investigation, and reporting of suspected cases of Medicaid Fraud and Abuse must be submitted to the Rhode Island EOHHS for review and approval within 90 days of the execution of this Agreement and then on an annual basis thereafter. Such policies and procedures shall conform to the *Minimum Fraud and Abuse Prevention, Detection and Reporting Requirements for and Rhody Health Options Members*.

3.07.03.02 Mandatory Components of Employee Education about False Claims Recovery

In accordance with Section 6032 of the Deficit Reduction Act of 2005, if the Contractor receives more than five million dollars (\$5,000,000) in Medicaid payments on an annual basis, then it must establish and disseminate written policies for all employees, including management and any subcontractor or agent of the Contractor, that include detailed information about the False Claims Act, established under sections 3279 through 3733 of Title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of Title 31, United States Code, any State laws pertaining to civil and criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f) of the Social Security Act.

Section 6032 of the Deficit Reduction Act establishes section 1902(a)(68) of the Social Security Act, which relates to “Employee Education About False Claims Recovery”. The Contractor’s written policies pertaining to employee education about false claims recovery may be on paper or in electronic form, but must be readily available to all of the Contractor’s employees, contractors, or agents. The Contractor’s policies and procedures must include detailed information about the prevention and detection of Medicaid waste, fraud, and abuse.

The Contractor shall also include in any employee handbook a specific discussion of the laws described in the written policies and the rights of employees to be protected as whistleblowers. The employee handbook must also include a specific discussion of the Contractor’s policies and procedures for preventing and detecting fraud, waste, and abuse.

3.07.03.03 Member Education about Medicaid Fraud and Abuse

The Contractor shall educate its members about Medicaid fraud and abuse by including this subject matter in the Contractor’s Member Handbook. This content shall address examples of possible Medicaid fraud and abuse by providers or vendors, as well by enrollees, and must be pre-approved by EOHHS.

In its Member Handbook, the Contractor shall also inform enrollees about how to report suspected Medicaid fraud and abuse, including any dedicated toll-free telephone number established by the Contractor for reporting possible Medicaid fraud and abuse, as well as information about how to contact EOHHS’s Fraud Unit.

These Member Handbook requirements are addressed further in Section 2.05.10.

3.07.03.04 Recipient Verification Procedures

In accordance with 42 CFR 455.20, the Contractor shall be responsible for establishing procedures to verify with enrollees whether services billed by providers and vendors. Recipient verification requirements specific to workflows for the generation and dissemination of explanation of member benefits (EOMB) are addressed further in Section 3.07.03.05.

The Contractor will document its recipient verification procedures and include these materials in

its submission of written operating policies, procedures, workflows, and relevant chart of organization which focus on the prevention, detection, investigation, and reporting of suspected cases of Medicaid Fraud and Abuse within 90 days of the execution of this Agreement and then on an annual basis thereafter. These recipient verification procedures may include but not be limited to the following:

- Informing enrollees in writing when goods or services have been prior authorized by the Contractor
- Notifying enrollees in writing when services which may require a concurrent authorization (such as a continued inpatient length of stay) have been approved by the Contractor
- Engaging in targeted outreach to enrollees whose pattern of health services utilization may warrant enrollment in any of the Contractor's care coordination or complex case management programs

Recipient verification procedures should delineate how the Contractor will respond to feedback from enrollees, including any interactions with recipients who report that goods or services which had been billed by a provider or vendor were not received. These procedures should address how such information from enrollees will be communicated to the Contractor's Fraud and Abuse Investigations Unit. The Contractor's processes for conducting investigations of possible fraudulent or abusive billing by providers or vendors are addressed further in Section 3.08.03.6.

3.07.03.05 Explanation of Member Benefits

The Contractor shall, in conformance with sampling requirements established by EOHHS, issue individual notices within forty five (45) days of the payment of claims, to a sample of enrollees who received goods or services. The Contractor shall omit from its sampling pool any claims that are associated with confidential services (as defined by the State).

These notices, or explanation of member benefits, must specify the following:

- The service furnished
- The name of the provider furnishing the service
- The date on which the service was furnished
- The amount of the payment made for the service

The Contractor will document its EOMB procedures and include these materials in its submission of written operating policies, procedures, workflows, and relevant chart of organization which focus on the prevention, detection, investigation, and reporting of suspected cases of Medicaid Fraud and Abuse within 90 days of the execution of this Agreement and then on an annual basis thereafter. The EOMB procedures should delineate how the Contractor will respond to subsequent feedback from enrollees, including any interactions with recipients who report that goods or services which had been billed by a provider or vendor were not received. These procedures should address how such information from enrollees will be communicated to the Contractor's Fraud and Abuse Investigations Unit. The Contractor's processes for conducting investigations of possible fraudulent or abusive billing by providers or vendors are addressed further in Section 3.07.03.6 (Investigating and Reporting Suspected Fraud and Abuse).

3.07.03.06 Investigating and Reporting Suspected Fraud and Abuse

The Contractor shall have methods and criteria for identifying suspected Medicaid fraud and abuse. The Contractor shall initiate an investigation of possible Medicaid fraud and abuse based upon a variety of data sources, including but not limited to the following:

- Claims data mining to identify aberrant billing patterns
- Feedback from enrollees based upon EOMB transmittal processes
- Calls received on the Contractor's toll-free telephone number for reporting possible Medicaid fraud and abuse
- Peer profiling and provider credentialing functions
- Analyses of utilization management reports and prior authorization requests
- Monthly reviews of the CMS' List of Excluded Individuals and Entities (LEIE) and the System for Award Management (SAM)
- Queries from State or Federal agencies

At the conclusion of its initial investigation, in the event that the Contractor determines that possible provider or vendor fraud and/or abuse has been identified, then the Contractor will notify the State's Medicaid Fraud Control Unit (MFCU) at the RI Department of the Attorney General (RI DAG) by secure electronic mail of its findings. This notification by the Contractor must take place within five (5) business days of the Contractor's conclusion of its initial investigation.

In addition to reporting any suspected cases of provider or vendor fraud and/or abuse to the Medicaid Fraud Control Unit (MFCU) within five (5) business days following the close of an initial investigation, the Contractor shall also submit quarterly reports to EOHHS and to the State's Medicaid Fraud Control Unit documenting the Contractor's open and closed cases. The quarterly reports shall be formatted in conformance with requirements established by EOHHS in *Minimum Fraud and Abuse Prevention, Detection and Reporting Requirements for Rhody Health Options* members and shall document all open and closed cases of suspected provider and vendor fraud and/or abuse. These quarterly reporting requirements are addressed further in Section 2.14.06 (Fraud and Abuse Reports).

3.07.04 Damages

Contractor shall use ordinary care and reasonable diligence in the exercise of its powers and the performance of its duties under this Agreement. Contractor shall be liable for any loss resulting from its exercise (or failure to exercise) its powers and performance (or failure to perform) of its duties under this Agreement, up to a maximum cap of One Hundred Thousand Dollars (\$100,000); provided, however, that Contractor agrees to indemnify and hold harmless EOHHS from and against any and all claims, lawsuits, settlements, judgments, costs, penalties, and expenses, including attorneys' fees, with respect to this Agreement, resulting or arising out of the dishonest, fraudulent, or criminal acts of Contractor or its employees, acting alone or in collusion

with others; and provided, further, that this maximum cap on damages shall not apply in the event that the loss arises in a situation in which Contractor failed to follow its own policies and procedures.

The maximum civil monetary penalty levied shall be in conformance with 42 CFR 438.704.

3.07.04.01 Non-Compliance with Program Standards

Contractor shall ensure that performance standards as described in Section 3.07.01 are met in full. The size of the damages associated with failure to meet performance standards will vary depending on the nature of the deficiency. Therefore, in the event of any breach of the terms of this Agreement with respect to performance standards, unless otherwise specified below, damages shall be assessed against Contractor in an amount equal to the costs incurred by the State to ensure adequate service delivery to the affected members. When the non-compliance results in transfer of members to another Health Plan, the damages shall include a maximum amount equal to the difference in the capitation rates paid to Contractor and the rates paid to the replacement Health Plan. Damages shall not be imposed until such time that the State has notified Contractor in writing of a deficiency and has allowed a reasonable period of time for resolution.

3.07.04.02 Non-Compliance with Monthly Reconciliation Tasks

Contractor shall carry out the monthly member reconciliation tasks described in Article II. Contractor shall be liable for the actual amount of any detected overpayments or duplicate payments identified as a result of State or Federal claims reviews or as reported by providers or from other referrals, which are a result of incorrect Contractor action in conducting monthly member reconciliation.

3.07.04.03 Non-Compliance with Data Reporting Standards

Contractor shall comply with the operational and financial data reporting requirements described respectively in Sections 2.14, 2.16.04, and 2.17.03 of Article II. Contractor shall be liable for up to two-thousand five-hundred dollars (\$2,500.00) for each business day that any report is delivered after the date when it is due, or includes less than the required information, or is not in the approved media or format. Damages shall not be imposed until such time that the State has notified Contractor in writing of a deficiency and has allowed a reasonable period of time for resolution.

3.07.04.04 Compliance with Other Material Contract Provisions

The objective of this standard is to provide the State with an administrative procedure to address general compliance issues under this Agreement which is not specifically defined as performance requirements listed above or for which damages due to non-compliance cannot be quantified in the manner described in Section 3.07.04.01.

The State may identify contractual compliance issues resulting from Contractor's performance of its responsibilities through routine contract monitoring activities. If this occurs, the EOHHS Administrator or designee will notify Contractor in writing of the nature of the performance issue. The State will also designate a period of time, not to be less than thirty (30) calendar days,

in which Contractor must provide a written response to the notification and will recommend, when appropriate, a reasonable period of time in which Contractor should remedy the non-compliance, but not less than thirty (30) days.

If the non-compliance is not corrected by the specified date, the State may assess damages up to the amount of two thousand five hundred dollars (\$2,500.00) per day after the due date until the non-compliance is corrected.

3.07.05 Deduction of Damages from Payments

Amounts due the State as damages may be deducted by the State from any money payable to Contractor pursuant to this Agreement. The Contract Administrator shall notify Contractor in writing of any claim for damages at least fifteen (15) days prior to the date the State deducts such sums from money payable to Contractor.

The State may, at its sole discretion, return a portion or all of any damages collected as an incentive payment to Contractor for prompt and lasting correction of performance deficiencies.

3.08 INSPECTION OF WORK PERFORMED

3.08.01 Access To Information

Pursuant to Section 434.6(a)(5), the Rhode Island Executive Office of Health and Human Services (EOHHS) and/or its designees, including its management and external quality review organization contractors, the Medicaid Fraud Unit of the Department of Attorney General, and CMS and/or its designees, shall have access to medical information, quality of service information, financial information, service delivery information including authorization requests and denials or other adverse decisions, complaint, grievance and appeal information, and other such information of Contractor, and its subcontractors and agents in order to evaluate through inspection or other means, the quality, appropriateness and timeliness of services performed under this Agreement and compliance with this Agreement.

3.08.02 Inspection of Premises

The State Executive Office of Health and Human Services, the State Department of Health, State Auditor of Rhode Island, the U.S. Department of Health and Human Services, Government Accountability Office, the Comptroller General of the United States, the U.S. Office of the Inspector General, Medicaid Fraud Control Unit of the State Department of the Attorney General or their authorized representatives shall, during normal business hours, have the right to enter into the premises of Contractor and/or all subcontractors and providers, or such other places where duties under this Agreement are being performed, to inspect, monitor, or otherwise evaluate the work being performed.

Such inspections will include, but not be limited to, the CMS or State-mandated annual operational and financial Health Plan reviews, determinations of compliance with this Agreement, and the CMS or State-mandated independent evaluation of the Rhody Health Options programs. All inspections and evaluations shall be performed in such a manner as to not unduly interfere with or delay work.

3.08.03 Approval of Written Materials

Contractor agrees to submit to EOHHS for approval all written materials Contractor produces for dissemination to actual and potential members including but not limited to materials produced for recipient education, outreach, marketing, the Member handbook, and written grievance procedures. EOHHS shall review such documents in draft form and determine whether to grant approval for Contractor to disseminate such documents to the recipient population. In the event EOHHS does not respond within thirty (30) days after Contractor submits such materials for approval, the materials shall be deemed approved by EOHHS.

Contractor's policies and procedures pertaining to Rhody Health Options which are not produced for dissemination to actual and potential Members, including but not limited to procedures for determining eligibility for coverage as a related group, also shall be subject to inspection and approval by the State.

3.09 CONFIDENTIALITY OF INFORMATION

3.09.01 Maintain Confidentiality of Information

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, the RFP and proposal, or which becomes available to the Contractor in carrying out this Agreement and the RFP and the proposal, and agrees to comply with the requirements of the Executive Office for safeguarding of client and such aforementioned information. Confidential information includes, but is not limited to: names, dates of birth, home and/or business addresses, social security numbers, protected health information, financial and/or salary information, employment information, statistical, personal, technical and other data and information relating to the State of Rhode Island data, and other such data protected by the office laws, regulations and policies ("confidential information"), as well as State and Federal laws and regulations. All such information shall be protected by the Contractor from unauthorized use and disclosure and shall be protected through the observance of the same or more effective procedural requirements as are applicable to the Executive Office.

The Contractor expressly agrees and acknowledges that said confidential information provided to and/or transferred to provider by the Executive Office or to which the Contractor has access to for the performance of this Agreement is the sole property of the Executive Office and shall not be disclosed and/or used or misused and/or provided and/or accessed by any other individual(s), entity(ies) and/or party(ies) without the express written consent of the Executive Office. Further, the Contractor expressly agrees to forthwith return to the Executive Office any and all said data and/or information and/or confidential information and/or database upon the Executive Office's written request and/or cancellation and/or termination of this Agreement.

The Contractor shall not be required under the provisions of this paragraph to keep confidential any data or information, which is or becomes legitimately publicly available, is already rightfully in the Contractor's possession, is independently developed by the Contractor outside the scope of this Agreement, or is rightfully obtained from third parties under no obligation of confidentiality.

The Contractor agrees to abide by all applicable, current and as amended Federal and State laws and regulations governing the confidentiality of information, including to but not limited to the

Business Associate requirements of HIPAA (WWW.HHS.GOV/OCR/HIPAA), to which it may have access pursuant to the terms of this Agreement. In addition, the Contractor agrees to comply with the Executive Office confidentiality policy recognizing a person's basic right to privacy and confidentiality of personal information. ("confidential records" are the records as defined in section 38-2-3-(d) (1)-(1-19) of the Rhode Island General Laws, entitled "access to public records" and described in "access to Department of Health records.")

In accordance with this Agreement and all Addenda thereto, the Contractor will additionally receive, have access to, or be exposed to certain documents, records, that are confidential, privileged or otherwise protected from disclosure, including, but not limited to: personal information; Personally Identifiable Information (PII), Sensitive Information (SI), and other information (including electronically stored information), records sufficient to identify an applicant for or recipient of government benefits; preliminary draft, notes, impressions, memoranda, working papers-and work product of state employees; as well as any other records, reports, opinions, information, and statements required to be kept confidential by state or federal law or regulation, or rule of court ("State Confidential Information"). State Confidential Information also includes PII and SI as it pertains to any public assistance recipients as well as retailers within the SNAP Program and Providers within any of the State Public Assistance programs.

Personally Identifiable Information (PII) is defined as any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, social security number, date and place of birth, mother's maiden name, biometric records, etc., including any other personal information which is linked or linkable to an individual. (Defined in OMB Memorandum M-06-19: "Reporting Incidents Involving Personally Identifiable Information and Incorporating the Cost for Security in Agency Information Technology Investments").

Sensitive Information (SI) is information that is considered sensitive if the loss of confidentiality, integrity, or availability could be expected to have a serious, severe or catastrophic adverse effect on organizational operations, organizational assets, or individuals. Further, the loss of sensitive information confidentiality, integrity, or availability might: (i) cause a significant or severe degradation in mission capability to an extent and duration that the organization is unable to perform its primary functions; (ii) result in significant or major damage to organizational assets; (iii) result in significant or major financial loss; or (iv) result in significant, severe or catastrophic harm to individuals that may involve loss of life or serious life threatening injuries. (Defined in HHS Memorandum ISP-2007-005, "Departmental Standard for the Definition of Sensitive Information").

The Contractor agrees to adhere to any and all applicable State and Federal statutes and regulations relating to confidential health care and substance abuse treatment including but not limited to the Federal Regulation 42 CFR, Part 2; Rhode Island Mental Health Law, R.I. General Laws Chapter 40.1-5-26; Confidentiality of Health Care Communications and Information Act, R.I. General Laws Chapter 5-37.3-1 et seq, and HIPAA 45 CFR 160. The Contractor acknowledges that failure to comply with the provisions of this paragraph will result in the termination of this Agreement.

The Contractor shall notify the Covered Entity within one (1) hour by telephone call plus e-mail, web form or fax upon the discovery of any breach of security of PHI, PII or SI or suspected breach of security of PHI, PII or SI (where the use or disclosure is not provided for and permitted by this Agreement) of which it becomes aware. The Contractor shall, within forty-eight (48) hours, notify the Executive Office's designated security officer of any suspected breach of unauthorized electronic access, disclosure or breach of confidential information or any successful breach of unauthorized electronic access, disclosure or breach of confidential information. A breach is defined pursuant to HIPAA guidelines as well as those found in the "Health Information Technology for Economic and Clinical Health Act" (HITECH). A breach or suspected breach may be an acquisition, access, use or disclosure or suspected acquisition, access, use or disclosure of PHI in violation of HIPAA privacy rules that compromise PHI security or privacy. Additionally, a breach or suspected breach may be an acquisition, access, use or disclosure or suspected acquisition, access, use or disclosure of PII or SI. The notice of a breach or suspected breach shall contain information available to the Contractor at the time of the notification to aid the Executive Office in examining the matter. More complete and detailed information shall be provided to the Executive Office as it becomes available to the Contractor. Upon notice of a suspected security incident, the Executive Office and Contractor will meet to jointly develop an incident investigation and remediation plan. Depending on the nature and severity of the confirmed breach, the plan may include the use of an independent third-party security firm to perform an objective security audit in accordance with recognized cyber security industry commercially reasonable practices. The parties will consider the scope, severity and impact of the security incident to determine the scope and duration of the third party audit. If the parties cannot agree on either the need for or the scope of such audit, then the matter shall be escalated to senior officials of each organization for resolution. The Contractor will pay the costs of all such audits. Depending on the nature and scope of the security incident, remedies may include, among other things, information to individuals on obtaining credit reports and notification to applicable credit card companies, notification to the local office of the Secret Service, and or affected users and other applicable parties, utilization of a call center and the offering of credit monitoring services on a selected basis.

Notwithstanding any other requirement set out in this Agreement, the Contractor acknowledges and agrees that the HITECH Act and its implementing regulations impose new requirements with respect to privacy, security and breach notification and contemplates that such requirements shall be implemented by regulations to be adopted by the U.S. Department of Health and Human Services. The HITECH requirements, regulations and provisions are hereby incorporated by reference into this Agreement as if set forth in this Agreement in their entirety. Notwithstanding anything to the contrary or any provision that may be more restrictive within this Agreement, all requirements and provisions of HITECH, and its implementing regulations currently in effect and promulgated and/or implemented after the date of this Agreement, are automatically effective and incorporated herein. Where this Agreement requires stricter guidelines, the stricter guidelines must be adhered to.

Failure to abide by the Executive Office's confidentiality policy or the required signed Business Associate Agreement (BAA) will result in termination remedies, including but not limited to, termination of this Agreement. A Business Associate Agreement (BAA) shall be signed by the Contractor, simultaneously or as soon thereafter as possible, from the signing of this Agreement, as required by the Executive Office.

3.09.02 Confidentiality of Information

The Contractor agrees that all information, records and data collected in connection with this contract shall be protected from unauthorized disclosures and shall be used by the Contractor personnel solely for purposes directly connected with the Contractor's performance of this Agreement. In addition, the Contractor agrees to safeguard the confidentiality of qualified enrollee information. Access to enrollee identifying information shall be limited by the Contractor to persons, Health Plans or agencies, which require the information in order to perform their duties in accordance with this Agreement.

Any other person or entity shall be granted access to confidential information only after complying with the requirements of the State and Federal laws and regulations pertaining to such access. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form, which does not identify the particular individuals.

The Contractor agrees to comply with the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42U.S.C. Section 1320d, et seq., and regulations promulgated there under, as amended from time to time (statute and regulations hereinafter collectively referred to as the "privacy rule").

The Contractor's obligations and responsibilities:

- (a) Contractor agrees to not use or disclose protected health information other than is permitted or required by the agreement or as required by law.
- (b) Contractor agrees to use appropriate and most updated industry safeguards to prevent use or disclosure of the protected health information other than as provided by this agreement.
- (c) Contractor agrees to mitigate, to the extent practicable, any harmful effect that is known to the Contractor of a use or a disclosure of protected health information by the Contractor in violation of requirement of this Agreement.
- (d) Contractor agrees to report to EOHHS any use or disclosure of the protected health information not provided for by this Agreement of which it becomes aware.
- (e) Contractor agrees to maintain the security of protected health information it receives by establishing, at a minimum measures utilized in current industry standards.
- (f) Contractor agrees to notify EOHHS within one (1) hour of receiving a report of suspected or actual breach of security that may result or has resulted in the use or disclosure of protected health and other confidential information for purposes other than such proposed as specified in this Agreement.
- (g) Contractor agrees to prepare and maintain a plan, subject to review by EOHHS/DoIT upon request, specifying the method that the Contractor will employ to mitigate immediately, to extent practicable, any harmful affects that may or have been caused by such a breach.
- (h) Contractor agrees that EOHHS shall be held harmless in the event of such a breach and the Contractor accepts fully the legal and financial responsibility associated with mitigating any harmful effects that may or have been caused.
- (i) Contractor agrees that it is subject and shall ensure compliance with all HIPAA regulations in effect at the time of this Agreement and as shall be amended under HIPAA from time to time, and any and all reporting requirements required by HIPAA at the time of this Agreement and as shall be amended, under HIPAA from time to time. As well as

ensuring compliance with the Rhode Island Confidentiality of Health Care Information Act, Rhode Island General Laws, Section 5-37.3 seq.

3.09.03 Assurance of Security and Confidentiality

Each party agrees to take reasonable steps to ensure the physical security of such data under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files; guards; or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; such as passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data; such as limited terminal access; limited access to input documents and output documents; and design provisions to limit use of client or applicant names.

Each party agrees that it will inform each of its employees having any involvement with personal data or other confidential information, whether with regard to design, development, operation, or maintenance of the laws and regulations relating to confidentiality.

In the event of Contractor's failure to conform to requirements set forth above, EOHHS may terminate this Agreement under the provisions of Section 3.10.

3.09.04 Return Of Confidential Data

Contractor agrees to return all personal data furnished pursuant to this Agreement promptly at the request of the State in whatever form is maintained by Contractor. Upon the termination or completion of the Agreement, Contractor will not use any such data or any material derived from the data for any purpose not permitted by law and where so instructed by the State will destroy such data or material if permitted by law.

3.09.05 Hold Harmless

Contractor agrees to defend (subject to the approval of the Attorney General), indemnify, and hold harmless EOHHS and the State against any claim, loss, damage, or liability incurred as a result of any breach of the obligations of Section 3.09 by Contractor or any subcontractor.

3.09.06 State Assurance of Confidentiality

The State agrees to ensure Federal and State laws of confidentiality are maintained to protect Member and provider information.

3.09.07 Publicizing Safeguarding Requirements

Pursuant to 42 CFR 431.304, Contractor agrees to publicize provisions governing the confidential nature of information about applicants and recipients, including the legal sanctions imposed for improper disclosure and use. Contractor shall include these provisions to applicants and recipients and to other persons and agencies to which information is disclosed.

3.09.08 Types Of Information to Be Safeguarded

Pursuant to 42 CFR 431.305 and HIPAA, and subject to any permitted uses under this Agreement, Contractor agrees to maintain the confidentiality of recipient information regarding at least the following:

- Names and addresses
- Medical services provided
- Social and economic conditions or circumstances
- Department evaluations of personal information
- Medical data, including diagnosis and past history of diseases or disability and
- Any information received in connection with the identification of legally liable third party resources

Pursuant to 42 CFR 431.305 and HIPAA, the State agrees to maintain the confidentiality of recipient information regarding at least the following:

- Any information received for verifying income eligibility and amount of medical assistance payments
- Income information received from the Social Security Administration or the Internal Revenue Service must be safeguarded according to the requirements of the agency that furnished the data

3.09.09 Confidentiality and Protection of Public Health Information and Related Data

The Contractor shall be required to execute a Business Associate Agreement Data Use Agreement, and any like agreement, that may be necessary from time to time, and when appropriate. The Business Associate Agreement, among other requirements, shall require the successful Contractor to comply with 45 CFR 164.502(e), 164.504(e), 164.410, governing Protected Health Information (“PHI”) and Business Associates under the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et seq., and regulations promulgated there under, and as amended from time to time the Health Information Technology for Economic and Clinical Health Act (HITECH) and its implementing regulations there under, and as amended from time to time, the Rhode Island Confidentiality of Health Care Information Act, RI general Laws Section 5-37.3 et seq.

Notwithstanding any other requirement set out in this contract, the Contractor acknowledges and agrees that the Health Information Technology for Economic and Clinical Health Act and its implementing regulations (collectively, “HITECH”) impose new requirements with respect to privacy, security and breach notification and contemplates that such requirements shall be implemented by regulations to be adopted by the Department of Health and Human Services. The HITECH requirements, regulations and provisions are hereby incorporated by reference into

this contract as if set forth in this contract in their entirety. Notwithstanding anything to the contrary or any provision that may be more restrictive within this contract, all requirements and provisions of HITECH, and implementing regulations currently in effect and promulgated and/or implemented after the date of this Contract, are automatically effective and incorporated herein. Where this contract requires stricter guidelines, the stricter guidelines must be adhered to.

The Contractor shall be required to ensure, in writing that any agent including a subcontractor, to whom it provides Protected Health Information received from, or created or received by and/or through this contract, agrees to have the same restrictions and conditions that apply through the above described Agreements with respect to such information.

3.10 TERMINATION OF THE CONTRACT

This Agreement between the parties may be terminated only on the following basis:

- By mutual written agreement of the State and Contractor
- By the State, or by the Contractor, in whole or in part, whenever one party determines that the other party has failed to satisfactorily perform its contracted material duties and responsibilities and is unable to cure such failure within a reasonable period of time after receipt of a notice specifying that material breach.
- By the State, or Contractor, in whole or in part, whenever funding from State, Federal, or other sources is withdrawn, reduced, or limited, with at least sixty (60) days prior written notice.
- By the State, in whole or in part, whenever the State reasonably determines, based on adequate documentation, that the instability of Contractor's financial condition threatens delivery of covered services and continued performance of Contractor responsibilities.
- Upon a finding of just cause, if the State shall determine that such termination is in the best interest of the State, with sufficient prior notice to Contractor.
- By either party pursuant to Section 3.05.03 of this Agreement

3.10.01 Termination for Default

The State or Contractor may terminate this Agreement, in whole or in part, whenever either reasonably determines that the other party has failed to satisfactorily perform its contracted duties and responsibilities and is unable to cure such failure within a reasonable period of time as specified in writing by the State or Contractor, as applicable. Such termination shall be referred to herein as "Termination for Default."

Upon reasonable determination by the State or Contractor that the other party (the "Defaulting Party") has failed to satisfactorily perform its contracted duties and responsibilities, the Defaulting Party shall be notified in writing, by either certified or registered mail, of the failure. If the Defaulting Party is unable to cure the failure within sixty (60) days following the receipt of notice of default, unless a different time period is agreed to by the parties in writing, the State or

Contractor, as applicable, will notify the Defaulting Party that this Agreement, in whole or in part, has been terminated for default.

If, after notice of Termination for Default, it is determined by the State or Contractor, as applicable, or by a court of law of competent jurisdiction that the Defaulting Party was not in default or that the Defaulting Party's failure to perform or make progress in performance was due to causes beyond the control of, and without error or negligence on the part of, the Defaulting Party, the termination shall be deemed to be governed by Section 3.05.09 of this Agreement.

In the event of termination for default by the State, in full or in part as provided under this clause, the State may cover, upon such terms and in such manner as is deemed appropriate by the State, supplies or services similar to those terminated, and Contractor shall be liable for any costs for such similar supplies or services and all other damages allowed by law. In addition, Contractor shall be liable to the State for administrative costs incurred to procure such similar supplies or services as are needed to continue operations. Payment for such costs may be assessed against Contractor's performance bond or substitute security.

In the event of a termination for default by the State, Contractor shall be paid for any outstanding monies due less any assessed damages. If damages exceed monies due from invoices, collection can be made from Contractor's performance bond, cash deposit, letter of credit, or substitute security.

The rights and remedies of the State provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under the contract.

In the event of Termination for Default by Contractor, in whole or in part as provided under this clause, Contractor immediately may close to new enrollment (including Rhody Health Options eligible's whose enrollment) has been initiated but not yet completed as of the date specified in the notice of termination), without reduction of the premium rate for the then-current enrollees as provided in Attachment G. Contractor shall be paid for any capitation or other monies due through the date specified in the notice of termination, including risk sharing payment, within 90 days of termination. The rights and remedies of Contractor provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

Any fraudulent activities may result in criminal prosecution.

3.10.02 Termination for Unavailability of Funds

In the event funding from State, Federal, or other sources is withdrawn, reduced, or limited in any way after the effective date of this Agreement and prior to the anticipated contract expiration date, the State may terminate this Agreement upon at least thirty (30) days prior written notice.

In the event that the State elects to terminate this Agreement pursuant to this provision, Contractor shall be notified in writing by either certified or registered mail either thirty (30) days or such other reasonable period of time prior to the effective date, of the basis and extent of termination. Termination shall be effective as of the close of business on the date specified in the notice.

Upon receipt of notice of termination for unavailability of funds, Contractor shall be paid for any outstanding monies due.

3.10.03 Termination for Financial Instability

In the event that the State reasonably determines, based on adequate documentation, that Contractor becomes financially unstable to the point of threatening the ability of the State to obtain the services provided for under this Agreement, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or its assets, the State may, at its option, immediately terminate this Agreement effective the close of business on the date specified. In the event the State elects to terminate this Agreement under this provision, Contractor shall be notified in writing by either certified or registered mail specifying the date of termination. In the event of the filing of a petition in bankruptcy by or against a principal subcontractor, Contractor shall immediately so advise the Contract Administrator. Contractor shall ensure that all tasks related to the subcontract are performed in accordance with the terms of this Agreement.

3.10.04 Procedures on Termination

Upon delivery by certified or registered mail to Contractor of a Notice of Termination specifying the nature of the termination and the date upon which such termination becomes effective, Contractor shall:

- Stop work under this Agreement on the date and to the extent specified in the Notice of Termination.
- With the approval of the State, settle all outstanding liabilities and all claims arising out of such termination of orders and subcontracts, the cost of which would be reimbursable in whole or in part, in accordance with the provision of this Agreement.
- Complete the performance of such part of the work as has not been terminated by the Notice of Termination.
- Provide all reasonably necessary assistance to the State in transitioning members out of the Health Plan to the extent specified in the Notice of Termination. Such assistance shall include, but not be limited to, the forwarding of medical and other records; facilitation and scheduling of medically necessary appointments for care and services; and identification of chronically ill, high risk, hospitalized and pregnant Members in their last four weeks of pregnancy.
- Provide to the State on a monthly basis, until the earlier of six (6) months from the termination or instructed otherwise, a monthly claims aging report by provider/creditor that includes IBNR amounts; a monthly summary of cash disbursements; and copies of all bank statements received by Contractor in the preceding month. Such reports will be due on the fifteenth (15th) working day of each month for the prior month.

3.10.05 Refunds of Advance Payments

Contractor shall return within thirty (30) days of receipt any funds advanced for coverage of members for periods after the date of termination.

3.10.06 Liability for Medical Claims

Contractor shall be liable for all medical claims incurred up to the date of termination. This shall include the hospital inpatient claims incurred for members hospitalized at the time of termination. In the event of termination of solvency, the Contractor is responsible for payment for services received by members in any month for which capitation was paid, as well as for the relevant portion of inpatient services for members hospitalized at time of termination.

3.10.07 Termination Claims

After receipt of a Notice of Termination, Contractor shall submit any termination claims in the form and with the certifications prescribed by the State. Such claims shall be submitted promptly, but in no event later than six (6) months from the effective date of termination, unless one or more extensions in writing are granted by the State within such six- (6) month period or authorized extension thereof.

Subject to the timeliness provisions in the previous paragraph, and subject to any review required by State procedures in effect as of the date of execution of the contract, Contractor and State may agree upon the amounts to be paid to Contractor by reason of the total or partial termination of work. This Agreement shall be amended accordingly (see Section 3.03, *Contract Amendments*).

In the event of a failure to agree in whole or in part as to the amounts to be paid to Contractor in connection with the total or partial termination of work pursuant to this article, the State shall determine on the basis of information available the amount, if any, due to Contractor by reason of termination and shall pay to Contractor the amount so determined. Contractor shall have the right of appeal, as stated under Section 3.02.05, Disputes, of any such determination.

However, if the State determines that the facts justify such action, termination claims may be accepted and acted upon at any time after such six (6) month period or any extension thereof. Upon failure of Contractor to submit its termination claim within the time allowed, the State may, subject to any review required by the State procedures in effect as of the date of execution of the contract, determine on the basis of information available the amount, if any, due to Contractor by reason of the termination and shall pay to Contractor the amount so determined.

In no case shall Contractor's termination claims include any claim for unrealized anticipatory profits.

3.10.08 Notification of Members

In the event that this Agreement is terminated for any reasons outlined in above, or in the event that this Agreement is not renewed for any reason, EOHHS in consultation with Contractor regarding the content of any notice (such consultation to occur prior to the sending of any notice) shall be responsible for notifying all Members covered under this Agreement of the date of termination and the process by which those members will continue to receive Covered Services.

3.10.09 Non-Compete Covenant

EOHHS may cancel this Agreement without penalty, if any person significantly involved in negotiating, securing, drafting, or creating this Agreement on behalf of the State is or becomes at any time, while this Agreement or any extension of this Agreement is in effect, an employee of any party to this Agreement in any capacity or a consultant to Contractor or Subcontractor with respect to the subject matter in this Agreement. Cancellation shall be effective when written notice from EOHHS is received by Contractor unless the notice specifies a later time.

3.11 OTHER CONTRACT TERMS AND CONDITIONS

3.11.01 Environmental Protection

Contractor shall comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 USC 1857(h)), Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR, Part 15) which prohibit the use under nonexempt Federal contracts, grants, or loans, of facilities included on the EPA List of Violating Facilities. Contractor shall report violations to the applicable grantor Federal agency and the U.S. EPA Assistant Administrator for Enforcement.

3.11.02 Ownership of Data and Reports

Data, information, and reports collected or prepared directly for the State by Contractor in the course of performing its duties and obligations under this Agreement shall be deemed to be owned by the State of Rhode Island. This provision is made in consideration of Contractor's use of public funds in collecting or preparing such data, information, and reports. Nothing contained herein shall be deemed to grant to the State ownership or other rights in Contractor's proprietary information systems or technology used in conjunction with this Agreement.

3.11.03 Publicity

Any publicity given to the program or services provided herein, including, but not limited to, notices, information pamphlets, press releases, research, reports, signs, and similar public notices prepared by or for Contractor, shall identify the State of Rhode Island as the sponsor and shall not be released without prior written approval from the State.

3.11.04 Award of Related Contracts

The State may undertake other contracts for work related to this Agreement or any portion thereof. Examples of other such contracts include, but are not limited to, contracts with other Health Plans to provide Rhody Health Options services and contracts with management firms to assist in administration of the Rhody Health Options program. Contractor shall be bound to cooperate fully with such other Contractors as directed by the State in all such cases. All subcontractors will be required to abide by this provision as a condition of the contract between the subcontractor and the prime Contractor.

3.11.05 Conflict of Interest

No official or employee of the State of Rhode Island or the Federal government who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of this Agreement shall, prior to the completion of the project, voluntarily acquire any personal interest, direct or indirect, in the contract or proposed contract. All State employees shall be subject to the provisions of Chapter 36-14 of the General Laws of Rhode Island.

Contractor represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. Contractor further covenants that, in the performance of the contract, no person having any such known interests shall be employed.

3.11.06 Reporting of Political Contributions

In accordance with Rhode Island Executive Order 91-31, any Contractor who obtains a State contract or purchase order for goods or services, and whose charges to the State exceed two thousand five hundred dollars (\$2,500.00) in any State fiscal year, is required to file a form declaring the vendor's political contributions in excess of two hundred dollars (\$200.00) to candidates for State offices or the General Assembly. Upon payment to a Contractor being made in excess of two thousand five hundred dollars (\$2,500.00) year-to-date, Contractor will receive a form prepared by the Secretary of State upon which to make such declaration. Contractor shall update such form as future political contributions subject to this reporting requirement are made. Failure to complete or update said form accurately, completely, and in conformance with its terms, or to file it with the Secretary of State within sixty (60) days of receipt, will amount to a violation of these terms and conditions and may render Contractor ineligible for further State contracts. Additional disclosure forms, as may be required, may be obtained from the office of the Secretary of State.

3.11.07 Environmental Tobacco Smoke

Contractor shall comply with Public Law 103-227, Part C—Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994.

3.11.08 Titles Not Controlling

Titles of paragraphs used herein are for the purpose of facilitating ease of reference only and shall not be construed to infer a contractual construction of language.

3.11.09 Other Contracts

Nothing contained in this Agreement shall be construed to prevent Contractor from operating other comprehensive health care plans or providing health care services to persons other than those covered hereunder; provided, however, that Contractor shall provide EOHHS with a complete list of such plans and services, including rates, upon request. Nothing in this Agreement shall be construed to prevent EOHHS from contracting with other comprehensive health care plans in the same enrollment area. EOHHS shall not disclose any proprietary information pursuant to this information except as required by law.

3.11.10 Counterparts

This Agreement may be executed simultaneously in two or more counterparts each of which will be deemed an original and all of which together will constitute one and the same instrument.

3.11.11 Administrative Procedures Not Covered

Administrative procedures not provided for in this Agreement will be set forth where necessary in separate memoranda from time to time in accordance with Section 3.01.09.

IN WITNESS HEREOF, the parties have caused this Agreement to be executed under Seal by their duly authorized officers or representatives as of the day and year stated below:

STATE OF RHODE ISLAND:

**NEIGHBORHOOD HEALTH PLAN
OF RHODE ISLAND:**

ALDA REGO
CHIEF FINANCIAL OFFICER
EXECUTIVE OFFICE OF HEALTH &
HUMAN SERVICES

AUTHORIZED AGENT
TITLE: CHIEF EXECUTIVE OFFICER

JAMES HOOLEY
PRINT NAME

DATE

DATE

ADDENDUM I

FISCAL ASSURANCES

1. THE CONTRACTOR AGREES TO SEGREGATE ALL RECEIPTS AND DISBURSEMENTS PERTAINING TO THIS AGREEMENT FROM RECEIPTS AND DISBURSEMENTS FROM ALL OTHER SOURCES, WHETHER BY SEPARATE ACCOUNTS OR BY UTILIZING A FISCAL CODE SYSTEM.
2. THE CONTRACTOR ASSURES A SYSTEM OF ADEQUATE INTERNAL CONTROL WILL BE IMPLEMENTED TO ENSURE A SEPARATION OF DUTIES IN ALL CASH TRANSACTIONS.
3. THE CONTRACTOR ASSURES THE EXISTENCE OF AN AUDIT TRAIL WHICH INCLUDES: CANCELLED CHECKS, VOUCHER AUTHORIZATION, INVOICES, RECEIVING REPORTS, AND TIME DISTRIBUTION REPORTS.
4. THE CONTRACTOR ASSURES A SEPARATE SUBSIDIARY LEDGER OF EQUIPMENT AND PROPERTY WILL BE MAINTAINED.
5. THE CONTRACTOR AGREES ANY UNEXPENDED FUNDS FROM THIS AGREEMENT ARE TO BE RETURNED TO THE DEPARTMENT AT THE END OF THE TIME OF PERFORMANCE UNLESS THE DEPARTMENT GIVES WRITTEN CONSENT FOR THEIR RETENTION.
6. THE CONTRACTOR ASSURES INSURANCE COVERAGE IS IN EFFECT IN THE FOLLOWING CATEGORIES: BONDING, VEHICLES, FIRE AND THEFT, LIABILITY AND WORKER'S COMPENSATION.
7. THE FOLLOWING FEDERAL REQUIREMENTS SHALL APPLY AS INDICATED:

—	OMB CIRCULAR A-21 COST PRINCIPLES FOR EDUCATIONAL INSTITUTIONS
—	OMB CIRCULAR A-87 COST PRINCIPLES APPLICABLE TO GRANTS AND CONTRACTS WITH STATE AND LOCAL GOVERNMENTS
—	OMB CIRCULAR A-102 UNIFORM ADMINISTRATIVE REQUIREMENTS FOR GRANTS-TO-AID TO STATE AND LOCAL GOVERNMENTS
<u>X</u>	OMB CIRCULAR A-110 UNIFORM ADMINISTRATIVE REQUIREMENTS FOR GRANTS AND AGREEMENTS WITH INSTITUTIONS OF HIGHER EDUCATION, HOSPITALS, AND OTHER NONPROFIT ORGANIZATIONS
<u>X</u>	OMB CIRCULAR A-122 COST PRINCIPLES FOR NONPROFIT ORGANIZATIONS

8. IF THE CONTRACTOR EXPENDS FEDERAL AWARDS DURING THE PROVIDER'S PARTICULAR FISCAL YEAR OF \$500,000 OR MORE, THEN OMB CIRCULAR A-133, AUDITS OF STATES, LOCAL GOVERNMENTS AND NON-PROFIT ORGANIZATIONS SHALL ALSO APPLY.
9. THIS AGREEMENT MAY BE FUNDED IN WHOLE OR IN PART WITH FEDERAL FUNDS. IF SO, THE CFDA REFERENCE NUMBER IS 93.778.

ADDENDUM II

NOTICE TO EOHHS CONTRACTORS OF THEIR RESPONSIBILITIES UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

PUBLIC AND PRIVATE AGENCIES, ORGANIZATIONS, INSTITUTIONS, AND PERSONS THAT RECEIVE FEDERAL FINANCIAL ASSISTANCE THROUGH EOHHS ARE SUBJECT TO THE PROVISIONS OF TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 AND THE IMPLEMENTING REGULATIONS OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS), WHICH IS LOCATED AT 45 CFR, PART 80, COLLECTIVELY REFERRED TO HERINAFTER AS TITLE VI. EOHHS CONTRACTS WITH SERVICE PROVIDERS INCLUDE A CONTRACTOR'S ASSURANCE THAT IN COMPLIANCE WITH TITLE VI AND THE IMPLEMENTING REGULATIONS, NO PERSON SHALL BE EXCLUDED FROM PARTICIPATION IN, DENIED THE BENEFITS OF, OR BE OTHERWISE SUBJECTED TO DISCRIMINATION IN ITS PROGRAMS AND ACTIVITIES ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. ADDITIONAL DHHS GUIDANCE IS LOCATED AT 68 FR 47311-02.

EOHHS RESERVES ITS RIGHT TO AT ANY TIME REVIEW SERVICE CONTRACTOR TO ASSURE THAT THEY ARE COMPLYING WITH THESE REQUIREMENTS. FURTHER, EOHHS RESERVES ITS RIGHT TO AT ANY TIME REQUIRE FROM SERVICE PROVIDER'S CONTRACTORS, SUB-CONTRACTORS AND VENDORS THAT THEY ARE ALSO COMPLYING WITH TITLE VI.

THE CONTRACTOR SHALL HAVE POLICIES AND PROCEDURES IN EFFECT, INCLUDING, A MANDATORY WRITTEN COMPLIANCE PLAN, WHICH ARE DESIGNED TO ASSURE COMPLIANCE WITH TITLE VI. AN ELECTRONIC COPY OF THE SERVICE PROVIDERS WRITTEN COMPLIANCE PLAN AND ALL RELEVANT POLICIES, PROCEDURES, WORKFLOWS AND RELEVANT CHART OF RESPONSIBLE PERSONNEL MUST BE SUBMITTED TO RHODE ISLAND EOHHS UPON REQUEST.

THE CONTRACTOR'S WRITTEN COMPLIANCE PLAN MUST ADDRESS THE FOLLOWING REQUIREMENTS:

- ❑ WRITTEN POLICIES, PROCEDURES AND STANDARDS OF CONDUCT THAT ARTICULATE THE ORGANIZATION'S COMMITMENT TO COMPLY WITH ALL TITLE VI STANDARDS.
- ❑ DESIGNATION OF A COMPLIANCE OFFICER WHO IS ACCOUNTABLE TO THE SERVICE PROVIDER'S SENIOR MANAGEMENT.
- ❑ EFFECTIVE TRAINING AND EDUCATION FOR THE COMPLIANCE OFFICER AND THE ORGANIZATION'S EMPLOYEES.
- ❑ ENFORCEMENT OF STANDARDS THROUGH WELL-PUBLICIZED GUIDELINES.
- ❑ PROVISION FOR INTERNAL MONITORING AND AUDITING.
- ❑ WRITTEN COMPLAINT PROCEDURES

- ❑ PROVISION FOR PROMPT RESPONSE TO ALL COMPLAINTS, DETECTED OFFENSES OR LAPSES, AND FOR DEVELOPMENT AND IMPLEMENTATION OF CORRECTIVE ACTION INITIATIVES.
- ❑ PROVISION THAT ALL CONTRACTORS, SUB-CONTRACTORS AND VENDORS OF THE SERVICE PROVIDER EXECUTE ASSURANCES THAT SAID CONTRACTORS, SUB-CONTRACTORS AND VENDORS ARE IN COMPLAINE WITH TITLE VI.

THE CONTRACTOR MUST ENTER INTO AN AGREEMENT WITH EACH CONTRACTOR, SUB-CONTRACTOR OR VENDOR 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 CONTRACTOR MUST SUBMIT, WITHIN THIRTY-FIVE (35) DAY OF THE DATE OF A REQUEST BY DHHS OR EOHHS, FULL AND COMPLETE INFORMATION ON TITLE VI COMPLAINE BY THE CONTRACTOR AND/OR ANY CONTRACTOR, SUB-CONTRACTOR OR VENDOR OF THE SERVICE PROVIDER.

IT IS THE RESPONSIBILITY OF EACH CONTRACTOR TO ACQUAINT ITSELF WITH ALL OF THE PROVISIONS OF THE TITLE VI REGULATIONS. A COPY OF THE REGULATIONS IS AVAILABLE UPON REQUEST FROM THE COMMUNITY RELATIONS LIAISON OFFICER, RI EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES/DEPARTMENT OF HUMAN SERVICES, 57 HOWARD AVENUE, CRANSTON, RI; TELEPHONE NUMBER: (401) 462-2130.

THE REGULATIONS ADDRESS THE FOLLOWING TOPICS:

SECTION:

80.1	PURPOSE
80.2	APPLICATION OF THIS REGULATION
80.3	DISCRIMINATION PROHIBITED
80.4	ASSURANCES REQUIRED
80.5	ILLUSTRATIVE APPLICATIONS
80.6	COMPLIANCE INFORMATION
80.7	CONDUCT OF INVESTIGATIONS
80.8	PROCEDURE FOR EFFECTING COMPLIANCE
80.9	HEARINGS
80.10	DECISIONS AND NOTICES
80.11	JUDICIAL REVIEW
80.12	EFFECT ON OTHER REGULATIONS; FORMS AND INSTRUCTIONS
80.13	DEFINITION

ADDENDUM III

NOTICE TO EOHHS' CONTRACTORS OF 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 EOHHS ARE SUBJECT TO THE PROVISIONS OF SECTION 504 OF THE REHABILITATION ACT OF 1973 AND THE IMPLEMENTING REGULATIONS OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS), WHICH ARE LOCATED AT 45 CFR, PART 84 HERINAFTER COLLECTIVELY REFERRED TO AS SECTION 504. EOHHS CONTRACTS WITH SERVICE PROVIDERS INCLUDE THE PROVIDER'S ASSURANCE THAT IT WILL COMPLY WITH SECTION 504 OF THE REGULATIONS, WHICH PROHIBITS DISCRIMINATION AGAINST HANDICAPPED PERSONS IN PROVIDING HEALTH, WELFARE, OR OTHER SOCIAL SERVICES OR BENEFITS.

THE CONTRACTOR 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 CONTRACTOR'S WRITTEN COMPLIANCE PLAN AND ALL RELEVANT POLICIES, PROCEDURES, WORKFLOWS AND RELEVANT CHART OF RESPONSIBLE PERSONNEL MUST BE SUBMITTED TO RHODE ISLAND EOHHS UPON REQUEST.

THE CONTRACOR'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 CONTRACTOR'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, SUB-CONTRACTORS AND VENDORS OF THE SERVICE PROVIDER EXECUTE ASSURANCES THAT SAID CONTRACTORS, SUB-CONTRACTORS AND VENDORS ARE IN COMPLAINE WITH SECTION 504.

THE CONTRACTOR MUST ENTER INTO AN AGREEMENT WITH EACH CONTRACTOR, SUB-CONTRACTOR OR VENDOR UNDER WHICH THERE IS THE PROVISION TO FURNISH TO THE CONTRACTOR, DHHS, DHS OR TO EOHHS ON REQUEST FULL AND COMPLETE INFORMATION RELATED TO SECTION 504 COMPLIANCE.

THE SERVICE PROVIDER MUST SUBMIT, WITHIN THIRTY-FIVE (35) DAY OF THE DATE OF A REQUEST BY DHHS, EOHHS OR DHS, FULL AND COMPLETE INFORMATION ON SECTION 504 COMPLAINE BY THE SERVICE PROVIDER AND/OR ANY CONTRACTOR, SUB-CONTRACTOR OR VENDOR OF THE SERVICE PROVIDER.

IT IS THE RESPONSIBILITY OF EACH SERVICE PROVIDER TO ACQUAINT ITSELF WITH ALL OF THE PROVISIONS OF THE SECTION 504 REGULATIONS. A COPY OF THE REGULATIONS, TOGETHER WITH AN AUGUST 14, 1978 POLICY INTERPRETATION OF GENERAL INTEREST TO PROVIDERS OF HEALTH, WELFARE, OR OTHER SOCIAL SERVICES OR BENEFITS, IS AVAILABLE UPON REQUEST FROM THE COMMUNITY RELATIONS LIAISON OFFICER, , **RI EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES** , 57 HOWARD AVENUE, CRANSTON, RI 02920; TELEPHONE NUMBER (401) 462-2130.

CONTRACTORS SHOULD PAY PARTICULAR ATTENTION TO SUBPARTS A, B, C, AND F OF THE REGULATIONS WHICH PERTAIN TO THE FOLLOWING:

SUBPART A - GENERAL PROVISIONS

SECTION:

84.1	PURPOSE
84.2	APPLICATIONS
84.3	DEFINITIONS
84.4	DISCRIMINATION PROHIBITED
84.5	ASSURANCE REQUIRED
84.6	REMEDIAL ACTION, VOLUNTARY ACTION, AND SELF-EVALUATION

84.7	DESIGNATION OF RESPONSIBLE EMPLOYEE AND ADOPTIVE GRIEVANCE PROCEDURES
84.8	NOTICE
84.9	ADMINISTRATIVE REQUIREMENTS FOR SMALL RECIPIENTS
84.10	EFFECT OF STATE OR LOCAL LAW OR OTHER REQUIREMENTS AND EFFECT OF EMPLOYMENT OPPORTUNITIES

SUBPART B - EMPLOYMENT PRACTICES

SECTION:

84.11	DISCRIMINATION PROHIBITED
84.12	REASONABLE ACCOMMODATION
84.13	EMPLOYMENT CRITERIA
84.14	PREEMPLOYMENT INQUIRIES
84.15 - 84.20	(RESERVED)

SUBPART C - PROGRAM ACCESSIBILITY

SECTION:

84.21	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

ADDENDUM IV

DRUG-FREE WORKPLACE POLICY

DRUG USE AND ABUSE AT THE WORKPLACE OR WHILE ON DUTY ARE SUBJECTS OF IMMEDIATE CONCERN IN OUR SOCIETY. THESE PROBLEMS ARE EXTREMELY COMPLEX AND ONES FOR WHICH THERE ARE NO EASY SOLUTIONS. FROM A SAFETY PERSPECTIVE, THE USERS OF DRUGS MAY IMPAIR THE WELL-BEING OF ALL EMPLOYEES, THE PUBLIC AT LARGE, AND RESULT IN DAMAGE TO PROPERTY. THEREFORE, IT IS THE POLICY OF THE STATE THAT THE UNLAWFUL MANUFACTURE, DISTRIBUTION, DISPENSATION, POSSESSION, OR USE OF A CONTROLLED SUBSTANCE IS PROHIBITED IN THE WORKPLACE. ANY EMPLOYEE(S) VIOLATING THIS POLICY WILL BE SUBJECT TO DISCIPLINE UP TO AND INCLUDING TERMINATION. AN EMPLOYEE MAY ALSO BE DISCHARGED OR OTHERWISE DISCIPLINED FOR A CONVICTION INVOLVING ILLICIT DRUG BEHAVIOR, REGARDLESS OF WHETHER THE EMPLOYEES CONDUCT WAS DETECTED WITHIN EMPLOYMENT HOURS OR WHETHER HIS/HER ACTIONS WERE CONNECTED IN ANY WAY WITH HIS OR HER EMPLOYMENT. THE SPECIFICS OF THIS POLICY ARE AS FOLLOWS:

1. ANY UNAUTHORIZED EMPLOYEE WHO GIVES OR IN ANY WAY TRANSFERS A CONTROLLED SUBSTANCE TO ANOTHER PERSON OR SELLS OR MANUFACTURES A CONTROLLED SUBSTANCE WHILE ON DUTY, REGARDLESS OF WHETHER THE EMPLOYEE IS ON OR OFF THE PREMISES OF THE EMPLOYER WILL BE SUBJECT TO DISCIPLINE UP TO AND INCLUDING TERMINATION.
2. THE TERM "CONTROLLED SUBSTANCE" MEANS ANY DRUGS LISTED IN 21 USC, SECTION 812 AND OTHER FEDERAL REGULATIONS. GENERALLY, ALL ILLEGAL DRUGS AND SUBSTANCES ARE INCLUDED, SUCH AS MARIJUANA, HEROIN, MORPHINE, COCAINE, CODEINE OR OPIUM ADDITIVES, LSD, DMT, STP, AMPHETAMINES, METHAMPHETAMINES, AND BARBITURATES.
3. EACH EMPLOYEE IS REQUIRED BY LAW TO INFORM THE AGENCY WITHIN FIVE (5) DAYS AFTER HE/SHE IS CONVICTED FOR VIOLATION OF ANY FEDERAL OR STATE CRIMINAL DRUG STATUTE. A CONVICTION MEANS A FINDING OF GUILT (INCLUDING A PLEA OF NOLO CONTENDERE) OR THE IMPOSITION OF A SENTENCE BY A JUDGE OR JURY IN ANY FEDERAL OR STATE COURT.
4. THE EMPLOYER (THE HIRING AUTHORITY) WILL BE RESPONSIBLE FOR REPORTING CONVICTION(S) TO THE APPROPRIATE FEDERAL GRANTING

SOURCE WITHIN TEN (10) DAYS AFTER RECEIVING NOTICE FROM THE EMPLOYEE OR OTHERWISE RECEIVES ACTUAL NOTICE OF SUCH CONVICTION(S). ALL CONVICTION(S) MUST BE REPORTED IN WRITING TO THE OFFICE OF PERSONNEL ADMINISTRATION (OPA) WITHIN THE SAME TIME FRAME.

5. IF AN EMPLOYEE IS CONVICTED OF VIOLATING ANY CRIMINAL DRUG STATUTE WHILE ON DUTY, HE/SHE WILL BE SUBJECT TO DISCIPLINE UP TO AND INCLUDING TERMINATION. CONVICTION(S) WHILE OFF DUTY MAY RESULT IN DISCIPLINE OR DISCHARGE.
6. THE STATE ENCOURAGES ANY EMPLOYEE WITH A DRUG ABUSE PROBLEM TO SEEK ASSISTANCE FROM THE RHODE ISLAND EMPLOYEE ASSISTANCE PROGRAM (RIEAP). YOUR DEPARTMENT PERSONNEL OFFICER HAS MORE INFORMATION ON RIEAP.
7. THE LAW REQUIRES ALL EMPLOYEES TO ABIDE BY THIS POLICY.

EMPLOYEE RETAIN THIS COPY

ADDENDUM V

DRUG-FREE WORKPLACE POLICY

PROVIDER CERTIFICATE OF COMPLIANCE

I, **JAMES HOOLEY, CHIEF EXECUTIVE OFFICER, NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND**, A PROVIDER DOING BUSINESS WITH THE STATE OF RHODE ISLAND, HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE STATE'S POLICY REGARDING THE MAINTENANCE OF A **DRUG-FREE WORKPLACE**. I HAVE BEEN INFORMED THAT THE UNLAWFUL MANUFACTURE, DISTRIBUTION, DISPENSATION, POSSESSION, OR USE OF A CONTROLLED SUBSTANCE DEFINED IN ADDENDUM IV (TO INCLUDE BUT NOT LIMITED TO SUCH DRUGS AS MARIJUANA, HEROIN, COCAINE, PCP, AND CRACK, AND SUCH DRUGS AS IDENTIFIED IN ADDENDUM IV AND MAY ALSO INCLUDE LEGAL DRUGS WHICH MAY BE PRESCRIBED BY A LICENSED PHYSICIAN IF THEY ARE ABUSED), IS PROHIBITED ON THE STATE'S PREMISES OR WHILE CONDUCTING STATE BUSINESS. I ACKNOWLEDGE THAT MY EMPLOYEES MUST REPORT FOR WORK IN A FIT CONDITION TO PERFORM THEIR DUTIES.

AS A CONDITION FOR CONTRACTING WITH THE STATE, AS A RESULT OF THE FEDERAL OMNIBUS DRUG ACT, I WILL REQUIRE MY EMPLOYEES TO ABIDE BY THE STATE'S POLICY. FURTHER, I RECOGNIZE THAT ANY VIOLATION OF THIS POLICY MAY RESULT IN TERMINATION OF THE CONTRACT.

SIGNATURE:

TITLE:

DATE:

ADDENDUM VI
SUBCONTRACTOR COMPLIANCE

I, JAMES HOOLEY, CHIEF EXECUTIVE OFFICER, NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND, A PROVIDER DOING BUSINESS WITH THE STATE OF RHODE ISLAND, HEREBY CERTIFY THAT ALL APPROVED SUBCONTRACTORS PERFORMING SERVICES UNDER THE TERMS OF THIS AGREEMENT WILL HAVE EXECUTED WRITTEN CONTRACTS WITH THIS AGENCY, AND ALL CONTRACTS WILL BE MAINTAINED ON FILE AND PRODUCED UPON REQUEST. ALL CONTRACTS MUST CONTAIN LANGUAGE IDENTICAL TO THE PROVISIONS OF THIS AGREEMENT AS FOLLOWS:

SECTION 3.05.07

HOLD HARMLESS

SECTION 3.06.01

EMPLOYMENT PRACTICES

SIGNATURE:

TITLE:

DATE:

ADDENDUM VII

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

PUBLIC LAW 103-227, PART C - ENVIRONMENTAL TOBACCO SMOKE, ALSO KNOWN AS THE PRO-CHILDREN ACT OF 1994 (**ACT**), REQUIRES THAT SMOKING NOT BE PERMITTED IN ANY PORTION OF ANY INDOOR FACILITY OWNED OR LEASED OR CONTRACTED FOR BY AN ENTITY AND USED ROUTINELY OR REGULARLY FOR THE PROVISION OF HEALTH, DAY CARE, EDUCATION, OR LIBRARY SERVICES TO CHILDREN UNDER THE AGE OF 18, IF THE SERVICES ARE FUNDED BY FEDERAL PROGRAMS EITHER DIRECTLY OR THROUGH STATE OR LOCAL GOVERNMENTS, BY FEDERAL GRANT, CONTRACT, LOAN, OR LOAN GUARANTEE. THE LAW DOES NOT APPLY TO CHILDREN'S SERVICES PROVIDED IN PRIVATE RESIDENCES, FACILITIES FUNDED SOLELY BY MEDICARE OR MEDICAID FUNDS, AND PORTIONS OF FACILITIES USED FOR INPATIENT DRUG OR ALCOHOL TREATMENT. FAILURE TO COMPLY WITH THE PROVISIONS OF THE LAW MAY RESULT IN THE IMPOSITION OF A CIVIL MONETARY PENALTY OF UP TO \$1000 PER DAY AND/OR THE IMPOSITION OF AN ADMINISTRATIVE COMPLIANCE ORDER ON THE RESPONSIBLE ENTITY.

BY SIGNING AND SUBMITTING THIS APPLICATION THE APPLICANT/GRANTEE CERTIFIES THAT IT WILL COMPLY WITH THE REQUIREMENTS OF THE **ACT**. THE APPLICANT/GRANTEE FURTHER AGREES THAT IT WILL REQUIRE THE LANGUAGE OF THIS CERTIFICATION BE INCLUDED IN ANY SUBAWARDS WHICH CONTAIN PROVISIONS FOR CHILDREN'S SERVICES AND THAT ALL SUBGRANTEES SHALL CERTIFY ACCORDINGLY.

SIGNATURE:

TITLE:

DATE:

ADDENDUM VIII

INSTRUCTIONS FOR CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS

PRIMARY COVERED TRANSACTIONS

BY SIGNING AND SUBMITTING THIS CONTRACT, THE PROSPECTIVE PRIMARY PARTICIPANT IS PROVIDING THE CERTIFICATION SET OUT BELOW.

THE INABILITY OF A PERSON TO PROVIDE THE CERTIFICATION REQUIRED BELOW WILL NOT NECESSARILY RESULT IN DENIAL OF PARTICIPATION IN THIS COVERED TRANSACTION. IF NECESSARY, THE PROSPECTIVE PARTICIPANT SHALL SUBMIT AN EXPLANATION OF WHY IT CANNOT PROVIDE THE CERTIFICATION. THE CERTIFICATION OR EXPLANATION WILL BE CONSIDERED IN CONNECTION WITH THE DEPARTMENT'S DETERMINATION WHETHER TO ENTER INTO THIS TRANSACTION. HOWEVER, FAILURE OF THE PROSPECTIVE PRIMARY PARTICIPANT TO FURNISH A CERTIFICATION OR EXPLANATION SHALL DISQUALIFY SUCH PERSON FROM PARTICIPATION IN THIS TRANSACTION.

THE CERTIFICATION IN THIS ADDENDUM IS A MATERIAL REPRESENTATION OF FACT UPON WHICH RELIANCE WAS PLACED WHEN THE DEPARTMENT DETERMINED THAT THE PROSPECTIVE PRIMARY PARTICIPANT KNOWINGLY RENDERED AN ERRONEOUS CERTIFICATION, IN ADDITION TO OTHER REMEDIES AVAILABLE TO THE DEPARTMENT. THE DEPARTMENT MAY TERMINATE THIS TRANSACTION FOR CAUSE OR DEFAULT.

THE PROSPECTIVE PRIMARY PARTICIPANT SHALL PROVIDE IMMEDIATE WRITTEN NOTICE TO THE DEPARTMENT IF AT ANY TIME THE PROSPECTIVE PRIMARY PARTICIPANT LEARNS THAT ITS CERTIFICATION WAS ERRONEOUS WHEN SUBMITTED OR HAS BECOME ERRONEOUS BY REASON OF CHANGED CIRCUMSTANCES.

THE TERMS "COVERED TRANSACTION," "DEBARRED," "SUSPENDED," "INELIGIBLE," "LOWER TIER COVERED TRANSACTION," "PARTICIPANT," "PERSON," "PRIMARY COVERED TRANSACTION," "PRINCIPAL," "PROPOSAL," AND "VOLUNTARILY EXCLUDED," AS USED IN THIS CLAUSE, HAVE THE MEANINGS SET OUT IN THE DEFINITIONS AND COVERAGE SECTIONS OF THE RULES IMPLEMENTING EXECUTIVE ORDER 12549: 45 CFR PART 76.

THE PROSPECTIVE PRIMARY PARTICIPANT AGREES BY SUBMITTING THIS CONTRACT THAT, SHOULD THE PROPOSED COVERED TRANSACTION BE ENTERED INTO, IT SHALL NOT KNOWINGLY ENTER INTO ANY LOWER TIER

COVERED TRANSACTION WITH A PERSON WHO IS DEBARRED, SUSPENDED, DECLARED INELIGIBLE, OR VOLUNTARILY EXCLUDED FROM PARTICIPATION IN THIS COVERED TRANSACTION, UNLESS AUTHORIZED BY THE EXECUTIVE OFFICE.

THE PROSPECTIVE PRIMARY PARTICIPANT FURTHER AGREES BY SUBMITTING THIS CONTRACT THAT IT WILL INCLUDE THE CLAUSE TITLED CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION - LOWER TIER COVERED TRANSACTIONS, PROVIDED BY EOHHS, WITHOUT MODIFICATION, IN ALL LOWER TIER COVERED TRANSACTIONS AND IN ALL SOLICITATIONS FOR LOWER TIER COVERED TRANSACTIONS.

A PARTICIPANT IN A COVERED TRANSACTION MAY RELY UPON A CERTIFICATION OF A PROSPECTIVE PARTICIPANT IN A LOWER TIER COVERED TRANSACTION THAT IS NOT DEBARRED, SUSPENDED, INELIGIBLE, OR VOLUNTARILY EXCLUDED FROM THE COVERED TRANSACTION, UNLESS IT KNOWS THAT THE CERTIFICATION IS ERRONEOUS. A PARTICIPANT MAY DECIDE THE METHOD AND FREQUENCY BY WHICH IT DETERMINES THE ELIGIBILITY OF ITS PRINCIPALS. EACH PARTICIPANT MAY, BUT IS NOT REQUIRED TO, CHECK THE NONPROCUREMENT LIST (OF EXCLUDED PARTIES).

NOTHING CONTAINED IN THE FOREGOING SHALL BE CONSTRUED TO REQUIRE ESTABLISHMENT OF A SYSTEM OF RECORDS IN ORDER TO RENDER IN GOOD FAITH THE CERTIFICATION REQUIRED BY THIS CLAUSE. THE KNOWLEDGE AND INFORMATION OF A PARTICIPANT IS NOT REQUIRED TO EXCEED THAT WHICH IS NORMALLY POSSESSED BY A PRUDENT PERSON IN THE ORDINARY COURSE OF BUSINESS DEALINGS.

EXCEPT FOR TRANSACTIONS AUTHORIZED UNDER PARAGRAPH 6 OF THESE INSTRUCTIONS, IF A PARTICIPANT IN A COVERED TRANSACTION KNOWINGLY ENTERS INTO A LOWER TIER COVERED TRANSACTION WITH A PERSON WHO IS SUSPENDED, DEBARRED, INELIGIBLE, OR VOLUNTARILY EXCLUDED FROM PARTICIPATION IN THIS TRANSACTION, IN ADDITION TO OTHER REMEDIES AVAILABLE TO THE FEDERAL GOVERNMENT, THE DEPARTMENT MAY TERMINATE THIS TRANSACTION FOR CAUSE OF DEFAULT.

ADDENDUM IX

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

THE CONTRACTOR, AS THE PRIMARY PARTICIPANT, CERTIFIES TO THE BEST OF THE CONTRACTOR'S KNOWLEDGE AND BELIEF, THAT THE CONTRACTOR AND ITS PRINCIPALS:

1. ARE NOT PRESENTLY DEBARRED, SUSPENDED, PROPOSED FOR DEBARMENT, DECLARED INELIGIBLE, OR VOLUNTARILY EXCLUDED FROM COVERED TRANSACTIONS BY ANY FEDERAL DEPARTMENT OR AGENCY;
2. HAVE NOT WITHIN A THREE (3) YEAR PERIOD PRECEDING THIS CONTRACT BEEN CONVICTED OF OR HAD A CIVIL JUDGMENT RENDERED AGAINST THEM FOR COMMISSION OF FRAUD OR A CRIMINAL OFFENSE IN CONNECTION WITH OBTAINING, ATTEMPTING TO OBTAIN, OR PERFORMING A PUBLIC (FEDERAL, STATE OR LOCAL) TRANSACTION OR CONTRACT UNDER PUBLIC TRANSACTION; VIOLATION OF FEDERAL OR STATE ANTITRUST STATUTES OR COMMISSION OF EMBEZZLEMENT, THEFT, FORGERY, BRIBERY, FALSIFICATION OR DESTRUCTION OF RECORDS, MAKING FALSE STATEMENTS, OR RECEIVING STOLEN PROPERTY;
3. ARE NOT PRESENTLY INDICTED OR OTHERWISE CRIMINALLY OR CIVILLY CHARGED BY A GOVERNMENTAL ENTITY (FEDERAL, STATE OR LOCAL) WITH COMMISSION OF ANY OF THE OFFENSES ENUMERATED IN PARAGRAPH (1) AND (2) OF THIS ADDENDUM; AND
4. HAVE NOT WITHIN A THREE-YEAR PERIOD PRECEDING THIS CONTRACT HAD ONE OR MORE PUBLIC TRANSACTIONS (FEDERAL, STATE OR LOCAL) TERMINATED FOR CAUSE OR DEFAULT.

WHERE THE PROSPECTIVE PRIMARY PARTICIPANT IS UNABLE TO CERTIFY TO ANY OF THE STATEMENTS IN THIS CERTIFICATION, SUCH PROSPECTIVE PRIMARY PARTICIPANT SHALL ATTACH AN EXPLANATION TO THIS CONTRACT.

SIGNATURE:

TITLE:

DATE:

ADDENDUM X

LIQUIDATED DAMAGES

THE PROSPECTIVE PRIMARY PARTICIPANT CONTRACTOR AGREES THAT TIME IS OF THE ESSENCE IN THE PERFORMANCE OF CERTAIN DESIGNATED PORTIONS OF THIS CONTRACT. THE EXECUTIVE OFFICE AND THE CONTRACTOR AGREE THAT IN THE EVENT OF A FAILURE TO MEET THE MILESTONES AND PROJECT DELIVERABLE DATES OR ANY STANDARD OF PERFORMANCE WITHIN THE TIME SET FORTH IN THE EXECUTIVE OFFICE'S BID PROPOSAL AND THE CONTRACTOR'S PROPOSAL RESPONSE (ADDENDUM XVI), DAMAGE SHALL BE SUSTAINED BY THE EXECUTIVE OFFICE AND THAT IT MAY BE IMPRACTICAL AND EXTREMELY DIFFICULT TO ASCERTAIN AND DETERMINE THE ACTUAL DAMAGES WHICH THE EXECUTIVE OFFICE WILL SUSTAIN BY REASON OF SUCH FAILURE. IT IS THEREFORE AGREED THAT EXECUTIVE OFFICE, AT ITS SOLE OPTION, MAY REQUIRE THE CONTRACTOR TO PAY LIQUIDATED DAMAGES FOR SUCH FAILURES WITH THE FOLLOWING PROVISIONS:

1. WHERE THE FAILURE IS THE SOLE AND EXCLUSIVE FAULT OF THE EXECUTIVE OFFICE, NO LIQUIDATED DAMAGES SHALL BE IMPOSED. TO THE EXTENT THAT EACH PARTY IS RESPONSIBLE FOR THE FAILURE, LIQUIDATED DAMAGES SHALL BE REDUCED BY THE APPORTIONED SHARE OF SUCH RESPONSIBILITY.
2. FOR ANY FAILURE BY THE CONTRACTOR TO MEET ANY PERFORMANCE STANDARD, MILESTONE OR PROJECT DELIVERABLE, THE EXECUTIVE OFFICE MAY REQUIRE THE CONTRACTOR TO PAY LIQUIDATED DAMAGES IN THE AMOUNT(S) AND AS SET FORTH IN THE STATE'S GENERAL CONDITIONS OF PURCHASE AS DESCRIBED PARTICULARLY IN THE LOI, RFP, RFQ, OR SCOPE OF WORK, HOWEVER, ANY LIQUIDATED DAMAGES ASSESSED BY THE EXECUTIVE OFFICE SHALL NOT EXCEED 10 % OF THE TOTAL AMOUNT OF ANY SUCH MONTH'S INVOICE IN WHICH THE LIQUIDATED DAMAGES ARE ASSESSED AND SHALL NOT IN THE AGGREGATE, OVER THE LIFE OF THE AGREEMENT, EXCEED THE TOTAL CONTRACT VALUE.

WRITTEN NOTIFICATION OF FAILURE TO MEET A PERFORMANCE REQUIREMENT SHALL BE GIVEN BY THE EXECUTIVE OFFICE'S PROJECT OFFICER TO THE CONTRACTOR'S PROJECT OFFICER. THE CONTRACTOR SHALL HAVE A REASONABLE PERIOD DESIGNATED BY THE EXECUTIVE OFFICE FROM THE DATE OF RECEIPT OF WRITTEN NOTIFICATION. IF THE FAILURE IS NOT MATERIALLY RESOLVED WITHIN THIS PERIOD, LIQUIDATED DAMAGES MAY BE IMPOSED RETROACTIVELY TO THE DATE OF EXPECTED DELIVERY.

IN THE EVENT THAT LIQUIDATED DAMAGES HAVE BEEN IMPOSED AND RETAINED BY THE EXECUTIVE OFFICE, ANY SUCH DAMAGES SHALL BE REFUNDED, PROVIDED THAT THE ENTIRE SYSTEM TAKEOVER HAS BEEN ACCOMPLISHED AND APPROVED BY THE EXECUTIVE OFFICE ACCORDING TO THE ORIGINAL SCHEDULE DETAILED IN THE CONTRACTOR'S PROPOSAL RESPONSE INCLUDED IN THIS CONTRACT (ADDENDUM XVI) AS MODIFIED BY MUTUALLY AGREED UPON CHANGE ORDERS.

TO THE EXTENT LIQUIDATED DAMAGES HAVE BEEN ASSESSED, SUCH DAMAGES SHALL BE THE SOLE MONETARY REMEDY AVAILABLE TO THE EXECUTIVE OFFICE FOR SUCH FAILURE. THIS DOES NOT PRECLUDE THE STATE FROM TAKING OTHER LEGAL ACTION

ADDENDUM XI

EQUAL EMPLOYMENT OPPORTUNITY

DURING THE PERFORMANCE OF THIS AGREEMENT, THE CONTRACTOR AGREES AS FOLLOWS:

1. THE CONTRACTOR SHALL NOT DISCRIMINATE AGAINST ANY EMPLOYEE OR APPLICANT FOR EMPLOYMENT RELATING TO THIS AGREEMENT BECAUSE OF RACE, COLOR, RELIGIOUS CREED, SEX, NATIONAL ORIGIN, ANCESTRY, AGE, PHYSICAL OR MENTAL DISABILITY, UNLESS RELATED TO A BONA FIDE OCCUPATIONAL QUALIFICATION. THE CONTRACTOR 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 CONTRACTOR AGREES TO POST IN CONSPICUOUS PLACES AVAILABLE TO EMPLOYEES AND APPLICANTS FOR EMPLOYMENT NOTICES SETTING FORTH THE PROVISIONS OF THIS NONDISCRIMINATION CLAUSE.

2. THE CONTRACTOR SHALL, IN ALL SOLICITATIONS OR ADVERTISING FOR EMPLOYEES PLACED BY OR ON BEHALF OF THE CONTRACTOR RELATING TO THIS AGREEMENT, STATE THAT ALL QUALIFIED APPLICANTS SHALL RECEIVE CONSIDERATION FOR EMPLOYMENT WITHOUT REGARD TO RACE, COLOR, RELIGIOUS CREED, SEX, NATIONAL ORIGIN, ANCESTRY, AGE, PHYSICAL OR MENTAL DISABILITY.
3. THE CONTRACTOR SHALL INFORM THE CONTRACTING EXECUTIVE OFFICE'S EQUAL EMPLOYMENT OPPORTUNITY COORDINATOR OF ANY DISCRIMINATION COMPLAINTS BROUGHT TO AN EXTERNAL REGULATORY BODY (RI ETHICS COMMISSION, RI DEPARTMENT OF ADMINISTRATION, US DHHS OFFICE OF CIVIL RIGHTS) AGAINST THEIR AGENCY BY ANY INDIVIDUAL AS WELL AS ANY LAWSUIT REGARDING ALLEGED DISCRIMINATORY PRACTICE.
4. THE CONTRACTOR SHALL COMPLY WITH ALL ASPECTS OF THE AMERICANS WITH DISABILITIES ACT (ADA) IN EMPLOYMENT AND IN THE PROVISION OF SERVICE TO INCLUDE ACCESSIBILITY AND REASONABLE ACCOMMODATIONS FOR EMPLOYEES AND CLIENTS.
5. CONTRACTORS AND SUBCONTRACTORS WITH AGREEMENTS IN EXCESS OF \$50,000 SHALL ALSO PURSUE IN GOOD FAITH AFFIRMATIVE ACTION PROGRAMS.
6. THE CONTRACTOR SHALL CAUSE THE FOREGOING PROVISIONS TO BE

AGREEMENT # NHPRI RHO 14/16-001
INSERTED IN ANY SUBCONTRACT FOR ANY WORK COVERED BY THIS
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.

ADDENDUM XII

BYRD ANTI-LOBBYING AMENDMENT

NO FEDERAL OR STATE APPROPRIATED FUNDS SHALL BE EXPENDED BY THE CONTRACTOR 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 AGREEMENT FULFILLS THE REQUIREMENT THAT CONTRACTORS RECEIVING OVER \$100,000 IN FEDERAL OR STATE FUNDS FILE WITH THE EXECUTIVE OFFICE ON THIS PROVISION.

IF ANY NON-FEDERAL OR STATE FUNDS HAVE BEEN OR WILL BE PAID TO ANY PERSON IN CONNECTION WITH ANY OF THE COVERED ACTIONS IN THIS PROVISION, THE CONTRACTOR SHALL COMPLETE AND SUBMIT A "DISCLOSURE OF LOBBYING ACTIVITIES" FORM.

THE CONTRACTOR MUST CERTIFY COMPLIANCE WITH ALL TERMS OF THE BYRD ANTI-LOBBYING AMENDMENT (31 U.S.C 1352) AS PUBLISHED IN THE FEDERAL REGISTER MAY 27, 2003, VOLUME 68, NUMBER 101.

THE CONTRACTOR HEREBY CERTIFIES THAT IT WILL COMPLY WITH BYRD ANTI-LOBBYING AMENDMENT PROVISIONS AS DEFINED IN 45 CFR PART 93 AND AS AMENDED FROM TIME TO TIME.

FINAL RULE REQUIREMENTS CAN BE FOUND AT:

<http://www.socialsecurity.gov/oag/grants/20cfr438.pdf>

https://www.socialsecurity.gov/OP_Home/cfr20/435/435-ap01.htm

SIGNATURE:

TITLE:

DATE:

ADDENDUM XIII

BID PROPOSAL

Please see attached technical proposal for LOI # 7461245 related to Medicaid Integrated Care Initiative for the Rhody Health Options Program.

ADDENDUM XIV

James Hooley
Chief Executive Officer
Phone: 401-459-6141
Fax: 401-427-6778
Email: jhooley@nhpri.org

Mack Johnston, MD
Chief Medical Officer
Phone: 401-459-6086
Fax: 401-427-6778
Email: mjohnston@nhpri.org

Shantha Diaz
Chief Operating Officer
Phone: 401-459-6620
Fax: 401-459-6021
Email: sdiaz@nhpri.org

T. Clark Phillip
Chief Financial Officer
Phone: 401-459-6611
Fax: 401-427-6778
Email: cphillip@nhpri.org

Beth Marootian
Program Manager
Phone: 401-459-6148
Fax: 401-459-6021
Email: bmarootian@nhpri.org

Kathleen Sullivan
Contract Manager
Phone: 401-427-6745
Fax: 401-459-6021
Email: ksullivan@nhpri.org

ADDENDUM XV

FEDERAL SUBAWARD REPORTING

**The Federal Funding Accountability and Transparency Act (FFATA)
Subaward Reporting & Executive Compensation**

1. Name and address of entity receiving the grant:
Neighborhood Health Plan of RI, 299 Promenade Street, Providence, RI 02908
2. DBA name: Neighborhood Health Plan of RI
3. Does the entity receive equal to or greater than \$25,000 each fiscal year on or after October 1, 2010 (mandatory & discretionary grants) X Yes No
(does not include ARRA funds)
4. Amount of this Award: Based on enrollment into RI's Medicaid Rhody Health Options Program at the stated capitation rates according to Attachment G
5. Federal Funding Agency: CMS/Medicaid
6. CFDA Number: 93.778
7. Award title (descriptive of the purpose of the funding action):
Rhody Health Options; Administering Medicaid Benefits
8. Location of the entity (including congressional district):
Neighborhood Health Plan of RI, 299 Promenade Street, Providence, RI 02908
9. Place of performance (including congressional district): #1
Neighborhood Health Plan of RI, 299 Promenade Street, Providence, RI 02908
10. Unique identifier (DUNS) of the entity and its parent and DUNS +4: 87-450-3998
11. If the entity received 80 percent of its annual gross revenues in Federal funding awards and \$25 million or more in annual gross revenues from Federal awards in the preceding fiscal year, they must disclose the total compensation and names of top five (5) executives:

Name	Compensation
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

I hereby attest that the information provided above is true, accurate and complete to the best of my knowledge and understanding.

T. CLARK PHILLIP, CHIEF FINANCIAL OFFICER

Name & Title



Authorized Agent/Signature

6/27/13

Date

IMPORTANT ITEMS TO NOTE ABOUT NEW REQUIREMENT

-- The Federal Funding Accountability and Transparency Act (FFATA or Transparency Act - P.L.109-282, as amended by section 6202(a) of P.L. 110-252) requires the Office of Management and Budget (OMB) to maintain a single, searchable website that contains current information on all Federal spending awards. That site is at www.USASpending.gov.

--Includes both mandatory and discretionary grants

--Do not include grants funded by the Recovery Act (ARRA)

--For more information about Federal Spending Transparency, refer to <http://www.whitehouse.gov/omb/open>

--If the initial award is below \$25,000 but subsequent grant modifications result in a total award equal to or over \$25,000, the award will be subject to the reporting requirements, as of the date the award exceeds \$25,000

--If the initial award equals or exceeds \$25,000 but funding is subsequently de-obligated such that the total award amount falls below \$25,000, the award continues to be subject to the reporting requirements of the Transparency ACT and this Guidance.

ADDENDUM XVI

BUSINESS ASSOCIATE AGREEMENT

Except as otherwise provided in this Business Associate Agreement Addendum, **Neighborhood Health Plan of Rhode Island**, (hereinafter referred to as “Business Associate”), may use, access or disclose Protected Health Information to perform functions, activities or services for or on behalf of the State of Rhode Island, **Executive Office of Health and Human Services** (hereinafter referred to as the “Covered Entity”), as specified herein and the attached Agreement between the Business Associate and the Covered Entity (hereinafter referred to as “the Agreement”), which this addendum supplements and is made part of, provided such use, access, or disclosure does not violate the Health Insurance Portability and Accountability Act (HIPAA), 42 USC 1320d et seq., and its implementing regulations including, but not limited to, 45 CFR, parts 160, 162 and 164, hereinafter referred to as the Privacy and Security Rules and patient confidentiality regulations, and the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, Public Law 111-5 (HITECH Act) and any regulations adopted or to be adopted pursuant to the HITECH Act that relate to the obligations of business associates, Rhode Island Mental Health Law, R.I. General Laws Chapter 40.1-5-26, and Confidentiality of Health Care Communications and Information Act, R.I. General Laws Chapter 5-37.3-1 et seq. Business Associate recognizes and agrees it is obligated by law to meet the applicable provisions of the HITECH Act.

1. Definitions:

A. Generally:

- (1) Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in 45 C.F.R. §§ 160.103, 164.103, and 164.304, 164.501 and 164.502.
- (2) The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA, the Privacy and Security Rules 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, and Use.

B. Specific:

- (1) "Addendum" means this Business Associate Agreement Addendum.
- (2) "Agreement" means the contractual Agreement by and between the State of Rhode Island, **(EOHHS/BHDDH/DHS/DOH/DCYF/DEA/DVA(PICK AS APPROPRIATE))** and Business Associate, awarded pursuant to State of Rhode Island’s Purchasing Law (Chapter 37-2 of the Rhode Island General Laws) and Rhode Island Department of Administration, Division of

Purchases, Purchasing Rules, Regulations, and General Conditions of Purchasing.

C. "Business Associate" generally has the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean [Insert Name of Business Associate].

D. "Client/Patient" means Covered Entity funded person who is a recipient and/or the client or patient of the Business Associate.

E. "Covered Entity" generally has the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean [Insert Name of Covered Entity].

F. "Electronic Health Record" means an electronic record of health-related information on an individual that is created, gathered, managed or consulted by authorized health care clinicians and staff.

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

H. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

I. "HIPAA Privacy Rule" means the regulations promulgated under HIPAA by the United States Department of Health and Human Services to protect the privacy of Protected Health Information including, the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

J. "HITECH Act" means the privacy, security and security Breach notification provisions applicable to Business Associate under Subtitle D of the Health Information Technology for Economic and Clinical Health Act, which is Title XII of the American Recovery and Reinvestment Act of 2009, Public Law 111-5, and any regulations promulgated thereunder and as amended from time to time.

K. "Secured PHI" means PHI that was rendered unusable, unreadable or indecipherable to unauthorized individuals through the use of technologies or methodologies specified under or pursuant to Section 13402 (h)(2) of the HITECH Act under ARRA.

L. "Security Incident" means any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information.

M. "Security Rule" means the Standards for the security of Electronic Protected Health Information found at 45 CFR Parts 160 and 162, and Part 164, Subparts A and C. The application of Security provisions Sections 164.308, 164.310, 164.312, and 164.316 of title 45, Code of Federal Regulations shall apply to Business Associate of Covered Entity in the same

manner that such sections apply to the Covered Entity.

N. "Suspected breach" is a suspected acquisition, access, use or disclosure of protected health information ("PHI") in violation of HIPPA privacy rules, as referenced above, that compromises the security or privacy of PHI.

O. "Unsecured PHI" means PHI that is not secured, as defined in this section, through the use of a technology or methodology specified by the Secretary of the U.S. Department of Health and Human Services.

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 Agreement 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 Agreement. 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 of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.
- D. Business Associate agrees to report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement, including breaches of unsecured PHI as required by 45 C.F.R. § 164.410, and any Security Incident of which it becomes aware, within five (5) days of the incident.
- E. 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 Agreement to Business Associate with respect to such information through a contractual arrangement that complies with 45 C.F.R. § 164.314.
- F. 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.

- G. 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.
- H. Business Associate agrees to make its internal 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.
- I. 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.
- J. 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 Agreement, 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.
- K. If Business Associate accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses Unsecured Protected Health Information (as defined in 45 C.F.R. § 164.402) for Covered Entity, it shall, following the discovery of a breach of such information, notify Covered Entity of such breach within a period of five (5) days after discovery of the breach. Such notice shall include: a) 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; b) a brief description of what happened, including the date of the breach and discovery of the breach; c) a description of the type of Unsecured PHI that was involved in the breach; d) a description of the investigation into the breach, mitigation of harm to the individuals and protection against further breaches; e) the results of any and all investigation performed by Business Associate related to the breach; and f) contact information of the most knowledgeable individual for Covered Entity to contact relating to the breach and its investigation into the breach.
- L. To the extent the Business Associate is carrying out an obligation of the Covered Entity's under the Privacy Rule, the Business Associate must comply with the

requirements of the Privacy Rule that apply to the 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 Agreement.
 - 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 a Written Information Security Program as required by any state law as applicable.
 - ii. The safeguards set forth in this Agreement 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 Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Service Arrangement, 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 Agreement, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
- c. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the 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 the 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 Agreement, 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 Service Arrangement, 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 Agreement shall begin as of the effective date of the Service Arrangement 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 Agreement and the Service Arrangement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity.
 - ii. Immediately terminate this Agreement and the Service arrangement if Business Associate has breached a material term of this Agreement and cure is not possible.
- c. Except as provided in paragraph (d) of this Section, upon any termination or expiration of this Agreement, 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 notification of the conditions that make return or destruction infeasible. Upon Covered Entity's written agreement that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Agreement 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.

7. Miscellaneous.

- a. A reference in this Agreement 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 Agreement from time to time as is necessary for Covered Entity to comply with the requirements of HIPAA, the Privacy and Security Rules and HITECH.
- c. The respective rights and obligations of Business Associate under Section 6 (c) and (d) of this Agreement shall survive the termination of this Agreement.
- d. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with HIPAA and HITECH.
- 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 Agreement 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 Agreement 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 Agreement shall be binding upon the parties hereto, and their respective legal representatives, trustees, receivers, successors and permitted assigns.
- i. Should any provision of this Agreement be found unenforceable, it shall be deemed severable and the balance of the Agreement shall continue in full force and effect as if the unenforceable provision had never been made a part hereof.
- j. This Agreement 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 Agreement, including such portions as are incorporated by reference herein, constitutes the entire agreement by, between and among the parties, 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 Business Associate Agreement and such insurance coverage shall apply to all services provided by Business Associate or its agents or subcontractors pursuant to this Business Associate Agreement. 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 Business Associate Agreement, including, but not limited to, negligent or intentional acts or omissions. This provision shall survive termination of this Agreement.

8. Acknowledgment.

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

Acknowledged and agreed to by:

STATE OF RHODE ISLAND:

ALDA REGO
CHIEF FINANCIAL OFFICER
EXECUTIVE OFFICE OF HEALTH
AND HUMAN SERVICES

DATE

**NEIGHBORHOOD HEALTH PLAN
OF RHODE ISLAND:**

AUTHORIZED AGENT/SIGNATURE
TITLE: CHIEF EXECUTIVE OFFICER

JAMES HOOLEY
PRINT NAME

DATE

ATTACHMENT A

SCHEDULE OF IN-PLAN BENEFITS

ATTACHMENT A

SCHEDULE OF IN-PLAN BENEFITS

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Inpatient Hospital Care	Up to 365 days per year based on medical necessity. EOHHS shall be responsible for inpatient admissions or authorizations while Member was in Medicaid fee-for-service, prior to member's enrollment in Health Plan. Contractor shall be responsible for inpatient admissions or authorizations, even after the Member has been disenrolled from 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.	Yes
Outpatient Hospital Services	Covered as needed, based on medical necessity. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting. (Contractor has the option to deliver these types of services in other appropriate settings.)	Yes
Physical Therapy Evaluation and Services	Physical therapy evaluation for home accessibility appliances or devices by an individual with a State-approved licensing or certification. Preventive physical therapy services are available prior to surgery if evidence-based practice has demonstrated that the therapy will enhance recovery or reduce rehabilitation time.	Yes
Physician Services	Covered as needed, based on medical necessity, including primary care, specialty care, obstetric and newborn care. Up to one annual and five GYN visits annually to a network provider for family planning is covered without a PCP referral.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Family Planning Services	Enrolled female members have freedom of choice of providers of family planning services.	Yes
Prescription Drugs	Covered when prescribed by a Health Plan physician/provider (or other physician for SPMI). Generic substitution only unless provided for otherwise as described in the <i>Medicaid Managed Care Pharmacy Benefit Plan Protocols</i> .	Yes
Non-Prescription Drugs	Covered when prescribed by a Health Plan physician/provider. Limited to non-prescription drugs, 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.	Yes
Laboratory Services	Covered when ordered by a Health Plan physician/provider (or other physician for SPMI), including urine drug screens	Yes
Radiology Services	Covered when ordered by a Health Plan physician/provider	Yes
Diagnostic Services	Covered when ordered by a Health Plan physician/provider (or other physician for SPMI)	Yes
Mental Health and Substance Abuse - Outpatient	Treatment covered as needed based on medical necessity, except groups/services identified as out-of-plan in Attachment B.	Yes, except for services as described in Attachment B
Mental Health and Substance Abuse -Inpatient	Treatment covered as needed, based on medical necessity. (Butler Hospital may be used for services). Covered Services subject to limitations described in Appendix B.	Yes, except for services, as described in Attachment B
Home Health Services	Covered services include those services provided under a written plan of care authorized by a physician including full-time, part-time, or intermittent skilled nursing care and certified nursing assistant services as well as physical therapy, occupational therapy, respiratory therapy and speech-language pathology, as ordered by a health plan physician. This service also includes medical social services, durable medical equipment and medical supplies for	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
	use at home. Home Health Services do not include respite care, relief care or day care.	
Home Care Services	Covered services include those provided under a written plan of care authorized by a physician including full-time, part-time or intermittent care by a licensed nurse or certified nursing assistant as well as; physical therapy, occupational therapy, respiratory therapy and speech therapy. Home care services 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. Home care services do not include respite care, relief care or day care.	Yes
Emergency Room Service and Emergency Transportation Services	Covered both in- and out-of-State, for Emergency Services (Section 2.10.03), or when authorized by a Health Plan Provider, or in order to assess whether a condition warrants treatment as an emergency service.	Yes
Nursing Home Care and Skilled Nursing Facility Care	Covered when ordered by a Health Plan physician, up to 365 days a year. All skilled and custodial care covered.	Yes
Services of Other Practitioners	Covered if referred by a Health Plan physician. Practitioners certified and licensed by the State of Rhode Island including nurse practitioners, physicians' assistants, social workers, licensed dietitians, psychologists and licensed nurse midwives.	Yes
Podiatry Services	Covered as ordered by Health Plan physician	Yes
Optometry Services	Benefit is limited to examinations that include refractions and provision of eyeglasses if needed once every two years. Eyeglass lenses are covered more than once in 2 years only if medically necessary.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
	Eyeglass frames are covered only every 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.	
Oral Health	<p><i>Inpatient:</i> Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an inpatient setting.</p> <p><i>Outpatient:</i> Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an outpatient hospital setting.</p> <p><i>Oral Surgery:</i> Treatment covered as medically necessary. As detailed in the <i>Schedule of In-Plan Oral Health Benefits</i>.</p>	Yes
Hospice Services	Covered as ordered by a Health Plan physician. Services limited to those covered by Medicare.	Yes
Crossover Claims	For services covered by Medicare, Medicare is the primary payer. The Health Plan is obligated to reimburse claims where Medicare is the primary payer, in accordance with Section 1902(a)(10)(E) of the Social Security Act, and as outlined in the CMS Informational Bulletin issued on June 7, 2013 (CIB 06-07-13).	Yes
Durable Medical Equipment	Covered as ordered by a Health Plan physician as medically necessary.	Yes
Adult Day Health	Day programs for frail seniors and 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.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Nutrition Services	Covered as delivered by a licensed dietitian for certain medical conditions as defined in Attachment D and as referred by a Health Plan physician.	Yes
Group/Individual Education Programs	Including healthy lifestyles/weight management, and tobacco cessation programs and services.	Yes
Interpreter Services	Covered as needed.	Yes
Transplant Services	Covered when ordered by a Health Plan physician.	Yes
Preventive Services		
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 him/herself 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.	Yes
Minor Environmental Modifications	Minor modifications to the home may include grab bars, versa frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats, and other simple devices or appliances, such as eating utensils, transfer bath bench, shower chair, aids for personal care (e.g., reachers), and standing poles to improve home accessibility adaption, health, or safety.	Yes
Physical Therapy Evaluation and Services	Physical therapy evaluation for home accessibility appliances or devices by an individual with a State-approved licensing or certification. Preventive physical therapy services are available prior to surgery if evidence-based practice has demonstrated that the therapy will enhance recovery or reduce rehabilitation time.	Yes
Respite	Temporary care giving services given to an individual unable to care for himself/herself because of the absence or need for relief of	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
	those persons normally providing the care. Respite services can be provided in the individual's home or in a facility approved by the State, such as a hospital, nursing facility, adult day services center, foster home, or community residential facility. An individual qualifies for these respite services if he/she requires the services of a professional or qualified technical health professional or requires assistance with at least two activities of daily living.	
LONG TERM SERVICES AND SUPPORTS		
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 him or herself 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.	Yes
Environmental Modifications (Home Accessibility Adaptations)	Those physical adaptations to the private residence and/or vehicle of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Modifications to the home may include grab bars, versa frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats, and other simple devices or appliances, such as eating utensils, transfer bath bench, shower chair, aids for personal care (e.g., reachers),	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
	<p>and standing poles to improve home accessibility adaption, health, or safety. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g. in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheel chair). All services shall be provided in accordance with applicable State or local building codes and are prior approved on an individual basis by the MCO.</p>	
<p>Special Medical Equipment (Minor Assistive Devices)</p>	<p>Specialized Medical Equipment and supplies to include (a) devices, controls, or appliances, specified in the plan of care, which enable participants to increase their ability to perform activities of daily living; (b) Devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live. All items shall meet applicable standards of manufacture, design and installation. Provision of Specialized Medical Equipment requires prior approval on an individual basis by the MCO.</p>	<p>Yes</p>
<p>Meals on Wheels (Home Delivered Meals)</p>	<p>The delivery of hot meals and shelf staples to the waiver recipient'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.</p>	<p>Yes</p>

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Personal Emergency Response (PERS)	PERS is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center, as specified by EOHHS. This service includes coverage for installation and a monthly service fee. Providers are responsible to insure the upkeep and maintenance of the Devices/systems.	Yes
Skilled Nursing Services (LPN Services)	Licensed Practical Nurse services provided under the supervision of a Registered Nurse. Licensed Practical Nurse Services are available to participants who require interventions beyond the scope of Certified Nursing Assistant (C.N.A.) duties. LPN services are provided in accordance with the nurse practice act under the supervision of a registered nurse. This service is aimed at individuals who have achieved a measure of medical stability despite the need for chronic care nursing interventions.	Yes
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 person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do 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, services necessary for the individual's health and safety and activities to assess need, arrange for and procure needed resources.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
	Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person 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.	
Residential Supports	Assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in their own home and a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance (where applicable), or upkeep and improvement.	Yes
Day Supports	Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Day supports focus on enabling the individual to attain or maintain his/her maximum functioning level and are coordinated with any other services identified in the person's individual plan.	Yes
Supported Employment	Includes activities needed to sustain paid work by individuals receiving waiver services, including supervision, transportation and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
RIte @ Home (Supported Living Arrangements- 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 adults 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.	Yes
Private Duty Nursing	Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law and as identified in the ISP. These services are provided to an individual at home.	Yes
Supports for Consumer Direction (Supports Facilitation)	Focuses on empowering participants to define and direct their own personal assistance needs and services; guides and supports, rather than directs and manages, the participant through the service planning and delivery process. The Facilitator counsels, facilitates and assists in development of an Individual Service Plan which includes both paid and unpaid services and supports designed to allow the participant 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 in the event that regular services identified in the Individual Service Plan are temporarily unavailable.	Yes
Participant Directed Goods and Services	Participant Directed Goods and Services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need and are in the approved Individual Service Plan (including improving and maintaining the individual's opportunities for full membership in the community) and meet the following	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
	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 individual's self-directed budget through the fiscal intermediary when approved as part of the ISP. 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 his/her disability. This will not include any good/service that would be restrictive to the individual or strictly experimental in nature.	
Financial Management Services (Fiscal Intermediary)	Payroll services for program participants; responsible for all taxes, fees, and insurances required for the program participant 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 under the demonstration comply with the participant's approved spending plan/ and conduct criminal background and abuse registry screens of all participant employees.	Yes
Senior Companion (Adult Companion Services)	Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the participant with such tasks as meal preparation, laundry and shopping. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks, which are incidental to the care and supervision of the participant. This service is provided in accordance with a therapeutic goal in the service plan of care.	Yes
Assisted Living	Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
	<p>under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed community care facility in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility but the care provided by these other entities supplements that provided by the community care facility and does not supplant it. Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room, or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the in right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and</p>	

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
	treat each person with dignity and respect. Costs of room and board are excluded from payments for assisted living services.	
Personal Care Assistance Services	<p>Personal Assistance Services provide direct support in the home or community to individuals in performing tasks they are functionally unable to complete independently due to disability, based on the Individual Service and Spending Plan. Personal Assistance Services include:</p> <ul style="list-style-type: none"> • Participant assistance with activities of daily living, 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 (bed making, dusting, vacuuming, laundry, grocery shopping, cleaning) • Assistance with transferring, ambulation; use of special mobility devices • Assisting the participant by directly providing or arranging transportation (If providing transportation, the PCA must have a valid driver's license and liability coverage as verified by the FI). 	Yes
Respite	<p>Respite can be defined as a service provided to participants 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 participant. Federal Financial Participation is not claimed for the cost of room and board as all respite services under this waiver are provided in a private home setting, which may be in the participant'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 EOHHS-certified respite agency, a respite agency staff person works with the family to assure they have the</p>	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
	<p>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 EOHHS. These hours will be released in six-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 individual/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 participant in the waiver may receive up to 100 hours of respite services in a year. Additional hours may be available for urgent situations, at the discretion of the Contractor.</p>	
Rehabilitation Services	<p>Physical, Occupational and speech therapy services may be provided with physician orders by RI DOH licensed outpatient Rehabilitation Centers. These services supplement home health and outpatient hospital clinical Rehabilitation services already when the individual requires specialized rehabilitation services not available from a home health or outpatient hospital provider.</p>	Yes

***RIte @ Home:** provides a home-like setting for individuals who cannot live alone but who want to continue to live in the community as long as possible. There are two components to RIte & Home: (1) the RIte @ Home agency and (2) the caregiver and the host home.

The RIte @ Home Agency helps the person who needs care to find an appropriate host home/ caregiver. This may be someone the person already knows, like a relative, neighbor or friend. The RIte @ Home Agency will “match” a client with a caregiver and will make sure the caregiver receives all needed training and support. The RIte @ Home Agency will:

- Oversee and monitor services;
- Ensure the safety of the host home;
- Provide training for the caregiver;
- Provide nursing services as needed, and
- Develop an individualized *Shared Living Service and Safety Plan*.

The Caregiver /Host Home

Typically, the caregiver lives in their own home and agrees to have the person needing care live with them. In some situations, the caregiver may agree to move into the care recipient’s home. The Caregiver is responsible for:

- Personal care, including assistance with Activities of Daily Living (ADLs)
- Homemaker services
- Chore services
- Meals
- Transportation
- Being on call 24/7
- Providing socialization and a home-like environment

Medicaid pays the RIte @ Home agency for its role and provides funding for caregiver stipends. However, Medicaid does not pay for room and board. Room and board is typically paid from the client’s SSI and/or Social Security check. Also, the client (recipient of care) may incur a “cost share” for the services (not including room and board), depending on their income.

ATTACHMENT B

SCHEDULE OF OUT-OF-PLAN BENEFITS

ATTACHMENT B

SCHEDULE OF OUT-OF-PLAN BENEFITS

These benefits are not included in the capitated benefit and are not the responsibility of the Contractor to provide or arrange. The Contractor is expected to refer to and coordinate with these services as appropriate. These services will be provided by existing Medicaid-approved providers who will be reimbursed directly by the State on a fee-for-service or contractual basis.

BENEFIT(S) PROVIDED OUT-OF-PLAN
<p>Dental services</p> <p>Court-ordered mental health and substance abuse services</p> <p>Non-Emergency Transportation Services (Non-Emergency transportation is coordinated by the contracted Health Plans).</p> <p>AIDS non-medical case management</p> <p>Residential services for MR/DD clients</p> <p>In addition to the services listed above, all members will receive the following mental health and substance abuse services out-of-plan:</p> <p><u>Mental Health</u></p> <ul style="list-style-type: none"> ▪ Psychiatric Rehabilitation Day Programs ▪ Community Psychiatric Supportive Treatment (CPST) ▪ Crisis Intervention for individuals with severe and persistent mental illness (SPMI) enrolled in the Community Support Program (CSP) ▪ Clinician's services delivered at a Community Mental Health Organization (CMHO) for individuals with SPMI enrolled in CSP ▪ Mental Health Psychiatric Rehabilitation Residence (MHPRR) ▪ RI-Assertive Community Treatment I and II <p><u>Substance Abuse</u></p> <ul style="list-style-type: none"> ▪ Community-based narcotic treatment ▪ Community-based detoxification ▪ Residential treatment

ATTACHMENT C

SCHEDULE OF NON-COVERED SERVICES

ATTACHMENT C
SCHEDULE OF NON-COVERED SERVICES

- Experimental Procedures
- Abortion services, except to preserve the life of the woman, or in cases of rape or incest
- Private rooms in hospitals (unless medically necessary)
- Cosmetic surgery
- Infertility Treatment Services
- Medications for sexual or erectile dysfunction

ATTACHMENT D

NUTRITION STANDARDS FOR ADULTS

**Criteria For Referral to a Registered Dietitian (RD), Licensed Dietitian/Nutritionist (LDN) –
for Adults**

1. Referral to a Registered Dietitian (RD), Licensed Dietitian/Nutritionist (LDN) is required pursuant to screening routinely completed as part of periodic health exams as defined below:

SCREENING	STANDARD FOR REFERRAL TO RD, LDN
Weight Status*:	
Underweight	BMI \leq 18.5
Overweight	BMI 25 – 29.9
Obesity	BMI \geq 30
Unintended, Clinically Significant Weight Loss	Weight Loss \geq 10% of Normal Body Weight
Blood Pressure	Diastolic \geq 80 mm Hg Systolic \geq 130 mm Hg
Fasting Blood Lipids	Cholesterol > 200 mg/dl LDL > 130 mg/dl (for individuals with diabetes, LDL > 100 mg/dl) HDL < 40 mg/dl TG > 150 mg/dl
Blood Glucose:	
Diabetes	Fasting blood glucose >126 mg/dl on two occasions or A1C > 6.5
Pre-Diabetes	Fasting blood glucose 100-125 mg/dl on two occasions or A1C > 6.2

* Weight Status Assessed Using Body Mass Index (BMI)

2. Referral to a RD, LDN is required as a result of a diagnosis of chronic disease, which can be managed, controlled, or ameliorated through Medical Nutrition Therapy, such as:

DISEASE/ CONDITION

Cardiovascular Disease
Hypercholesterolemia
Dyslipidemia
Chronic Renal Disease
Pulmonary Disease
Gastrointestinal Disease
Diabetes
Pre-Diabetes
Obesity
Eating Disorders
Hypertension
Autoimmune Disease
Anemia
Liver Disease/Hepatitis
HIV Positive/AIDS
Severe chronic food allergies
Phenylketonuria
Muscular-Skeletal Disease

3. Referral to a RD, LDN is also required under the following circumstances:
- Prescription regimen that has proven impact on nutrient absorption utilization and metabolism, i.e. Dilantin, Phenobarbital, MAO inhibitors, Coumadin, etc.
 - Other conditions as medically necessary.

ATTACHMENT E

FQHC AND RHC SERVICES

ATTACHMENT E

FQHC AND RHC SERVICES

Page 1 of 2

CATEGORY OF SERVICE	COVERED SERVICES
<p>Core Services as Defined in Section 1861 (Aa)(1)(A)-(C) of the Social Security Act</p>	<p>Physician services</p> <p>Services and supplies incidental to physician services (including drugs and biologicals that cannot be self-administered)</p> <p>Pneumococcal vaccine and its administration and influenza vaccine and its administration</p> <p>Physician assistant services</p> <p>Nurse practitioner services</p> <p>Clinical psychologist services</p> <p>Clinical social work services</p> <p>Services and supplies incidental to clinical psychologist and clinical social worker services as would otherwise be covered if furnished by or incidental to physician services</p> <p>Part-time or intermittent nursing care and related medical supplies to a homebound individual (in the case of those FQHCs that are located in an area that has a shortage of home health agencies)</p>

ATTACHMENT E

Page 2 of 2

CATEGORY OF SERVICE	COVERED SERVICES
Additional FQHC Services	In addition to the above Core Services, FQHCs (as opposed to RHCs) are required to provide preventive primary health services under Sections 329, 330, and 340 of the Public Health Service Act and defined in Regulation 405.2448
Other Ambulatory Services	Any other Title XIX-payable ambulatory services offered by the Medicaid program that the FQHC undertakes to provide

ATTACHMENT F

CONTRACTOR'S LOCATIONS

Neighborhood Health Plan of Rhode Island
299 Promenade Street
Providence, RI 02908

ATTACHMENT G

CAPITATION RATES

ATTACHMENT H

**CONTRACTOR'S INSURANCE CERTIFICATES AS SPECIFIED IN SECTION
3.05.08**

Note: Documents to be submitted to the Department of Administration, Division of
Purchasing, as indicated in tentative award letter

ATTACHMENT I

RATE-SETTING PROCESS

ATTACHMENT J

PERFORMANCE GOALS

ATTACHMENT J

PERFORMANCE GOALS

The state of Rhode Island believes in an ever-evolving and robust performance based program as a component of its mission to have an integrated health care system for all Medicaid-only and MME members that will achieve improved health and well-being, better healthcare and lower costs.

This section of the Quality and Reporting Requirements lists the preliminary measures for the contract period, which is defined as calendar dates March 1, 2014 through June 30, 2014, of the Performance Goal Program. Performance measures for subsequent contract periods shall be determined by the Rhode Island Executive Office of Health and Human Services (EOHHS) at a future date.

Quality Incentive Payments

	Calendar Dates
Contract Period	March 1, 2014 – June 30, 2014

Payment awards shall be subject to the Contractor's performance in the achievement of certain established quality and financial performance, due to the availability of state funds.

These thresholds are based upon a combination of certain selected core quality incentive measures as well as State-specified quality measures.

Contract Period Performance Measures

The selected preliminary quality incentive measures for the contract period are as follows:

- **Member Services**
 - **Member ID Cards** - % of identification cards distributed within 10 calendar days of Plan receipt of enrollment information
 - **Call Answer Timeliness** - % of calls received by Member Services (during operating hours) that were answered by a live voice within 30 seconds
- **Care Management**
 - **Initial Telephonic Assessment (Community Non-LTSS members)** - Non-LTSS Members receive an initial telephonic assessment within forty-five (45) days of enrollment.
 - **Comprehensive Assessment (Community Non-LTSS members)** - Non-LTSS Members receive an initial telephonic assessment within forty-five (45) days of enrollment. non-LTSS Members who are identified for a comprehensive functional needs assessment will have a face to face visit assessment completed within thirty (30) days following the initial telephonic assessment.

- **Comprehensive Assessment (Community LTSS and Nursing Home members)** - A comprehensive face-to-face visit assessment is completed within fifteen (15) days for recipients of Community - LTSS within thirty (30) days for nursing home residents
- **Care Plan Development** - % of care plans with evidence of member/guardian shared decision making, involvement in plan development, and assessment of member goals and preferences; which clearly demonstrate adequate and appropriate care and service plan, including social and environmental supports.
- **Nursing Home Transitions**
 - **Risk Assessment** - % of Members who have a risk assessment completed by the Health Plan or contracted entity prior to discharge and/or transition to the community
 - **Home Visit** - % of Members have a home visit within one (1) calendar day of their transition to the community
- **Grievances and Appeals**
 - **Resolution Timeframe** - % of grievances and appeals resolved within Federal Budget Act timeframes

1. Member Services – Member ID Cards	
Quality Indicator	% of identification cards distributed within 10 calendar days of Plan receipt of enrollment information
Performance Measure	<ul style="list-style-type: none"> • Numerator: Number of ID cards distributed within 10 calendar days in measurement time period • Denominator: Number of new member information received by MCO
Timeframe	Contract Period
Reporting Requirements	MCO Provides Member-specific data to determine whether the ID cards were generated in a timely manner based on a random sample of new members produced by EOHHS
Benchmark	98%

2. Member Services – Call Answer Timeliness	
Quality Indicator	% of calls received by Member Services (during operating hours) that were answered by a live voice within 30 seconds average speed to answer
Performance Measure	<ul style="list-style-type: none"> • Numerator: Number of phone calls received during MCO's hours of operation • Denominator: Number of phone calls answered in 30 seconds during operating hours by MCO
Timeframe	Contract Period
Reporting Requirements	MCO Provides Call center data periodically as determined by EOHHS
Benchmark	90%

3. Care Management - Initial Telephonic Assessment (Community Non-LTSS members)	
Quality Indicator	Community non-LTSS Members receive an initial telephonic assessment within forty-five (45) days of enrollment.
Performance Measure	<ul style="list-style-type: none"> • Numerator: Number of non-LTSS members who receive appropriately designated assessment method in the appropriate time. • Denominator: Number of non-LTSS members
Timeframe	Contract Period
Reporting Requirements	MCO Provides Member-specific data to determine whether appropriately designated assessment method in the appropriate time based on a random sample of new members produced by EOHHS
Benchmark	95%

4. Care Management - Comprehensive Assessment (Community Non-LTSS members)	
Quality Indicator	Non-LTSS Members who are identified for a comprehensive functional needs assessment will have a face to face visit assessment completed within thirty (30) days of the initial telephonic assessment.
Performance Measure	<ul style="list-style-type: none"> Numerator: Number of non-LTSS members who receive appropriately designated assessment method in the appropriate time. Denominator: Number of non-LTSS members
Timeframe	Contract Period
Reporting Requirements	MCO Provides Member-specific data to determine whether appropriately designated assessment method in the appropriate time based on a random sample of new members produced by EOHHS
Benchmark	95%

5. Care Management - Comprehensive Assessment (Community LTSS and Nursing Home members)	
Quality Indicator	A comprehensive face-to-face visit assessment is completed within fifteen (15) days for recipients of Community LTSS; within thirty (30) days for nursing home residents
Performance Measure	<ul style="list-style-type: none"> Numerator: Number of members stratified by population: (1) Community LTSS or (2) Nursing Home residents who receive appropriately designated assessment method in the appropriate time. Denominator: Number of members stratified by population: (1) Community LTSS or (2) Nursing Home residents
Timeframe	Contract Period
Reporting Requirements	MCO Provides Member-specific data to determine whether appropriately designated assessment method in the appropriate time based on a random sample of new members produced by EOHHS
Benchmark	95%

6. Care Management – Care Plan Development	
Quality Indicator	% of care plans that clearly demonstrate adequate and appropriate care and service plan, including social and environmental supports, shared decision making, involvement of the member and/or caregiver in plan development, and assessment of member goals and preferences
Performance Measure	<ul style="list-style-type: none"> Numerator: Number of care plans with appropriate required evidence Denominator: Total number of random sample of care plans assessed, as determined by EOHHS

Timeframe	Contract Period
Reporting Requirements	MCO Provide Member-specific data to determine whether appropriately designated care and service plan are in place based on a random sample of new members produced by EOHHS
Benchmark	95%

7. Nursing Home Transitions – Risk Assessment	
Quality Indicator	% of Members who have a risk assessment (as defined per NHT protocol) completed by the Health Plan or contracted entity prior to discharge and/or transition to the community
Performance Measure	<ul style="list-style-type: none"> Numerator: Number of members who have completed a risk assessment within the one (1) calendar day period prior to discharge and/or transition Denominator: Total number of members discharged and/or transitioned to the community
Timeframe	Contract Period
Reporting Requirements	MCO Provide Member-specific data to determine whether risk assessment conducted in the appropriate time based on a random sample of new members produced by EOHHS
Benchmark	100%

8. Nursing Home Transitions – Home Visit	
Quality Indicator	Members have a home visit within one (1) calendar day of their transition to the community
Performance Measure	<ul style="list-style-type: none"> Numerator: Number of members who have a home visit within one (1) calendar day period prior to discharge and/or transition Denominator: Total number of members discharged and/or transitioned to the community
Timeframe	Contract Period
Reporting Requirements	MCO Provides Member-specific data to determine whether home visit conducted within the appropriate time based on a random sample of new members produced by EOHHS
Benchmark	100%

9. Grievances and Appeals – Resolution Timeframe	
Quality Indicator	% of grievances and appeals resolved within Federal Budget Act timeframes
Performance Measure	<ul style="list-style-type: none"> Numerator: Number of grievances and appeals resolved within the appropriate contractual time period Denominator: Number of grievances and appeals received
Timeframe	Contract Period
Reporting	MCO Provide Member-specific data to determine whether

Requirements	grievances and appeals were resolved within the appropriate contractual time period based on a random sample of new members produced by EOHHS
Benchmark	98%

10. Nursing Home Transitions	
Quality Indicator	The number of members who have transitioned out of a nursing home and to the community, who are eligible for the Rhode to Home program.
Performance Measure	
Timeframe	Contract Period
Reporting Requirements	MCO provides operational report, which is validated by EOHHS staff.
Benchmark	30

ATTACHMENT K

SPECIAL TERMS & CONDITIONS

Gain Sharing/Risk Sharing for Rhody Health Options

ATTACHMENT K

SPECIAL TERMS & CONDITIONS

Gain Sharing/Risk Sharing for Rhody Health Options

1. Definitions

- (1) **Baseline:** Baseline means one hundred percent (100%) of the medical portion of the rate for each Premium Rating Group as identified in Attachment G.
- (2) **Contract Period:** For the contract beginning November 1, 2013, Contract Period means the period beginning November 1, 2013 and ending June 30, 2014. Subsequently, Contract Period means each 12-month period beginning July 1, and ending June 30, of the next year.
- (3) **Gain Share:** Gain Share means the terms by which EOHHS and the Contractor share in the gain realized from participating in the program for a Contract Period.
- (4) **Medical Expenses:** Medical Expenses means those benefits and services that the Contractor is obligated to provide or pay for pursuant to Attachments A, including but not limited to preventive services, laboratory, diagnostic and radiology services, inpatient and outpatient hospital services, physician services, mental health and substance abuse services, long-term services and supports, prescription drugs, family planning services, behavioral health, emergency and palliative services, oral surgery, general anesthesia, interpreter/translation services, and behavior management. Medical expenses must be reduced by any recoveries from other payers including those pursuant to coordination of benefits, third party liability, reinsurance, rebates, or adjustments in claims paid or from providers, including adjustments to claims paid.
- (5) **Medical Expense Threshold:** For purposes of Risk Share, Medical Expense Threshold means Baseline plus one and a half percent (1.5%) of Baseline (or 101.5% of Baseline). For purposes of Gain Share, Medical Expense Threshold means Baseline minus one and a half percent (1.5%) of Baseline (or 98.5% of Baseline).
- (6) **Medical Portion of the Rate:** The Medical Portion of the Rate is as shown in Attachment G.
- (7) **PMPM:** PMPM means Per Member Per Month
- (8) **Premium Rate:** For any given period, Premium Rate means the capitation payments made PMPM by the State to the Contractor for Members for each Premium Rating Group enrolled during that period. Premium rate includes a medical and administrative portion.
- (9) **Premium Rating Group:** Those groups, as defined in Attachment G for which the State issues a capitation payment to the Contractor on a PMPM basis.

- (10) **Quarter:** Quarter means a calendar quarter (e.g. January 1 through March 31, April 1, through June 30, July 1 through September 30 and October 1 through December 31)
- (11) **Risk Share:** Risk Share means the terms by which EOHHS and the Contractor share in the loss realized from participating in the program for the duration of a Contract Period.
- (12) **Reinsurance:** Contractor will reinsure Medical Expenses for Members. Such costs will be a component of Medical Expense that will be reduced by any claims against reinsurance.

2. Risk Sharing/Gain Sharing Methodology

Risk sharing/Gain sharing is based on the Contract Period and is based on the cumulative experience for all Premium Rating Groups.

The actual cumulative Medical Expenses for the Contract Period and in aggregate for all premium rating groups combined for the Contract Year will be reported to EOHHS each month based on Medical Expenses for claims paid for services provided on dates of service during the Contract Period.

(a) Risk Share/Gain Share for Rhody Health Options

- 1. If the actual cumulative Medical Expenses for the Premium rating groups exceed the Baseline, those expenses will be shared by the Contractor and the EOHHS as follows:

For the term of this Agreement, EOHHS will assume the risk of seventy percent (70%) of the excess and the Contractor will assume the risk of thirty percent (30%) of the excess, for medical expenses between the baseline and the baseline plus three and a half (3.5) percent (101.5% - 105%).

- 2. If the actual cumulative Medical Expenses are more than three and a half (3.5) percent above the baseline (105%), the excess will be shared by the Contractor and EOHHS as follows:

For the term of this Agreement, the excess will be shared ninety percent (90%) to EOHHS and ten percent (10%) to the Contractor.

- 3. If the actual cumulative Medical Expenses for the Premium Rating Groups are less than the Baseline, those gains will be shared by the Contractor and the EOHHS as follows:

For the term of this Agreement, where cumulative Medical Expenses are between the Baseline and the Baseline minus three and a half (3.5) percent (98.5% to 95%), EOHHS share will be seventy percent (70%) of the gains and the Contractor share will be thirty percent (30%) of the gains.

Where cumulative Medical Expenses are more than three and a half (3.5) percent below the Baseline (95%) EOHHS share of the gains will be ninety percent (90%) and the Contractor share will be ten percent (10%).

All contracts for services and the terms of those contracts, including payment arrangements with all providers that serve Medicaid enrollees must be available for review by the State or its agents. Contracts with medical providers that are not made available will be subject to exclusion from the Risk-Share/Gain Share arrangement.

EOHHS will conduct a re-review of the risk/gain share arrangement described in this Attachment K, and recommend appropriate changes at 150% of risk-based capital as outlined in the Interagency Agreement between EOHHS and the Office of the Health Insurance Commissioner (OHIC) dated June 2013.

(b) Exclusions for purposes of the Risk-Share and Gain Share Calculations Include:

- Provider pay-for-performance incentive arrangements that were not approved by EOHHS.
- Provider pay-for-performance incentives that exceed EOHHS approved levels, in accordance with EOHHS issued Guidelines for Provider Pay-for Performance.

(c.) Offsets for the purposes of the Risk-Share/Gain Share calculations:

- All TPL collections by contractor, including those pursuant to subrogation.
- Reinsurance payments made to the Contractor
- Drug Rebates received or receivable for drugs provided to members during the contract.
- EOHHS reserves the right to alter the process for subrogation collections at a future date.

Reconciliation and Payment

The cumulative Medical Expenses for the Contract Period shall be submitted each month on a form set forth by EOHHS, including attestation as to the accuracy and completeness of the report. In the event that reported Medical expenses exceed the Medical Expenses Threshold, the signed Medical Expenses Report shall serve as the risk-sharing request for payment to the Plan. A separate report shall be completed by the Plan for each population covered by the Plan. EOHHS shall review the Medical Expenses Report submissions on a routine and periodic basis and the parties mutually shall resolve any questions concerning the amount of the risk-sharing request for payment. The risk sharing payment shall be made within 90 days in accordance with the next routine payment cycle after receipt and reconciliation of

the Contractor's Medical Expense Report. Final settlement is based on review of the complete experience for the contract period following the full twelve-month run out as set forth below. When EOHHS requests Contractor to perform a reconciliation of encounter data, Contractor agrees to submit the reconciliation to EOHHS within fifteen (15) business days. In the event Contractor's response takes longer to be submitted, EOHHS may at its discretion move forward to final settlement without regard to any additional medical expenses that might have been identified.

- The cumulative Medical Expense Report will include no allowance for incurred but not reported (IBNR) claims. Risk sharing will be paid only on claims paid experience. To assure fairness in resolving outstanding claims, EOHHS will allow inclusion of claims for services provided to eligible and enrolled members for a period not to exceed 365 days from the date of a Covered Service. In its request for payment to EOHHS, the Contractor will separately identify claims with dates of service from prior periods to assure accurate calculation of the Risk- Share payment. This procedure will assure that no Risk Share/Gain Share period goes back to a date earlier than 365 days from the date of service.
- This Agreement provides Risk- Share/Gain Share for claims paid for Covered Services for eligible and enrolled members with dates of service during the applicable the Contract Period.

ADDITIONAL SPECIAL TERMS AND CONDITONS

1. Performance Requirements

The success of this Agreement depends on the parties' shared commitment to work toward achievement of goals designed to improve health and functional status of enrollees. To achieve these goals, Contractor agrees to implement certain activities to improve access to primary health services and community-based long-term services and supports, to improve appropriate use of the emergency room, and to implement specific person-centered care management programs for populations that are frequent users of services. Such programs will be developed by Contractor in consultation with staff of EOHHS or EOHHS' designees and will be subject to approval by EOHHS. It is agreed that such goals and programs will be reviewed at least annually and that a report will be submitted by Contractor to EOHHS and the board of directors of Contractor describing the programs and the outcomes of the programs.

In accordance with requirements as issued by the US Office of Inspector General (OIG), the contractor shall collaborate with EOHHS and/or its designee(s) to develop specific audit procedures to ensure the Contractor's reported medical expenses, as detailed in risk share financial statements, are accurate and compliant with medical expenses as defined in the Agreement.

2. Reports

It is a requirement of this Agreement that Contractor submit monthly reports to EOHHS in a form and format approved by EOHHS. The report will be due to EOHHS within forty-five (45)

days of the calendar day of the month of the report. The report will include:

- Utilization and expense data for the reporting month and year-to-date
- Institutional Services – separate reporting for admissions to: medical/surgical, obstetrics, and mental health; other institutional services such as: length of stay and total days. The report will include: ambulatory surgery, emergency department visits and other outpatient services that are provided at the hospital.
- Professional services: primary care, specialty services, emergency department physician services, mental health visits, mental health intensive outpatient or partial hospital services
- Long-term services and supports
- Crossover payment (cost sharing payments for Medicare covered services)
- Pharmacy reported as number of prescriptions
- Quarterly pharmacy claims information in a format that is compliant with CMS published guidelines and approved by EOHHS
- Other: all other services used
- Actual expenses and per member per month for the categories above
- A specific report that identifies cases where the expense for a Member exceeds \$25,000 in the reporting period
- Reinsurance expense and recoveries
- Administrative costs
- Other reports EOHHS may request to explain certain Medical Expenses as those expenses affect the risk-share agreement

EOHHS agrees that all reports and discussions will be maintained confidentially and provided to other parties only as require by state or federal law or regulation.

3. Operational Reports

Contractor agrees to maintain during the term of this Agreement detailed records allocating Medical Expenses, by each Premium Rating Group. EOHHS may conduct a routine and periodic review of such records, provided, however, that EOHHS may adjust its review, if necessary, to include information contained in the reporting described above.

4. Payments to Certified Patient Centered Medical Homes

For all enrolled members whose medical home is (a) certified as a Patient Centered Medical Home or (b) a participating practice in the Rhode Island Chronic Care Sustainability Initiative, Contractor shall pay that practice a minimum care management fee of \$3 per member per month

5. State Right to Open Up Participation

The State reserves the right, after contract award, to open up participation, without competition, to other health plans, including ones meeting the definition of a Medicaid managed care organization under Section 4701 of the Balanced Budget Act of 1997.

ATTACHMENT L

**CARE MANAGEMENT PROTOCOLS FOR RHODY HEALTH OPTIONS
PROGRAM**

ATTACHMENT L

CARE MANAGEMMENT PROTOCOL FOR RHODY HEALTH OPTIONS PROGRAM

The overriding goal of the Rhody Health Partners and Rhody Health Options programs is to provide eligible members access to quality services and supports tailored to their needs that maximize their health care status, promote their independence, and maintain their quality of life in the most cost-effective manner. To this end, the Contractor shall be required to develop and maintain policies and procedures directed at this goal that is approved by EOHHS. The Contractor shall comply with all State and Federal legal, administrative and programmatic requirements related to these programs and adhere to the provisions of the Contract.

This Attachment L highlights the guiding principles and care philosophies of the Rhody Health Options programs and the following key components of care management:

- Person-Centered System of Care
- Risk Profiling
- Overview of Care Management
- Telephonic Initial Health Screen
- Comprehensive Functional Needs Assessment
- Designated Lead Care Manager
- Plan of Care
- Multi-Disciplinary Care Management Team
- Implementation, Coordination and Monitoring of the Plan of Care
- Transitional Care Planning
- Analysis of Care Management Effectiveness, Appropriateness and Patient Outcomes

Each of these topics is discussed below. The Contractor shall develop a Care Management Plan indicating the policies, procedures and practices to cover all components addressed in this Attachment and provide it to the EOHHS for approval thirty (30) days prior to the effective commencement date of operations.

1. Guiding Principles and Care Philosophy

The following are the guiding principles and care philosophy that the Contractor shall

embrace in administering the Rhody Health Partners and Rhody Health Options programs.

- Establish and maintain a person-centered care system
- Facilitate access to timely, appropriate, accessible and quality primary, acute, behavioral health, long-term care and community support services
- Provide Member with the full continuum of Medicaid covered services through a multi-disciplinary team of providers
- Promote a integrated and coordinated system of care that meets Member needs
- Ensure that the primary care setting serve as an effective medical home
- Conduct a comprehensive functional needs assessment to assess the Member's medical status, behavioral health, risk factors and human service conditions
- Develop an integrated Plan of Care tailored to members medical, behavioral health, long-term care, human services, support and special needs
- Provide services delivered in the most appropriate care setting for each member based on their medical, behavioral health, and social needs
- Increase the proportion of individuals successfully residing in a community setting
- Decrease avoidable hospitalizations, emergency room utilization and reduce nursing home admissions and lengths of stay
- Build on existing Medicaid long-term care re-balancing and *Rhode to Home* initiatives
- Build on and link with existing community resources to meet Member needs
- Tailor “successful evidenced-based practices” from other environments to meet the needs of Rhode Islanders
- Maximize the use of technology to improve access care and provision of care while reducing cost
- Empower members to self-direct their care, when appropriate
- Build on existing Medicaid long-term care re-balancing initiatives including the *Rhode to Home* demonstration grant to leverage existing resources and to improve health care outcomes

The following highlights the key components for the Rhody Health Options programs.

2. Person Centered System of Care

The Contractor shall implement a person-centered system of care that governs the care provided to Rhody Health Options members. The focus of a person-centered system of care is on the individual, their strengths, and their network of family and community supports in developing a flexible and cost effective plan to allow the individual maximum choice and control over the supports they need to live in the community.

A person-centered system of care respects and responds to individual needs, goals and values. Within a person-centered system of care, individuals and providers work in full partnership to guarantee that each person's values, experiences, and knowledge drive the creation of an individual plan as well as the delivery of services. A person-centered system of care is built on the principle that members' have rights and responsibilities, know their circumstances and needs first-hand, and should be invested in the care they receive. Person-centered care establishes a foundation for independence, self-reliance, self-management, and successful intervention outcomes.

For members requiring long-term care services and supports (LTSS), Care Managers role in the person-centered process is to enable and assist LTSS members to identify and access covered services and available providers. The member's personally defined outcomes, preferred methods for achieving them; training supports, therapies, treatments, and other services needed to achieve those outcomes become part of a written person-centered services and support plan. The person-centered Plan of Care also supports individuals' ability to self-direct services.

A person-centered system of care is strength based. While recognizing and addressing needs, deficits, and supports; interventions are crafted based on the unique set of strengths, resources, and motivations that each member brings. The member, or his/her designee, is meaningfully involved in all phases of the care management process including in the comprehensive functional assessment of needs, development of an integrated care plan, delivery of care and support services, and in evaluating the effectiveness and impact of care including the need for continued care or supports. In a person-centered system of care the member has the primary decision-making role in identifying his or her need, preferences and strengths, and a shared decision making role in determining the services and supports that are most effective and helpful to them. Person-centered systems require the leveraging of existing community resources to support Member needs and the involvement of the member's informal support system. Person-centered system often requires agreements with community organizations to provide peer navigators/mentors to address the non-medical needs of members. Most importantly, person-centered systems require direct "High-Touch" face-to-face contact throughout the care management process between care managers/providers with the member. The Contractor ensures that these values and requisites prevail in the program for Rhody Health Partners and Rhody Health Options members. The person-centered system of care facilitates a partnership among the member, his/her family, providers, and treatment team coordinators.

The following are illustrative key requisites of a person-centered system of care:

- Member participates in developing choices with respect to their services and supports, and must hold decision-making authority over which of the available services and

supports to employ and which of the available providers to work with. Enrollees should not face any penalty or reduction in benefits for exercising freedom of choice.

- Member has control over who is included in the planning process.
- Member has choices about the extent of involvement of their personal care provider(s) in their individual care team and appeal processes (ranging from no involvement to acting on individual's behalf for all care decisions).
- Member has the right to choose to designate someone (e.g. a family Member, friend or caregiver) to serve as their representative for a range of purposes or time periods. If a representative is needed at a point in time when an individual is too impaired to make a choice, the representative should be someone who has a history of close involvement with the person.
- Member is a part of the Interdisciplinary Care Management Team.
- Care planning meetings are held at a time and place that is convenient and accessible to the Member.
- MCOs provide information that allows a member to understand and make informed decisions about service options including providing information about *Olmstead*¹ rights to all individuals who use LTSS. Health Plans must also provide information about advance directives.
- Mechanisms are in place to minimize conflict of interests in the facilitation and development of the plan.

Person-centered systems of care emphasize self-direction, which is a service model that empowers public program participants and their families by expanding their degree of choice and control over LTSS they need to live at home. Many self-directing program participants share authority with or delegate authority to family members or others close to them. Designation of a representative enables minor children and adults with cognitive impairments to participate in self-direction programs.

Self-direction represents a major paradigm shift in the delivery of publicly funded home and community-based services (HCBS). In the traditional service delivery model, decision making and managerial authority is vested in professionals who may be either state employees/contractors or service providers. Self-direction transfers much (though not all) of this authority to participants and their families (when chosen or required to represent them).

Self-direction has two basic features, each with a number of variations. The more limited

¹ The Supreme Court decision in *Olmstead v. L.C.* is a ruling that requires states to eliminate unnecessary segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs. More information is available at <http://www.ada.gov/olmstead/index.htm>.

form of self-direction—which the Centers for Medicare & Medicaid Services (CMS) refer to as employer authority—enables individuals to hire, dismiss, and supervise individual workers (e.g., personal care attendants and homemakers). The comprehensive model—which CMS refers to as budget authority—provides participants with a flexible budget to purchase a range of goods and services to meet their needs.

The core feature of self-direction is the choice and control that participants have in regard to the paid personnel who provide personal assistance services. This is because almost all participants receiving HCBS receive personal assistance services and, for many, this is either the only or the primary service they use.

In Rhode Island, the self-directed program is called Personal Choice. The goal of the Personal Choice Program is to provide a home and community-based personal care program where individuals who are eligible for Long Term Services and Supports (LTSS) have the opportunity to exercise choice and control (i.e., hire, fire, supervise, manage) individuals who provide their personal care, and to exercise choice and control over a specified amount of funds in a participant-directed budget. Participants choose a service advisement agency and a fiscal agent to assist in making informed decisions that are consistent with their needs and that reflect their individual circumstances. Additional information regarding the Personal Choice program is available in the procurement library at <http://www.ohhs.ri.gov>.

The Contractor shall implement a self-directed model for members. The Contractor shall work with EOHHS in adopting self-directed programs and in identifying the appropriate population groups and members to participate in a self-directed program.

In administering a self-directed model, the Contractor shall be required to continue to contract with PARI and Tri-Town for the first twelve (12) months of program operations to support self-directed members. (These sub-contractors conduct on-line assessments, background checks on care givers as well as serve as a fiscal intermediaries and advisors to members). The Contractor will oversee and approve Plans of Care and personal budgets. The Contractor shall indicate in the Care Management Plan how they perform these functions. After the first twelve (12) month period, the Contractor shall be required to subcontract with organizations to perform fiscal intermediary responsibilities for members who receive self-directed supports and services. The Contractor has the option to enable the fiscal intermediary sub-contractor to perform care management functions and to conduct the re-assessments.

Rewarding Work (www.rewardingwork.org) is a website that provides an online registry of personal care assistants/individual support providers to people with disabilities and/or their families. Rhode Island is one of several States that has an agreement with Rewarding Work Resources, a 501 (c) (3) nonprofit corporation, to provide access to the Registry for Medicaid recipients enrolled in Self-Directed Care programs. Rhode Island Medicaid recipients who are enrolled in the following programs receive free access to the worker registry on Rewarding Work:

- Personal Assistance Services and Supports (PASS)

- Respite for Children Program
- Personal Choice Program

In addition, entities that provide care management and care coordination to participants in the above programs have access to the Registry as well in order to assist participants in locating and hiring support staff. Rhode Island has participated in Rewarding Work since 2007 and there are currently 750 Medicaid recipients and/or their families who have memberships subsidized by this agreement and they have access to a pool of approximately 2800 workers from which to choose from.

The Contractor shall have policies and procedures to ensure that a person-centered system is maintained that will also be part of the Contractor's Care Management Plan.

3. Risk Profiling

The Contractor shall be required to have policies, procedures, practices and systems that identify Rhody Health Options members who require, who are "at risk" of requiring, and who may benefit from care management. The Contractor shall establish priorities regarding who receives care management as well as the amount and scope of care management members receive. The identification of members requiring care management occurs initially upon enrollment and shall continue throughout the care delivery process. The current Rhody population consists of individuals with varying medical, behavioral health and LTSS needs, who are in different care settings, and are in different stages of their life. Consequently, Members require different levels and types of care management. Conceptually, there may be Members with Low Level, Medium Level, and High Level needs depending on the complexity of their conditions and the availability of their existing informal support network. Since care management resources are finite, the Contractor shall establish priorities and determine which population subgroups to prioritize receipt of care management. In essence, the Contractor uses a Predictive Modeling capability that identifies Members with immediate care management needs and identifies those who are "at risk" of requiring care management and may benefit from care management. This type of assessment enhances positive healthcare outcomes as a result of interventions provided to members. A thorough analysis of claims data, encounter data or data from other systems over a two-year period shall be used in Predictive Modeling. A risk score shall be used to establish the level and type of action or care management that is required. For example, some members may only require a Telephonic Screen, others may require a Comprehensive Functional Needs Assessment, others may require the development of a Plan of Care, still others may require a Peer or Para-Professional Care Manager, while other Members may require a Medical or Social Work clinical professional Care Manager. A data "sweep" and subsequent analysis of the data to identify new members requiring care management assessment is conducted monthly.

The ability to intervene at any given point of time is most critical to the next treatment phase or to the outcomes of intervention on members. Member needs change throughout the care delivery process and thus their care management needs change. The Contractor shall have an integrated system that tracks a member's condition and documents events (e.g. emergency room

encounters, hospital admissions, nursing home admissions) that suggest a member requires care management. The system shall provide the Care Managers with vital information in a timely fashion so that the appropriate interventions (e.g. care coordination, care management or additional services and supports, Plan of Care changes) may be provided to improve a member's health care status and to avoid unnecessary use of limited resources.

An Initial Telephonic Screen or a Comprehensive Functional Needs Assessment shall be conducted on members identified as requiring or at risk of care management services, depending on their risk level.

4. Overview of Care Management

The mission of the Integrated Care Program is to transform the delivery system through purchasing person-centered, comprehensive, coordinated, quality health care and support services that promote and enhance the ability of Medicaid-only and Medicaid/Medicare eligible (MME) recipients to maintain a high quality of life and live independently in the community. Care management is a critical component of this strategy. EOHHS will build upon, improve and integrate with current Care Management programs to better meet the needs of the target population. Care should be less fragmented and more person-centered; care managers should strive to better communicate across settings and providers; and Members should have greater involvement in their care management. The goals of care management are to:

- **Improve member health and quality of life** as indicated by: (1) improved quality of care, health outcomes and quality of life for Members, (2) ensured involvement of Members and their families in the care management process, (3) promoted effective and ongoing health education and disease prevention activities, and (4) provided and coordinated support for family caregivers,
- **Decrease Care Fragmentation** as indicated by: (1) provided maximum physical and functional integration of care management through the primary care site, (2) facilitated access to timely, appropriate, accessible, and person-oriented physical and behavioral health care, LTSS, and other community based resources, (3) increased communication and coordination of care across all members of the care team, and (4) identification of duplicative care management activities and the designation of a principle care manager, and
- **Optimize Resource Utilization** by reducing avoidable emergency room visits, hospitalizations, and nursing home admission and lengths of stay.

Optimal care management requires a combination of three basic types of activities: (1) a set of "high-touch," person-centered, care management activities requiring direct interaction with the recipient and the care team, (2) data collection, analysis, interpretation, and communication of data to the care team, and (3) monitoring and quality assurance of care management activities.

EOHHS believes that for certain individuals, person-centered care management activities are optimally delivered when functionally and, where possible, physically integrated into a multi-disciplinary, primary care-based practice team with the capacity to support this function.

The Contractor shall provide care management to Rhody Health Options members who are receiving community-based or institutional long-term services and supports. The Contractor shall document those members who decline care management and the reasons for denial. The Contractor shall provide care management services to Rhody Health Options members who may benefit from care management such as Members with complex medical conditions or Members that exhibit “risk” behaviors that may lead to institutional care or high cost services. The Contractor shall establish an early warning system and procedure that foster the early identification of “at risk” members and has the capability to identify member’s emerging needs. The Contractor shall also have effective systems, policies, procedures and practices in place to identify Members in need of care management services.

Care management consists of nine major components: (1) Telephonic Initial Health Screen, (2) Comprehensive Functional Needs Assessment conducted face-to-face, (3) Designation of a Lead Care Manager, (4) Development of a Plan of Care, (5) Creation of a Multi-Disciplinary Care Management Team, (6) Conflict Free Case management, (7) Implementation, Coordination and Monitoring of Plans of Care, (8) Transition Care Planning, and (9) Analysis of Care Management Effectiveness, Appropriateness and Patient Outcome. These components are discussed below.

5. Telephonic Initial Health Screen

The Contractor shall conduct a Telephonic Initial Health Screen on all new members not currently receiving LTSS within forty-five (45) days of enrollment and every one hundred and eighty (180) days thereafter, unless a member’s condition or needs dictate otherwise. (Members receiving LTSS receive a Comprehensive Functional Needs Assessment as discussed below). For the first twelve (12) months of the program, the re-assessment may be conducted annually. Members for whom the Contractor is unable to reach via phone, may be mailed an assessment, while outreach attempts continue by Contractor.

The Contractor shall use a structured and standardized screening instrument to serve as a guide to conduct and to document the results of the Telephonic Initial Health Screen. The Telephonic Initial Health Screen explores the member’s condition and need for care management services. The result of this assessment is to identify those Members who require a Comprehensive Functional Needs Assessment. The Contractor shall have policies and procedures governing the Telephonic Initial Health Screen Assessment including the instrument and the criteria to be used to select members who will receive a Comprehensive Functional Needs Assessment that is part of the Contractor’s Care Management Plan, approved by the EOHHS. EOHHS reserves the right to designate the screening tool.

6. Comprehensive Functional Needs Assessment

The Contractor shall conduct A Comprehensive Functional Needs Assessment for the following three populations:

- **Members Living in the Community Receiving Long-Term Services and Supports (LTSS) Services.** An assessment shall be completed within fifteen (15) days of enrollment. The assessment is conducted in person. The in-person re-assessment shall be conducted every ninety (90) days or sooner if required based on the Member's conditions or needs.
- **Members Living in an Institution.** An assessment shall be conducted within thirty (30) days of enrollment. The assessment shall be conducted in-person. The in-person re-assessment shall be conducted every one hundred and eighty (180) days or sooner if required based on the Member's condition or needs.
- **Members Living in the Community Who are not using Long-Term Services and Supports (LTSS) But Where Determined to be "At-Risk" by the Health Plan and Would Benefit From Care Management During the Initial Screen, Care Management Resources Permitting.** If required upon completion of the Initial Health Screen, a Comprehensive Functional Needs Assessment shall be conducted within fifteen (15) days as being selected to receive care management. The assessment is conducted in-person. The in-person re-assessment is conducted every one hundred and eighty (180) days or sooner if required based on the Member's condition or needs.

The Contractor has one hundred and eighty (180) days to complete assessments on all members enrolled during the initial start-up period of this contract. Failure to meet this requirement will result in sanctions to the Contractor.

The Contractor shall provide a consultation and assessment within fifteen (15) calendar days of a Member's or caregiver's request. For post-hospitalizations, a home re-assessment shall occur within five (5) days and adjustments to the Plan of Care shall be made, as necessary.

The Comprehensive Functional Needs Assessment shall be conducted in-person face-to-face at the member's residence. The Telephonic Initial Health Screen and the in-person Comprehensive Functional Needs Assessment may be conducted by a paraprofessional non-licensed staff person under the supervision and oversight of a licensed clinician.

The Comprehensive Functional Needs Assessment is strength based and person center assessment that at minimum shall cover the following to determine member existing condition, level of needs and individual preferences:

- Medical history
- Functional status
- Mental health screen, including depression screen

- Cognitive functioning and dementia
- Alcohol, tobacco, and other drug use
- Nutritional status
- Developmental Disabilities
- Social service needs (heating, food insecurity, etc.)
- Risk factors identification
- Identification of avoidable hospitalizations or other high cost institutional services
- Housing
- Home Modifications (i.e. ramps, chairlifts)
- Informal support system
- Other service needs (e.g. legal)
- Home safety evaluation, including fall risk screen
- Family structure and social supports
- Well-being (self-report)
- How to report abuse and neglect
- Willingness or interest in vocational rehabilitation or future employment
- Self-identified areas of unmet needs and wants, such as transportation arrangements
- Advocacy agencies to support the member such as the State Ombudsman
- Information regarding Statewide health information exchange: CurrentCare

State staff authorizes HCBS for a transitional period (may be thirty days) after determined to be eligible for LTSS and provides the Contractor with all relevant clinical and authorization materials to use in the Comprehensive Functional Needs Assessment conducted in the Member's residence.

The Contractor shall be required to establish policies and procedures that govern the comprehensive functional assessment and level of care determination including an assessment tool that covers the topics noted above including the policies, procedures, practices, assessment tools and criteria used in needs assessments and level-of-care determinations. EOHHS shall approve the policies, procedure and Comprehensive Functional Needs Assessment Tool.

In conforming to the precepts of a person-centered system of care, the Member, his/her care giver, and family shall take an active role in identifying Member conditions, strengths/weaknesses, and unmet needs.

7. Designated Lead Care Manager

The Contractor shall ensure that every member receiving care management services has a designated lead Care Manager. The background, training and experience of the lead Care Manager shall be determined by the member's principal needs. The Care Manager may be: a registered nurse (RN) for those members with complex and chronic medical conditions, a licensed and registered nurse with experience with members receiving long-term care services, a licensed clinical social worker or counselor for members with behavioral health needs, or a peer navigator/care coordinator for members with social service needs. The Contractor shall establish

and EOHHS shall approve minimum qualifications and experience for Care Managers. The Contractor shall maintain policies and procedure for assigning individuals criteria for assigning Care Managers to ensure an equitable distribution of workload. The Contractor also has established case load for the Care Manager based on the type of care managers and the population they serve. Case loads shall be based on the varying needs of the different populations groups and the intensity of support required based on the intensity of their medical, behavioral health, and long-term needs and existing informal support system.

The Contractor shall establish the role and responsibilities of each type of Care Manager for the different populations served. In some cases, the Care Manager may be required to provide intensive care management and care coordination relating to the provision of physical, behavioral health, and LTSS for members with complex medical conditions and chronic disorders. The Care Manager's responsibilities may include:

- Participate in development of a care plan
- Refer Members for care
- Follow-up with providers to obtain treatment results
- Provide health education including the proper use of medical resources including the emergency room
- Provide or link to self-management and disease management education
- Explain desired treatment results and outcomes
- Coordinate the delivery of medical, behavioral health care, and long-term care
- Track and monitor Plan of Care progress and achievement of treatment goals and objectives
- Review the Plan of Care periodically and make appropriate revisions in collaboration with the Member and the Member's provider(s)
- Assist providers in obtaining the necessary authorization to provide services, including access to alternative therapies
- Coordinate service delivery among all the providers associated in the Member's care, and
- Provide other medically related support.

Some members may only require assistance in accessing support services, coordinating non-medical care or require a "peer mentoring" relationship. The responsibilities of these Care Managers may include:

- Assist with making appointments for health care services
- Cancel scheduled appointments if necessary
- Assist with transportation needs
- Follow up with members and providers to assure that appointments are kept
- Reschedule missed appointments
- Link members to alternatives to high cost institutional based medical resource including the emergency room, when appropriate
- Assist members to access both formal and informal community-based support services such as child care, housing, employment, and social services

- Assist members to deal with non-medical emergencies and crises
- Assist members in meeting Plan of Care goals, objectives and activities
- Provide emotional support to members, when needed,
- Serve as a role model in guiding the member to practice responsible health behavior.

Members are able to receive Care Management through care management programs already available by the Contractor. In other cases, new Care Manager Positions may have to be developed. The Contractor shall review existing Care Manager staffing and propose the entire Care Manager capability that shall be available to Rhody Health Options program including the roles and responsibilities of Care Manager for the different populations groups covered. The Contractor shall indicate in its Care Management Plan whether the care managers will be employees of the Contractor or employees of a sub-contractor.

The Contractor shall employ only State licensed clinical staff for person receiving LTSS. Para-professionals or non-licensed staff may serve as Care Managers for members not receiving LTSS. The Contractor shall designate the licensure, certification, and experience for the Care Manager for each of the populations they serve in the Care Management Plan.

EOHHS maintains the right to approve the type of Care Managers, their background and experience, the populations they serve, their roles and responsibilities, and their caseloads.

Although it is advantageous for the lead Care Manager to be on-site in the PCP's office where practical, it is not a requirement.

8. Plan of Care

The Contractor shall ensure that a Plan of Care is developed and services in place within five (5) days of the completion of the Comprehensive Functional Needs Assessment for all Rhody Health Options members who receive care management. The Plan of Care reflects the needs of the member as identified in the Comprehensive Functional Needs Assessment. The Plan of Care shall be based on a structured predefined format prescribed by the Contractor that will also be flexible to document individual member needs. The development of the Plan of Care shall be a collaborative process with the member, his/her designee, Care Manager, Primary Care Provider (PCP) and other medical, behavioral health or social service providers, depending on the members needs. The Plan of Care shall be comprehensive and documents the needs and interventions based on a member's medical, behavioral health, LTSS, social services and other critical needs (e.g. legal or housing) related to the member. The Plan of Care shall reflect that members receive needed care and services through a seamless, person-centered and integrated system. The Plan of Care shall balance formal and informal community and family resources. The Plan of Care shall be personalized and built on member strengths and preferences. The Plan of Care shall establish the framework to integrate and coordinate the entire range of care required by the Member.

The Plan of Care and its related processes shall advance the principles and tenets of the person-centered system of care. Examples of these principles and tenets include, but are not

limited, to the following:

- The person centered plan shall integrate all elements of needed medical, behavioral health, LTSS, social service community living supports. An Integrated Multidisciplinary Care Team has responsibility for developing and implementing the Plan of Care.
- The Plan of Care shall be prepared in person-first singular language and is comprehensible to the consumer and/or representative.
- In order to be strength based, the positive attributes of the member shall be documented at the beginning of the plan.
- The Plan of Care shall identify risks and the measures taken to reduce risks without restricting the individual's autonomy to undertake risks to achieve goals.
- Goals shall be documented in the member's or their representative's own words and the amount, duration, and scope of services and supports is understood by the Member.
- Specific person(s) and/or any provider agency responsible for delivering services and supports shall be identified.
- The Plan of Care shall include a discussion of acute care preferences and anticipates care transitions needed for a return to the community from any temporary setting including the emergency room, a hospitalization, or a nursing home admission, as well as transitions requested by any individual who desires and is capable of a less restrictive community placement.
- Other non-paid supports and items needed to achieve the goal shall be documented. The Plan includes the signatures of all people with responsibility for its implementation, including the individual and/or representative, and a timeline for plan review.
- The Plan of Care shall identify the person and/or entity responsible for monitoring the Plan and everyone involved (including the member) must receive a copy of the Plan.
- The Plan of Care shall include strategies for resolving conflict or disagreement within the process, and includes clear conflict-of-interest guidelines for all planning participants, as well as a method for the beneficiary to request revision of a plan, or appeal the denial, termination, or reduction of a service.

The following are topics that shall be covered in the Plan of Care, at a minimum:

- Member's physical and behavioral health status

- Primary and secondary diagnosis
- Functional needs and status
- Chronic conditions
- Short and long term goals, objective, and expected outcomes
- Barriers to goal, objectives, and expected outcomes
- Medical interventions needed
- Disease and self-management intervention needed
- Prevention and wellness interventions needed
- Interventions to address special needs (e.g. pain management, cognitive impairment, physical/vocational/speech therapy)
- Behavioral Health interventions needed
- Developmental disability services
- Long-term interventions (institutional and HCBS)
- Informal support system interventions
- Emergency Back-Up Plan for LTSS Members
- Self-directed services and supports
- Social service interventions
- Other required interventions (e.g. housing, legal, recreational)
- Advanced Care Planning/Living Will
- Risk Mitigation Plan to address members' risk-factors for LTSS Members

The Plan of Care shall identify the amount, scope, intensity and duration of services and interventions. The Plan of Care will also indicate responsibilities for the coordination of care and the periodicity for reviewing Plans of Care. Copies of the Plan of Care shall be provided to Members, his/her designee, Care Manager, PCP and other key providers.

The Contractor shall honor the service authorizations and providers used by Members (including staying in the nursing home they reside in) enrolled in the Health Plan during the start-up period for the duration of the current service authorization. New members who are enrolled in the Health Plan after the initial start-up date shall be required to use the Contractor's provider network.

The Contractor shall comply with the benefits and related requirements for members who are enrolled in the Federal *Rhode to Home* demonstration grant. The Contractor shall comply with the reporting requirements of that program so that EOHHS meets Federal demonstration requirements. Details regarding the *Rhode to Home* demonstration are discussed later in this document and in the operational protocol governing the Demonstration that is contained in the Procurement Library.

To ensure that decisions are close to the delivery of services, the Contractor encourages and empowers decision-making authority closest to the member as possible. For example, Care Managers may authorize and arrange transportation to a community organization or event for a depressed member who is depressed and needs social interaction, or authorize a nursing home stay for respite purposes. Additionally, Care Managers may coordinate discharge planning to

manage transitions across care settings. Another example includes purchasing gym Memberships for a Member who is overweight.

The Contractor shall establish Plan of Care policies, procedures and practices including the development of a standardized, flexible and informative Plan of Care format. The Contractor shall also have procedures to monitor the development of Plans of Care including reviewing a representative sample of Plans of Care to ensure that requirements are met, and to take appropriate action to remedy problems. Contractor shall have procedures in place to monitor and follow up implementation of individual's person-centered plans. This process includes mechanisms to ensure that paid and unpaid services and supports are delivered, and that integrated care teams monitor progress toward achieving individuals' goals, and review the care plan according to the established timeline. The Contractor shall provide a feedback mechanism for the individual to report on progress, issues and problems. The Contractor's policies, procedures and practices related to Plans of Care shall be approved by the EOHHS.

9. Multi-Disciplinary Care Management Team

A Multi-Disciplinary Care Management Team (Care Management Team) shall be assembled to meet the Member needs as identified in the Comprehensive Functional Needs Assessment and the required intervention services and supports noted in the Plan of Care. The Multi-Disciplinary Care Management Team may consist of all or some of the following individuals:

- Member
- Family Member and care givers, at the discretion of the Member
- Lead Care Manager
- Secondary Care Manager
- Peer Navigator
- Pharmacist
- PCP
- Behavioral Health Specialist
- Therapists
- Long-term care provide
- Other key medical specialists or human service providers

The Contractor shall establish policies, procedures and practices to ensure the assembly and proper functioning of a Multi-Disciplinary Care Management Team to meet member needs, including the frequency of Care Management Team meeting. The Contractor shall also ensure that Care Management Team meetings are conducted at times and locations that considers the members circumstances. EOHHS reserves the right to approve the policies, procedures and practices related to the Care Team the establishment and functioning of Care Teams.

The Contractor shall establish policies and procedures for the establishment of care management ratios that take into account the risk profile the enrolled population that reflects:

- Need for interpreters,
- Case Mix,
- Need for acute services,
- Travel time,
- Lack of family and social support, and
- Other factors deemed appropriate by the Contractor.

New members may have been receiving primary care services through a Patient Centered Medical Home (PCMH) site. Where possible, the Care Managers at those sites shall be an integral part of the Multi-Disciplinary Care Management Team for those members. The Contractor shall indicate in its Care Management Plan how the Multi-Disciplinary Care Management Team shall continuously inform the provider team regarding the Plan of Care and the authorization of LTSS services in the home.

Contractors shall be required to subcontract with a community-based organization to provide peer navigator services that meet EOHHS specified performance requirements and meet the performance standards in the Model Contract.

10. Conflict Free Case Management

The Contractor shall implement a conflict free case management system with the following characteristics.

- ***There is separation of case management from direct services provision:*** Structurally or operationally, case managers should not be employees of any organization that provides direct services to the individuals. Ideally, conflict free case management agencies are stand-alone and provide **no** other direct services. This prevents financial pressure for case managers to make referrals to their own organization or the “trading” of referrals.
- ***There is separation of eligibility determination from direct services provision:*** Eligibility for services is established separately from the provision of services, so assessors do not feel pressure to make individuals eligible to increase business for their organization. Eligibility is determined by an entity or organization that has no fiscal relationship to the individual.
- ***Case managers do not establish funding levels for the individual:*** The case manager’s responsibility is to develop a plan of supports and services based on the individual’s assessed needs. The case manager cannot make decisions as to the amount of resources (individual budget, resource allocation, or amount of services).
- ***Individuals performing evaluations, assessments, and plans of care cannot be*** related by blood or marriage to the individual or any of the individual’s paid caregivers, financially responsible for the individual, or empowered to make financial or health-related decisions on behalf of the individual.

11. Implementation, Coordination and Monitoring of the Plan of Care

The lead Care Manager shall be responsible for executing the linkages and monitoring the provision of needed services identified in the plan. This includes making referrals, coordinating care, promoting communication, ensuring continuity of care, and conducting follow-up. Implementation of the member's Plan of Care shall enhance his/her health literacy while being considerate of the member's overall capacity to learn and (to the extent possible) assist the member to become self directed and compliant with his/her Plan of Care. Critical components of the care coordination/implementation process shall include:

- Refer members to services
- Track and follow-up on care provided
- Serve as a "communication hub" in the coordination of care between primary care, specialty care, behavioral care, institutional care, LTSS and end of life care
- Communicate and refer to community-based resources
- Support transitions from hospital to community or nursing facility to community
- Provide member education and self-management support
- Collaborate with providers
- Utilize behavior change techniques and motivational interviewing practices
- Coordinate medication management with a pharmacist,
- Coordinate the provision of community-based services and supports
- Refer as appropriate to end-of-life services and supports
- Monitor changes in Member's conditions and needs
- Monitor the impact of services and care, and the need for continued or additional services

Monthly telephone contact is required for members receiving care management services. Quarterly home visits are required with one (1) home visit annually shall be unannounced. Visits shall be conducted monthly for RItE @ Home members.

The lead Care Manager must establish an Emergency Back-Up Plan that will provide support to members twenty-four (24) hours per day and seven (7) days per week. The Back-Up Plan identifies key people or agencies that the member should contact when there is a disruption in the on-going support that is provided to them so that they remain safe and able to function in the community. The Care Manager may utilize the individual's informal or formal supports to comprise initial emergency back-up procedures for the individual. Additionally, the Bidder must assist in obtaining emergency services and supports in urgent cases where the disruption in the on-going support that is provided to the individual has placed him or her at risk.

The Contractor shall coordinate with providers the provision of all out-of-plan services including Members with SPMI and developmental disabilities.

The Contractor shall use existing data and analytic capacities to identify the changing needs and risks of members; stratify members' needs according to acuity and risk for

hospitalization or nursing home placement, communicate with care teams regarding high risk Members, and ensure that Members receive appropriate, timely and comprehensive care management services. The ability to modify members Plan of Care to ensure the appropriateness of service is an essential component. The Contractor shall apply systems, science, and information to identify members with potential care management needs and assist members in accessing care management services with the goal of improving and maintaining quality of life.

The Contractor shall be responsible for monitoring and ensuring the quality and effectiveness of care management activities in multiple ways, including through contractual arrangements with PCPs, community health and social service resources or other entities providing integrated care management services. The effectiveness of the care management process is measured by the review and analysis of patient outcomes. Contractors shall develop processes to collect and submit population based measures to the State quarterly for review. State approved measures must be used to monitor success.

Contractor shall ensure clear delineation of responsibilities between Health Home and Contractor in order to avoid duplication by the Contractor of services provided by the Health Home. Contractor shall refer to *Operational Protocols for Collaboration Between Health Plans and Health Homes*.

12. Management of Care Transitions

Success of this program depends on the ability of the Contractor to manage the transition of Members when they move across care settings, such as:

- Hospital to nursing home
- Hospital to home/community
- Nursing home to hospital
- Nursing home to community
- Community to nursing home
- Community to hospital

Transition Management Models exist throughout the nation (e.g. The Coleman Care Transitions Intervention program is based on the work of Eric Coleman, MD, from the University of Colorado). The Contractor must adopt or modify existing transition models, or develops their own to ensure effective transitions and the continuity of care when Members move between levels of care. A key in transition management is to have effective strategies that prevent Members from moving to a higher level of care, when it is avoidable.

Transitional Care Management means that care management and support during transitions across care settings are available 24/7. This includes a transitional care management program that provides onsite visits with the Care Manager upon discharge from hospitals, nursing homes, or other institutional settings. Care Managers will assist with the development of discharge plans. Transitional care reflects Rhode Island's best practices in hospital transitions of

care, by requiring the Contractor to incorporate experiences, lesson learned and best practices the Nursing Home Transitions Program and from the *Rhode to Home* demonstration grant.

The Contractor shall have policies, procedures and practices for transitioning Members between levels of care settings that are approved by EOHHS.

13. Analysis of Care Management Effectiveness, Appropriateness and Patient Outcomes

The Contractor shall be responsible for monitoring and ensuring the quality and effectiveness of care management activities in multiple ways, including through contractual arrangements with primary care providers, community health workers or other entities providing integrated care management services. Expectations for care management activities will be developed by EOHHS. Each Member with care management needs shall have a Plan of Care that addresses his/her individual health related needs that when successfully implemented, assists him/her to reach their optimal level of wellness and self direction.

The effectiveness of the care management process shall be measured by the review and analysis of patient outcomes. The Contractor shall develop processes to collect and submit population based measures to EOHHS quarterly for review. EOHHS approved measures are used to monitor success.

The Contractor shall maintain effective systems, policies, procedures and practices that govern the Care Management process. The Contractor is expected to have integrated electronic information systems that maximizes interoperability in order to provide care managers with access to all essential data related to the member (including but not limited to: Member's clinical history, diagnosis, sentinel events, urgent/on-going care need), other data sources (pharmacy, utilization) and data mining tools (predictive modeling, risk scores) to: (1) place a Member into his/her appropriate care management model (for that particular date in time); (2) implement his/her Plan of Care; (3) monitor care plan for effectiveness and appropriateness; and (4) modify the care plan to accurately reflect any change in the member's circumstances. Strong consideration should be given to the use of the State's Health Information Exchange, **Currentcare**, to support information exchanges, particularly around transitions of care.

These are the Care Management protocols that Contractors shall comply with in serving Rhody Health Options programs. The following are the standards for community-based organizations performing Peer Navigator Services for Rhody Health Options members.

STANDARDS FOR COMMUNITY-BASED ORGANIZATION PERFORMING PEER NAVIGATOR SERVICES FOR RHODY HEALTH OPTIONS MEMBERS

For Peer Navigator Services, the Contractor shall contract with a community-based entity that meets the following qualifications.

- Ability to establish and maintain a productive partnership with Contractor.
- Ability to integrate and coordinate peer navigator services with the care provided through the Contractor. The Community Based Entity must assign a specific Supervisor and specific Peer Navigator staff to the Rhody Health Options members in order to foster that integration and coordination of care and to establish staff familiarity.
- Hire and maintain diverse and qualified full-time and/or part-time peer navigators, as required to meet member needs based on a caseload not exceeding 35 - 40 members per full-time equivalent.
- All staff hires are contingent on successful background checks through nationally recognized organizations (e.g. BCI)
- Train and prepare Peer Navigators to provide services to members beginning November 1, 2013. The training protocols shall be approved by EOHHS and the Contractor and shall include, but not be limited to: organizational training protocols; confidentiality and appeal process requirements; motivational interviewing; the Rhody Health Options program overview/training; the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) substance abuse treatment guidelines and programming including Recovery Coach training materials. See Attachment A for EOHHS required trainings.
- Provide peer navigators with on-going training, technical support and supervision in providing peer navigation services, as needed and specified in EOHHS and Contractor training and operational requirements.
- Supervisors and Peer Navigators will be expected to provide assistance with member outreach and engagement. The assigned Supervisor and Peer Navigators will conduct initial health screens and comprehensive needs assessments as needed.
- Ensure that Federal and State requirements related to the confidentiality of protected health information are complied with and that the appropriate releases of information are and informed consent exists from the member.
- Maintain a policy and procedures manual for peer navigator services that at minimum includes:
 - Receipt and logging of incoming referrals
 - Assignment of referral to Peer Navigators
 - Monitoring Peer Navigator and Supervisor case loads and performance
 - Communication between Peer Navigator and the Contractor

- Tracking and reporting peer navigator services
- Discharge of Rhody Health Options members from care management
- Maintain Rhode Island-based central office space for program administration purposes and space for meetings between members and Peer Navigators, when necessary (Although these meetings may occur at provider sites, community sites, or in member homes).
- Conduct initial outreach of members within five business days of referral from the Health Plan.
- Submit monthly reports to the Health Plan on contract performance including information on referrals received, members served, referral and linkages made to services, the status of members, and other key elements related to the efficacy of contract services
- Meet future contract requirements as agreed upon with the Health Plan throughout the contract period.

Supervisor Responsibilities

A supervisor shall be assigned to supervise Peer Navigators assigned to Rhody Health Options members. The Supervisor performs as a day-to-day liaison to the Health Plan and is essential in the development and maintenance of a positive working relationship between the Health Plan and the Community Based Entity. The supervisor and Peer Navigators act in concert with and as an adjunct to the Health Plan care management staff and therefore, the supervisor's role is essential in assuring that peer navigator services are integrated and coordinated with the care provided by the Health Plan.

Supervisors shall also perform the following activities:

- Review the cases referred by the Health Plan.
- Oversight and assure completion of initial health screens and/or comprehensive functional needs assessments.
- Assign Peer Navigator specific cases based on member needs.
- Monitor Peer Navigator caseloads and performance.
- Provide on-going technical assistance, supervision and training to Peer Navigators.
- Provide each Peer Navigator with intensive supervision weekly for the first 60 days of their employment and biweekly thereafter, as needed.
- Initially accompany new Peer Navigators to meetings with Medicaid and MME beneficiaries and periodically thereafter, as required and accompany Peer Navigators on difficult cases, as needed.
- Discuss difficult cases or resolve pressing issues, daily.
- At a minimum, conduct group meetings twice monthly with all Peer Navigators to review cases and to discuss available community resources.

- Track and summarize peer navigator services provided and members served.
- Monitor contract compliance and the overall performance of the Peer Navigator services.

Peer Navigator Responsibilities

The Peer Navigator shall be a problem solver, teacher and peer of the member who has intimate knowledge of available community resources; ability to link members with a total array of resources that assist members overcome barriers to proper use of the health care system; the skills and experience to assist members be responsible, accountable and self-sufficient; and relate to members and serve as their mentor and coach to achieve the desired outcomes. The Peer Navigator must be able to function as an extension of the care management team and, at the same time, be an advocate for the member. Specifically the Peer Navigator shall perform the following activities:

- Conduct Initial Health Screens and in-person Comprehensive Functional Needs Assessments
 - Assist in locating and engaging members.
 - Complete initial health screens and comprehensive functional needs assessments with members.
 - Collaborate with appropriate Health Plan staff.
- Develop Plan of Care
 - Contact Health Plan staff and providers to obtain details about the case, where necessary.
 - Communicate, collaborate and coordinate on the development of a person centered plan of care.
 - Further identify member's health care status, access and barriers to care.
 - Participates with the member in developing an action plan to help address and resolve social issues, as appropriate.
- Continue to Outreach and Engage the Member Throughout Treatment Process
 - Contact and meet with members throughout the treatment process.
 - The Peer Navigator uses motivational interviewing skills to engage with member.
 - Assist members to achieve their goals, objectives and activities/action steps in the plan of care.
- Reduce Barriers to Non-Emergent Care
 - Link/reinforce medical home concept.
 - Link members to alternatives to ER (e.g. urgent care settings) for non-emergent care.
 - Assist/train members with obtaining, scheduling and rescheduling health care appointments.
 - Assist/train members in arranging medical appointment transportation.
 - Follow-up with providers to assure appointments are kept.
- Develop Resources to Non-Emergencies and Crises

- Assist/train members to access both formal and informal community-based support services (e.g. child care, housing, employment, legal, social services).
- Teach/coach members in effective use of community-based health and social service systems
- Link members to ongoing social support mechanisms or "social networks" (e.g. group, neighbors, extended family, associations or other social networks).
- Provide Emotional Support and Serve as a Role Model
 - Assist members in developing coping skills when needed.
 - Serve as a role model and guide members to practice responsible health behaviors.
- Transition Members to Independence /Case Closure
 - Continue to engage with members and provide Peer Navigation services until the goals in the Plan of Care are met
 - Provide transitional support (e.g. referral to any specific targeted on-going support services, contact Health Plan Lead Care Manager should problems resurface, assist members with re-engagement if necessary, etc.) at case closure.
 - Maintain records, documentation, and statistics as required by the Health Plan and/or EOHHS.

Required Staffing Skills and Qualifications

The specific skills and qualifications of a Peer Navigator shall include the following:

- High school education or higher
- Paraprofessional with personal experience in serving those with special health care needs and those with complex medical problems and chronic conditions
- Possess life experience as a consumer, parent or family member of a consumer with special needs
- Ability to relate to Medicaid and MME beneficiaries and to address barriers to care
- Ability to work collaboratively among members, families, treatment providers, and Health Plan program staff, etc.
- Ability to promote person and family centered, culturally sensitive care
- Trained in motivating Medicaid beneficiaries and serving as a peer navigator
- Able to advocate for person and family centered care
- Skilled/trained to use Motivational Interviewing with Medicaid members
- Knowledgeable of Rhode Island health care environment
- Demonstrated prior success in accessing community-based resources in Rhode Island, is preferred
- A person in good community standing

EOHHS Approved Training Program

EOHHS shall approve all training for Peer Navigators. The training shall include the following:

- Overview of the Integrated Care Initiative including: Medicaid 101 Understanding Emergent Health Care and Alternatives and how to reach the “unreachable members”.
- Overview of other EOHHS and DHS Programs,
- Orientation to Health Plans
- Motivational Interviewing
- Home Visiting & Safety Training
- The “Professional Peer” – From My Story to All Stories
- Navigation – systems, organizations, accessing available services
- Department of Health Initiatives and Programs
 - Medical Home Projects Department of Health
 - Injury Prevention Initiative
 - Comprehensive Cancer Control Program
 - Diabetes
 - Immunization
 - Asthma Program
 - Adolescent Transition
 - Minority Health & Cultural Competencies
 - Initiative for a Healthy Weight
 - Chronic Disease Self-Management Program
- Behavioral Health and Programs in RI
- Community and State Health and Wellness Initiatives
- The POINT
- SSA Benefits and E-Services, Employment Network
- RI Public Transit
- Rhodes to Independence Initiatives
- Rhodes to Independence Home Modifications
- Programs offered through The Office of Rehabilitation Services
- Governor’s Commission on Disabilities
- Rhode Island Council of Community Mental Health Organizations
- Rhode Island Disability Law Center
- Intro to Understanding Culture and Diversity
- Effective Communication Skills and Conflict Resolution
- Boundaries, Confidentiality and Ethical Practices
- Overview of Substance Abuse and Recovery
- Employment Resources
- RI Housing (e.g. Sect 8, Subsidized and Crossroads)
- Care Coordination, Documentation and Note Taking
- Understanding Community Resources and Diverse Agencies in RI
- Overview - Dept. of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH)
- Division of Elderly Affairs Programs (e.g. Elderly Protective Services)
- Overview of the Ombudsman

- Navigating DME and other resources related to equipment
- Additional training to be determined by the Contractor or EOHHS

ATTACHMENT M

NURSING HOME TRANSITION INCLUDING RHODE HOME REQUIREMENTS

ATTACHMENT M

NURSING HOME TRANSITION *INCLUDING RHODE TO HOME* REQUIREMENTS

1. Nursing Home Transition Including *Rhode to Home* Members

The Contractor shall establish policies, procedures and practices for Medicaid recipients in the *Rhode to Home* (*RTH*) demonstration grant, and other nursing home transition processes.

2. *RTH* Eligibility

Eligibility for the *RTH* demonstration is regulated by Federal demonstration requirements and final approval of all potential *RTH* enrollees is conducted by EOHHS. The Contractor shall follow EOHHS's policies and procedures related to the *Rhode to Home* eligibility process. To identify potential *RTH* participants prior to transition, the Contractor must confirm the following criteria have been met and submit the appropriate documentation to the State for approval (as established by the State). A member shall meet initial enrollment eligibility criteria.

- Reside in a nursing home for at least 90 consecutive days (the days may not include those days that were for the sole intent and purpose of receiving short term rehabilitation).
- Be Medicaid eligible (at least one day immediately prior to discharge); and (1) once the above criteria have been met, the Contractor must inform the member about the *RTH* demonstration grant, and (2) obtain an informed consent to participate in the *RTH* demonstration grant which is signed by the member or their legal guardian (if applicable).
- The Contractor reports to EOHHS for review a list of all potential *Rhode to Home* participants that meet the initial enrollment criteria outlined above. EOHHS establishes all reporting requirements for initial enrollment.
- Members that meet all initial enrollment criteria and have signed an informed consent will be deemed "*RTH* Enrollees".
- EOHHS will provide verification of enrollment status for those members that meet all criteria for initial enrollment in the *RTH* demonstration grant. Members that meet all initial enrollment criteria and have been verified by the State as eligible for enrollment will be deemed "*RTH* Enrollees".

The specific criteria to determine a member's eligibility to participate in the *RTH* demonstration grant include:

- The member must move to a *RTH* qualified residence that meets the requirements established by the EOHHS. The qualified residences include: (1) an individual's home, or apartment like setting that includes areas for sleeping, bathing, living and kitchen, (2) the home or apartment must be owned or leased by the individual or their caregiver or family member; and (3) the home may be a group home where no more than four individuals reside.
- Additional qualifying criteria may also apply such as: (1) the individual must have the right to choose their service provider; and (2) unless otherwise assessed and identified as a need within the individual's Plan of Care, the residence must offer unrestricted access to the areas within the residence; cannot require notification of absences; and cannot reserve the right to assign apartments or change apartment assignments.
- EOHHS establishes all required documentation for participation in the *RTH* Demonstration grant. EOHHS will provide verification of participation status for those members that meet all criteria for participation in the *Rhode to Home* demonstration grant. Members that meet all participation criteria and have been verified by EOHHS as eligible for participation will be deemed "*RTH* Participants".
- The Contractor shall forward all required documentation to the EOHHS at periodic intervals established by the EOHHS. Intervals established by the EOHHS may include, but are not limited to: pre-transition (length of stay in the nursing home, Medicaid eligibility status, and signed consent); immediately after transition (residence documentation); and ongoing care coordination (includes but is not limited to: progress and ongoing review, critical incidents, 24/7 back-up plan and all additional required reporting as established by the State).
- The Contactor tracks and reports to the State, in a manner established by the State, when an individual's participation in the *RTH* demonstration grant ends.

3. Referrals from Minimum Data Set 3.0 (MDS Section Q)

The Contractor shall receive referrals from the Office of Community Program (OCR), the State Local Contact Agency (LCA), regarding those individuals who indicated through the MDS Section Q that they are interested in learning more about LTSS that may be available in a community based residence. The Contractor shall utilize the information to identify individuals who are interested in receiving Long Term Care Options Counseling (LTC Options Counseling)

and reports back to the State the outcome of each referral in a manner established by the State..

4. Long Term Care Options Counseling

The Contractor shall coordinate with the State's Aging and Disability Resource Center (ADRC) to ensure that LTC Options Counseling is provided to members who were referred through the MDS Section Q process as well as other independent referrals received for individuals living in institutions and community based residences. LTC Options Counseling is provided in a manner that: (1) is consistent with the practice established by and provided by State representatives; and (2) utilizes materials and supports established by and/or approved by the State.

5. Nursing Home Referrals

EOHHS requires all referrals to be processed through the OCP. Nursing homes will be reminded to send all Section Q and transition referral to the OCP as is the current process. Should the Contractor receive referrals from other sources (i.e. from NF directly, from individuals, family members, physicians, or other sources), the Contractor is required to submit the required referral information to the State. The Contractor should also proactively review data to identify those individuals that have resided in a nursing home or other specified institutions that are likely candidates to transition to a community based residence and could potentially receive HCBS. The Contractor conducts a screen of potential candidates who desire to transition to a community-based residence and may be eligible to receive HCBS.

- For members that have resided in a nursing home for ninety (90) days or longer, the Contractor assesses the individual every 6 months for possible transition. The Contractor shall provide documentation to the State, if the individual, individual's guardian or responsible party determines that ongoing assessments are not appropriate.
- The Contractor shall provide documentation and reports, in the manner established by the State, on all members assessed, the potential ability to transition, barriers to potential transition, and any additional criteria established by the State.
- A Plan shall be developed to provide LTC Options Counseling and information for potential transition to a community based residence.
- Other information shall be reviewed such as, but not limited to: the patient's length of stay in the nursing home, assessed needs, the individual's eligibility status for Medicaid, the individual's preferred or potential home and community-based residence including any applicable rental leases as well as other screening criteria established by EOHHS.

The Contractor shall submit this information to EOHHS.

6. Affordable Housing

The Contractor shall develop policies and procedures to identify affordable housing options for Members that are interested in transitioning from nursing homes (and other institutions as specified by the State). The Contractor supports members to identify:

- Affordable apartment units listed within Public Housing Authorities.
- Tenant based rental assistance and voucher programs.
- Opportunities for members to reside in a home or apartment with a caregiver or family member.
- Supportive housing models including but not limited to: Assisted Living Residences with affordable units including those that participate in the State's Assisted Living Waiver program, subsidized housing options with personal care assistance and behavioral health supports
- Other affordable housing options including but not limited to low income housing tax credit programs.

The Contractor shall hire a Housing Specialists to assist members who are interested transitioning from a nursing home to a community based residence. The Housing Specialist utilizes resources of affordable housing options available to individuals across the State. Resources should include web-based housing search tools such as HomeLocatorRI.net, Rite Resources, SocialServe.com, and written materials for the individual to use in choosing a housing model. The Housing Specialists discusses with members varying housing alternatives and assists the member choose a suitable residence that is safe and meets their needs. The Housing Specialist works with the Transition Coordinator in assessing the suitability of housing options.

The Housing Specialists shall have the knowledge and experience in working with housing entities and advocating for individuals' rights in landlord-tenant general contracting practices. General knowledge and experience includes: expertise fair housing regulations, tenant-landlord rights and reasonable accommodation requests. Additionally, Housing Specialists are familiar with community based long term services and supports, that can be provided in the varying housing models to help support individuals residing in the community.

7. Transitioning Process to a Community-Based Residence

The Contractor shall designate a lead staff person to serve as a Transition Coordinator. The Transition Coordinator responsibilities shall be to ensure the following occurs.

- **Conduct a Comprehensive Clinical Assessment** that includes but is not limited to: a clinical assessment conducted by a nurse, a social services assessment containing a psychosocial evaluation, and a risk assessment.
- **Develop a Person Centered Plan of Care** to address all of the individual's LTSS needs that will be provided once they transition to a community based residence. The person centered Plan of Care includes but is not limited to services and care to be provided, clinical and non-clinical supports and services, a risk mitigation plan, and a 24/7 emergency back-up plan.
- **Transition Coordination and Care Management** is provided based on the specification outlined below for at least 365 days after the date of transition. Care Management is provided in a manner that meets the individual's varying medical and non-medical needs. Care Management includes non-traditional or specialized Care management when needed by the member. The Contractor's care management policies, procedures and practices must be approved by EOHHS. The Contractor shall be required to have systems in place to track and document the provision of services and care management provided to members throughout transition process.

The Contractor shall be required to conduct a face-to-face visits based upon the following minimum criteria (or more frequently based upon individual's need): (1) conduct a face-to-face visit in the individual's home on the date of discharge from the nursing home, (2) weekly visits and/or phone contact in the community during the first month of transition with a minimum of two face-to-face visits, (3) monthly visits and/or phone contact beginning month two through twelve after the individual transitions to a community based residence. For *RTH* participants' monthly visits and/or phone contact continues until the end date of *RTH* participation, which is tracked by the MCO. The frequency of face-to-face visits or phone contact occurs with members based on their individual needs.

The transition coordination and care management period shall begin once the member transitions to a community based residence and lives in the residence. A member's transition period may extend beyond 365 consecutive days if the individual experiences an interruption in their community support services due to hospitalization, critical incident, or other extenuating circumstances.

The care management process shall also include, but is not limited to, ensuring that a member's specialized service needs (e.g. physical disabilities, intellectual and/or

developmental disabilities, veterans with disabilities, elders with dementia, mental health and substance abuse illnesses, chronic homeless, caregiver support) are met so that members have the ability to live safely and independently in the community.

- **Ongoing Care Management** is provided once the individual completes the Tradition Coordination and Care Management period outlined above. The Member begins receiving ongoing care management as established in the prior Section.
- **Quality of Life** surveys must be conducted for all members transitioning from nursing homes, and other institutions as defined by the State, to community based residences to ensure that they are receiving the services and supports they need to maintain the quality of life they desire.

The Contractor shall contract with the Alliance for Better Long Term Care to perform Quality of Life surveys for all Transition cases, in the manner established by the State and utilizing the Quality of Life survey tool approved by the State.

For members transitioning from nursing homes to community based residences, Quality of Life surveys are required to be conducted three (3) times per individual: at least three (3) days prior to transition, eleven (11) months post discharge from the nursing home, and twenty-four (24) months post discharge from the nursing home. For *RTH* cases, the results of the Quality of Life survey must be reported to the State in the manner established by the State.

8. Additional Services

The Contractor shall provide Peer Navigator/Peer Mentor specialized care management services to meet member needs who do not require complex high level clinical support but require assistance and peer mentoring to access community services such as persons: with disabilities; who are elderly; with a history of homelessness, who have been identified as a veteran; with intellectual or developmental disabilities, and other possible specialized needs that may be identified on an individualized basis.

The State also supports and strongly recommends the use of an Ombudsman to serve as an advocate for transitioning members who receive HCBS such as home care and need additional advocacy during their transition period.

9. Critical Incidences

For Nursing Home Transition Members, EOHHS reviews and monitors critical incidents that impact the individual during their transition coordination and care management phase. The Contractor shall submit documentation, in the manner established by EOHHS, on all critical incidents such as: hospitalizations, emergency room visits, medication errors, physical abuse,

neglect, self-neglect, financial exploitation, police involved incidences, and disasters that result in recipients that are displaced from their homes. EOHHS establishes the requirements for incident documentation, review, and ongoing monitoring process. The Contractor shall review all critical incidents as they are reported to ensure the member remains safe in their home environment including the circumstances surrounding the critical incident and the continued needs of the member.

For *RTH* Participants, the State currently contracts with the Alliance for Better Long Term Care to report all critical incidents such as: hospitalizations, emergency room visits, medication errors, police involved incidences, and disasters that result in recipients that are displaced from their homes. For all *RTH* qualified participants, the Contractor shall be required to contract with the Alliance for Better Long Term Care to continue to report these critical incidences to the Health Plan in the manner established by the State.

10. Home and Community Care Emergency Back-up Plan

For members transitioning from an institutional setting to a home and community based setting, the Transition Coordinator shall establish an Emergency Back-Up Plan that shall provide support to the individual 24 hours per day and seven days per week. The Back-Up Plan identifies key people or agencies that the member should contact when there is a disruption in the on-going support that is provided to them so that they remain safe and able to function in the community. The Transition Coordinator may utilize the individual's informal or formal supports to comprise initial emergency back-up procedures for the individual. Additionally, the Contractor shall assist in obtaining emergency services and supports in urgent cases where the disruption in the on-going support that is provided to the individual has placed him or her at risk.

For *Rhode to Home* eligible participants, the Alliance for Better Long Term Care (Alliance) functions as the third or final level of back-up in emergent situations. In this role the Alliance works with the Member in determining the severity of their situation, identifies the steps the member took prior to calling the Alliance, and provide necessary support or service to meet the member's needs. For all *RTH* qualified participants, the Contractor shall be required to contract with the Alliance to continue to report usage and actionable occurrences under the 24/7 emergency backup plan to the Contractor in the manner established by EOHHS.

11. Reports to EOHHS

The Contractor shall be required to report on all nursing home transition and *RTH* members as required by EOHHS including but not limited to information related to: referrals, assessments, Plans of Care, transitions, residence information, service provision and care coordination, risk and mitigation plans, critical incidences, 24/7 emergency back up plans, service outcomes, case management progress and review updates, service and supports encounter data and other information required by EOHHS and in the prescribed frequency and formats.

The Contractor shall assist EOHHS to monitor certain benchmarks and program goals for Rhode to Home members. One such benchmark goal is to increase the number of individuals participating in a self-directed option. EOHHS will establish the baseline number of self-

directed program members and the Contractor will increase the number of participants in the self-directed option by five percent (5%) each year and will ensure ten percent (10%) of the Rhode to Home participants receive LTSS through a self-directed model. Another such benchmark would be to assist EOHHS in meeting the Rhode to Home transition benchmarks as outlined in the Money Follows the Person Operational Protocol for the Rhode Island *Rhode to Home* Demonstration Project.

12. EOHHS Support

EOHHS shall designate a staff person to work with the Contractor in implementing and operating the Nursing Home Transition Program and *Rhode to Home* demonstration grant. The State is prepared to share its policies, procedures, protocols and tools, and report systems currently employed in the nursing home transition and *Rhode to Home* demonstration grant as well as train Health Plan staff.

The Contractor will designate a staff person to work with EOHHS to implement and ensure on going compliance with all transition and documentation requirements outlined in this Attachment and in this agreement.

EOHHS will provide technical assistance, oversight and monitoring activities, throughout the duration of the Federal Demonstration period, regarding all aspects of the *RTH* demonstration program.

ATTACHMENT N

QUALITY AND OPERATIONS REPORTING REQUIREMENTS

ATTACHMENT N

QUALITY AND OPERATIONS REPORTING REQUIREMENTS

This section of the Quality and Reporting Requirements lists the preliminary measures for Phase I and provisional measures for Phase II. The Rhode Island Executive Office of Health and Human Services (EOHHS) reserve the right to add, modify, or remove measures. The reporting format and periodicity of a reporting schedule is to be determined by EOHHS. Indicators described below may be assessed either by reports submitted by contractor or one site reviews by EOHHS. Data are to be provided in aggregate, Member-specific, and program-specific formats as determined by EOHHS. In addition, to the preliminary performance indicators listed below, the Bidder is expected to submit reports in the following areas:

Care Management:

A monthly report of the percentage of Members in Care Management (total) and stratified by HCBS program, using a snapshot point in time. This report should also include the percentage of Members who decline Care Management.

A quarterly Member-specific Care Transitions report of follow-up visits within thirty (30) days after discharge from an acute care setting partitioned by the following time frames: seven (7), fourteen (14), twenty-one (21), and thirty (30) days.

Critical Incidents:

A monthly report of the number and percent of critical incidents partitioned by the following, at a minimum:

- Hospitalizations
- Emergency Department (ED) Visits
- Involvement with the criminal justice system
- Natural disaster
- Missing person
- Falls
- Medication error which resulted in an ED visit and/or hospitalization
- Abuse
- Homicides
- Natural death
- Exploitation
- Suicide
- Attempted suicide
- Self-neglect/neglect
- Use of 24-hour emergency back up

This report should also include the percentage of Intentional Injuries caused by others and by type, including those reported to Adult Protective Services (e.g., abuse or neglect), intentional self-inflicted injuries, and number and rates of death by type (e.g., natural, accident, homicide, suicide, or critical incident). Critical incidents are to be reported as required per federal and state law.

Nursing Home Transitions:

A monthly report of the number and percent of all members that transitioned from a nursing home, including, the percent of members that remain in the community at minimum six (6) month post discharge from the nursing home, and the number and percent of failed nursing home placements. This report should be stratified by all nursing home transitions and members participating in the Rhode to Home (RTH) Program. A case review is to be completed for any member who transitions from a nursing home, including those members participating in RTH who are placed back in a Nursing Home within six months of their transition date

If one or more of the criteria below are met, the placement will be considered a failed placement.

- **Transfer Trauma.** A worsening of the client's medical condition or symptoms after the transition that could be attributable to the transition. This could be due to the transfer itself or to the change in environment, including caretaker issues.
- **Failure to adjust.** A lessening of the client's ability or perceived ability to live in the new setting might include such manifestations as anxiety, depression, lack of appetite, medication refusal, lessening mobility, frequent falls, sleep disturbance, incontinence and personality changes.
- **Failure of the service plan.** Inadequate service hours, service unavailability, inadequate or inappropriate housing, loss of housing, poor quality services and unanticipated changes in caretaker involvement or family support.
- **Inadequate documentation and education to client and family.** A transition that was made in the absence of adequate documentation, including medical and psycho-social issues. Clients, family, and other appropriate representatives must be provided with adequate information to make a responsible choice, and failure to provide that information may constitute a failed placement. The burden of proof is on the Office of Community Programs to show that full and accurate information was provided to the client and/or the representative of the client and that transition orientation, preparation and training was adequate for both client and family members.

Phase I: Preliminary Performance Indicators			
Area	Goal	Benchmark	Source of

			Measure
Member Services	Identification cards are distributed within 10 calendar days of Plan receipt of enrollment information*	98%	Health Plan
	Member handbooks and materials are distributed within ten (10) calendar days of Plan receipt of enrollment notification	98%	Health Plan
	Two new Member welcome call attempts are documented within thirty (30) calendar days of enrollment	98%	Health Plan
	During operation hours Member Service calls are answered by a live voice in 30 seconds average speed to answer*	98%	Health Plan
	Grievances and Appeals are resolved within Federal Balanced Budget Act time frames*	98%	Health Plan
Beneficiary Protection	For members that report a critical incident, the Care Plan must demonstrate the completion of an updated risk assessment and mitigation plan	100%	Health Plan
	Member and/or caregivers receive education and information, annually at a minimum, about how to identify and report instances of abuse and neglect	100%	Health Plan
Care Management	Non-LTSS Members receive an initial telephonic assessment within forty-five (45) days of enrollment*	95%	Health Plan
	Non-LTSS Members who are identified for a comprehensive needs assessment will have a face to face visit assessment completed within thirty (30) days of the initial telephonic assessment*	95%	Health Plan
	A comprehensive face-to-face visit assessment is completed within fifteen (15) days for recipients of Community Long Term Care Services and Supports (LTSS); within thirty (30) days for nursing home residents *	95%	Health Plan
	Members identified as requiring a comprehensive assessment must have an individualized Plan of Care completed within five (5) calendar days	100%	Health Plan
	Members receive a follow up visit including the completion of a risk assessment within five (5) days post hospitalization	98%	Health Plan
	All comprehensive needs assessments	98%	Health Plan

	conducted by the plan should include documentation of completed home safety evaluations and appropriate follow up thereafter		
	Members receive options counseling (see Table of Contents, Article I: Definitions, page II) as part of the comprehensive needs assessment (telephonic and home visit)	95%	Health Plan
	Plan of Care should be reviewed and updated no less than five (5) calendar days after completion of a comprehensive needs re-assessment	95%	Health Plan
	Care plans clearly demonstrate adequate and appropriate care and service plan, including social and environmental supports, shared decision making, involvement of the Member and/or caregiver in plan development, and assessment of Member goals and preferences*	95%	Health Plan
	All Members are screened for Fall Risk at least once within a twelve- (12-) month period	98%	Health Plan
	Members are screened for clinical depression using a standardized tool and follow up is documented	98%	Health Plan
Nursing Home Transitions (NHT)	Members have a risk assessment (as defined per NHT protocol) prior to transition to the community*	100%	Health Plan
	Members have a Care Plan in place as part of transition to community which includes the following elements: -risk mitigation plan -twenty-four (24) hour back-up plan -identification of risks (completion of risk assessment & how those risks were addressed) -shared decision-making -assessment of Member goals and preferences	100%	Health Plan
	The number and percent of failed nursing home placements based on Nursing Home Transitions failed placement criteria	5%	Health Plan
	Members have a home visit within one (1) calendar day of their transition to the community*	100%	Health Plan

	Members transitioned into the community are transitioned into a home and setting of their choice that is fully accessible on the day of transition	100%	Health Plan
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* Denotes Performance Goal Measure

Nursing Home Quality Measures		
% of LTC patients with a hospital admission	Percent of long-stay nursing facility residents (i.e., residing in a nursing facility continuously for 100 days prior to the second quarter of the calendar year) who were hospitalized within six (6) months of baseline assessment	CMS, MEDPAR Administrative Claims
% of High Risk Residents with Pressure Ulcers (Long Stay) 5 star	Percent of all long-stay ² residents in a nursing facility with an annual, quarterly, significant change or correction MDS assessment during the selected quarter who were identified at high risk and who have one more stage 2-4 pressure ulcers	CMS MDS Data
% of LTC patients with a Urinary Tract Infection (UTI) (Long Stay)	Percent of all long-stay residents with a selected target assessment that indicates a urinary tract infection within the last thirty (30) days	CMS MDS Data
% of long stay residents who received an antipsychotic medication	Percentage of all long-stay residents with a selected target assessment where the following condition is true: antipsychotic medications received	CMS MDS Data
% of long-stay residents who report either (1) almost constant or frequent moderate to severe pain in the last 5 days or (2) any very severe/horrible in the last 5 days.	Percent of long-stay residents with a selected target assessment where the target assessment meets either or both of the following two conditions: <ol style="list-style-type: none"> 1. Resident report almost constant or frequent moderate to severe pain in the last five (5) days. Both of the following conditions must be met: Almost constant or frequent pain and at least one episode of moderate to severe pain. 2. Resident reports very severe/horrible pain of any frequency 	CMS MDS Data

Phase 2: Provisional Performance Indicators

2 All residents in an episode whose cumulative days in the facility is greater than or equal to 101 days at the end of the target period. An episode is a period of time spanning one or more stays, beginning with an admission and ending with either a discharge or the end of the target period (whichever comes first). A target period is the span of time that defines the QM reporting period (e.g. a calendar quarter).

HEDIS^{®3} (Effectiveness of Care, Access/Availability of Care, & Utilization & Resource Use)		
Measure Name	Measure Description	Measure Steward & Data Source
Persistence of Beta-Blocker Treatment After a Heart Attack	Percent of Members 18+ during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six (6) months after discharge	NCQA Administrative Claims
Cervical Cancer Screening	Percent of Member women 21-64 years of age who received one or more Pap tests to screen for cervical cancer	NCQA Administrative Claims
Use of Imaging Studies for Low Back Pain	Percent of members (18-50) with a primary diagnosis of low back pain who did not have an imaging study	NCQA Administrative Claims
Annual Monitoring for Patients on Persistent Medications	Percent of Members 18+ who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year (ACE/ARB, Digoxin, Diuretics, Anticonvulsants and total rate)	NCQA Administrative Claims
Follow Up After Hospitalization for Mental Illness	Percent of discharges for Members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner	NCQA Administrative Claims
Care for Older Adults	Percent of Member adults 65 years and older who received the following during the measurement year (Advance Care Planning, Medication Review, Functional Status Assessment, Pain Screening)	NCQA Administrative Claims and/or Hybrid
Colorectal Cancer Screening	Percent of Members 50-75 years of age who had appropriate screening for colorectal cancer	NCQA Administrative Claims

³ (Healthcare Effectiveness Data and Information Set) is a registered trademark of the National Committee for Quality Assurance (NCQA).

Glaucoma Screening in Older Adults	Percent of Medicare members 65+ who received a glaucoma eye exam by an eye care professional for early identification of glaucomatous conditions	NCQA Administrative Claims
Flu Shot for Older Adults (CAHPS®)	Percent of Medicare members 65+ as of January 1 of the measurement year who received an influenza vaccination between November 1 of the measurement year and the date when the Medicare CAHPS® Survey was completed	AHRQ/NCQA Survey
Pneumonia Vaccination Status for Older Adults (CAHPS®)	Percent of Medicare members 65+ as of January 1 of the measurement year who ever received a pneumococcal vaccine	AHRQ/NCQA Survey
Medication Reconciliation Post D/C	Percent of Member discharges from January 1 to -December 31(?) of the measurement year for members 66 + for whom medications were reconciled and/or within 30 days	NCQA Administrative Claims and/or Hybrid
Fall Risk Management (Medicare Health Outcome Survey)	Discussing Fall Risk: Percent of Medicare members 75 years of age and older or 65-74 years with balance or walking problems or a fall in the past twelve (12) months, who were seen by a practitioner in the past twelve (12) months and who discussed falls or problems with balance or walking. Managing Fall Risk: Percent of Medicare members 65+ and older who had a fall or had problems with balance or walking in the past twelve (12) months, who were seen by a practitioner in the past twelve (12) months and who received fall risk intervention from their current practitioner	NCQA/CMS Medicare HOS Survey
Cholesterol Management for Patients w/ Cardiovascular Conditions	Percent of Members 18-75 years of age who were discharged alive for AMI, coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) from January 1 to November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and prior to the measurement year, who had each of the following during the measurement year (LDL-C screening & LDL-C control (<100 mg/dl))	NCQA Administrative Claims
Adults' Access to Preventive/Ambulatory Health Services	Percent of Members 20+ who had an ambulatory or preventive care visit	NCQA Administrative Claims

Initiation & Engagement of Alcohol and Other Drug Dependence (AOD) Treatment	Percent of adolescent and adults with a new episode of AOD dependence who: a) initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospital within fourteen (14) days of diagnosis B) Initiated treatment and who had two or more additional services with a diagnosis of AOD within thirty (30) days of the initiation visit	NCQA Administrative Claims
Adherence to antipsychotics for individuals with Schizophrenia	Percent of Members 18–64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least eighty (80) percent of their treatment period	NCQA Administrative Claims
Medicare Health Outcome Survey (HOS) and/or HOS-M® <ul style="list-style-type: none"> Improving or Maintaining Health Monitoring Physical Activity 	This measure (survey) provides a general indication of how well an organization providing benefits and services to a Medicare population manages the physical and mental health of its members. The survey measures each member's physical and mental health status at the beginning and the end of a two year period. HOS-M is a modified version for use with vulnerable populations	CMS Survey
Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care) (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	Percent of Members, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements	American Medical Association-Physician Consortium for Performance Improvement Electronic Health Record
Timely Transmission of Transition Record (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	Percent of Members, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	American Medical Association-Physician Consortium for Performance Improvement Electronic Health Record

Plan All Cause Readmission® (Note: This measure is not included in HEDIS® 2013 set for Medicaid Plans)	The number of acute inpatient stays for Members 18 years of age and older during the measurement year followed by an acute readmission for any diagnosis within thirty (30) days and the predicted probability of an acute readmission	NCQA Administrative Claims
Inpatient Utilization	This measure summarizes utilization of acute inpatient care and services in the following categories: Total Inpatient, Medicine, and Surgery	NCQA Administrative Claims (Continued Enrollment N/A)
Ambulatory Care	Utilization of outpatient visits and ED visits	NCQA Administrative Claims (Continued Enrollment N/A)
Hospital Wide (Unplanned) 30 day unadjusted all cause readmission (Note: This measure is for All Medicaid populations)	This measure estimates the hospital level, risk standardized rate of unplanned, all cause readmission after admission for any eligible within 30 days	CMS/Yale Administrative Claims

ATTACHMENT O

MEDICARE READINESS CHECKLIST AND CMS REQUIREMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850



CENTERS FOR MEDICARE & MEDICAID SERVICES

DATE: January 9, 2013

TO: Organizations Interested in Participating as Medicare-Medicaid Plans in States Seeking to Implement Capitated Financial Alignment Demonstrations in 2014

FROM: Melanie Bella
Director, Medicare-Medicaid Coordination Office

Jonathan Blum
Acting Principal Deputy Administrator and Director, Center for Medicare

SUBJECT: 2014 Capitated Financial Alignment Demonstration Timeline

This guidance provides an overview of the requirements and timeframes for the Medicare portion of the joint CMS and state plan selection process for the Capitated Financial Alignment Demonstrations. These instructions apply only to organizations seeking to offer Medicare-Medicaid Plans (MMPs) in states that anticipate implementing demonstrations in 2014. CMS will issue separate guidance on the annual resubmission requirements for organizations seeking to offer MMPs in states implementing Capitated Financial Alignment Demonstrations in 2013.

The Medicare plan selection requirements described in this document are in addition to any that may be required for the state selection process. It is important to note that many critical aspects of the demonstrations—such as self-directed care, community integration, and recovery-oriented behavioral health services—are addressed in the state requirements and are not addressed in the minimum Medicare requirements that are the focus of this guidance. The Medicare and state review processes are complementary and do not conflict with, supersede, or undermine one another's requirements. In addition, some information submitted to CMS during the Medicare plan selection process will be subject to approval by both the state and CMS. Materials that do not require state approval will also be shared with the state and may be considered in the state selection process.

CMS has aligned its plan selection timeframes with the standard Medicare Advantage and Part D review and approval schedule. Interested organizations should familiarize themselves with the Medicare process and timeframes.

CMS requires that interested organizations submit and obtain approval of, among other items, the following elements:

- A demonstration-specific application, which includes, among other items, demonstrating a network adequate to provide enrollees with timely and reliable access to providers and pharmacies for Medicare drug and medical benefits;
- A model of care that meets Medicare, Medicaid, and demonstration-specific requirements;
- A formulary that meets Part D requirements;
- A medication therapy management program (MTMP) that meets Part D requirements; and
- A plan benefit package (PBP) that integrates Medicare, Medicaid, and demonstration-specific benefits.

Table 1 below catalogues previously released guidance on the Medicare-required materials. CMS will release updated or new guidance as necessary; where more recent guidance exists or is released for topics that appear in previously released documents, interested organizations should use the most recent document.

Table 1. Previously Released Guidance

Topic	Link to document
CY 2014 Notice of Intent to Apply	http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NOIA_Memo.pdf
Preferred Demonstration Standards (Appendix 1)	http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf
Readiness Review	https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Mass_RR_memo.pdf
Waiver of Part D LIS Cost-Sharing Amounts	http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Part_D_Cost_Sharing_Guidance.pdf
Model of Care Scoring Criteria (Appendix 2)	http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MarchGuidanceDocumentforFinancialAlignmentDemo.pdf
Model of Care Submission Requirements	http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MOCGuidance.pdf

Past Performance Review
Methodology Updates
for CY 2014 4

<http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Fall2012PastPerformanceMethodology.pdf>.

A. Past Performance

It is a priority for both CMS and states to assess MMPs' capacity and experience in order to promote access to those plans that are best equipped to serve Medicare-Medicaid beneficiaries, both prior to and following the plan selection process. The joint plan selection process will therefore take into account interested organizations' previous performance in Medicare and Medicaid, as applicable. Previous performance in the Medicare program will also be used to determine organizations' eligibility for receiving passively enrolled beneficiaries. The CMS policies described in this guidance are the minimum demonstration standards and in no way prevent a state from establishing higher standards for plan selection or stricter eligibility requirements for receiving passive enrollment. Among the mechanisms CMS will use to assess an organization's Medicare performance are sanctions, the past performance review methodology, and the Medicare Plan Finder "consistently low performing" icon (LPI).

1. Sanctions

In our March 29, 2012, guidance, CMS explained that organizations currently under Medicare enrollment and/or marketing sanction are ineligible to participate in the demonstration. CMS clarifies that organizations will be ineligible to participate if they are under sanction, as described in 42 CFR 422.750 and 42 CFR 423.750, at the time CMS and the state seek to execute the three-way contract. As such, CMS will accept applications from all organizations, regardless of their sanction status, and will consider all organizations potentially eligible to participate as MMPs prior to the execution of the contracts. If, however, an organization is under sanction and that sanction is not removed at the time CMS and the state seek to execute the three-way contract, the organization will not be permitted to offer an MMP for the duration of the demonstration. An organization that is sanctioned after the execution of a contract will be unable to enroll any new members – either through passive or opt-in enrollment – until the sanction is lifted.

2. Past Performance Review and "Consistently Low Performing" Icon (LPI)

CMS' additional mechanisms for assessing an organization's overall Medicare performance, past performance outlier status and the "consistently low performing" icon (LPI), are separate designations:

- Past performance outlier status is based on an entity's performance in 11 categories – compliance letters, performance metrics, multiple ad hoc corrective action plans (CAPs), ad hoc CAPs with beneficiary impact, failure to maintain fiscally sound operation, one-third financial audits, performance audits, exclusions, enforcement actions, terminations and non-renewals, and outstanding compliance concerns not otherwise captured. An overview of the current CMS past performance methodology is included in CMS' December 2, 2011,

4 As indicated in the 2014 Application Cycle Past Performance Review Methodology Update – REQUEST FOR COMMENTS, CMS expects to issue guidance on the final methodology in January 2014. Information on the current 2013 Application Cycle Past Performance Review Methodology is available at the following link: <http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Part-C-HPMS-Guidance-History-Items/CMS1255618.html>.

HPMS memorandum entitled “2013 Application Cycle Past Performance Review Methodology Update” available at the following link: <http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Part-C-HPMS-Guidance-History-Items/CMS1255618.html>. CMS recently released draft past performance review methodology guidance for CY 2014 for comment; this guidance is available at the following link: <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Fall2012PastPerformanceMethodology.pdf>. CMS plans to release final past performance review methodology guidance for CY 2014 in January 2013.

- LPI designation is given to entities with poor or below average Medicare plan ratings (also called “star ratings” or “quality ratings”) – i.e., less than three stars for three or more consecutive years.

An interested organization that is an outlier in CMS’ past performance analysis for the upcoming Contract Year (CY) 2014 and/or has an LPI on the Medicare Plan Finder website for CY 2014 may qualify to offer an MMP, provided that the organization meets all plan selection requirements in the CMS-state joint plan selection process. However, any such organization will be ineligible to receive passive enrollment until it is no longer considered by CMS to be a past performance outlier and/or it no longer has an LPI on Medicare Plan Finder.

CMS and/or the state will determine whether an MMP is eligible to accept passive enrollment prior to the scheduled date of execution of the three-way contract. An organization that is ineligible to receive passive enrollment will only be able to enroll: 1) individuals who are currently enrolled in another Medicare or Medicaid managed care plan sponsored by the same organization; and 2) individuals who opt into the organization’s MMP. When an organization is no longer considered by CMS to be a past performance outlier and/or no longer has an LPI on Medicare Plan Finder, it may be eligible to receive passive enrollment. As discussed in Section B.1 of this guidance, CMS and the state may establish additional requirements for MMPs’ receipt of passive enrollment, such as demonstrating sufficient capacity during readiness review and meeting implementation milestones for those beneficiaries who are already enrolled.

The results of the past performance review for the CY 2014 Medicare Advantage and Part D application and contracting cycle will be finalized in early April 2013. In addition, CMS will provide states with the results of its interim past performance analysis in early 2013. CMS releases plan ratings each fall, and these plan ratings are the basis for determining whether an organization has an LPI designation. States should consider all this information, along with any applicable previous performance in the Medicaid program, in their plan selection processes.

3. Treatment of New Legal Entities in CMS’ Past Performance Methodologies

Some interested organizations that have little or no experience in the Medicare program may have a parent or sibling organization with previous Medicare experience. For these entities, CMS’ past performance and LPI methodologies consider information about the parent and sibling organizations’ previous Medicare past performance.

a. Treatment of New Legal Entities under the Past Performance Review Methodology

Under the Medicare past performance methodology, CMS identifies applying contracting

organizations with no prior contracting history with CMS (i.e., a legal entity brand new to the Medicare program). We determine whether that entity is held by a parent of other Part C or D contracting organizations. In these instances, it is reasonable, in the absence of any actual contract performance by the subsidiary applicant, to impute to the applicant the performance of its sibling organizations as part of CMS' application evaluation. This approach prevents parent organizations whose subsidiaries are poor Part C or D performers from evading CMS' past performance review authority by creating new legal entities to submit Part C or D applications. It also forces parent organizations to direct their attention away from acquiring new Medicare business when their focus should be on bringing their current Medicare contract performance up to an acceptable level. Should one or more of the sibling organizations have a high negative performance score, the application from the new legal entity will be denied.

We will apply this same methodology for purposes of determining whether a new legal entity applying as an MMP will be eligible to receive passive enrollment.

b. Treatment of New Legal Entities under the LPI Analysis

To determine whether a new legal entity applying to be an MMP will be eligible to receive passive enrollment, CMS will impute an LPI to a new legal entity – one that does not currently operate as a Medicare Advantage organization (MAO) or a Prescription Drug Plan (PDP) sponsor, or one that is too new to the Medicare program to have a plan rating calculation – if any of the sibling organizations held by that organization's parent company has an LPI prior to the execution of the three-way contract.

B. Passive Enrollment Policies

Although each state's enrollment strategy will be outlined in its Memorandum of Understanding (MOU), the following policies will serve as the minimum standards for any state requesting to use passive enrollment in its demonstration. These policies are a framework upon which states may build more stringent passive enrollment requirements.

1. Minimum Standards for Plans to be Eligible for Passive Enrollment

In addition to the CMS and state requirements for an interested organization to participate in the demonstration, MMPs must meet additional criteria to be eligible to receive passive enrollment:

- The MMP must have been selected to operate in a demonstration service area in which CMS and the state have agreed to implement passive enrollment;
- The MMP must have successfully completed the readiness review; and
- The MMP must not be a past performance outlier or have an LPI designation.

CMS and the state may also establish additional prerequisites for receiving passive enrollment at any time prior to or during the demonstration. Prior to implementation, MMPs will be required to demonstrate sufficient capacity for their projected enrollment during their readiness review. After receipt of passively enrolled beneficiaries, CMS will conduct implementation monitoring requiring MMPs to demonstrate that they can fully address the needs of those enrollees before receiving additional cohorts of passively enrolled beneficiaries.

2. Maintaining Beneficiary Choice in the Context of Passive Enrollment

Capitated Financial Alignment Demonstrations will be subject to the requirement that beneficiaries have a choice of at least two plans in a region when the state mandates Medicaid managed care enrollment for all eligible individuals, as provided in Section 4701 of the Balanced Budget Act of 1997 (BBA, P.L. 105-33) and implemented in 42 CFR 438.52. The requirement does not apply in states that do not mandate Medicaid managed care enrollment, in areas that have obtained rural or other exceptions under Medicaid rules, or to California's County Organized Health Systems (COHS). CMS will only allow passive enrollment in an area with one MMP if that service area is exempt from the aforementioned BBA requirements.

We note that, regardless of the number of plans in a service area, disenrollment from MMPs and any transfers between MMPs must be allowed on a month-to-month basis anytime during the year throughout the entire duration of the demonstration.

For those demonstrations that are required to offer a choice of at least two plans, and for which CMS has approved the use of passive enrollment, each demonstration service area must meet both of the following requirements in order to implement passive enrollment:

- The service area must have at least two MMPs that successfully pass the required readiness review;⁵ and
- At least one of the MMPs that successfully passes the readiness review in a given service area must be eligible to receive passive enrollment.

a. If at least two MMPs pass readiness review but only 1 MMP in a given service area is eligible for passive enrollment

In areas where a choice of at least two MMPs is required, and at least two MMPs pass readiness review but only one of the MMPs is eligible for passive enrollment, CMS and the state will implement strategies to ensure that the MMP eligible to accept passive enrollment also has the capacity to serve the anticipated number of new enrollees. Such strategies may include, but are not limited to, multiple periods of passive enrollment, enrollment caps, and readiness review and implementation monitoring processes that assess the MMP's capacity to accommodate the anticipated number of plan enrollees. CMS will work with states to design and implement appropriate risk mitigation strategies. As outlined more fully in Section A of this memorandum, an MMP that is not eligible to receive passive enrollment at the beginning of a demonstration may become eligible to receive passive enrollment once it is no longer identified as a past performance outlier and/or is no longer associated with an LPI in Medicare Plan Finder.

b. If only 1 MMP in a service area passes readiness review

In a service area where a choice of at least two MMPs is required but only one MMP passes the readiness review, the service area does not meet the Medicaid standard for offering beneficiaries a choice of at least two plans. As such, CMS will not permit passive enrollment in that service area even if the plan that passed the readiness review is also eligible to receive passive enrollment. In such a circumstance, CMS and the state will develop alternate strategies for enrollment, such as allowing enrollment only on an opt-in basis into the plan that passed the readiness review, or delaying enrollment for the entire service area until at least two plans have passed the readiness

⁵ For additional information on readiness reviews and implementation monitoring, states should review the Massachusetts readiness review materials available at the following link: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Mass_RR_memo.pdf.

review.

3. Passive Enrollment Phasing

CMS strongly encourages states to phase in passive enrollment during the first year of the demonstration. We also strongly encourage states to begin their implementation with a period of opt-in only enrollment. Phasing enrollment will enable CMS and a state to assess a plan's ability to serve its currently enrolled beneficiaries before allowing it to enroll new beneficiaries. The process will also spread MMPs' intensive intake and assessment efforts over a several periods of passive enrollment. The details of each state's proposed enrollment strategy will be addressed during the MOU development, at which time CMS and the state will ensure that the enrollment strategy provides robust protections to enrollees.

In order to provide states with additional CMS support that is dedicated specifically to monitoring and mitigating any operational or beneficiary access issues during MMPs' implementation of passive enrollment, CMS is offering states a choice of four timeframes in which each MMP may conduct its first phase of passive enrollment: January 1, April 1, July 1, or September 1, 2014. These options apply only to the initial round of passive enrollment for a particular MMP within a particular state; an MMP's subsequent phases of passive enrollment may occur outside these timeframes. For example, a state may choose to effectuate its initial phase of passive enrollment for all MMPs in April 2014, with a second phase of passive enrollment in June 2014 if the first wave is successfully implemented, as determined by the implementation monitoring conducted by CMS and the state.

The timeframes for initial passive enrollment phases will not affect the start dates for opt-in enrollment, which can occur at any time between January and September 2014. CMS may update this policy if there are significant challenges with rolling start dates for opt-in enrollees during the 2013 demonstration year.

4. Passive Enrollment of Individuals Included in Medicare Part D Reassignment Effective January 1, 2014

Medicare-Medicaid enrollees who are included in the Medicare Part D reassignment effective January 1, 2014, or are moved from their current (2013) Medicare Prescription Drug Plan (PDP) or terminating Medicare Advantage Prescription Drug Plan (MA-PD) to another PDP, will be eligible for passive enrollment into a state's MMP, with an opportunity to opt-out, effective January 1, 2015.

C. Notice of Intent to Apply (NOIA)

CMS' October 19, 2012, guidance⁶ provided plans with an overview of the NOIA submission process. CMS advised interested organizations to complete the CY 2014 NOIA by November 14, 2012, to guarantee that applicants will have access to the online application tool in January 2013. Though CMS cannot guarantee timely application tool access for organizations submitting NOIAs after November 14, 2012, CMS will continue to process NOIAs through January 31, 2013. Timely completion of the NOIA, as well as the CMS User ID connectivity form, is necessary for interested organizations to obtain HPMS access and meet key program deadlines. Submitting a NOIA does not

⁶ Memo available at: http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NOIA_Memo.pdf.

bind an organization to submit a formulary, application, MTMP, plan benefit package, or any other information to CMS.

D. Health Plan Management System (HPMS)

CMS uses the Health Plan Management System (HPMS) as the system of record for managing Medicare health plans and prescription drug plans. Current and prospective Medicare plans submit their applications, provider networks, plan benefit packages, formularies, and other information via HPMS. The system tracks and records CMS' review and approval of submitted materials. State reviewers will also use HPMS to review and, in some cases, approve the information submitted by plans in their respective states.

E. Demonstration Plan Application

CMS will release the HPMS Capitated Financial Alignment Demonstration Application module on January 10, 2013. Interested organizations will be required to submit their applications via HPMS by **February 21, 2013**. States will have access to interested organizations' application submissions and may use any of the submitted documentation to support the state components of the plan selection process.

Interested organizations' applications must satisfy CMS' requirements for participation in the demonstration, including:

- Part D requirements under 42 CFR §423;
- Part D and Medicare medical service network adequacy standards under 42 CFR §422.112, §422.114, and §423.120;
- A model of care for the targeted population consistent with requirements under 42 CFR §422.152(g);
- Documentation to demonstrate state licensure and solvency requirements, as well as CMS standards for fiscal soundness, consistent with 42 CFR §422.2 and §422.400; and
- Administrative and management requirements consistent with 42 CFR §422.503(b) and 42 CFR §423.504(b).

CMS will host a webinar training on the Capitated Financial Alignment Demonstration application. More information on this training is provided below.

Topic: 2014 MMP Application

Date: January 17, 2013

Time: 1:00 p.m. – 4:00 p.m. ET

Conference Line: 877-267-1577

Meeting ID: 6865

Webinar: <https://webinar.cms.hhs.gov/MMPapplicationtraining2014/>

F. Network Adequacy Determinations

Network adequacy standards will help ensure that each plan has a network of providers that is sufficient in number, variety, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. As detailed in our January 25, 2012, guidance,⁷ CMS' minimum standard for demonstrating network adequacy under the Capitated Financial Alignment Demonstration is to use Medicare standards for medical services and prescription drugs.^{8,9} For long-term care supports and services (LTSS), MMPs will use state Medicaid network adequacy standards.¹⁰ For services that are covered under both Medicaid and Medicare, such as home health, the appropriate (and more beneficiary-friendly) network adequacy standard will be determined via the CMS-state MOU development process and included in the three-way contract. In addition to meeting minimum network standards, all selected MMPs should have processes for continuously building their networks to respond to the needs and preferences of beneficiaries. Continuous network improvement efforts should include options for beneficiaries to direct their own services, as appropriate.

Interested organizations will work directly with states during the plan selection process to satisfy state-specific network adequacy requirements for LTSS, behavioral health, and any Medicare/Medicaid overlapping services for which the Medicaid standard has been agreed to by CMS and the state in the MOU. In addition, interested organizations will work with CMS to submit the necessary documentation to be evaluated against Medicare network standards for Part D and medical services. CMS understands that interested organizations and providers will require payment rate information prior to executing signed contracts. If rate information is not available prior to the February 21, 2013, application deadline, interested organizations may submit their anticipated networks based on those medical providers from whom the organization has secured

⁷ Guidance available at: <http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf>.

⁸ Medicare Advantage requires that plans maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are typically used in the network as primary care providers (PCPs), specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers. Also, plans must provide or arrange for necessary specialty care. The MA organization arranges for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet an enrollee's medical needs. 42 CFR 422.112

⁹ Part D plans must have a contracted pharmacy network that assures convenient access to network pharmacies, including retail, home infusion, long-term care, and I/T/U pharmacies. 42 CFR 423.120

¹⁰ Medicaid managed care contracts must require the plan give assurances to the state and provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the state's standards for access to care. Among other requirements, plans must maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. 42 CFR 438.207

letters of intent (LOIs). CMS and the state will verify MMPs' provider network adequacy, including executed contracts, during readiness reviews. As such, interested organizations do not need to submit their LOIs during the initial network review, though CMS may request copies of an interested organization's LOIs if necessary.

During the readiness review stage, MMPs will be able to utilize an exceptions process in areas where Medicare's medical service network adequacy standards may not reflect the number or needs of Medicare-Medicaid beneficiaries. Note that the exception request process pertains only to the medical service networks and does not apply to pharmacy networks. As part of the selection and/or readiness review process, CMS and states will establish a joint exceptions review team to evaluate MMPs' requests for exceptions for portions of service areas where the Medicare medical service standard cannot be met or where an alternate standard has been established in the MOU. The CMS-state exceptions review teams will review all submitted exceptions requests to determine the adequacy of plans' networks in areas where exceptions have been requested. Exception requests are designed to accommodate areas in which existing standards are not applicable due to limited numbers of providers or facilities or because of the specific needs of the area's Medicare-Medicaid enrollee population. The review team will not consider exceptions based solely on an interested organization's inability to contract with a sufficient number of providers and facilities in a timely manner.

G. Model of Care (MOC)

All interested organizations must submit a model of care (MOC) that meets CMS and state requirements for providing high quality care to the targeted population. MOCs are submitted as part of the Medicare application and are due no later than **February 21, 2013**. Organizations that have an approved MOC for a non-demonstration Medicare Advantage (MA) special needs plan (SNP) will be required to submit a demonstration-specific MOC.

As outlined in MMCO's March 29, 2012 and May 25, 2012, guidance memoranda,¹¹ the National Committee for Quality Assurance (NCQA) will review and approve MOC submissions on CMS' behalf based on the same 11 elements and scoring standards CMS has established for approval of MA SNP MOCs.¹² CMS approves MOCs for one, two, or three years based on the score assigned to a MOC during its review. NCQA will score the MOCs strictly based on CMS' current scoring criteria for the 11 required elements, though states may require interested organizations to include additional elements in their MOCs. For example, a state may require that interested organizations include a twelfth element that addresses demonstration-specific requirements not otherwise captured in CMS' 11 existing elements. Alternatively, states may require organizations to address state-specific requirements within the 11 elements required by CMS.

CMS has requested that states provide guidance to interested organizations on any state-specific MOC requirements by **January 25, 2013**. Interested organizations must receive sufficient guidance

¹¹ Guidance available at: <http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MarchGuidanceDocumentforFinancialAlignmentDemo.pdf> and <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MOCGuidance.pdf>.

¹² Refer to section 90 and Appendix 1 of Chapter 16b of the Medicare Managed Care Manual for more information about CMS' model of care requirements for SNPs: <http://www.cms.gov/manuals/downloads/mc86c16b.pdf>.

in advance of the February application deadline to ensure that they are able to develop and submit comprehensive, integrated MOCs by **February 21, 2013**. We have recommended that states instruct interested organizations to address state-specific requirements in separate and easily distinguishable sections and sub-sections.

NCQA will evaluate MOCs submitted in HPMS beginning in February 2013. States that elect to review MOCs will review MOCs concurrently with the NCQA review. Interested organizations will have two opportunities to correct any deficiencies identified during the review process; however, we note that the process for correcting those deficiencies is being revised for both SNPs and MMPs. Per the Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter,¹³ starting in the CY 2014 application cycle, interested organizations will only be allowed to resubmit their MOCs if they score below 70 percent. Regardless of the score earned on the subsequent resubmission, organizations receiving an initial score below 70% will only be granted a one-year approval and will be required to reapply for approval of their MOCs for CY 2015. Interested organizations that score above 70 percent on their initial submission will not be permitted to resubmit their MOCs to further improve their scores and obtain longer approval periods for their MOCs. States may elect to allow additional MOC resubmissions to allow interested organizations to address deficiencies relative to the state-specific requirements.

CMS expects that the information contained in demonstration plan MOCs will be made public. The information will be provided in a format that is easily understandable to the public, and without compromising any proprietary data that may be contained in plans' MOCs. We expect to issue further guidance on this issue.

CMS will offer two trainings on the standard MOC elements. Note that these trainings will not cover any MMP-specific requirements that states may add for their interested organizations. In addition, CMS will offer a general MOC technical assistance call. More information for the trainings and the technical assistance call is provided below.

Topic: MOC elements 1 through 5

Date: January 16, 2013

Time: 2:00 p.m. – 3:30 p.m. EST

Conference Line: 877-474-1132

Meeting ID: 83870664

Webinar: <https://ncqaevents.webex.com/ncqaevents/onstage/g.php?t=a&d=662714982>

Event Password: Approval2013

Topic: MOC elements 6 through 11

Date: January 22, 2013

Time: 2:00 p.m. – 3:30 p.m. EST

Conference Line: 877-474-1132

Meeting ID: 83878792

Webinar: <https://ncqaevents.webex.com/ncqaevents/onstage/g.php?t=a&d=661681594>

Event Password: Approval2013

¹³ Call letter available at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvgtgSpecRateStats/Downloads/Announcement2013.pdf>

Topic: MOC Technical Assistance

Date: February 5, 2013

Time: 2:00 p.m. – 3:30 p.m. EST

Conference Line: 877-474-1132

Meeting ID: 84021331

H. Formulary and Supplemental Drug Files

MMPs must submit and be approved to offer an integrated formulary that meets both Medicare Part D and Medicaid requirements. The formulary approval process requires interested organizations to submit: (1) a base Part D formulary and supplemental Part D formulary files; and (2) a supplemental non-Part D drug formulary file. Interested organizations must submit their base formularies no later than **May 31, 2013**.

In addition to submitting a base formulary, interested organizations must submit supplemental formulary files in HPMS by **June 7, 2013**.

All MMPs must submit a supplemental formulary file called the Additional Drug Demonstration (ADD) file which can only contain non-Part D drugs. Non-Part D drugs include drugs in Medicare Part D excluded categories, over-the-counter drugs, and other products required by the state to be included on the integrated formulary.

CMS has requested that states provide guidance to interested organizations as early as possible in 2013 regarding drugs required to be included on the ADD file, by NDC and/or UPC, to ensure that interested organizations indicate coverage for all state-required products, and that this guidance indicate whether interested organizations should submit a single proxy NDC or multiple NDCs on the ADD file.

State reviewers will have state-specific review tracks in HPMS that will enable them to view the base formulary submission and to review and approve the ADD file submitted by each prospective MMP in that state. The states are solely responsible for reviewing and approving the ADD file; however, CMS will approve all other submitted formulary files. Reviews will begin immediately after the submission deadline and will continue until all deficiencies have been resolved.

I. Medication Therapy Management Program (MTMP)

As provided under 42 CFR §423.153(d) and in Chapter 7 of the Prescription Drug Benefit Manual,¹⁴ interested organizations are required to submit a Medication Therapy Management Program (MTMP). Although state reviewers will be able to view MTMP submissions in HPMS, CMS is fully responsible for reviewing and approving interested organizations' MTMPs. Each interested organization must establish an MTMP that:

- Is designed to ensure that covered Part D drugs prescribed to targeted beneficiaries (those that have multiple chronic conditions, are taking multiple Part D drugs, and are likely to incur annual Part D drug costs above a certain threshold) are appropriately used to optimize therapeutic outcomes through improved medication use;

¹⁴ <http://www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter7.pdf>

- Is designed to reduce the risk of adverse events, including adverse drug interactions, for targeted beneficiaries;
- May be furnished by a pharmacist or other qualified provider; and
- Offers a minimum level of MTM services for each beneficiary enrolled in the MTMP, including interventions for both beneficiaries and prescribers, an annual comprehensive medication review (CMR) with written summaries in CMS standardized format (the CMR must include an interactive person-to-person, or telehealth consultation), and quarterly targeted medication reviews with follow-up interventions when necessary.

CMS expects to release guidance on the 2014 MTMP submission requirements via an HPMS memorandum. The 2014 MTMP submission module will be launched in April 2013, with a submission deadline in May 2013. Prior to the release of the CY2014 guidance memorandum, states may obtain MTMP information from the guidance memorandum provided to Part D sponsors regarding CY 2013 MTMP submissions.¹⁵

J. Plan Benefit Package (PBP)

1. Plan Benefit Package Submission and Review

Interested organizations must submit a plan benefit package that accurately describes the coverage details and cost-sharing for all Medicare, Medicaid, and demonstration-specific benefits. CMS will launch the HPMS PBP module in mid-April 2013; interested organizations must submit their integrated PBPs to CMS by **June 3, 2013**. No later than the launch of the PBP module in April, states should issue guidance that clearly defines the state-required Medicaid benefits and supplemental demonstration benefits. CMS will hold a training on the PBP software for interested organizations in early 2013.

The PBP review will be conducted jointly between CMS and states. CMS and states will review PBPs to ensure the data entry is consistent with minimum coverage and cost sharing requirements under Medicaid, Medicare Parts A, B, and D, and the state's demonstration. CMS and the states will also verify that the PBP includes, as necessary, any demonstration-specific supplemental benefits, which are benefits not currently covered under Medicaid or Medicare.

2. Premium and Cost Sharing Requirements

MMPs are prohibited from charging Part C or Part D premiums under the Capitated Financial Alignment Demonstration. In addition, Medicare Parts A and B services must be offered at zero cost-sharing.

Interested organizations will be permitted to charge copays for Part D drugs consistent with current Medicare policy. However, states may also encourage or require plans to further reduce Part D drug cost-sharing for all enrollees as a way of testing whether reducing enrollee cost sharing for pharmacy products improves health outcomes and reduces overall health care expenditures through improved medication adherence under the demonstration. This cost sharing reduction can be offered by plans consistent with a waiver of certain Medicare rules described in a recent HPMS

¹⁵ <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Memo-Contract-Year-2013-Medication-Therapy-Management-MTM-Program-Submission-v041012.pdf>

guidance memorandum entitled “Waiver of Part D Low-Income Subsidy Cost-Sharing Amounts by Medicare-Medicaid Plans and Operational Implications for Prescription Drug Event Data and Plan Benefit Package Submissions,” available at the following link: <http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Part D Cost Sharing Guidance.pdf>.

Appendix 1. Key Dates for Medicare Requirements Portion of the Demonstration Plan Selection Process

Summarized below are the key dates for demonstration plan approval for the 2014 contract year. Our primary focus in this section is on the Medicare-specific requirements that interested organizations will need to satisfy to operate as MMPs. These activities and their timeframes are in addition to any state selection activities. Additional information about key operational timeframes as well as additional criteria established by states will be issued as necessary in CMS sub-regulatory vehicles.

Key Date	Entity	Required Action
Late 2012 – Early 2013	CMS and states	CMS and states continue MOU development and approval.
November 14, 2012	Interested organizations	Recommended timeframe for interested organizations to submit NOIAs to ensure sufficient time to obtain a CMS User ID and HPMS access. CMS will continue to process NOIAs through January 31, 2013, though CMS cannot guarantee access to the application tool by the application release date for organizations submitting NOIAs after November 14, 2012.
December 6, 2012	Interested organizations	Interested organizations must have submitted CMS User ID connectivity forms to ensure applicants have access to the CMS Health Plan Management System (HPMS).
January 16, 2013	CMS and interested organizations	Training on MOC Elements 1 through 5 Time: 2:00 p.m. – 3:30 p.m. EST Conference 877-474-1132 Line: Meeting ID: 83870664 Webinar: https://ncqaevents.webex.com/ncqaevents/onstage/g.php?t=a&d=662714982 Event Password: Approval2013
January 17, 2013	CMS and interested organizations	Training on the Capitated Financial Alignment Demonstration application Time: 1:00 p.m. – 4:00 p.m. ET Conference 877-267-1577 Line: Meeting ID: 6865 Webinar: https://webinar.cms.hhs.gov/MMPapplicationtraining2014/
January 22, 2013	CMS and interested organizations	Training on MOC elements 6 through 11 Time: 2:00 p.m. – 3:30 p.m. EST Conference 877-474-1132 Line: Meeting ID: 83878792 Webinar: https://ncqaevents.webex.com/ncqaevents/onstage/g.php?t=a&d=661681594 Event Password: Approval2013
January 25, 2012	States	States provide interested organizations with guidance on their MOC submissions.
February 5, 2013	CMS and interested organizations	MOC Technical Assistance Call Time: 2:00 p.m. – 3:30 p.m. EST Conference Line: 877-474-1132 Meeting ID: 84021331

Key Date	Entity	Required Action
February 21, 2013	Interested organizations	MMP application due in HPMS. Note that as a part of the MMP application, interested organizations must submit a Model of Care and preliminary network information. Plan Benefit Packages and formularies are not submitted as a part of the application.
Late February – April 2013	CMS and states	CMS, via its contract with the National Committee for Quality Assurance, and state reviewers will evaluate the Models of Care (MOCs) submitted as part of the MMP application. State participation in the MOC review process is at the state’s discretion.
April 2013	CMS	Release of the Plan Benefit Package module in HPMS.
April 2013	CMS	Release of the CY 2014 Medication Therapy Management Program (MTMP) submission module in HPMS.
May 2013	Interested organizations	Deadline for submitting MTMPs.
May 13, 2013	CMS	Release of HPMS Part D formulary submission module for CY 2014.
May 31, 2013	Interested organizations	Part D formulary submissions due to CMS. Note that CMS will require all MMPs to submit a demonstration-specific formulary.
June 3, 2013	Interested organizations	Deadline for submitting proposed plan benefit packages.
June 7, 2013	Interested organizations	Deadline for submitting Additional Demonstration Drug file and Part D supplemental formulary files (Free First Fill File, Over-the-Counter Drug File, and Home Infusion File) through HPMS.
June - July 2013	CMS and states	CMS and the states review plan benefit packages and drug file submissions.
June - August 2013	CMS and states	CMS and states conduct readiness reviews for selected plans. CMS and states make final preparations for implementation, test operational systems, and review adherence to contract requirements prior to implementation. CMS and states jointly confirm MMPs have met readiness requirements.
August 2013	CMS	CMS completes MTMP reviews.
September 2013	CMS	Roll-out of MA and Part D plan landscape documents, which include details (including high-level information about benefits and cost-sharing) about all available Medicare health and prescription drug plans for CY 2014.
September 2013	CMS, states, and selected organizations	Three-way contracts between selected plans, states, and CMS should be finalized and signed. State-specific timeframes may vary.
Mid- to late September 2013	CMS	CMS mails the CY 2014 Medicare & You handbook. The handbook includes high-level information – including basic cost-sharing and premium information – about available health plan options in a beneficiary’s specific geographic location.

Key Date	Entity	Required Action
October 1, 2013	Selected organizations	CY 2014 marketing activity begins. Demonstration plans must have met all demonstration requirements, including successful completion of the readiness review, to begin marketing.
October 1, 2013	CMS	Medicare Plan Finder on www.medicare.gov goes live for CY 2014.
October 15, 2013 – December 7, 2013	Beneficiaries	Annual Coordinated Election Period.
60 days prior to an individual's passive enrollment effective date	States	The state must provide written notification to individuals passively enrolled into an MMP no fewer than 60 days prior to the effective date of any such enrollment.
January 1, 2014	Selected organizations, beneficiaries	Earliest possible enrollment effective date (for plans that have met all plan selection and readiness review requirements).

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850



CENTERS FOR MEDICARE & MEDICAID SERVICES

DATE: November 28, 2012

TO: Medicare-Medicaid Plans

FROM: Tim Engelhardt, Director
Models and Demonstration Group

SUBJECT: Readiness Reviews

Introduction

As part of the Medicare-Medicaid Capitated Financial Alignment Demonstration, the Centers for Medicare & Medicaid Services (CMS) and participating States want to ensure that every selected Medicare-Medicaid plan (MMP) is ready to accept enrollment, protect and provide the necessary continuity of care, ensure access to the spectrum of Medicare, Medicaid, and pharmacy providers most frequently utilized by the Medicare-Medicaid population, and fully meet the diverse needs of the Medicare-Medicaid population. In order to ensure the demonstrations will preserve and strengthen Medicare-Medicaid enrollees' access to care, quality of care, and benefits, CMS and the States will assess MMPs' ability to implement and continue operations under the demonstration. We will employ a multi-pronged oversight strategy for MMPs, which at a high level, includes:

- Base requirements: Plans must meet core Medicare and Medicaid requirements, State procurement requirements, and State insurance rules (as applicable).
- Readiness review: Prior to the start of each Capitated Financial Alignment Demonstration, CMS and the State will perform an assessment of each MMP's operational capacity and ability to offer high-quality, coordinated care while adhering to all federal and State requirements. The readiness review will also inform CMS' and the State's implementation monitoring strategy by identifying areas where additional implementation and ongoing monitoring may be required.
- Implementation monitoring: Prior to the first enrollment and at regular intervals throughout the implementation process, we will ensure that MMPs are meeting objective implementation milestones as a condition for receiving enrollments. These implementation milestones, and subsequent ongoing monitoring measures, will build off of the readiness review.
- Ongoing monitoring: Over the course of each demonstration, a joint contract management team composed of CMS and State representatives will ensure that MMPs

continue to adhere to program requirements and provide comprehensive, high-quality services in all aspects of the beneficiary experience.

The purpose of this memo is to share the Massachusetts readiness review tool with stakeholders and potential MMPs to provide an opportunity to give CMS feedback as we continue to work with other States developing readiness review tools.

Financial Alignment Joint Readiness Review

As described in previous CMS guidance, each MMP seeking to participate in the Capitated Financial Alignment Demonstration must meet all applicable Medicare and Medicaid program requirements. In addition to the plan selection process, all selected plans, regardless of previous Medicare or Medicaid experience, must pass a joint readiness review conducted by CMS and the State prior to enrolling beneficiaries. The readiness review represents a critical step in ensuring that MMPs have the capability and capacity to serve enrollees. Each selected plan will undergo a thorough readiness review that will assess its ability to meet federal and State requirements and its capacity to provide and ensure access to care and quality services.

All readiness reviews will include a desk review and a separate network validation review. A site visit may also be conducted for selected MMPs. We will determine which MMPs require additional validation of readiness through a site visit based on an evaluation of prior Medicare and/or Medicaid experience, responses during the application and State selection process, and the results of the desk review.

Attached is the Massachusetts readiness review plan that CMS and the Commonwealth developed based on stakeholder feedback that Massachusetts and CMS received through letters and public meetings, the Memorandum of Understanding signed on August 22, 2012, the Commonwealth's Request for Responses (RFR) from Integrated Care Organizations, and applicable Medicare and Medicaid regulations.

The Massachusetts readiness review tool is tailored to the requirements of the approved demonstration, and the State's target population. It addresses 15 functional areas of health plan operations related to the delivery of Medicare and Medicaid services including:

- | | |
|--|--|
| 1. Assessment processes | 9. Performance and quality improvement |
| 2. Care coordination | 10. Program integrity |
| 3. Confidentiality | 11. Provider credentialing |
| 4. Enrollment | 12. Provider network |
| 5. Enrollee and provider communications | 13. Qualifications of first-tier, downstream, and related Entities |
| 6. Enrollee protections | 14. Systems (e.g., claims, enrollment, payment, etc.) |
| 7. Financial soundness | 15. Utilization management |
| 8. Organizational structure and staffing | |

All State readiness review tools will address key areas that directly impact a beneficiary's ability to receive services including, but not limited to: assessment processes, care coordination,

provider network, staffing, and systems to ensure that the organization has the capacity to handle the increase in enrollment of the complex and heterogeneous Medicare-Medicaid enrollee population. The criteria will also focus on whether a MMP has the appropriate beneficiary protections in place, including but not limited to, whether the MMP has policies that adhere to the Americans with Disabilities Act, uses person-centered language and reinforces beneficiary roles and empowerment, reflects independent living philosophies, and promotes recovery-oriented models of behavioral health services.

Each State-specific readiness review tool will be completed after CMS and the State has a signed Memorandum of Understanding. CMS welcomes comments on the Massachusetts readiness review tool as we continue to work jointly with other States interested in participating in the Capitated Financial Alignment Demonstration. Please send comments to MMCOCAPSMODEL@cms.hhs.gov by December 12, 2012.

Assessment Processes	
Readiness Review Criteria	Example Evidence
<i>A. Transition to New ICO and Continuity of Care</i>	
<p>1. The Integrated Care Organization (ICO) ensures continuity of care for medical, behavioral, long-term services and supports (LTSS) and pharmacy services upon new enrollment. The ICO shall for 1) a period of up to 90 days, unless the assessment is done sooner and the Enrollee agrees to the shorter time period; or 2) until the ICO completes an initial assessment of service needs, whichever is longer:</p> <ul style="list-style-type: none"> a. allow enrollees to maintain their current providers; b. honor prior authorizations issued by MassHealth, its contracted managed care entities; and c. reimburse providers at their current provider rates at the time of enrollment. <p>The ICO shall also contact providers not already members of its network with information on becoming credentialed as in-network providers; and assure that enrollees who are authorized to receive personal care attendant (PCA) services at the time of enrollment with the ICO have the option to continue to receive their Fiscal Intermediary (FI) services through their current FI.</p>	<p>Continuity of care plan includes these provisions</p>
<p>2. The ICO assures that, within the first 90 days of coverage, it will provide a temporary supply of drugs when the enrollee requests a refill of a non-formulary drug that otherwise meets the definition of a Part D drug or is a drug that MassHealth is requiring the ICO to cover under the demonstration.</p>	<p>System testing outputs confirm the claims processing system correctly processes the claim; and</p> <p>Policies and Procedures (P&P) allows and defines a time period (at least within the first 90 days of coverage) when it will provide temporary fills on re-fills of non-formulary drugs that otherwise meet the definition of a Part D drug and drugs that MassHealth is requiring the ICO to cover under the demonstration.</p>
<p>3. The ICO assures that, in outpatient settings, temporary fills of non-formulary drugs that otherwise meet the definition of a Part D drug and drugs that MassHealth is requiring the ICO to cover under the demonstration, contain at least a 30-day supply.</p>	<p>System testing outputs confirm the claims processing system correctly processes the claim; and</p> <p>Transition plan P&P and/or drug dispensing P&P defines temporary drug supply in outpatient settings to be at least 30 days.</p>
<p>4. The ICO assures that, in long term care settings, temporary fills of non-formulary drugs that otherwise meet the definition of a Part D drug contain at least a 91-day supply, unless a lesser amount is requested by the prescriber.</p>	<p>System testing outputs confirm the claims processing system correctly processes the claim; and</p> <p>Transition plan P&P and/or drug dispensing P&P defines temporary drug supply in long term care settings to be at least 91 days.</p>

Assessment Processes	
Readiness Review Criteria	Example Evidence
5. The ICO provides written notice to each enrollee within 3 business days after the temporary fill if his or her prescription is not part of the formulary.	Transition plan P&P defines a time period (within 3 business days) when it must provide enrollee with notice about temporary fill during transition time and the ability to file an exception or consult with prescriber to find alternative equivalent drug that is on the formulary.
6. The ICO has staff designated to contact enrollees when they refill a non-formulary drug or receive a non-covered service to assist them during the transition period.	Transition plan P&P states that the ICO has staff available to contact enrollees when they refill a non-formulary drug or receive a non-covered service during the transition period.
<p>7. If, as a result of the initial assessment, the ICO proposes modifications to the enrollee's prior authorized services, the ICO shall provide written notification about, and an opportunity to appeal, the proposed modifications no less than 10 days prior to implementation of the enrollee's ICP. The enrollee shall be entitled to all appeal rights, including services pending appeal.</p> <p>Beyond the initial assessment period, the ICO must offer single-case out-of-network agreements to providers who: 1) are not willing to enroll in the ICO provider network, 2) are currently serving enrollees, and 3) are willing to continue serving them at the ICO's in-network rate of payment, under the following circumstances:</p> <ul style="list-style-type: none"> a. The ICO's network does not have an otherwise qualified network provider to provide the services within its provider network, or transitioning the care in-house would require the enrollee to receive services from multiple providers/facilities in an uncoordinated manner which could significantly impact the enrollee's condition; b. Transitioning the enrollee to another provider could endanger life, cause suffering or pain, cause physical deformity or malfunction, or significantly disrupt the current course of treatment; or c. Transitioning the enrollee to another provider would require the enrollee to undertake a substantial change in recommended treatment for Medically Necessary Covered Services. 	P&P on continuity of care or continuity of care plan includes the required process in the situation where the ICO modifies the enrollee's prior authorized services as a result of the initial assessment.

Assessment Processes	
Readiness Review Criteria	Example Evidence
<i>B. Assessment</i>	
<p>1. The ICO must have a process for the following:</p> <ul style="list-style-type: none"> a. Administering an initial assessment to all enrollees in person within 90 days of enrollment. b. Administering a MDS-HC by a nurse in person to all enrollees within 90 days of enrollment; this includes a full assessment of physical and behavioral health needs as well as assessment data entry into the Virtual Gateway portal. 	<p>Assessment P&P outline the process by which the ICO will administer the initial assessment. At a minimum, the process should include these requirements, but it should further outline the process for identifying, contacting, and conducting the assessment within 90 days.</p>
<p>2. Upon enrollment and as appropriate thereafter, the ICO will perform in-person comprehensive assessments, which will be the starting point for creating an Individualized Care Plan (ICP). These assessments:</p> <ul style="list-style-type: none"> a. May be done at the same time or a different time as the initial assessment; b. Must be conducted by appropriate care team members as determined by the enrollee's needs identified in the initial assessment (e.g. IL-LTSS) using a MassHealth/CMS approved assessment tool in a location that meets the needs of the enrollee; c. Will encompass social, functional, medical, behavioral, wellness and prevention domains, as well as the enrollees' strengths and goals, need for any specialists and the individualized plan for care management and coordination; and d. Identify the natural supports necessary to sustain the enrollee in his or her current place of residence. 	<p>Assessment P&P includes these requirements for the comprehensive assessment.</p>
<p>3. For enrollees identified in their initial assessments as needing intensive behavioral health services or LTSS, during the comprehensive assessment, the ICO will determine:</p> <ul style="list-style-type: none"> a. The enrollee's understanding of available services; the enrollee's desire to self-manage all or part of his/her care plan regardless of the severity of disability, and understanding of his or her self-management responsibilities; b. The enrollee's preferences regarding privacy, services, caregivers, and daily routine; c. The enrollee's understanding of and engagement in recovery-oriented activities; d. The enrollee's preferred living situation and a risk assessment for the stability of housing; e. Risk factors for abuse and neglect in the enrollee's personal life or finances to ensure safety without compromising the enrollee's autonomy; and f. The enrollee's understanding of his/her rights. 	<p>Assessment P&P includes these requirements for the comprehensive assessment for enrollees identified in the initial assessment as needing intensive BH services or LTSS.</p>

Assessment Processes	
Readiness Review Criteria	Example Evidence
<p>4. The ICO describes how the assessment and annual re-assessment are conducted for each enrollee (i.e., should be face-to-face) and ensures that it has the capacity to administer them in a format suitable to enrollee's preferences and abilities.</p> <p>A re-assessment will also be conducted when the enrollee experiences a major change that is: not temporary, impacts more than one area of health status, and requires interdisciplinary review or revision of the ICP.</p>	<p>Assessment P&P explains how and in what format the ICO will adapt its risk assessment tool to the specific needs of the target population</p> <p>Assessment P&P explains how often and when the assessment and re-assessment are provided to new and current enrollees</p>
<p>5. The ICO's assessment tool for the comprehensive health assessment will include the following domains:</p> <ul style="list-style-type: none"> a. Immediate needs and current services, including LTSS needs; b. Health conditions and current medications; c. Functional status, including what the enrollee identifies as his/her strengths and interests; d. Mental health and substance abuse; e. Personal goals; f. Accessibility requirements (including specific communication needs, need for transfer equipment, need for personal assistance, need for appointments at the particular time of day, etc.; g. Equipment needs inducing adaptive technology; h. Transportation access; i. Housing/home environment; j. Employment status and interest; k. Involvement with other care coordinators, care teams, or other state agencies; l. Informal supports/caregiver supports; m. Social supports, including cultural and ethnic orientation towards the enrollee's presenting problems; n. Food, security, and nutrition; o. Wellness and exercise; and p. Advance directive/guardianship. 	<p>ICO's comprehensive assessment tool includes these domains.</p>

Assessment Processes	
Readiness Review Criteria	Example Evidence
6. The ICO has policies for staff to follow up and to document when enrollees refuse to participate in a comprehensive assessment.	<p>Assessment P&P explains how staff from the ICO will respond to those enrollees who decline to participate in a comprehensive assessment</p> <p>Assessment P&P describes how the ICO staff will assist enrollees who require additional prompting/guidance about participating in the assessment (e.g., enrollees with co-morbidities such as mental health and substance abuse issues along with physical disabilities)</p> <p>Assessment P&P explains how the ICO will monitor those enrollees who decline to participate in the risk assessment process</p>
7. The ICO has a procedure for working with an enrollee who agrees to do an assessment but not to do so in person.	Assessment P&P explains how the ICO will work with an enrollee to secure agreement for an in-person comprehensive assessment whenever possible, but also identifies an alternative approach that the ICO will offer an enrollee who refuses an in-person approach.

Care Coordination	
Readiness Review Criteria	Example Evidence
<i>A: Care Coordinator (or Clinical Care Manager) Assignment and Interdisciplinary Care Team (ICT)</i>	
1. The ICO has a process to ensure that every enrollee who wants an Individualized Care Team (ICT) to coordinate the delivery of services and benefits will have access to one.	Care coordination P&P defines how an ICT is formed for each enrollee.
2. The ICO describes a process for determining the composition of the ICT, including a description of how the beneficiary and/or his or her caregiver are involved in determining the ICT. At a minimum, the ICT will include the primary care provider, the enrollee's care coordinator (or Independent Living and Long Term Services and Supports (IL-LTSS) Coordinator or Clinical Care Manager, as applicable) and other individuals at the discretion of the enrollee as applicable.	Care coordination P&P defines how the ICO builds its ICT and how the beneficiary and/or his or her caregiver are involved in determining the ICT.
3. The ICO defines ICT care coordination functions to include at least the following: <ul style="list-style-type: none"> a. Develop and implement an individualized plan of care (ICP) with enrollee and/or care giver participation; b. Conduct ICT meetings periodically, including face-to-face meetings, at the member's discretion c. Maintain a single electronic medical record (EMR) to manage communication and information flow regarding referrals, transitions, and care delivered outside the primary care site; 	Care coordination P&P defines the role and responsibilities of the ICT and either this P&P or other P&Ps include the specified functions.

Care Coordination	
Readiness Review Criteria	Example Evidence
<ul style="list-style-type: none"> d. Maintain a call line or other mechanism for enrollee inquiries and input; e. Conduct conference calls among the ICO, providers, and enrollees; f. Maintain a mechanism for enrollee complaints and grievances; and g. Use secure e-mail, fax, and written correspondence to communicate. 	
4. ICOs will offer care coordination services to all enrollees by a Care Coordinator, IL-LTSS coordinator or Clinical Care Manager, as applicable, for medical and behavioral health services.	Care coordination P&P articulates that all beneficiaries will have a care coordinator, IL-LTSS coordinator or clinical care manager (as applicable) and explains when a clinical care manager or care coordinator is used.
5. The ICO has a process for assigning an enrollee to a Care Coordinator, Clinical Care Manager, or IL-LTSS Coordinator with the appropriate experience and qualifications based on an enrollee's assigned risk level and individual needs (e.g., communication, cognitive or other barriers).	<p>Care coordination P&P requires each enrollee to be assigned a care coordinator based on his or her risk level and/or individual needs and outlines the process for assigning such care coordinator</p> <p>ICO describes reasonable measures taken to ensure that staff and enrollees are matched based on their expertise and special needs</p>
6. The IL-LTSS coordinator will be available to an enrollee: <ul style="list-style-type: none"> a. at any time at the request of an enrollee with LTSS needs; b. during the initial assessment; c. when the need for community-based LTSS is identified by the enrollee or ICT; d. if the enrollee is receiving targeted case management or rehabilitation services purchased by DMH; and e. in the event of a contemplated admission to a nursing facility, psychiatric hospital, or other institution. 	P&P on IL-LTSS Coordinator services includes these responsibilities.
7. The ICO has a process to ensure that an enrollee and/or care giver is able to request a change in his/her Care Coordinator, Clinical Care Manager or IL-LTSS Coordinator (as applicable)	Care coordination P&P describes the process by which an enrollee may request a change in his/her Care Coordinator, Clinical Care Manager or IL-LTSS Coordinator (as applicable)
8. The ICO will provide services through an IL-LTSS Coordinator that include (as applicable): <ul style="list-style-type: none"> a. representing the LTSS needs of the enrollee, b. advocating for the enrollee; c. providing education on LTSS for the care team and enrollee; d. participating in assessments; e. arranging for and coordinating (with agreement of the ICT) the authorization and provision of community LTSS resources; f. assisting enrollees with PCA services; g. monitoring the provision and functional outcomes of community LTSS to assure they are in accordance with the ICP; 	P&P for IL-LTSS Coordinator services includes these requirements.

Care Coordination	
Readiness Review Criteria	Example Evidence
<ul style="list-style-type: none"> h. determining community-based alternatives to long-term care; and i. assessing the enrollee's appropriateness for facility-based LTSS if indicated. 	
<p>9. The Care Coordinator is accountable for providing care coordination services, which include:</p> <ul style="list-style-type: none"> a. assuring appropriate referrals and timely two-way transmission of useful patient information; b. obtaining reliable and timely information about services in addition to those provided by the Primary Care Provider; c. supporting safe transitions in care for enrollees moving between settings; d. serving on ICTs; e. facilitating meetings and other activities of ICTs; and f. participating in the initial assessment of each enrollee they serve. 	Care coordination P&P will outline the services of a Care Coordinator
<p>10. The ICO will ensure the provision of Clinical Care Management services directly or through the primary care provider, as feasible, to enrollees identified as high risk. Specific Clinical Care Management services will include:</p> <ul style="list-style-type: none"> a. Assessment of the clinical risks and needs of each enrollee; b. Medication review and reconciliation; c. Medication adjustment by protocol; d. Enhanced self-management training and support for complex clinical conditions, including coaching to family members and other caregivers, as appropriate; e. Frequent enrollee contact, as appropriate; f. Identification of the enrollee's strengths, preferences and family and community supports that can assist in addressing the clinical risks; and g. Follow-up within 24 hours of an enrollee's admission to an acute hospital, and coordination with the enrollee and hospital staff to facilitate hospital discharges. 	<p>The clinical care management P&P describes the components of clinical care management and who will oversee it.</p> <p>The primary care provider's responsibilities for clinical care management are detailed in the contract template</p>
<p>11. The ICO:</p> <ul style="list-style-type: none"> a. conducts training on the person-centered planning processes, cultural competence, accessibility and accommodations, independent living and recovery, and wellness principles, along with other required training, as specified by the Commonwealth for ICT members and potential ICT members (i.e., providers and staff qualified to serve on ICTs), initially and on an annual basis; b. documents completion of training by all ICT members, including both employed and contracted personnel and has specific policies to address non-completion; and c. documents that all members of the ICT have agreed to participate in approved training. 	<p>Sample training materials for ICT members and potential ICT members include the required topics</p> <p>P&P on care coordination defines the consequences associated with non-completion of ICT trainings</p> <p>Sample attendee lists, web-based attendance confirmation, electronic training records for trainings</p> <p>Sample ICT participation form includes ICT's members agreement to participate in the training</p>

Care Coordination	
Readiness Review Criteria	Example Evidence
<i>B. Plan of Care/Service Plan</i>	
<p>1. The ICO will:</p> <ul style="list-style-type: none"> a. work with the enrollee to develop the Individualized Care Plan (ICP); and b. use the information gathered from the assessments of the enrollee in developing the ICP. 	<p>Care planning P&P outlines a process that describes how the ICO will involve the enrollee in developing the ICP and will use the information gathered from the assessment(s) of the enrollee in developing the ICP.</p> <p>Care planning P&P states that the ICO intends to provide person-centered care to all of its enrollees, and describes strategies for assuring this.</p>
<p>2. The ICO will ensure that the enrollee receives any necessary assistance and accommodations to prepare for and fully participate in the care planning process, and that the enrollee receives clear information about:</p> <ul style="list-style-type: none"> a. his/her health conditions and functional limitations; b. how family members and social supports can be involved in the care planning as the enrollee chooses; c. self-directed care options and assistance available to self-direct care; d. opportunities for educational and vocational activities; and e. available treatment options, supports and/or alternative courses of care. 	<p>P&P on care planning describes how the ICO will ensure that the enrollee receives necessary assistance and the types of information specified.</p>
<p>3. Essential elements incorporated into the ICP include:</p> <ul style="list-style-type: none"> a. Results of the initial and comprehensive assessments; b. Summary of the enrollee's health; c. Preferences for care; d. A prioritized list of concerns, goals and objectives, and strengths; e. Specific services and benefits; f. The plan for addressing concerns or goals; g. The person(s) responsible for specific interventions; and h. The due date for the intervention. 	<p>Care planning P&P states that the ICO assures that these elements are incorporated into the plan of care.</p>
<p>4. The ICO specifies:</p> <ul style="list-style-type: none"> a. the frequency for ICP review and revision (at minimum upon change of condition or annually); b. the frequency with which enrollee health data is used to assess whether the goals and objectives in the ICP are being met (at a minimum annually); and c. the frequency for updating the ICP in response to routine and non-routine reviews and revisions, including required updates when enrollees are not meeting their plan of care goals. 	<p>Care planning P&P explains how and when the ICO reviews and revises the contents of an enrollee's plan of care, which is at a minimum upon change of condition or annually.</p>

Care Coordination	
Readiness Review Criteria	Example Evidence
5. For the purposes of assessment, care planning, and to provide services, the ICO is responsible for conducting outreach and networking with community-based providers to locate enrollees who may be homeless or hospitalized. The ICO must document within the Centralized Enrollee Record its efforts to locate these enrollees.	Outreach plan describes how ICO works with community-based providers to find enrollees and documents its efforts to conduct this outreach. Documentation of CBO relationships
6. The ICO accommodates enrollees' religious or cultural beliefs and basic enrollee rights in developing the ICP	Care planning P&P states that the ICO accommodates enrollees' religious or cultural beliefs and basic enrollee rights in developing the ICP.
<i>C. Personal Care</i>	
1. The ICO has policies to provide the enrollee the following information: <ul style="list-style-type: none"> a. A clear explanation that self-direction of PCA services is voluntary, and that the extent to which enrollees would like to self-direct is the enrollee's choice; b. A clear explanation of the options to select self-directed supports or agency personal care; and c. An overview of the supports and resources available to assist enrollees to participate to the extent desired in self-direction. 	Sample enrollee communications demonstrating that the ICO has provided the information contained within this criterion to enrollees eligible for self-direction
2. The ICO has the following policies regarding PCA services: <ul style="list-style-type: none"> a. the enrollee has the right to self-direct his/her own PCA services; b. if the enrollee was receiving PCA services at the time of enrollment, he/she may continue to use his/her current PCA provider; c. enrollees who did not have prior authorization for PCA services at the time of enrollment will be offered at least two personal care management (PCM) agencies to choose from (at least one of which must be an Independent Living Center); d. enrollees over age 60 must be offered PCM options via an Aging Service Access Point (ASAP) operating as an PCM; and e. enrollees can also select to have a surrogate to help them choose their PCA services. 	P&P on PCA services includes these elements
3. The ICOs must have the following policies for enrollees who choose not to self-direct their PCA services or who are not able to find a surrogate to assist them to self-direct: <ul style="list-style-type: none"> a. the enrollee must be given the option of having his/her PCA Services provided by a PCA agency provider; b. the ICO must contract with PCA agency providers selected by enrollees and provide enrollees with the choice of at least two PCA agency providers; and c. the enrollee must be able to choose the schedule for his/her PCA and who provides PCA services to him/her. 	P&P on PCA services includes these requirements

Care Coordination	
Readiness Review Criteria	Example Evidence
<p>4. The ICO must have the following policies regarding evaluation of PCAs:</p> <ul style="list-style-type: none"> a. The ICO must ensure that PCA evaluations are done in a timely manner to ensure appropriateness and continuity of services; b. The ICO may contract with PCM agencies under contract with the Commonwealth to perform evaluations for PCA services; and c. ICOs that do not contract with ILCs for PCA evaluations must provide and require training for their PCA evaluators on the independent living philosophy. 	<p>P&P on PCA services includes these requirements</p>
<i>D. Coordination of Services</i>	
<p>1. The ICO has a process to monitor and audit care coordination that includes, at a minimum:</p> <ul style="list-style-type: none"> a. documenting and preserving evaluations and reports for the care coordination program; and b. communicating these results and subsequent improvements to ICO advisory boards and/or stakeholders 	<p>Care coordination P&P explains how and when the ICO will evaluate the processes within the care coordination program.</p> <p>Care coordination P&P explains how the results of the evaluation will be communicated to ICO advisory boards and/or stakeholders.</p>
<p>2. The ICO facilitates timely and thorough coordination between the ICO, the primary care provider, and other providers (e.g., behavioral health providers, non-emergency medical transportation, durable medical equipment repair, dental providers, LTSS, etc.).</p>	<p>Care coordination P&P outlines how coordination between the parties will occur; this should include the mechanism by which information will be shared and how the ICO will facilitate the coordination.</p>
<p>3. The ICO shall require primary care providers to offer integrated primary care and behavioral health services, offering support as needed, as follows:</p> <ul style="list-style-type: none"> a. for enrollees without a behavioral health diagnosis, provide integrated Behavioral Health services through at least routine screening for depression, substance use disorders, and other behavioral health conditions; and b. for enrollees with behavioral health conditions, deliver evidence-based behavioral health treatment, and have established protocols for referral to behavioral health specialty providers. 	<p>The primary care provider's responsibilities for integration of primary care and behavioral health services are detailed in the contract provider template.</p>

Care Coordination	
Readiness Review Criteria	Example Evidence
<i>E. Transitions Between Care Settings</i>	
1. The ICO's outreach materials for enrollees living in institutional settings include explanation of the community supports available to them and the Money Follows the Person program, when applicable.	Sample communications the ICO plans to send to enrollees living in institutional settings contain information related to accessing community supports.
2. The ICO has a policy and procedure for monitoring transfers and minimizing unnecessary complications related to care setting transitions and hospital re-admissions through pre- and post-discharge planning.	<p>P&P on care setting transitions explains how the ICO and providers work together to minimize unnecessary complications related to care setting transitions and hospital readmissions and how the ICO monitors transfers and hospital readmissions.</p> <p>Evidence of relationship of data sharing agreements between hospitals and plans.</p> <p>Sample report(s) from the ICO describe how it tracks enrollee transfers and admissions.</p> <p>Care coordination P&P describes the role of the Care Coordinator in monitoring care setting transitions.</p>
3. The ICO's protocols for care setting transition planning ensure that all community supports, including housing, are in place prior to the enrollee's move and that providers are fully knowledgeable and prepared to support the enrollee, including interface and coordination with and among clinical services and LTSS.	<p>Care setting transitions P&P explains how the ICO ensures that community supports are available prior to an enrollee's move.</p> <p>Care setting transitions P&P explains how the ICO assesses the qualifications of those providers charged with caring for an enrollee after his or her move.</p> <p>Sample care setting transition plan(s) detail the steps the ICO takes to ensure continuity of care for an enrollee changing care settings.</p>
4. The ICO's care setting transition plans include all environmental adaptations and equipment and/or technology the enrollee needs for a successful care setting transition.	Sample care setting transition plan(s) include these elements.
5. The ICO identifies issues that could lead to care setting transitions and prevents unplanned and unnecessary care setting transitions where possible, consistent with the Table 7-B (Community Support Services Provided Through Managed Care Under the demonstration) of the CMS-Massachusetts MOU (MOU).	Care setting transition plan P&P outlines a process for managing the care setting transition process that includes methodologies for identifying issues that could lead to transitions and for preventing unplanned and unnecessary care transitions that are consistent with Table 7-B of the MOU.
6. The ICO helps enrollees transition to another provider if a provider leaves the ICO's network.	P&P on care coordination and/or provider handbook includes this policy.

Care Coordination	
Readiness Review Criteria	Example Evidence
7. The ICO has a process for transitioning enrollees to new providers, if needed, once the ICP is completed and signed.	P&P on care coordination and/or provider handbook includes this policy.

Confidentiality	
Readiness Review Criteria	Example Evidence
1. The ICO provides a privacy notice to provide to enrollees, which explains the policies and procedures for the use and protection of personal health information (PHI).	Sample privacy notice to be sent to enrollees explains how the ICO will safeguard PHI.
2. The ICO provides a privacy notice to provide to providers, which explains the policies and procedures for the use and protection of PHI.	Sample privacy notice to be sent to providers explains how the ICO will safeguard PHI and the provider's role in safeguarding PHI.

Enrollment	
Readiness Review Criteria	Example Evidence
<i>A. Enrollment</i>	
1. The ICO has enrollment policies and procedures in place that delineate the process from when the ICO receives an enrollment file from the Commonwealth to performing the initial and comprehensive assessments. This process must include, at a minimum: <ul style="list-style-type: none"> a. Sending enrollment material to potential enrollees; b. Using existing and available data to identify who may need additional assistance; c. Conducting initial outreach to enrollees to for initial and comprehensive health assessments; and d. Staffing to account for the increased enrollment. 	P&P on enrollment delineates all the specified elements of the process.
2. The ICO is prepared to send an enrollment confirmation notice that includes the effective date of enrollment to potential enrollees within 10 days of receiving notification from the Commonwealth of all enrollments.	Enrollment/Disenrollment P&P includes policy and disenrollment notification form/materials.
3. Member services staff have cultural and disability competencies based on the target populations and must be knowledgeable in effective communication to and from individuals with disabilities through email, telephone, and other electronic means, including through the use of tools such as TTY, computer aided transcription services, qualified interpreters for the Deaf, telephone headset amplifiers, videotext displays, assistive listening systems, and closed caption decoders.	<p>Sample of resumes of member services staff demonstrates that they have these competencies.</p> <p>Training modules for member services staff includes training on effective communication to and from individuals with disabilities.</p>

Enrollment	
Readiness Review Criteria	Example Evidence
<i>B. Disenrollment</i>	
1. The ICO has policies and procedures in place to help enrollees who disenroll to transition to other ICOs (e.g. Part D) maintain continuity of care.	Enrollment P&P includes a section for transitioning members who disenroll and addresses Troop and Part D requirements for continuity of care.
2. The ICO is prepared to provide the enrollee a disenrollment notice in a format meeting CMS and Commonwealth requirements within 10 days of disenrollment.	Enrollment/Disenrollment P&P includes policy for providing this disenrollment within 10 days of disenrollment.
3. The ICO staff does not encourage an enrollee to disenroll because of challenging behavior, complex care needs, or high medical expenses.	Enrollment P&P and/or employee manual state that staff members are prohibited from encouraging enrollees with medically-challenging or complex conditions to disenroll from the ICO.
<i>C. Enrollment Materials</i>	
1. The ICO's member services department representatives, upon request, make available to enrollees and potential enrollees information that includes, but is not limited to, the following: a. The identity, locations, qualifications, and availability of providers; b. Enrollees' rights and responsibilities; c. The procedures available to an enrollee and provider(s) to challenge or appeal the failure of the contractor to provide a covered service and to appeal any adverse actions (denials); d. How to access oral interpretation services and written materials in prevalent languages and alternative, cognitively accessible formats; e. Information on all covered services and other available services or resources (e.g., state agency services) either directly or through referral or authorization; and f. The procedures for an Enrollee to change Plans or to opt out of the demonstration.	Member services department P&P on enrollee information is tailored to these requirements. Member services training materials include training on providing this information to enrollees. Screen shots of pages customer service representatives reference when answering calls from enrollees.
2. The ICO has a policy and procedure for dealing with the failure of enrollees to respond to initial contacts from the ICO (e.g., additional contacts are attempted, using different modes/times of day).	Enrollment P&P provides a step-by-step guide on steps staff should take to make additional contact with non-responsive enrollees. Sample flow chart template documents the number and types of contacts made during the initial enrollment period.

Enrollee and Provider Communications	
Readiness Review Criteria	Example Evidence
<i>A. Enrollee and Provider Communications</i>	
1. The ICO maintains an enrollee services telephone line that is accessible via a toll-free number, and operates a minimum of twelve (12) hours a day seven (7) days a week. The ICO also requires contractors with direct enrollee contact maintain service lines during these hours.	<p>Enrollee services telephone line P&P confirms that the hotline is toll-free and available during required times for medical services, LTSS and drugs.</p> <p>Contract template with subcontractors with direct enrollee contact requires maintenance of enrollee service telephone line that operates during these hours.</p> <p>ICO provides actual 1-800 number for the enrollee services telephone line.</p>
2. The ICO or a subcontractor of the ICO maintains a contract with a language line company that provides interpreters for non-English speaking and limited English proficiency enrollees. The hours of operation for the ICO's language line are the same for all enrollees, regardless of the language or other methods of communication they use to access the hotline. The language line is TDD/TTY accessible.	<p>Enrollee hotline P&P states that the ICO supplies interpreters for non-English or limited English speaking enrollees.</p> <p>Enrollee hotline P&P details the language(s) for which the ICO staffs interpreters for the hotline.</p> <p>Contract with language line company includes these requirements, including mandatory hours of operation.</p>
3. The ICO has a policy that a trained Enrollee Services Representative (ESR) answers at least 90% of calls within 30 seconds and has an abandoned call rate of less than 5%.	<p>Enrollee services telephone line P&P states this policy and explains how the ICO tracks its wait times and call abandonment rates and analyzes and corrects any unusual or excessively long wait times and/or call abandonments.</p>

Enrollee and Provider Communications	
Readiness Review Criteria	Example Evidence
<p>4. The ICO has a compliant website or web page dedicated to the M-MP product with links to all of the required documents:</p> <ul style="list-style-type: none"> a. The ICO's service area; b. The benefits offered under the plan (including applicable conditions and limitations); c. Any applicable cost-sharing; d. The plan's drug formulary; e. The provider network and how to access services (including pharmacies, includes addresses and hours, etc.); f. Out-of-network coverage (including pharmacies); g. Coverage of emergency services; h. Prior authorization and review rules; i. Grievances, organization and coverage determinations, and appeals; j. Quality assurance policies and procedures; k. Disenrollment rights and responsibilities; l. Potential for contract termination; m. Medication therapy management program; and n. Link to the electronic complaint form on Medicare.gov. 	<p>The ICO has a website devoted to the plan offered in the demonstration (note: a website mock-up or screenshots of the website are acceptable; an active link is not necessary for the readiness review.)</p> <p>Each of these items is covered on the ICO's website.</p>
<p>5. The ICO's website may not:</p> <ul style="list-style-type: none"> a. Offer financial or other incentives to induce consumers to enroll in the ICO or to refer a friend, neighbor, or other person to enroll with the ICO; b. Make any statement that has not been pre-approved by EOHHS and CMS; c. Include any material that is inaccurate or false or that misleads, confuses, or defrauds the recipient of the material, including but not limited to any assertion or statement, whether written or oral, that: <ul style="list-style-type: none"> i. The recipient of the material must enroll in the ICO in order to obtain benefits or in order to not lose benefits; or ii. The ICO is endorsed by CMS, Medicare, the federal or state government or similar entity. d. Seek to influence an individual's enrollment in conjunction with the sale or offering of any non-health insurance products (e.g., life insurance); e. Engage in any activities which could mislead, confuse or defraud prospective or current members or misrepresent MassHealth, EOHHS, the ICO or CMS; or f. Engage in outreach activities which target prospective members on the basis of health status or future need for health care services, or which otherwise may discriminate against individuals eligible for health care services. 	<p>The ICO's website is 508-compliant and is accessible to enrollees with disabilities.</p> <p>ICO screenshots or web links show that the ICO is complying with the specified outreach rules. (Note: a website mock-up or screenshots of the website are acceptable; an active link is not necessary for the readiness review.)</p>

Enrollee and Provider Communications	
Readiness Review Criteria	Example Evidence
<p>6. The ICO must employ ESRs who are:</p> <ul style="list-style-type: none"> a. Trained to answer enrollee inquiries and concerns from enrollees and prospective enrollees; b. Trained in the use of TTY, Video Relay services, remote interpreting services, how to provide accessible PDF materials, and other alternative formats; c. Capable of speaking directly with, or arranging for someone else to speak with, enrollees in their primary language, including American Sign Language, or through an alternative language device or telephone translation service; d. Knowledgeable about MassHealth, Medicare, and all terms of the contract, including covered services; e. Available to enrollees to discuss and provide assistance with resolving enrollee grievances; and f. Have access to: <ul style="list-style-type: none"> i. The ICO's enrollee database; ii. EOHHS's Eligibility Verification System (EVS); and iii. An electronic provider directory. 	<p>P&P for ESRs includes these elements.</p> <p>Training materials for ESRs includes these elements.</p> <p>Training logs for ESRs shows that all ESRs have received the necessary training.</p>
<p>7. The ICO has policies and procedures that state that, with the enrollee's consent, the ICO shall assist enrollees in providing MassHealth with their current address (residential and mailing), phone numbers, and other demographic information including pregnancy, ethnicity, and race. The ICO shall update this demographic information into the change form via the My Account Page Application on the Virtual Gateway or via other information exchange processes established with MassHealth.</p>	<p>P&P for ESRs or other staff performing this function includes assisting enrollees in providing MassHealth with this information.</p> <p>P&P for updating enrollee information includes these procedures.</p>

Enrollee and Provider Communications	
Readiness Review Criteria	Example Evidence
<p>8. The ICO maintains a Nurse Advice Line, accessible by enrollees 24 hours a day, seven days a week. The Nurse Advice Line shall:</p> <ul style="list-style-type: none"> a. Be staffed by a registered nurse who shall be available to respond to enrollee questions about health or medical concerns; b. Be accessible through a dedicated toll-free telephone number; c. Provide direct access to a registered nurse for medical triage and health questions, based on industry standard guidelines, to assist enrollees in determining the most appropriate level of care for their illness or condition; d. Provide general health information to enrollees and answer general health and wellness-related questions; e. Offer an automated health information audio library through which enrollees can access pre-recorded health education and wellness information on a wide variety of topics applicable to the ICO's MassHealth population; f. Provide a direct transfer to the ICO's general customer service center for nonclinical administrative questions during the ICO's hours of operation, and to the ICO's behavioral health clinical question telephone line for clinical behavioral health questions during the ICO's hours of operation; g. Offer all services in both English and Spanish, at a minimum; h. Make oral interpretation services available free-of-charge to enrollees in all non-English languages spoken by enrollees; i. Maintain the availability of services, such as TTY services or comparable services for the Deaf and hard of hearing; and j. Provide coordination with the enrollee's Care Coordinator (or IL-LTSS Coordinator or Clinical Care Manager, as applicable) and PCP, when appropriate, based on protocols established by the ICO and incorporated into the sub-contractual arrangement with the Nurse Advice Line subcontractor, if any. 	<p>Contract with Nurse Advice Line company includes all these required services.</p> <p>P&P on after-hours services describes these services being offered by a Nurse Advice Line.</p>
B: Provider Hotline	
<p>1. The ICO maintains a provider hotline that is accessible to providers and pharmacies during the entire period in which the ICO sponsor's network pharmacies or providers in its plans' service areas are open, never less than 8:00 AM to 6:00 PM, Monday through Friday</p>	<p>Provider hotline P&P confirms that the hotline is toll-free and available never less than 8:00 AM to 6:00 PM, Monday through Friday.</p>

Enrollee and Provider Communications	
Readiness Review Criteria	Example Evidence
2. The ICO staffs an answering service or voicemail system for the provider hotline during non-business hours, which meets the following criteria: <ol style="list-style-type: none"> Indicates that the voicemail is secure; Lists the information that must be provided so the case can be worked, (e.g., provider identification, beneficiary identification, type of request (coverage determination or appeal), physician support for an exception request, and whether the member is making an expedited or standard request); and Indicates the time period in which a response to a voicemail can be expected. 	Provider hotline P&P includes the enumerated requirements.
3. The ICO (or PBM) has a pharmacy technical help desk call center that is prepared for increased call volume to handle new enrollments.	The ICO (or PBM) has a staffing plan that shows how it has arrived at an estimated staffing ratio for the pharmacy technical help desk call center and how and in what timeframe it intends to staff to that ratio.
4. The ICO ensures that pharmacy technical support is available at any time any of the network pharmacies are open.	Hours of operation for technical support cover all hours for which any network pharmacy is open.

Enrollee Protections	
Readiness Review Criteria	Example Evidence
<i>A: Enrollee Rights</i>	
1. The ICO has established enrollee rights and protections and assures that the enrollee is free to exercise those rights without negative consequences.	Enrollee rights P&P articulates enrollees' rights, states that enrollees will not face negative consequences for exercising their rights, and includes disciplinary procedures for staff members who violate this policy.
2. The ICO policies articulate that it will notify enrollees of their rights and protections at least annually, in a manner appropriate to their condition and ability to understand.	<p>Enrollee rights P&P provides a timeline for updating enrollees about changes or updates to their rights and protections.</p> <p>Enrollee rights P&P details how notifications will be adapted based on the enrollee's condition and ability.</p>

Enrollee Protections	
Readiness Review Criteria	Example Evidence
<p>3. The ICO provides enrollees with the following rights:</p> <ul style="list-style-type: none"> a. Be treated with respect and with due consideration for his or her dignity and privacy; b. Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand; c. Participate in decisions regarding his or her health care, including the right to refuse treatment; d. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation; e. Request and receive a copy of his or her medical records, and request that they be amended or corrected; and f. Receive information including all enrollment notices, informational materials, and instructional materials in a manner and format that may be easily understood. 	<p>Enrollee rights P&P states that an enrollee has these rights.</p> <p>Staff training on enrollee rights includes these rights.</p>
<p>4. The ICO does not discriminate against enrollees due to:</p> <ul style="list-style-type: none"> a. medical condition (including physical and mental illness); b. claims experience; c. receipt of health care; d. medical history; e. genetic information; f. evidence of insurability; or g. disability. 	<p>Enrollee rights P&P explains that the ICO will not discriminate against enrollees based on the enumerated reasons.</p> <p>Staff training includes discussion of enrollee rights.</p>
<p>5. The ICO informs enrollees that they will not be balanced billed by a provider for any service and this is articulated through policies and procedures and staff training modules.</p>	<p>Enrollee rights P&P explains that the ICO informs beneficiaries that they should not be balanced billed.</p>
<p>6. The ICO has policies and procedures to inform enrollees of their right to reasonable accommodation.</p>	<p>Enrollee rights P&P states that the ICO informs enrollees of their right to reasonable accommodation.</p>
B: Appeals and Grievances	
<p>1. The ICO notifies enrollees at least annually about their grievances and appeals rights.</p>	<p>Enrollee rights P&P provides a timeline for updating enrollees about changes or updates to their rights and protections.</p> <p>Enrollee rights P&P details how notifications will be adapted based on enrollee need.</p>
<p>2. The ICO's staff understand enrollee protections, including the organization and coverage determination and appeals and grievance processes.</p>	<p>Training materials contain information about the ICO's organization and coverage determination processes and the appeals and grievance processes.</p>
<p>3. The ICO provides enrollees with a "Notice of Denial of Medical Coverage" that provides appeal rights.</p>	<p>The Notice of Denial of Medical Coverage is consistent with CMS' template.</p>

Enrollee Protections	
Readiness Review Criteria	Example Evidence
4. The ICO provides enrollees with reasonable assistance in filing an appeal or grievance.	Grievances and appeals P&P explains to the extent to which the ICO will assist an enrollee in filing an appeal or grievance.
5. ICOs must provide continuing benefits for all prior approved non-Part D benefits that are terminated or modified pending internal ICO appeals. This means that such benefits will continue to be provided by providers to beneficiaries, and that ICOs must continue to pay providers for providing such services pending an internal ICO appeal.	Grievances and appeals P&P confirm that any benefits or services being appealed through the internal appeals process are continued for the length of the appeal.
6. Appeals of ICO actions concerning Medicaid-only benefits may be appealed to the MassHealth Board of Hearings.	Grievances and appeals P&P states that appeals of ICO decisions concerning Medicaid-only benefits may be appealed to the MassHealth Board of Hearings.
7. The ICO maintains an established process to track and maintain records on all grievances received both orally and in writing, including, at a minimum, the date of receipt, final disposition of the grievance, and the date that the ICO notified the enrollee of the disposition.	<p>Screenshots of or reports from the tracking system in which enrollee appeals and grievances are kept includes these elements.</p> <p>Data summaries or reports detail the types of reporting and remediation steps that are taken to ensure appeals are correctly handled.</p> <p>Grievances and appeals P&P define how staff from the ICO should document grievances and appeals within the tracking system.</p>

Enrollee Protections	
Readiness Review Criteria	Example Evidence
<p>8. The ICO shall maintain the following policies and procedures for enrollee grievances:</p> <ul style="list-style-type: none"> a. Enrollees shall be entitled to file internal grievances directly with the ICO. b. An enrollee grievance is an enrollee's written or oral expression of dissatisfaction with any aspect of the operations, activities or behavior of an ICO, or its providers, regardless of whether remedial action is requested. c. An enrollee may file an internal grievance at any time with the ICO or its providers, by calling or writing to the ICO or provider. d. An enrollee also may file an external grievance at any time by calling or writing to MassHealth. e. If remedial action is requested, the enrollee must submit the grievance to the ICO, his/her provider or MassHealth no later than 60 days after the event or incident triggering the grievance. f. The ICO must inform enrollees of the postal address or toll-free telephone number where an internal or external enrollee grievance may be filed. g. The ICO has a system in place for addressing enrollee grievances internally. The ICO must maintain written grievance policies and procedures, maintain records of all grievance activities, and notify MassHealth of all internal grievances. The system must meet the following standards: <ul style="list-style-type: none"> i. Timely acknowledgement of receipt of each enrollee grievance; ii. Timely review of each enrollee grievance; iii. Response, orally or in writing, to each enrollee grievance within a reasonable time, but no later than 30 days after the ICO receives the grievance; iv. Expedited response, orally or in writing, within 24 hours after the ICO receives the grievance to each enrollee grievance whenever an ICO extends the appeals timeframe or an ICO refuses to grant a request for an expedited appeal; and v. Availability to enrollees of information about enrollee appeals, including reasonable assistance in completing any forms or other procedural steps, which shall include interpreter services and toll-free numbers with TTY/TDD and interpreter capability. h. Enrollees may submit written or oral grievances directly to MassHealth. i. The ICO must track and resolve its grievances, or if appropriate, re-route grievances to the coverage decision or appeals processes. 	<p>P&P on grievances includes these specifications.</p>

Enrollee Protections	
Readiness Review Criteria	Example Evidence
<p>9. The ICO shall maintain the following policies and procedures for appeals for other than Part D:</p> <ul style="list-style-type: none"> a. Enrollees have 60 days to file an appeal related to coverage. b. Initial appeals will be filed with the ICO. <ul style="list-style-type: none"> i. Subsequent appeals for traditional Medicare A and B services will be automatically forwarded to the Medicare Independent Review Entity (IRE). ii. Services for which Medicare and Medicaid overlap (including Home Health, Durable Medical Equipment and skilled therapies, but excluding Part D) will be defined in a unified way in the three-way contract. Appeals related to these benefits will be auto-forwarded to the IRE, and may also be filed with the Board of Hearings. c. All ICO appeals must be resolved (at each level) within 30 days of their submission for standard appeals and within 72 hours of their submission for expedited appeals. 	<p>P&P on appeals includes these specifications.</p>
<p>10. Consistent with existing rules, if the ICO misses the applicable adjudication timeframe, Part D cases will be automatically forwarded to the IRE.</p>	<p>P&P on Part D appeals includes these requirements for processing appeals.</p>
<i>C: Enrollee Choice of PCP</i>	
<p>1. The ICO notifies enrollees about the process for choosing their primary care provider (PCP), including the enrollee's right to select his/her PCP.</p>	<p>PCP selection and assignment P&P explains how and when an enrollee may elect a new PCP.</p> <p>PCP selection and assignment P&P explains how primary care providers are assigned to enrollees who do not elect a provider and/or who are not capable of selecting a provider.</p>
<i>D: Emergency Services</i>	
<p>1. The ICO has a back-up plan in place in case an LTSS provider does not arrive to provide assistance with activities of daily living.</p>	<p>Emergency services P&P explains how the ICO is prepared to provide care to LTSS enrollees when an LTSS provider does not arrive to provide care.</p>
<p>2. The ICO can connect enrollees with emergency behavioral health services, when applicable.</p>	<p>Emergency services P&P explains how the ICO is prepared to provide emergency mental health services to enrollees in crisis.</p>
<p>3. The ICO has a crisis hotline service that is available to enrollees 24 hours per day, 7 days per week, which is staffed with behavioral health professionals who are qualified to assist in a crisis situation.</p>	<p>Emergency services P&P confirms that the ICO maintains a behavioral health crisis hotline that is available to enrollees 24 hours a day, 7 days per week, and that it is staffed with qualified behavioral health professionals who are qualified to assist in a crisis situation.</p> <p>Resumes of staff for the crisis hotline demonstrate that staff for</p>

Enrollee Protections	
Readiness Review Criteria	Example Evidence
	the crisis hotline are qualified behavioral health professionals.

Financial Soundness	
Readiness Review Criteria	Evidence
1. ICO must provide assurances that its provision against the risk of insolvency is adequate to ensure that its enrollees will not be liable for the entity's debts if the entity becomes insolvent. ICO must produce adequate documentation satisfying the Commonwealth that it has met its solvency requirements, including: letters of financial support (or credit, bond, loan guarantee, letter of parental guarantee, reserve guarantee, or other financial guarantees) in at least an amount that guarantees the ICO's contract obligations will be performed, a detailed plan to establish and maintain reserves or other funds necessary to cover any risks projected and not otherwise assumed by another entity, copies of all reinsurance agreements, adequate liability insurance to perform contractually agreed services, accounting system statement for incurred but not reported liabilities, detailed description of mechanisms to monitor financial solvency, and certificate from the taxing authority in the state where the ICO has its principal office attesting that the ICO is not in default. ICOs must also maintain reserves to remain solvent for a 45-day period, and provide satisfactory evidence to the State of such reserves.	Required financial documentation of solvency.

Organizational Structure and Staffing	
Readiness Review Criteria	Example Evidence
<i>A. Organizational structure and staffing</i>	
1. The ICO maintains and updates all required points of contact in CMS ICO Management System (HPMS), including but not limited to CEO, COO, and CFO.	HPMS.
2. The ICO identifies <ul style="list-style-type: none"> a. A Behavioral Health Clinical Director; and b. A Director of LTSS. 	Staff resumes indicate that qualified and experienced staff with appropriate expertise fill these positions.
3. The ICO must establish at least one consumer advisory committee and a process for that committee to provide input to the governing board. The ICO must also demonstrate participation of consumers with disabilities, including enrollees, within the governance structure of the ICO.	Bylaws governing ICO's consumer advisory committee state that consumers with disabilities are to participate on the committee (or otherwise have a role in the governance structure of the ICO) and that the committee has a process for providing input to the ICO's governing board.
4. ICO has established a work plan and identified an individual in its organization who is responsible for Americans with Disabilities Act (ADA) compliance related to this demonstration.	The ICO submits an ADA work plan and has identified an individual responsible for oversight of ADA compliance.

Organizational Structure and Staffing

Readiness Review Criteria	Example Evidence
<p>5. The ICO has a utilization management (UM) committee that exhibits an expertise in the range of services provided by the plan (e.g., behavioral health and LTSS expertise).</p>	<p>Note: For ICOs with current UM committees, review will focus on the change in composition to address the new services (e.g., LTSS and BH).</p> <p>UM committee members are appropriate based on the target population described in the CMS-State MOU (e.g., including behavioral health providers and providers with expertise in LTSS).</p>
<p>6. The ICO's Quality Improvement (QI) committee includes physicians, psychologists, providers with expertise in LTSS and others, who represent a range of health care services used by enrollees in the target population.</p>	<p>Note: For ICOs with current QI committees, review will focus on the change in composition to address the new services (e.g., LTSS and BH).</p> <p>QI committee members are appropriate based on the target population described in the MOU.</p>
<p>7. The ICO has an individual or committee responsible for provider credentialing.</p>	<p>A provider credentialing point of contact or committee is reflected in org chart.</p> <p>The provider credentialing point of contact is experienced and qualified to oversee provider credentialing for the full range of providers (e.g., medical, LTSS, pharmacy).</p>
<p>8. The ICO informs the Commonwealth when the points of contact at ICO change.</p>	<p>P&P requires the Commonwealth to be notified should any changes occur among head contact staff.</p>

Organizational Structure and Staffing	
Readiness Review Criteria	Example Evidence
<i>B: Sufficient Staff</i>	
<p>1. The ICO's hiring process includes:</p> <ul style="list-style-type: none"> a. A strategic plan for hiring new employees or contractors, as needed, which must include the following positions; Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, Chief Medical Officer, Director of Quality Management, Behavioral Health Clinical Director (or equivalent), Director of Long Term Support Services and Supports (or equivalent), and ADA Compliance Officer; b. A timeline by which key hiring activities are to be completed; and c. A designated staff member responsible for overseeing the hiring process. 	<p>The ICO's strategic hiring plan is consistent with the volume of anticipated monthly enrollment.</p> <p>Recruitment approach provides detail and timelines (e.g. job postings, advertising, use of head-hunters), job descriptions and resumes of staff responsible for overseeing recruitment.</p> <p>Key leadership roles have been filled.</p>
<p>2. The ICO demonstrates that it has sufficient employees and/or contractor staff to complete comprehensive and ongoing assessments as required (including at least annually), in a timely manner for all enrollees through its staffing plan, which explains:</p> <ul style="list-style-type: none"> a. how the ICO arrived at its estimation of sufficient staffing for this function; and <ul style="list-style-type: none"> a. how and in what timeframe it will staff to the level indicated; and b. how it matches the needs of various sub-populations. 	<p>The ICO has a staffing plan that shows how it has arrived at an estimated staffing ratio for completing health risk assessments and how and in what timeframe it intends to staff to that ratio.</p>
<p>3. The ICO staff, contractors, or providers performing comprehensive-assessments have the appropriate education and experience for the sub-populations (e.g., experience in LTSS or behavioral health).</p>	<p>Job descriptions include relevant educational and experience requirements.</p> <p>Resumes for selected staff indicate that staff meet job description requirements.</p>
<p>4. The ICO demonstrates that it has sufficient employees and/or contractor staff to meet the care coordination needs of the target population through its staffing plan, which explains:</p> <ul style="list-style-type: none"> a. how the ICO arrived at its estimation of sufficient staffing for this function; and b. how and in what timeframe it will staff to the level indicated; and c. how it matches the needs of various sub-populations. 	<p>The ICO has a staffing plan that shows how it has arrived at an estimated staffing ratio for providing care coordination and how and in what timeframe it intends to staff to that ratio.</p>
<p>5. The qualifications for a Care Coordinator include:</p> <ul style="list-style-type: none"> a. being a provider-based clinician, or b. or trained individual employed or contracted by the enrollee's primary care provider. 	<p>P&P on Care Coordinator qualifications includes those listed.</p>
<p>6. The qualifications for a clinical care manager include:</p> <ul style="list-style-type: none"> a. being a licensed registered nurse or other individual employed by the enrollee's primary care provider or ICO; and b. being licensed to provide clinical care management. 	<p>P&P on Clinical Care Manager qualifications includes those listed.</p>

Organizational Structure and Staffing	
Readiness Review Criteria	Example Evidence
<p>7. The qualifications for a IL-LTSS coordinator include:</p> <ul style="list-style-type: none"> a. a bachelor's degree in social work or human services or at least two years working in a human service field with the target population; b. completion of person-centered planning and person-centered direction training, experience working with disabled populations or elders in need of LTSS; c. knowledge of the home and community-based service system and how to access and arrange for services; d. experience in conducting LTSS needs assessments and monitoring LTSS delivery; e. cultural competency; f. the ability to provide informed advocacy; g. the ability to write an Individualized Care Plan; h. the ability to communicate effectively, verbally and in writing across complicated service and support systems; and i. meeting all requirements of their CBO employer. 	<p>P&P on IL-LTSS coordinator qualifications includes those listed.</p>
<p>8. The ICO demonstrates that it has sufficient employees and/or contractor staff to handle care coordination oversight, monitoring, and quality assurance activities through its staffing plan, which explains:</p> <ul style="list-style-type: none"> a. how the ICO arrived at its estimation of sufficient staffing for this function; b. how and in what timeframe it will staff to the level indicated; and c. how it matches the needs of the sub-populations. 	<p>The ICO has a staffing plan that shows how it has arrived at an estimated staffing ratio for care coordination oversight, monitoring, and quality assurance activities and how and in what timeframe it intends to staff to that ratio.</p>
<p>9. The ICO demonstrates that it has sufficient employees and/or contractor staff to handle organization and coverage determinations and appeals and grievances through its staffing plan, which explains:</p> <ul style="list-style-type: none"> a. how the ICO arrived at its estimation of sufficient staffing for this function; and b. how and in what timeframe it will staff to the level indicated; and c. how it matches the needs of the sub-populations. 	<p>The ICO has a staffing plan that shows how it has arrived at an estimated staffing ratio for organization and coverage determinations and appeals and grievances, and how and in what timeframe it intends to staff to that ratio.</p>
<p>10. The ICO demonstrates that it has sufficient employees and/or contractor staff to handle its call center operations through its staffing plan, which explains:</p> <ul style="list-style-type: none"> a. how the ICO arrived at its estimation of sufficient staffing for this function; and b. how and in what timeframe it will staff to the level indicated. 	<p>The ICO has a staffing plan that shows how it has arrived at an estimated staffing ratio for completing health risk assessments and how and in what timeframe it intends to staff to that ratio.</p>
<p>11. The plan medical director is responsible for ensuring the clinical accuracy of all Part D coverage determinations and redeterminations involving medical necessity.</p>	<p>Utilization management program description or coverage determination P&P includes requirement that medical director is responsible for ensuring the clinical accuracy of all Part D coverage determinations and redeterminations involving medical necessity.</p> <p>Job description for the medical director includes this</p>

Organizational Structure and Staffing	
Readiness Review Criteria	Example Evidence
	responsibility.
<i>C: Staff Training</i>	
1. The ICO has a cultural competency and disability training plan to ensure that staff deliver culturally-competent services in both oral and written enrollee communications (e.g., person-first language, target population competencies).	<p>The ICO's cultural competency and disability training plan (or P&P) identifies which staff receive this training and how often and includes a schedule of training activities for new staff.</p> <p>The ICO's training materials include training on cultural competency and disability.</p>
2. The ICO's staff are adequately trained to handle critical incident and fraud and abuse reporting. Training includes, among other things, ways to detect and report instances of abuse, neglect and exploitation of enrollees by service providers and/or natural supports.	The ICO's training materials include training on critical incident and fraud and include these topics.
3. The training program for Care Coordinators includes (but is not limited to): <ul style="list-style-type: none"> a. Roles and responsibilities; b. Timeframes for all initial contact and continued outreach; c. Needs assessment and care planning; d. Service monitoring; e. Long term services and support; f. Self-direction of PCA services; g. Behavioral health and the recovery model h. Care transitions; i. Skilled nursing needs; j. Abuse and neglect reporting; k. Pharmacy and Part D services; l. Community resources; m. Enrollee rights and responsibilities; n. Independent living philosophy; o. Most integrated/ least restrictive setting; p. How to identify behavioral health and LTSS needs; and q. How to obtain services to meet behavioral and LTSS needs. 	The ICO's training materials for Care Coordinators include modules or sections on each of these elements.
4. The training program for primary care providers includes: <ul style="list-style-type: none"> a. how to identify behavioral health needs and how to obtain behavioral health services; and b. how to identify LTSS needs and how to obtain services. 	The ICO's training materials for PCPs include modules or sections on behavioral health needs and services.

Organizational Structure and Staffing	
Readiness Review Criteria	Example Evidence
5. The ICO has adequate personnel and training resources so that all staff have the ability to access required training materials in a timely manner; a designated staff member is in charge of ensuring required trainings are completed on schedule.	The ICO's training materials describe which staff receive training and how often, including a schedule of training activities for new staff retraining schedule (e.g., protecting enrollee rights, assisting with grievances and appeals).
6. The ICO's staff are trained on confidentiality guidelines and have received training to meet HIPAA compliance obligations.	The ICO's training materials include training on HIPAA compliance, including confidentiality guidelines.
7. The ICO or PBM has scripts for its pharmacy customer service hotline staff including, but not limited to: <ul style="list-style-type: none"> a. Best Available Evidence policy; b. Request for pre-enrollment information; c. Benefit information; d. Cost-sharing information; e. Continuity of care requirements; f. Enrollment/disenrollments; g. Formulary information; h. Pharmacy information, including whether an enrollee's pharmacy is in the ICO's network; i. Provider information, including whether an enrollee's physician is in the ICO's network; j. Out-of-network coverage; k. Claims submission, processing, and payment; l. Formulary transition process; m. Grievance, coverage determination, and appeals process (including how to address Medicaid drug appeals); n. Information on extra help, including how the enrollee can obtain extra help o. Current TrOOP status; p. Information on how to obtain needed forms; q. Information on replacing an identification card; and r. Service area information. 	Copies of pharmacy customer service hotline staff scripts contain content related to the competencies listed in the criteria.
8. The ICO ensures that enrollee services telephone line and pharmacy customer service hotline staff have been adequately trained in the following areas: <ul style="list-style-type: none"> a. Explaining the operation of the ICO and the roles of participating providers; b. Assisting enrollees in the selection of a primary care provider; c. Assisting enrollees to obtain services and make appointments; and d. Handling or directing enrollee inquiries or grievances. 	<p>Content from training programs or orientation modules demonstrates staff from the ICO trains its enrollee services telephone line staff and pharmacy customer service line personnel on the enumerated topics.</p> <p>Step-by-step procedures or a flow chart showing how staff from the ICO would walk through assisting enrollees in explaining or selecting services.</p>
9. The ICO's training for internal beneficiary complaint and appeal staff covers accessibility obligations related to the Americans with Disabilities Act (ADA) and community integration priorities and	ICO's training materials include modules on the ADA.

Organizational Structure and Staffing

Readiness Review Criteria	Example Evidence
principles.	

Performance and Quality Improvement

Readiness Review Criteria	Example Evidence
<i>Performance and quality improvement</i>	
1. The ICO collects and tracks critical incidents and abuse for enrollees receiving LTSS.	<p>QI program description explains how the ICO tracks incidents and cases of abuse for enrollees receiving LTSS.</p> <p>Sample annual performance report includes ICO's method of tracking and reporting cases of incidents and abuse.</p>
2. The ICO is prepared to report all Year 1 core quality measures required under the demonstration, including all Medicare Advantage (Part C) required measures, HEDIS, HOS and CAHPS data, as well as measures related to behavioral health, care coordination/transitions, LTSS as required by the MOU (see Figure 7-1), and all patient ED wait times prior to inpatient behavioral health admission.	<p>QI program description details how the ICO collects these measures for its enrollees.</p> <p>Sample annual performance report includes ICO's method of reporting these measures.</p>
3. The ICO collects prescription drug quality measures, consistent with Medicare Part D requirements and has established quality assurance measures and systems to reduce medication errors and adverse drug interactions and improve medication use.	<p>QI program description explaining health's plans means of collecting and reviewing drug quality measures.</p> <p>Sample annual performance report includes ICO's method of reporting these measures.</p>
4. The ICO has a detailed plan to monitor the performance on an ongoing basis of all first-tier, downstream, and related entities.	<p>The ICO has a detailed plan that explains how the ICO monitors first-tier, downstream, and related entities (e.g., via monthly reviews or reports, on-site visits).</p>
5. The ICO, as a condition of payment, complies with the requirements mandating that Provider Preventable Conditions be reported and that payment for these conditions be prohibited.	<p>P&P for reporting Provider Preventable Conditions and non-payment of those conditions.</p> <p>ICO provider contract templates include provisions on provider preventable conditions.</p>

Program Integrity

Readiness Review Criteria	Example Evidence
1. In accordance with 42 CFR §438.608, 42 CFR §422.503, and 42 CFR §423.504 the ICO shall have administrative and management arrangements or procedures, including a mandatory compliance plan,	The ICO's compliance plan includes these arrangements and/or procedures.

Program Integrity	
Readiness Review Criteria	Example Evidence
<p>which is designed to guard against Fraud and Abuse. The arrangements or procedures must include the following:</p> <ul style="list-style-type: none"> a. Written policies, procedures, and standards of conduct articulate the organization's commitment to comply with all applicable Federal and State standards, describe compliance expectations, and implement the compliance program; b. Written policies, procedures, and standards of conduct provide guidance to employees and others on how to deal with potential compliance issues, identify how to communicate compliance issues to appropriate compliance personnel, and describe how potential compliance issues are investigated and resolved by the organization; c. Policies, procedures, and standards of conduct include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including, but not limited to, reporting potential issues, investigating issues, conducting self-evaluations, audits, remedial actions, and reporting to appropriate officials; d. The designation of a compliance officer and compliance committee who report directly to and are accountable to the organization's CEO or other senior management; the compliance officer is an employee of the ICO; e. The compliance officer and committee periodically submit reports to the health plan's governing body on the activities and status of the compliance program, including those issues that are identified, investigated, and resolved; f. The ICO's governing body is knowledgeable about the content and operation of the compliance program and exercises oversight, with respect to its implementation and effectiveness; g. Effective training materials and education programs that ensure that employees, management, governing body members, and any of the organization's first tier, downstream, and related entities understand and are able to comply with the compliance program. The training occurs at least annually and is part of the orientation for everyone who is required to have the training; h. Effective lines of communication between the compliance officer and the Contractor's employees; i. Enforcement of standards through well-publicized disciplinary guidelines; and j. Provision for prompt response to detected offenses, and for development of corrective action initiatives. 	
<p>2. The ICO shall:</p> <ul style="list-style-type: none"> a. Develop a comprehensive internal Fraud and Abuse program, as part of the Contractor's compliance program to prevent and detect program violations; b. In accordance with Mass. Gen. Laws. ch. 12, section 5J, not discriminate against an employee for reporting a fraudulent activity or for cooperating in any government or law enforcement authority's investigation or prosecution; c. Upon a complaint of Fraud or Abuse from any source or upon identifying any questionable practices, conduct a preliminary review to determine whether in the Contractor's judgment, there is reason 	<p>The ICO's compliance plan includes these arrangements and/or procedures.</p>

Program Integrity	
Readiness Review Criteria	Example Evidence
<p>to believe that the Provider, the Enrollee, or a Contractor employee, has engaged in Fraud or Abuse, and where reason exists, report the matter in writing to EOHHS within ten days;</p> <p>d. If such preliminary review, or any further review or audit of a Provider suspected of Fraud involves contacting the Provider in question, the Contractor shall first notify EOHHS and receive its approval prior to initiating such contact;</p> <p>e. Make diligent efforts to recover improper payments or funds misspent due to fraudulent or abusive actions by the Contractor, or its parent organization, its Providers or its subcontractors;</p> <p>f. Require providers to implement corrective actions or terminate Provider Contracts, as appropriate;</p> <p>g. Submit on an annual basis a fraud and abuse report according to the format specified by EOHHS, and submit ad hoc reports as needed, or as requested by EOHHS;</p> <p>h. Have the CEO or CFO certify in writing on an annual basis to EOHHS, using the appropriate certification checklist, that after a diligent inquiry, to the best of his/her knowledge and belief, the Contractor is in compliance with this Contract and has not been made aware of any instances of Fraud and Abuse in any program covered by this Contract, other than those that have been reported by the Contractor in writing to EOHHS;</p> <p>i. Notify EOHHS upon contact by the Medicaid Fraud Division (MFD), the Bureau of Special Investigations (BSI) or any other investigative authorities conducting Fraud and Abuse investigations, unless specifically directed by the investigative authorities not to notify EOHHS. The Contractor, and where applicable any subcontractors or Material Subcontractors, shall cooperate fully with the MFD, BSI and other agencies that conduct investigations; full cooperation includes, but is not limited to, timely exchange of information and strategies for addressing Fraud and Abuse, as well as allowing prompt direct access to information, free copies of documents, and other available information related to program violations, while maintaining the confidentiality of any investigation. The Contractor shall make knowledgeable employees available at no charge to support any investigation, court, or administrative proceeding; and</p> <p>j. Notify EOHHS of all Provider overpayments above \$75,000, or any voluntary Provider disclosures resulting in receipt of overpayments in excess of \$75,000, even if there is no suspicion of fraudulent activity.</p>	

Provider Credentialing	
Readiness Review Criteria	Example Evidence
<i>A: Provider Organization Credentialing</i>	
<p>1. The ICO shall:</p> <ul style="list-style-type: none"> a. Maintain appropriate, documented processes for the credentialing and re-credentialing of physician providers and all other licensed or certified providers who participate in the ICO's provider network that require, at a minimum, that the scope and structure of the processes be consistent with recognized managed care industry standards and relevant state regulations, including regulations issued by the Board of Registration in Medicine at 243 CMR 3.13; b. Ensure that all providers are credentialed prior to becoming network providers and that a site visit is conducted with recognized managed care industry standards and relevant state regulations; c. Maintain a documented re-credentialing process that shall occur regularly and that requires that physician providers and other licensed and certified professional providers, including behavioral health providers, maintain current knowledge, ability, and expertise in their practice area(s) by requiring them, at a minimum, to conform with recognized managed care industry standards. 	<p>Provider credentialing P&P includes these requirements.</p>
<p>2. Prior to contracting with a new provider, the ICO verifies the following:</p> <ul style="list-style-type: none"> a. A valid license to practice medicine, when applicable; b. A valid DEA certificate, when applicable, by specialty; c. Other education or training, as applicable, by specialty; d. Malpractice insurance coverage, when applicable; e. Work history; f. History of medical license loss; g. History of felony convictions; h. History of limitations of privileges or disciplinary actions; i. Medicare or Medicaid sanctions; and j. Malpractice history. 	<p>Provider credentialing P&P states that the ICO will review these documents and this information, as applicable, prior to contracting with a provider.</p> <p>Sample initial completed credentialing application instructions.</p>
<p>3. The ICO requires all contracted laboratories to maintain certification under the Clinical Laboratory Improvement Amendments (CLIA) or have a waiver of CLIA certification.</p>	<p>The ICO submits a CLIA certificate or a waiver of CLIA certification along with a CLIA identification number for each laboratory with which the ICO has contracted.</p>
<p>4. The ICO maintains a policy with respect to board certification for primary care providers and specialty physicians that ensures that the percentage of board certified primary care providers and specialty physicians participating in the provider network, at a minimum, is approximately equivalent to the community average for primary care providers and specialty physicians in the ICO's service area.</p>	<p>P&P on provider credentialing ensures that the percentage of board certified primary care providers and specialty physicians participating in the provider network is approximately equivalent to the community average.</p>

Provider Network	
Readiness Review Criteria	Example Evidence
<i>A: Establishment and Maintenance of Network, including Capacity and Services Offered</i>	
<p>1. The ICO has a set of procedures that govern participation in the medical, behavioral, pharmacy, and LTSS provider networks, including written rules of participation that cover:</p> <ul style="list-style-type: none"> a. terms of payment; b. credentialing; and c. other rules directly related to participation decisions. <p>When an ICO makes a material change in its participation procedures, it agrees to submit written notice to CMS and Massachusetts before the change is in effect.</p>	<p>The ICO's rules for participation for medical, behavioral, pharmacy, and LTSS provider networks include all necessary items and specify that written notice of material changes in the rules will be submitted to CMS and Massachusetts prior to changes taking effect.</p>
<p>2. The ICO has a clear plan to meet the Medicare and Medicaid provider network standards that takes into account:</p> <ul style="list-style-type: none"> a. The anticipated enrollment; b. The expected utilization of services, taking into consideration the characteristics and health care needs of the target populations; c. The numbers and types (i.e., training, experience, and specialization) of providers required to furnish the contracted services including pharmacies and LTSS providers; d. Whether providers are accepting new enrollees; e. The geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees, and whether the location provides access for enrollees; f. Access to primary care services for enrollees within a reasonable distance of enrollees' places of residence; g. Access to specialty care services for enrollees within a reasonable distance from enrollees' places of residence; h. Access to at least two outpatient behavioral health providers within a 15-mile radius or 30 minutes from the Enrollee's ZIP code of residence; i. Access to at least two community LTSS Providers for each covered LTSS service within a 15-mile radius or 30 minutes from the Enrollee's ZIP code of residence; j. Access to pharmacy services for enrollees within a reasonable distance from enrollees' places of residence; k. Access to facility services for enrollees within a reasonable distance from enrollees' places of residence, including outpatient dialysis; and l. Out-of-network providers. 	<p>Provider network P&P defines expected number of demonstration enrollees and required number of providers.</p> <p>Provider network P&P defines specialties covered and how they relate to the specific needs of the target population.</p> <p>Review of fully contracted network during network validation (following the completion of rates)</p> <ul style="list-style-type: none"> • ICOs will submit HSD tables for fully contracted Medicare network • ICOs will submit lists of Medicaid providers and maps for fully contracted Medicaid network
<p>3. The ICO has processes to monitor the pharmacy networks and to continually contract with providers in order to maintain the networks to meet Medicare Part D requirements.</p>	<p>Proof that the plan covers mail order, long-term care pharmacy, and home infusion therapy.</p> <p>The ICO contracts with any willing pharmacy provider.</p>

Provider Network	
Readiness Review Criteria	Example Evidence
4. The ICO meets the network adequacy standards for specialists and specialty facilities that are directly linked to the target population; these may include CMHCs, ID/DD service providers, centers for independent living, wheelchair vendors, and seating specialists.	<p>Provider network P&P includes this requirement.</p> <p>Provider network P&P defines how it will monitor and maintain the LTSS network.</p> <p>Review of fully contracted network during network validation review (following the completion of rates)</p> <ul style="list-style-type: none"> • ICOs will submit HSD tables for fully contracted Medicare network • ICOs will submit lists of Medicaid providers and maps for fully contracted Medicaid network
5. The ICOs has executed written agreements with all Medicare medical, behavioral, and pharmacy network providers.	Sample of contract signature pages show executed contracts.
6. The ICOs has executed written agreements with all Medicaid medical, behavioral, and LTSS network providers required by the State.	Sample of contract signature pages show executed contracts.
<p>7. The ICO has a policy and procedure and training materials that demonstrate that the medical, behavioral, LTSS, and pharmacy provider networks are trained in cultural competency in delivering services to the following target populations:</p> <ol style="list-style-type: none"> Adults with serious mental illness; Enrollees with substance abuse disorders; Enrollees with a dual diagnosis of mental health and substance abuse; Enrollees with a dual diagnosis of intellectual disabilities and mental health; Adults with disabilities who are homeless; Enrollees with complex medical needs; Enrollees with physical disabilities; Enrollees with Traumatic Brain Injury; Enrollees with intellectual disabilities; Enrollees with dementia/Alzheimer's; Enrollees with ESRD; Enrollees with HIV/AIDS; Adults with physical disabilities; Adults with developmental disabilities; Adults with disabilities with multiple chronic illnesses or functional or cognitive limitations; and Older adults. 	<p>Provider network P&P explains how its primary care, specialty, behavioral health, LTSS, and pharmacy providers are prepared to meet the additional competencies necessary to serve enrollees within the target population.</p> <p>Provider training materials for all of these groups include sections on cultural competency when serving target populations.</p>

Provider Network	
Readiness Review Criteria	Example Evidence
8. The ICO has a policy and procedure that states that it establishes a panel of primary care providers (PCPs) from which enrollees may select a PCP.	P&P describes PCP requirements and minimum required numbers of PCPs for counties or other plan areas and for sub-populations of enrollees if applicable.
9. The ICO has a policy and procedure that states that it covers services from out-of-network providers and pharmacies when a network provider or pharmacy is not available within a reasonable distance from the enrollee's place of residence.	Provider network P&P explain how and when services outside of the network may be covered and under what circumstances.
10. Medical, pharmacy, behavioral, and LTSS networks' providers have the capacity to accept new enrollees.	Samples of patient panel sizes for primary care and specialty providers within the ICO's network are within normal ranges.
11. The ICO collects and tracks requests, referrals, and use of non-network providers.	P&P explains how the ICO tracks all requests and referrals to non-network providers.
12. The ICO provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.	Provider network P&P provides a description of and process for obtaining second opinion coverage from in-network and out-of-network providers
13. The ICO ensures that enrollees have access to the most current and accurate information, by updating its online provider directory and search functionality on a timely basis.	Provider network P&P includes timeframes for updating provider directory and search functionality (for online provider directories).
14. In establishing and maintaining its provider network, the ICO must consider the following: <ul style="list-style-type: none"> a. Anticipated enrollment by sub-population; b. Expected utilization of services, taking into consideration the cultural and ethnic diversity, and other demographic characteristics and health care needs of specific MassHealth populations enrolled with the ICO; c. The numbers and types (in terms of training, experience and specialization) of Providers required to furnish covered services; d. The number of network providers who are not accepting new patients; and e. The geographic location of providers and enrollees, considering distance, travel time, and the means of transportation ordinarily used by enrollees. 	Provider network P&P includes these requirements.

Provider Network	
Readiness Review Criteria	Example Evidence
<p>15. The ICO shall meet the following requirements in contracting with Community-Based Organizations (CBO):</p> <ol style="list-style-type: none"> ICO shall contract with multiple CBOs, including at least one Independent Living Center (ILC), where geographically feasible, in its service area for the ILLTSS Coordinator. The ICO must contract with an adequate number of CBOs to allow enrollees a choice of at least two IL-LTSS Coordinators. Additional CBOs may include, but are not limited to, Recovery Learning Communities, ASAPs, and other CBOs serving people with disabilities. The ICO must offer enrollees over the age of 60 the option of receiving IL-LTSS Coordinator services through an Aging Services Access Point (ASAP). The ICO shall not have a direct or indirect financial ownership interest in an entity that serves as a CBO which is contracted to provide IL-LTSS Coordinators. Providers of facility- or community-based LTSS that are compensated by the ICO may not function as IL-LTSS Coordinators, except if the ICO obtains a waiver of this requirement from EOHHS. For the purposes of this provision, an organization compensated by the ICO to provide only evaluation, assessment, coordination, skills training, peer supports and Fiscal Intermediary (FI) services is not considered a provider of LTSS. 	<p>Provider network P&P includes these requirements.</p>
<p>16. The ICO must maintain relationships with the Emergency Service Programs (ESPs) that are located within the ICO's service area to provide ESP services.</p> <p>Each ICO must execute and maintain contracts with ESPs that are not run by the Department of Mental Health. ICOs are not required to contract with the DMH ESPs; however, ICOs are required to coordinate admissions and triage with DMH ESPs as they would with any contracted ESP. Of the ESPs identified in Appendix G of the RFR, the DMH ESPs are: Brockton Multi-Service Center, Cape & Islands Emergency Services, Corrigan Mental Health Center, and Norton Emergency Services.</p>	<p>Provider network P&P includes this requirement.</p>
<p>17. The ICO delivers preventive health care services including, but not limited to, cancer screenings and appropriate follow-up treatment to Enrollees, other screenings or services as specified in guidelines set by EOHHS or, where there are no EOHHS guidelines, in accordance with nationally accepted standards of practice.</p>	<p>P&P on preventive services or covered services includes this requirement.</p>
<p>18. The ICO delivers prenatal and postpartum services to pregnant enrollees, in accordance with guidelines set by EOHHS or, where there are no EOHHS guidelines, in accordance with nationally accepted standards of practice.</p>	<p>P&P on covered services planning services includes these requirements.</p>
B: Accessibility	
<p>1. The ICO medical, behavioral, pharmacy, and LTSS networks include providers whose physical locations and diagnostic equipment accommodate individuals with disabilities.</p>	<p>Provider network P&P explains how the ICO will alert its enrollees of providers able to accommodate enrollees with disabilities (e.g., icons in provider directory, information</p>

Provider Network	
Readiness Review Criteria	Example Evidence
	available upon request).
2. Medical, behavioral, LTSS, and pharmacy network providers provide linguistically- and culturally-competent services.	<p>Template includes requirements for translation services as appropriate (e.g., hospitals required to have Spanish translator on call at all times).</p> <p>Provider training includes training on cultural competency.</p>
3. Medical, behavioral, LTSS, and pharmacy network providers exhibit competency in the following areas: <ul style="list-style-type: none"> a. Utilize waiting room and exam room furniture that meet needs of all enrollees, including those with physical and non-physical disabilities b. Accessibility along public transportation routes, and/or provide enough parking c. Utilize clear signage and way finding (e.g., color and symbol signage) throughout facilities d. Provide secure access for staff-only areas. 	<p>Provider training materials detail special needs required by enrollees and provide suggestions or solutions on how to work with such enrollees.</p> <p>Templates require providers to take these actions as condition for participation.</p>
<i>C: Provider Training</i>	
1. The ICO requires disability, literacy and competency training for its medical, behavioral, LTSS, and pharmacy providers, including information about the following: <ul style="list-style-type: none"> a. Various types of chronic conditions prevalent within the target population b. Awareness of personal prejudices c. Legal obligations to comply with the ADA d. Definitions and concepts, such as communication access, medical equipment access, physical access, and access to programs e. Types of barriers encountered by the target population f. Training on person-centered planning and self-determination, the social model of disability, the independent living philosophy, and the recovery model g. Use of evidence-based practices and specific levels of quality outcomes h. Working with enrollees with mental health diagnoses, including crisis prevention and treatment. 	<p>Each of the listed elements is included in the provider training curricula.</p> <p>Template specifies that completion of these trainings is mandatory.</p>
2. The ICO's training for all providers and ICT members includes coordinating with behavioral health and LTSS providers, information about accessing behavioral health and LTSS, and lists of community supports available.	Provider training materials include modules on coordination of care, behavioral health services, LTSS, and community supports, see also care coordinator training in the care coordination section.
3. The ICO provides training to providers that their contracts require there be no balance billing under the demonstration.	Provider training materials and provider handbook include information informing them of no balance billing.

Provider Network	
Readiness Review Criteria	Example Evidence
4. The ICO has procedures to address LTSS providers who are not required to have National Provider Identifiers (NPIs).	Data systems management guidelines for LTSS providers address LTSS providers who are not required to have National Provider Identifiers (NPIs).
<i>D: Provider Handbook</i>	
1. The ICO prepares an understandable, accessible provider handbook (or handbooks for medical, behavioral, LTSS, and pharmacy providers), which includes the following: <ul style="list-style-type: none"> a. Updates and revisions; b. Overview and model of care; c. ICO contact information; d. Enrollee information; e. Enrollee benefits; f. Quality improvement or health services programs; g. Enrollee rights and responsibilities; and h. Provider billing and reporting. 	Each of the listed elements is included in the provider handbook.
2. The ICO makes resources available (such as language lines) to medical, behavioral, LTSS, and pharmacy providers to ensure in dealing with enrollees who require culturally-, linguistically-, or disability-competent care.	Provider handbook is 508 compliant and includes information on how to access language lines and resources for providers on how to provide culturally, linguistically, or disability-competent care (e.g., overviews and training materials on ICO website, information about local organizations serving specific subpopulations of the target population).
3. The ICO prepares a pharmacy handbook.	Each of the listed elements is included in the pharmacy handbook: <ul style="list-style-type: none"> a. Updates and revisions b. ICO contact information c. Enrollee information d. Enrollee benefits e. Enrollee rights and responsibilities f. Provider billing and reporting.
<i>E: Ongoing Assurance of Network Adequacy Standards</i>	
1. The ICO ensures that the hours of operation of all of its network, including medical, behavioral, LTSS, and pharmacy providers, are convenient to the population served and do not discriminate against ICO enrollees (e.g. hours of operation may be no less than those for commercially insured or public fee-for-service insured individuals); plan services are available 24 hours a day, 7 days a week, when medically necessary.	Provider contract templates include provision requiring non-discrimination against enrollees and convenient hours of operation.

Provider Network

Readiness Review Criteria	Example Evidence
2. The ICO has a policy and procedure that states that the provider network arranges for necessary specialty care, LTSS, and behavioral health.	<p>P&P on provider network states that the provider network arranges for necessary specialty care.</p> <p>List of network providers includes specialties in all geographic regions.</p>

Qualifications of First-Tier, Downstream, and Related Entities

Readiness Review Criteria	Example Evidence
1. If the ICO proposes to subcontract with a Material Subcontractor for any services (either exclusively, or in combination with any other services under the Contract), the ICO shall, for each proposed Material Subcontractor identify the services to be performed by the Material Subcontractor and; 1. Provide all of the information in RFR Sections 9.7 (Financial Ability/Financial Solvency Standards) for each Material Subcontractor. 2. Submit the resume of the individual in each Material Subcontractor organization responsible for overseeing such Material Subcontract.	P&P on material subcontractors, financial documentation material subcontractor resumes.
2. Material Subcontractors maintain at their own expense, insurance in standard amounts to cover workers' compensation, public liability and property damage insurance, medical malpractice and professional liability insurance and any other insurance that may be necessary for the performance of the work under the Contract. The ICO must provide EOHHS and CMS with certificates of the above insurance coverage.	P&P on material subcontractors, certificates of insurance.
3. Material Subcontractors demonstrate any services they provide are coordinated, integrated and delivered in a person-centered manner to maximize independent living, community-based care, and the health and well-being of Enrollees.	P&P on material subcontractors, sample service plans.

Systems

Readiness Review Criteria	Example Evidence
A: Data Exchange	

Systems	
Readiness Review Criteria	Example Evidence
<p>1. The ICO has developed a system to electronically exchange data with the State, CMS, subcontractors, and providers. Specifically, requires:</p> <ul style="list-style-type: none"> a. ICO has established the appropriate External Point of Contact (EPOC) and has a plan for authorizing submitters and other users, and b. ICO has completed the connectivity testing with the MAPD Help Desk. 	<p>Documentation that ICO has EPOC.</p> <p>Documentation that ICO completed testing with MAPD Help Desk.</p> <p>Information technology P&P explains how the ICO utilizes network connectivity to connect CMS, the State, and any applicable subcontractors, at a minimum MARx, PDE, 4Rx, and encounter data.</p>
<p>2. The ICO is able to electronically exchange the following types of data:</p> <ul style="list-style-type: none"> a. Enrollee benefit plan enrollment, disenrollment and enrollment-related data b. Claims data (including paid, denied, and adjustment transactions) c. Financial transaction data (including Medicare C, D, and Medicaid payments) d. Third-party coverage data e. Enrollee demographic and assessment information f. Provider data g. Prescription drug event (PDE) data. 	<p>System specifications explain how enrollment, encounter, transaction, personal and provider data are stored.</p> <p>Documentation specifying system design, quality controls, and data permissions and addressing the anticipated volume for each type of data, monthly.</p> <p>The ICO's data is 5010 compliant.</p>
<p>3. The ICO is able to exchange Part D data with the TrOOP Facilitator.</p>	<p>ICO demonstrates systems "test" of sample Part D data exchange with TrOOP Facilitator.</p>
<p>4. The ICO is able to make timely and accurate submissions of Part D pricing data for posting on the Medicare Plan Finder.</p>	<p>P&P on Information technology includes the steps the ICO's IT staff take to ensure timely and accurate submission of pricing data for posting on the Medicare Plan Finder.</p>
<p>5. The ICO reviews Medicare Part D monthly Patient Safety Reports via the Patient Safety Analysis website.</p>	<p>Quality P &P explains process for reviewing monthly patient safety reports.</p>
<p>6. The ICO's financial information reporting (FIR) processor is certified by the Transaction Facilitator.</p>	<p>ICO is able to provide Transaction Facilitator certification documentation for its FIR.</p>

Systems	
Readiness Review Criteria	Example Evidence
<i>B: Data Security</i>	
1. The ICO has a disaster recovery plan to ensure business continuity in the event of a catastrophic incident.	<p>The ICO demonstrates an ability to continue operations in the event of a disaster, including maintenance of back-up data at a separate location.</p> <p>The ICO has a detailed plan to restore full operations within a specified timeframe.</p>
2. The ICO facilitates the secure, effective transmission of data.	<p>System specifications explain how tools and utilities support secure connectivity and system access, including, at a minimum, encryption and password protection procedures.</p> <p>ICO demonstrates the necessary infrastructure, tools, and/or utilities to support secure connectivity and access to the system.</p>
3. The ICO maintains a history of changes, adjustments, and audit trails for current and past data systems.	<p>The ICO is able to provide changes, adjustments, and audit trails for the sample of historic data.</p> <p>The system manual describes the tracking of changes and adjustments to current and past data system records, including claims, encounters, membership, and provider systems.</p>
4. The ICO complies with all applicable standards, implementation specifications, and requirements pertinent to the National Provider Identifier (Standard Unique Health Identifier for Health Care Providers).	NPI is included in provider contracting, claims processing, and other applicable areas.

Systems	
Readiness Review Criteria	Example Evidence
<i>C: Enrollment Systems</i>	
<p>1. The system generates and maintains records pertinent to enrollment including:</p> <ul style="list-style-type: none"> a. Name b. Medicare HIC # c. Medicaid ID d. Birth date e. Family status f. Gender g. Language capability h. Special Needs i. Phone number j. Physical address k. Power of attorney or other representative l. Emergency contact m. Enrollment start date n. Enrollment end date 	<p>Required elements are described in the enrollment system manual and specifications.</p> <p>The ICO has built-in system structure to prevent obvious errors in data entry (e.g., ID numbers have the required number of digits, inability to enter a birth year that has not yet occurred).</p>
<p>2. The ICO's system has the capacity to process the expected volume of enrollees.</p>	<p>System specifications and information technology P&P explain any system limitations that would inhibit the importation of a large volume of enrollees and the steps the ICO will take to remedy these deficiencies if necessary.</p> <p>Results from systems test demonstrating the plan has capacity to process expected volume of enrollees.</p>
<p>3. The ICO maintains the enrollment system and addresses technological issues as they arise.</p>	<p>Specifications describe required routine maintenance.</p> <p>Specifications describe process and chain of command for resolving unexpected issues.</p>
<p>4. The ICO has reviewed and implemented CMS guidance for MARx system software improvements.</p>	<p>ICO has a designated individual responsible for monitoring HPMS memoranda for forthcoming changes.</p>
<p>5. The ICO audits the enrollment system on a regular basis.</p>	<p>The ICO has a specific process and schedule for auditing enrollment system and data.</p>

Systems	
Readiness Review Criteria	Example Evidence
6. The ICO enrollment system has interface capability with the Virtual Gateway for access to MDS-HC for assessment data entry. Access to POSC is also needed to verify eligibility and access 834 transactions. Access to the data warehouse for report encounter data.	System specifications and information technology P&P explain capability to interface with these systems and P&P on how and when this will occur. Systems test.
7. ICO can demonstrate its system has capacity to collect all specified elements. Specifically, the ICO's Centralized Enrollee Record (CER) includes data fields in which to capture enrollees' answers to questions on the specified demographics: race, ethnicity, disability type, primary language, and homelessness.	Plan's Centralized Enrollee Record (CER) includes data fields in which to capture enrollees' answers to questions on the specified demographics: race, ethnicity, disability type, primary language, and homelessness.
<i>C: Claims Processing</i>	
1. The ICO processes accurate, timely, and HIPAA-compliant claims and adjustments 'and can calculate adjudication rates.	Training materials and records of training attendance for staff processing claims Specific edits on claims (first fill, emergency, OON), as they are adjudicated, noting whether the edits are performed pre- or post-payment and are manual or automated.
2. The ICO processes adjustments and issues refunds or recovery notices within 45 days of receipt for complete information regarding a retroactive medical and LTSS claims adjustment.	Data systems management guidelines identifies the 45-day requirement.
3. The claims systems have the capacity to process the volume of claims anticipated under the demonstration.	Successful systems tests.
4. The claims system fee schedule includes all medical and LTSS Medicare and Medicaid services.	Fee schedule for claims system includes all services covered under the demonstration.
5. The claims processing system properly adjudicates claims for prescription and over the counter drugs.	ICO pays claims appropriately based on test of sample. Contract with PBM includes list of over-the-counter drugs and drugs covered by Medicare and Medicaid.
6. The ICO is able to monitor acceptance rates for optical character recognition (OCR) vendor.	The ICO monitors the number of paper claims accepted and timeframe for acceptance in the OCR format, the time between day and conducts data validity checks for accuracy.

Systems	
Readiness Review Criteria	Example Evidence
<i>D: Claims Payment</i>	
1. The ICO pays 95% of "clean medical and LTSS claims" within 30 days of receipt.	<p>P&P on claims payment describes clean claims payment procedure.</p> <p>Contracts with providers regarding ICO's responsibility for claims payment.</p> <p>Reports monitoring the number of days between receipt and payment of claims.</p>
2. The ICO pays clean claims from network pharmacies (other than mail-order and long-term care pharmacies) within 14 days of receipt for electronic claims and within 30 days of receipt all other claims ICO pays interest on clean claims that are not paid within 14 days (electronic claims) or 30 days (all other claims).	<p>P&P on claims payment describes clean claims payment procedure.</p> <p>Contracts with providers regarding ICO's responsibility for claims payment.</p> <p>Reports monitoring the number of days between receipt and payment of claims.</p>
3. The ICO assures that pharmacies located in, or having a contract with, a long-term care facility must have not less than 30 days, nor more than 90 days, to submit to the Part D sponsor claims for reimbursement under the plan.	<p>P&P on claims payment describes clean claims payment procedure.</p> <p>Contracts with providers regarding ICO's responsibility for claims payment.</p> <p>Reports monitoring the number of days between receipt and payment of claims.</p>
4. The ICO's claims processing system checks claims payment logic to identify erroneous payments.	<p>P&P on claims payment describes checks for claims payment logic (e.g., duplicate payments, incompatibility between gender and procedure, procedure code-diagnosis edits, gender code-diagnosis edits).</p> <p>If procured or maintained from a vendor, contract between vendor and ICO.</p>

Systems	
Readiness Review Criteria	Example Evidence
5. The ICO's claims processing system checks for pricing errors to identify erroneous payments.	<p>P&P on claims payment describes checks for pricing errors (e.g., payment for the service does not correspond with the pricing schedule on file for the date of service).</p> <p>If procured or maintained from a vendor, contract between vendor and ICO.</p>
<i>E: Provider Systems</i>	
1. The system generates and maintains records on medical provider and facility networks, including: <ul style="list-style-type: none"> a. Provider type b. Services offered and availability c. Licensing information d. Affiliation e. Provider location f. Office hours g. Language capability h. Medical specialty, for clinicians i. Panel size j. Accessibility of provider office k. Competency of provider staff to serve enrollees of the target population l. Credentialing information m. Proximity to public transportation. 	<p>Required elements are described in the provider system manual and specifications.</p>
<i>F: Pharmacy Systems</i>	
1. The ICO generates and maintains records on the pharmacy networks, including locations and operating hours.	<p>Required elements are described in the pharmacy system manual and specifications.</p> <p>Specifications describe required routine maintenance.</p> <p>Specifications describe process and chain of command for resolving unexpected issues.</p>
2. The ICO updates records providers and deletes records of no longer participating pharmacies.	<p>Pharmacy system manual provides instructions and timelines for updating records, including adding pharmacies and contract terminations.</p> <p>Specifications describe any automated processes that update pharmacy records, so that changes to pharmacy data cascade to other systems, as applicable.</p>

Systems	
Readiness Review Criteria	Example Evidence
3. The ICO audits the pharmacy system on a regular basis.	The ICO has a specific process and schedule for auditing the pharmacy system and data, by staff whose primary responsibility is not related to pharmacy.
4. The ICO can submit Prescription Drug Event Data (PDEs) on a monthly basis.	The ICO can provide sample PDE submission and notes in the pharmacy systems manual that this occurs monthly.
5. The ICO has access to the Acumen PDE Analysis and Reports website.	ICO demonstrates that it has access to the website.
6. The ICO is prepared to ensure pharmacies can clearly determine that claims are for Part D covered drugs or Medicaid covered drugs and secondary payers can properly coordinate benefits by utilizing unique routing identifiers and beneficiary identifiers.	ICO ensures pharmacies are able to properly bill for claims and coordinate with secondary payers.
7. The ICO's system identifies enrollees that fill a prescription during the transition period and require outreach and assistance in requesting an exception or a substitute formulary drug.	The ICO provides a screen print of a "flag" or systems manual documentation that indicates how an enrollee event is identified that event that requires outreach.
<i>G: Encounter Data System</i>	
1. The ICO has a system for producing medical and LTSS encounter data that is, at a minimum, 99% complete and 95% accurate.	<p>The ICO is able to provide a description of processes and procedures for producing and submitting encounter data that meet this standard for completion and accuracy.</p> <p>For plans that pay medical providers on a capitated basis, there is a detailed description of how medical providers are to report claims to the ICO.</p>
2. The ICO verifies the accuracy of PDE encounter data consistent with the Part D requirements.	<p>The ICO is able to provide a description of processes and procedures for producing and submitting PDE encounter data.</p> <p>Successful transmission of PDE files.</p>
<i>H: Care Coordination System</i>	
1. The system generates and maintains records necessary for care coordination, including: <ul style="list-style-type: none"> a. Enrollee data (from the enrollment system); b. Provider network; c. Inter-disciplinary care team membership for specific enrollees; d. Enrollee assessments; 	Required elements are described in the Care Coordination system manual and specifications.

Systems	
Readiness Review Criteria	Example Evidence
e. Enrollee plans of care; f. Interdisciplinary care team case notes; and g. Claims information.	
2. The ICO maintains the care coordination system and addresses technological issues as they arise.	Specifications describe required routine maintenance. Specifications describe process and chain of command for resolving unexpected issues and the required response times to resolve issues. Manual backup procedure for system downtime.
3. The ICO verifies the accuracy of care coordination data and amends or corrects inaccuracies.	Specifications describe automated processes for finding data anomalies. Specifications describe processes for manually overwriting data in the instance of an error.
4. The enrollee assessments and plans of care are available to enrollee interdisciplinary care teams and any of the enrollee's other providers.	Specifications and manual describe how ICT members and other providers can access the risk assessment and plan of care, either by accessing the system directly or working with the care coordinator to receive needed information.
5. The care coordination system includes a mechanism to alert interdisciplinary care team members of ED use or inpatient admissions.	Specifications and manual describe alert system to notify ICT members when an enrollee ends up in the hospital.
6. The ICO has systems and mechanisms designed to make enrollees' medical history and treatment information available, within applicable legal limitations, at the various sites where the same enrollee may be seen for care, especially for enrollees identified as homeless.	Required elements are described in the care coordination system manual and specifications.

Utilization Management	
Readiness Review Criteria	Example Evidence
A: The ICO has a utilization management (UM) program to process requests for initial and continuing authorizations of covered services.	

Utilization Management	
Readiness Review Criteria	Example Evidence
1. The ICO's UM program description specifies procedures under which the enrollee may self-refer services requiring prior authorization, and services requiring a referral.	<p>The ICO's UM program description explains for which services an enrollee can self-refer and services for which the enrollee or provider must obtain prior authorization.</p> <p>The ICO's UM program description outlines for which specialties and services an enrollee or provider must obtain a referral.</p>
2. Medically Necessary services are defined as services: <ul style="list-style-type: none"> a. For Medicare Part C and D services: that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. b. For MassHealth services: <ul style="list-style-type: none"> i. That are provided in accordance with MassHealth regulations at 130 CMR 450.204; ii. That are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the enrollee that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; iii. For which there is no other medical service or site of service, comparable in effect, available, and suitable for the enrollee requesting the service, that is more conservative or less costly; and iv. That are of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality. 	<p>The ICO's UM program description and prescription drug manual include these definitions of medical necessity.</p>
3. The UM program description defines the review criteria used, information sources, and process used to review and approve the provision of services and prescription drugs	<p>The ICO's UM program description and prescription drug manual list the rationale the ICO uses to determine which services and prescription drugs it approves (e.g., review criteria used, information sources, review processes).</p>
4. The UM program description describes policies and systems to detect both under- and over-utilization of services and prescription drugs.	<p>The ICO's UM program description details how the ICO monitors its under and overutilization of services (e.g., regular data analysis, periodic review meetings).</p>
5. The UM program description includes the methodology for periodically reviewing and amending the UM review criteria, including the criteria for prescription drug coverage.	<p>The ICO's UM program description explains how often and under what circumstances the plan updates the UM review criteria and who is responsible for this function (e.g., process to integrate new treatments or services into the review criteria, make updates based on clinical guidelines).</p>

Utilization Management	
Readiness Review Criteria	Example Evidence
6. The ICO outlines its process for authorizing out-of-network services; if specialties necessary for enrollees are not available within the network, the ICO will make such services available.	Out-of-network service authorization P&P explains how an enrollee or provider may obtain authorization for a service being provided by a provider outside of the ICO's network.
7. The ICO provides evidence that enrollees are able to obtain a second opinion from a qualified health professional at no cost.	The enrollee handbook, UM program description, and the prescription drug manual note the right for enrollees to obtain a second opinion.
8. The ICO describes its processes for communicating to all providers which services require prior authorizations and ensuring that all contracting providers are aware of the procedures and required time-frames for prior authorization (e.g., periodic training, provider newsletters).	The ICO's UM program description details mechanisms for informing network providers of prior authorization requirements and procedures. The ICO's provider materials describe prior authorization requirements and procedures.
<i>B: Utilization management guidelines</i>	
1. The ICO policies for adoption and dissemination of practice guidelines require that the guidelines: <ul style="list-style-type: none"> a. Be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; b. Consider the needs of the ICO's members; c. Be adopted in consultation with contracting health care professionals; d. Be reviewed and updated periodically; and e. Provide a basis for utilization decisions and member education and service coverage. 	The ICO's P&P on practice guidelines includes these requirements.
2. The ICO shall ensure its provider contracts require: <ul style="list-style-type: none"> a. That no payment shall be made by the contractor to a provider for a provider-preventable condition; and b. As a condition of payment from the ICO, that all providers comply with reporting requirements on provider-preventable conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by the ICO and/or EOHHS. 	The ICO's UM program description instructs staff to determine whether a claim is for a provider-preventable condition and states that such claims will be denied. Provider contract templates include these requirements pertaining to provider-preventable conditions.

Utilization Management	
Readiness Review Criteria	Example Evidence
<p>3. The ICO shall develop and implement policies and procedures for the identification, reporting and non-payment of provider-preventable conditions that are consistent with federal law, including but not limited to 42 C.F.R. § 434.6(a)(12), 42 C.F.R. § 438.6(f)(2), and 42 C.F.R. § 447.26, and guidance and be consistent with EOHHS policies, procedures, and guidance on Provider Preventable Conditions. The ICO's policies and procedures shall also be consistent with the following:</p> <ul style="list-style-type: none"> a. The ICO shall not pay a provider for a Provider Preventable Condition. b. The ICO shall require, as a condition of payment from the ICO, that all providers comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by the ICO and/or EOHHS. c. The ICO shall not impose any reduction in payment for a Provider Preventable Condition when the condition defined as a Provider-Preventable Condition for a particular Enrollee existed prior to the provider's initiation of treatment for that Enrollee. d. An ICO may limit reductions in Provider payments to the extent that the following apply: <ul style="list-style-type: none"> i. The identified Provider Preventable Condition would otherwise result in an increase in payment. ii. The ICO can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the Provider Preventable Condition. 	<p>P&Ps on identification, reporting and non-payment of provider-preventable conditions include these requirements.</p>
<p>4. The ICO shall report all identified provider-preventable conditions in a form and format and frequency specified by EOHHS, including but not limited to any reporting requirements.</p>	<p>Sample report template for reporting provider-preventable conditions.</p>
<p>5. The ICO shall ensure that its non-payment for provider-preventable conditions does not prevent enrollee access to services.</p>	<p>The ICO's UM program description states that non-payment for provider-preventable conditions does not prevent enrollee access to services.</p>

Utilization Management	
Readiness Review Criteria	Example Evidence
<p>6. The ICO shall develop and maintain behavioral health inpatient services and diversionary services authorization policies and procedures, which shall, at a minimum, require the ICO to have:</p> <ul style="list-style-type: none"> a. If prior authorization is required for any behavioral health inpatient services admission or diversionary service, assure the availability of such prior authorization 24 hours a day, seven days a week; b. A plan and a system in place to direct enrollees to the least intensive but clinically appropriate service; c. A system to provide an initial authorization and communicate the initial authorized length of stay to the enrollee, facility, and attending physician for all behavioral health emergency inpatient admissions verbally within 30 minutes, and within two hours for non-emergency inpatient authorization and in writing within 24 hours of admission; d. Processes to ensure placement for enrollees who require behavioral health inpatient services when no inpatient beds are available, including methods and places of care to be utilized while Enrollee is awaiting an inpatient bed; e. A system to concurrently review Behavioral Health Inpatient Services to monitor medical necessity for the need for continued stay, and achievement of behavioral health inpatient services treatment goals; f. Verification and authorization of all adjustments to behavioral health inpatient services treatment plans and diversionary services treatment plans; and g. Processes to ensure that treatment and discharge needs are addressed at the time of authorization and concurrent review, and that the treatment planning includes coordination with the PCP and other providers, such as community based mental health services providers, as appropriate. 	<p>The ICO's UM program description and P&P describe authorization policies and procedures for behavioral health inpatient services and diversionary services authorization that include these standards.</p>
<p>7. The ICO develops and maintains non-diversionary services authorization policies and procedures. Such policies and procedures shall be submitted to EOHHS for review and approval.</p>	<p>The ICO's UM program description and P&Ps address non-diversionary services authorization policies and procedures.</p>
<p>8. The ICO develops and maintains behavioral health outpatient services policies and procedures that include, but are not limited to, the following:</p> <ul style="list-style-type: none"> a. Policies and procedures to automatically authorize at least 12 behavioral health outpatient services; b. Policies and procedures for the authorization of all behavioral health outpatient Services beyond the initial 12 outpatient services; c. Policies and procedures to authorize behavioral health outpatient services based upon behavioral health clinical criteria; and d. Policies and procedures based upon behavioral health clinical criteria to review and approve or deny all requests for behavioral health outpatient services based on clinical criteria. 	<p>The ICO's UM program description and P&Ps address authorization of behavioral health services consistent with these requirements.</p>

Utilization Management	
Readiness Review Criteria	Example Evidence
<p>9. The ICO must develop an authorization process for LTSS and flexible community-based services that consider the enrollee's entire ICP.</p> <ul style="list-style-type: none"> a. At a minimum, ICO authorizations of LTSS listed in Appendix C, Table 1 must comply with MassHealth FFS authorization criteria for those covered services. b. However, the ICO has the discretion to authorize LTSS and flexible community-based services more broadly in terms of criteria, amount, duration and scope, if the ICO determines that such authorization would provide sufficient value to the enrollee's care. Value shall be determined in light of the full range of services included in the ICP, considering how the services contribute to the health and independent living of the enrollee as well as cost-effectiveness (the role of the service in preventing higher-cost alternative care such as acute medical or psychiatric hospitalization, institutional long-term care, or emergency department use). 	<p>The ICO's UM program description and/or P&P on coverage determination process address LTSS and flexible community-based services and are consistent with these requirements.</p>
<i>C: The Utilization Management program has timeliness, notification, communication, and staffing requirements in place.</i>	
<p>1. The ICO has a policy and procedure for appropriately informing enrollees of coverage decisions, including tailored strategies for enrollees with communication barriers.</p>	<p>Plan management guidelines or the ICO's UM program description describes the type of communications that will be sent to enrollees, regarding their receipt or denial of referrals of service authorizations.</p> <p>Sample "Notice of Denial of Medical Coverage" is consistent with CMS template.</p>
<p>2. For the processing of requests for initial and continuing authorizations of covered services, the ICO shall:</p> <ul style="list-style-type: none"> a. Have in place and follow written policies and procedures; b. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions; c. Consult with the requesting provider when appropriate. 	<p>The ICO's UM program description explains the process for obtaining initial and continuing authorizations for services. Prescription drug manual explains the process for obtaining approval for prescription drug coverage that is considered urgent.</p>

Utilization Management	
Readiness Review Criteria	Example Evidence
<p>3. The ICO ensures that prior authorization requirements are not applied to the following services:</p> <ul style="list-style-type: none"> a. Emergency and post-stabilization services, including emergency behavioral health care b. Urgent care c. Crisis stabilization, including mental health d. Urgent care support for home and community service-based recipients: <ul style="list-style-type: none"> i. Outside the service area, and ii. Within the service area under unusual or extraordinary circumstances when the contracted medical provider is unavailable or inaccessible e. Family planning services f. Preventive services g. Communicable disease services, including STD and HIV testing h. Post-stabilization care services i. Out-of-area renal dialysis services. 	<p>The ICO's UM program description lists those services that are not subject to prior authorization and this list is consistent with the required elements.</p>
<p>4. The ICO follows the rules for the timing of authorization decisions for Medicaid services in 42 CFR §438.210(d) and for Medicare services in 42 CFR §§422.568, 422.570 and 422.572. For overlap services, the ICO follows the contract.</p>	<p>The ICO's UM program description includes these requirements.</p>
<p>5. The ICO shall assure that all behavioral health authorization and utilization management activities are in compliance with 42 U.S.C. § 1396u-2(b)(8). The ICO must comply with the requirements for demonstrating parity quantitative treatment limitations between mental health and substance use disorder and medical/surgical inpatient, outpatient and pharmacy benefits.</p>	<p>The ICO's UM program description and behavioral health services authorization P&P state that behavioral health authorization and utilization management activities comply with federal mental health parity law.</p>
<p>6. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's medical condition, performing the procedure, or providing the treatment. Behavioral health services denials must be rendered by board-certified or board-eligible psychiatrists or by a clinician licensed with the same or similar specialty as the Behavioral health services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist.</p>	<p>The ICO's UM program description includes this requirement.</p> <p>Resumes for staff who review coverage decisions and for manager show that these staff have appropriate competencies to apply ICO policies equitably.</p> <p>Resume for the UM manager who reviews denials show that this individual has the appropriate experience and training to conduct this function.</p>
<p>7. The ICO shall ensure that a physician and a behavioral health provider are available 24 hours a day for timely authorization of medically necessary services and to coordinate transfer of stabilized enrollees in the emergency department, if necessary. The ICO shall institute a record keeping process documenting the amount of time each enrollee spends in a hospital emergency department awaiting admission to a behavioral health inpatient bed.</p>	<p>The ICO's UM program description states that a physician and behavioral health provider are available 24/7 for timely authorization of medically necessary services and to coordinate transfer of stabilized enrollees in the emergencies.</p> <p>The ICO has a P&P that describes the record-keeping process described in the criterion.</p>

ATTACHMENT P

**PROVISIONS FOR IMPLEMENTATION OF THE PRIMARY CARE PROVIDER PAYMENT
INCREASE**

ATTACHMENT V
PROVISIONS FOR IMPLEMENTATION OF THE PRIMARY CARE PROVIDER PAYMENT INCREASE

The provisions in this attachment stipulate the requirements for the Contractor to comply with Title 42 of the Code of Federal Regulations (CFR), Section 440.50. This section of the CFR entitles certain providers to increased reimbursement rates for the period beginning January 1, 2013 and ending December 31, 2014.

1. Eligible Providers

Physicians with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine are eligible for the increased payment at a rate no less than 100 percent of the payment rate that applies to such services and physicians under Part B of Title XVIII (i.e. Medicare). Increased payment is not available for services provided by a physician delivering services at Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs).

Primary care services properly billed under the provider number of a physician who is enrolled as one of the specified primary care specialists or subspecialists, regardless of whether furnished by the physician directly or under the physician's personal supervision, will be reimbursed at the higher rate. This provision allows for nurse practitioners and physician assistants to receive the increased reimbursement.

On or around May 5, 2013, the Contractor will receive a file from EOHHS that specifies all providers eligible for the increased reimbursement. The Contractor will be responsible for reimbursing all providers on this file the increased rates, including non-participating providers who have received prior authorization to provide services to members. On or around the fifth (5th) of each subsequent month, the Contractor will receive a refreshed file from EOHHS with newly eligible providers. The Contractor must have policies and procedure to accept the file in the agreed upon format and implement the required reimbursement of all eligible providers. Contractors' policies and procedures are subject to review and approval by EOHHS.

2. Eligible Services

To the extent that they are covered codes under the Rhode Island Medicaid State Plan, Healthcare Common Procedure Coding System (HCPCS) (E&M) codes 99201 through 99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474 or their successors will be eligible for higher payment. Among these are certain E&M codes which, though not reimbursed by Medicare, are also eligible for higher payment. These codes are listed below:

- New Patient/Initial Comprehensive Preventive Medicine—codes 99381 through 99387;
- Established Patient/Periodic Comprehensive Preventive Medicine—codes 99391 through 99397.

3. Reimbursement Rates

Contractor shall reimburse eligible providers per the fee scheduled issued to the Contractor by EOHHS.

4. Payment and Reporting by Contractor for Non Sub-Capitated Providers

In order to qualify for EOHHS reimbursement of these supplemental payments, the Contractor will submit on a quarterly basis the amount requested for enhanced payment. This signed invoice will reflect the total amount requested and be supported by line detail that outlines all services paid to each provider for eligible CPT codes, with their base payment and eligible supplemental amount clearly delineated.

The detail file may look similar to the following, with final format to be determined by EOHHS:

- Claim identifier to allow for mapping to RI-EOHHS encounter data
- Servicing provider identifier
- Servicing provider name
- Billing provider identifier
- Billing provider name
- Type of provider (physician or midlevel practitioner)
- Date of service
- Member ID
- Eligible CPT code
- 2013 fee schedule amount (i.e., amount that would have applied in the absence of the enhanced payment requirement)
- Additional amount to achieve enhanced payment
- Total paid to provider

These detail reports will also be used to support the State's reporting requirements to CMS for evaluating the success of the initiative by quantifying changes in PCP penetration and availability to Medicaid members.

5. Payment and Reporting by Contractor for Sub-Capitated Providers

Documentation of the Contractor's compliance with the rate enhancement rule for sub-capitated providers, upon which EOHHS' claiming will rest, will be based on quarterly submissions of the following data, as will the amounts owed by EOHHS to the Contractor:

The Contractor will provide a list of all services eligible under the sub-capitated agreement, by CPT code (capitated fee schedule), whether those services are eligible or not for the enhanced rates. The data will be arranged by:

- CPT code
- Provider fee schedule applicable for non-sub-capitated situations
- Any modifications or payment instructions for non-physician providers

The Contractor will denote which eligible services under the sub-capitated agreement are also applicable to the approved E&M codes under the increased primary care payment rule. The Contractor will provide

line-level utilization detail for all sub-capitated services within the reconciliation period, whether eligible under the rule or not.

Line-level claim detail will include:

- Claim identifier which will allow for mapping to RI-EOHHS encounter data
- Common identifier which will allow tracking of the individual provider of service
- Marker per line to verify that service was rendered by an attested provider
- Marker per line to denote if the service was eligible under the sub-capitated arrangement, but was paid as fee for service. An example would be if the member receiving the eligible service was not considered enrolled under the clinic practice site when the service was provided.
- Marker to identify type of provider (physician or midlevel practitioner)
- CPT code
- Units paid/acknowledged under sub-capitation
- Amount paid as rate enhancement to the provider

If applicable, the Contractor will define any variation in payment methodology that would apply to non-physician but eligible providers (e.g. nurse practitioners, physician's assistants). The Contractor will identify the amount of capitation paid to the entity for the reconciliation period (medical expense only).

Using these data sources, the following sets of calculations will occur in order to verify compliance and determine the Federally claimable amount:

1. First, **all** services under the sub-capitated arrangement will be identified and priced hypothetically using the corresponding fee schedule value had that service been paid under fee for service by that MCO. These hypothetical prices will then be multiplied by the corresponding units of service paid under sub-capitation during the reconciliation period, to form the denominator of an allocation ratio.
2. Second, a similar process will be applied more narrowly to those sub-capitated services claimed as reimbursable under the rule – these will comprise the numerator of the ratio.
3. Third, the total sub-capitation paid will be determined for the same period, and this total will be multiplied by the allocation ratio to dollar value of sub-capitation that can be associated with the rule.
4. Fourth, the utilization and hypothetical rates used in #2 above will be arrayed to determine the total amount these services would have cost under the MCO's fee for service arrangement.
5. Fifth, dividing the allocation determined in #3 by the total determined in #4 will produce a scale factor. This scale factor will then be applied to the hypothetical rates in #4 to create an array of sub-capitated rates by procedure.
6. Sixth, these scaled-up hypothetical rates will be compared to the enhanced rates applicable under the rule, and the difference multiplied by the units reported for attesting providers, to determine the amounts to be reimbursed to the Contractor.

6. Reconciliation of Amount Owed by EOHHS to the Contractor

Enhanced payment amounts reported by the Contractor for attested providers will equal the amount owed to the Contractor by EOHHS, provided that the provider is properly attested, and that encounter data exists for the service in question.

7. Additional Requirements

The Contractor shall have policies and procedures to notify all participating providers on a quarterly basis of all payments received by the provider that were a result of this federal program. Notification to providers is subject to review and approval by EOHHS and shall occur on a quarterly basis.

EOHHS delegates to the Contractor the responsibility of providing, for an initial load to the State's physician attestation website, a list of those physicians who are reliably documented in the Contractor's credentialing system as both: a) practicing in one of the three eligible practice areas designated under the rule (i.e. Family Medicine, Internal Medicine and Pediatrics), and b) having active board certification in one of the applicable specialties or subspecialties recognized under the rule.

Contractor will, upon request, provide EOHHS with data and/or documentation necessary to support the State's claiming efforts for Federal funds participation in these rate enhancements, and will cooperate fully in audit efforts necessary to ensure compliance with the provisions of the rule.