Solicitation Information
November 12, 2021

Request for Qualification (RFQ): 7664814

TITLE: Medicaid Managed Care Services

Submission Deadline: January 28, 2022 at 1:00 PM ET (Eastern Time)

PRE-BID/ PROPOSAL CONFERENCE: Yes
MANDATORY: No

If YES, any Vendor who intends to submit a bid proposal in response to this solicitation must have its designated representative attend the mandatory Pre-Bid/ Proposal Conference. The representative must register at the Pre-Bid/ Proposal Conference and disclose the identity of the vendor whom he/she represents. A vendor's failure to attend and register at the mandatory Pre-Bid/ Proposal Conference shall result in disqualification of the vendor's bid proposals as non-responsive to the solicitation.

DATE: December 8, 2021 at 1:00 PM EST
LOCATION: Zoom
Division of Purchases is inviting you to a scheduled Zoom meeting.

Topic: RFQ# 7664814
Time: Dec 8, 2021 01:00 PM Eastern Time (US and Canada)

Join Zoom Meeting
https://us02web.zoom.us/j/84288266856?pwd=a2JOSXNBd2grMGZiMnRFbDJvVlFZZz09

Meeting ID: 842 8826 6856
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- **833 548 0276 US Toll-free**
- **877 853 5247 US Toll-free**
- **888 788 0099 US Toll-free**

Meeting ID: 842 8826 6856
Passcode: 463702
Find your local number: https://us02web.zoom.us/u/kmGGU7EVi

Questions concerning this solicitation must be received by the Division of Purchases at doa.purquestions1@purchasing.ri.gov no later than **December 15, 2021 at 1:00 PM (EST).** Questions should be submitted in a *Microsoft Word attachment.* Please reference the RFQ# on all correspondence. Questions received, if any, will be posted on the Division of Purchases' website as an addendum to this solicitation. It is the responsibility of all interested parties to download this information.

BID SURETY BOND REQUIRED: No

PAYMENT AND PERFORMANCE BOND REQUIRED: No

Nina M. Lennon, Interdepartmental Project Manager

Note to Applicants:

1. Vendors must register in RIVIP at the Division of Purchases' website at https://www.purchasing.ri.gov/RIVIP/VendorRegistration.aspx.
2. Proposals received without a completed RIVIP Vendor Certification Cover Form attached may result in disqualification.

THIS PAGE IS NOT A RIVIP VENDOR CERTIFICATION COVER FORM

COVID-19 EMERGENCY PROTOCOL FOR BID OPENINGS

Vendors and the public are advised that due to Covid-19 emergency social distancing requirements bid openings at the Division of Purchases shall be conducted via live streaming on the ZOOM website/application. Vendors and the public shall not be permitted to enter the Division of Purchases to attend bid openings. Vendors and the public who attend bid openings via live streaming shall be required to identify themselves and a record of all such attendees shall be maintained by the Division of Purchases. Vendor bid proposals shall be opened and read aloud at the date and time listed herein. The results of bid solicitations requiring a public copy for public works projects shall be posted on the Division of Purchases website as soon as possible after the bid opening. For RFQ solicitations only vendor names shall be read aloud at the opening.

Vendors and the public are further advised that visitor access to the Powers Building at One Capitol Hill, Providence, RI requires pre-screening at the entrance to the building. In accordance with the Governor's Executive Order(s) and Department of Health emergency regulations all visitors to the Powers Building must wear a cloth mask which covers the nose and mouth. Vendors delivering bid proposals to the Division of Purchases should allow sufficient time for the pre-screening process. The Division of Purchases assumes no responsibility for delays caused by the screening process or any other reason. Vendors are solely responsible for on time delivery of bid proposals. The Division of Purchases shall not accept late bids for any reason.

BID OPENING ZOOM INFORMATION

Division of Purchases is inviting you to a scheduled Zoom meeting.
Topic: RFQ# 7664814
Time: Jan 28, 2022 01:00 PM Eastern Time (US and Canada)
Join Zoom Meeting
https://us02web.zoom.us/j/83956576002?pwd=bVZ4Rm1McDRkZ25jdlVYaE9FekRvUT09

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Table of Contents

SECTION 1: INTRODUCTION

The Rhode Island Department of Administration/Division of Purchases, on behalf of the Executive Office of Health and Human Services (EOHHS) is soliciting proposals from qualified firms to provide statewide Medicaid Managed Care Program services for eligible and enrolled RIteCare, Rhody Health Partners and Adult Expansion populations under a capitation contract in accordance with the terms of this Request for Qualifications ("RFQ") and the State's General Conditions of Purchase, which may be obtained at the Division of Purchases' website at www.ridop.ri.gov.

The initial contract period will be for five (5) years, from July 1, 2023, until June 30, 2028. Contracts may be renewed for up to three (3) additional 12-month periods based on Bidder performance and the availability of funds. The State reserves the right to initiate a new procurement during the renewal period or prior to the end of year five (5) of the contract period. EOHHS also reserves the right to amend the contract to include new populations, services, or programs, including the RIte Smiles and Rhode Island Medicare-Medicaid Plan (MMP) programs.

Only successful bidders to this RFQ will be eligible to provide health care to RIteCare, Rhody Health Partners and Adult Expansion individuals. To serve these populations, a bidder must be selected to contract with and complete contract negotiations and the readiness review requirements outlined in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 2, "Readiness Review Requirements" of the "Model Contract".

The state anticipates selecting multiple vendors under this solicitation.

This is a Request for Qualifications, not a Request for Quotes. Responses will be evaluated on the basis of the of the Bidder's technical proposal that demonstrates through substantial detail and evidence the Bidder's past and current experience and capability to fully meet all requirements to achieve EOHHS's priorities and goals outlined in the RFQ. There will be no public opening and reading of responses received by the Division of Purchases pursuant to this solicitation, other than to name those Bidders who have submitted proposals.

Instructions and Notifications to Vendors

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For further information, contact the Rhode Island Equal Employment Opportunity Office via e-mail at odeo.eoo@doa.ri.gov.

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

11. In accordance with R. I. Gen. Laws §§ 37-14.1-1 and 37-2.2-1 it is the policy of the State to support the fullest possible participation of firms owned and controlled by minorities (MBEs) and women (WBEs) and to support the fullest possible participation of small disadvantaged businesses owned and controlled by persons with disabilities (Disability Business Enterprises a/k/a "DisBE")(collectively, MBEs, WBEs, and DisBEs are referred to herein as ISBEs) in the performance of State procurements and projects. As part of the evaluation process, vendors will be scored and receive points based upon their proposed ISBE utilization rate in accordance with 150-RICR-90-10-1, "Regulations Governing Participation by Small Business Enterprises in State Purchases of Goods and Services and Public Works Projects". As a condition of contract award vendors shall agree to meet or exceed their proposed ISBE utilization rate and that the rate shall apply to the total contract price, inclusive of all modifications and amendments. Vendors shall submit their ISBE participation rate on the enclosed form entitled "MBE, WBE and/or DisBE Plan Form", which shall be submitted in a separate, sealed envelope as part of the proposal. ISBE participation credit will only be granted for ISBEs that are duly certified as MBEs or WBEs by the State of Rhode Island, Department of Administration, Office of Diversity, Equity and Opportunity or firms certified as DisBEs by the Governor's Commission on Disabilities. The current directory of firms certified as MBEs or WBEs may be accessed at http://odeo.ri.gov/offices/mbeco/mbe-wbe.php. Information regarding DisBEs may be accessed at www.gcd.ri.gov. For further information, visit the Office of Diversity, Equity & Opportunity's website, at http://odeo.ri.gov/ and *see* R.I. Gen. Laws Ch. 37-14.1, R.I. Gen. Laws Ch. 37-2.2, and 150-RICR-90-10-1. The Office of Diversity, Equity & Opportunity may be contacted at, (401) 574-8670 or via email Dorinda.Keene@doa.ri.gov

12. In the RIVIP Vendor Certification Cover Form, Section 4, Question 11, bidders shall certify agreement to the State's contract terms. However, in accordance with Section 220-RICR-30-00-13.3(C)(3) of the General Conditions, the Vendor may submit in their bid or proposal, "[q]ualified or conditional offers which impose limitations of the Vendor's liability or modify the requirements of the solicitation, offers for alternate specifications, or offers which are made subject to different terms and conditions, including form

contracts, other than those specified by the State." However, qualified or conditional offers "may be, at the sole discretion of the State Purchasing Agent:

a. Rejected as being non-responsive; or,
b. Set aside in favor of the requirements set forth in the solicitation (with the consent of the Vendor); or,
c. Accepted, if the State Purchasing Agent determines in writing that such acceptance is in the best interest of the State."

By submitting a conditional or qualified offer, the Vendor bears the risk of their bid or proposal being considered non-responsive. In the event the State receives a conditional or qualified offer, the State reserves the right to adjust evaluation points in an RFQ procurement, conduct a best and final offer process offering the same terms to all vendors, and/or reject a qualified/conditional proposal as being non-responsive at any time during the review process. The Vendor should not assume that any further negotiation will occur upon selection.

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

***General Requirements**:*

14a) ☒ Liability - combined single limit of $1,000,000 per occurrence, $1,000,000 general aggregate and $1,000,000 products/completed operations aggregate.

14b) ☒ Workers compensation - $100,000 each accident, $100,000 disease or policy limit and $100,000 each employee.

14c) ☒ Automobile liability - $1,000,000 each occurrence combined single limit.

14d) ☒ Crime - $500,000 per occurrence.

***Professional Services**:*

14e) ☒ Professional liability ("errors and omissions") - $2,000,000 per occurrence, $2,000,000 annual aggregate.

14f) ☐ Environmental/Pollution Liability when past, present or future hazard is possible - $1,000,000 per occurrence and $2,000,000 aggregate.

14g) ☒ Working with Children, Elderly or Disabled Persons – Physical Abuse and Molestation Liability Insurance - $1,000,0000 per occurrence.

***Information Technology and/or Cyber/Privacy**:*

14h) ☒ Technology Errors and Omissions - Combined single limit per occurrence shall not be less than $5,000,000. Annual aggregate limit shall not be less than $10,000,000.

14i) ☒ Information Technology Cyber/Privacy – minimum limits of $5,000,000 per occurrence and $5,000,000 annual aggregate. If Contract Party provides:

a) ☐ key back office services Contract Party shall have a minimum limit of $10,000,000 per occurrence and $10,000,000 annual aggregate;

b) ☒ if Contract Party has access to Protected Health Information as defined in HIPAA and its implementing regulations, Personal Information as defined in in R.I. Gen. Laws § 11-49.3-1, et seq., or as otherwise defined in the Contract (together Confidential Information"), Contract Party shall have as a minimum the per occurrence, per annual aggregate, the total rounded product of projected number of persons data multiplied by $25 per person breach response expense per occurrence; but no less than $5,000,000 per occurrence, per annual aggregate; or,

c) ☒ if the Contract Party provides or has access to mission critical services, network architecture and/or the totality of confidential data $20,000,000 per occurrence and in the annual aggregate.

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

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

SECTION 2: BACKGROUND

2.1 Overview of Rhode Island Executive Office of Health and Human Services

The Executive Office of Health and Human Services ("EOHHS") serves as "the principal agency of the executive branch of state government" (R.I. Gen. Laws § 42-7.2-2) responsible for managing the departments of: Health ("DOH"); Human Services ("DHS"); Children, Youth and Families ("DCYF"); and Behavioral Healthcare, Developmental Disabilities and Hospitals

("BHDDH"). Last year, these agencies provided direct service to over 300,000 Rhode Islanders as well as an array of regulatory, protective and health promotion services. In State Fiscal Year, 2022, Health and Human Services benefits represent approximately $4.7 billion in spending per year, which is over 42 percent (42%) of the entire state budget.

Rhode Island EOHHS is the single state agency for Medicaid and administers Rhode Island's $2.8 billion[1] Medicaid program, which provides health care coverage for 337,864 eligible individuals representing one third (1/3) of all Rhode Islanders of all ages and from various ethnic and racial backgrounds. Medical Assistance, also referred to as Medicaid, accounts for sixty percent (60%) of the total EOHHS agency spending and twenty-five percent (25%) of the entire State budget.

This procurement is to secure the services of qualified Bidders to provide statewide Medicaid Managed Care Program services to eligible and enrolled RIteCare, Rhody Health Partners and Adult Expansion populations under a capitation contract. This RFQ and any subsequent award(s) are governed by the State's General Conditions of Purchase (available via internet at www.ridop.ri.gov). RI EOHHS welcomes qualified firms, including new entrants, with the capabilities to provide high quality and cost-effective services to Medicaid eligible populations in Rhode Island.

2.2 Overview of the Rhode Island Medicaid Managed Care Program

Rhode Island is committed to managed care as a primary vehicle for the organization and delivery of Medicaid covered services to eligible beneficiaries. Rhode Island initially implemented the Medicaid managed care program, RIte Care in 1994, enrolling over 70,000 low-income children and families. Since that time, Rhode Island has progressively expanded enrollment in managed care to include populations with increasingly complex health care needs As of the end of July, 2021, the program serves 286,533 individuals through the RIte Care (children and families, including children with health special health care needs and in substitute care), Medicaid Expansion (expansion adults nineteen (19) to sixty-four (64) years of age), and Rhody Health Partners (qualified aged, blind, and disabled adults) eligibility groups. Managed care expenditures for these populations account for approximately sixty percent (60%) or $1.4 billion of the Medicaid program expenditures.

Medicaid medical expenditures and expenditures for each major population group for SFY 2019 are noted below:

- **Adults with disabilities:** Adults with disabilities: Represents ten percent (10%) of the Medicaid population (32,235 individuals) and accounts for $771 million in Medicaid expenditures which is twenty-nine percent (29%) of the total Medicaid expenditures and at an average PMPM of $1,993. The major source of expenditures for this population is residential and rehabilitation services for persons with intellectual and developmental disabilities and hospital care.
- **Elders:** Represents seven percent (7%) of the Medicaid population (22,645 individuals) and accounts for $617million or twenty-three percent (23%) of Medicaid expenditures. Compared to all other Medicaid populations, elders have the highest average PMPM cost

[1] This $2.8 billion expenditure is inclusive of federal funds, general revenues, and restricted receipts.

at $2,270. Nursing facilities account for fifty-four percent (54%), slightly more than half of the State's expenditures.

- **Children and Families**: Represents fifty-three percent (53%) of the total Medicaid enrollment (164,630 individuals), including low-income children, parents and pregnant women who meet specific income requirements. This category accounts for twenty-three percent (23%) of the total expenditures ($590 million) and have the lowest PMPM cost of less than $300.
- **Children with Special Health Care Needs (CSHCN):** CSHCN is relatively small population, as it encompasses four percent (4%) of Medicaid beneficiaries (12,362 individuals) and accounts for seven percent (7%) of expenditures ($175 million).
- **Medicaid Expansion:** Represents twenty-five percent (25%) of the Medicaid population and accounts for eighteen percent (18%) of total expenditures ($477 million). Most of these expenditures are attributed to hospital and professional services.

Hospitals and nursing homes account for forty percent (40%) of all program expenditures. (Hospitals account for twenty-four percent (24%) and nursing facilities, including hospice, and nursing facilities account for sixteen percent (16%) of expenditures.) Medicaid expenditures are highly concentrated. The top five percent (5%) of Medicaid users, those with more than $25,000 in annual claims expenditures, account for nearly two thirds (63%) of claims expenditures. High-cost users, defined as recipients that incur more than $15,000 annually, account for seventy-one percent (71%) of Medicaid claims expenditures. These users include individuals residing in institutions or residential facilities, those receiving maternity/delivery services, and others residing in the community, more than half (53%) of which are adults with disabilities and the Medicaid Expansion population.

Additional information on the characteristics of the population enrolled in Medicaid managed care, cost, utilization and provider expense is available in the Procurement Library.

The managed care program serving RIte Care, Medicaid Expansion and Rhody Health Partners eligible members covers acute, primary and specialty care, pharmacy, and behavioral health services on a mandatory basis across the state.

Currently, EOHHS contracts with three (3) health plans to provide care for members. The three (3) health plans are:

1) Neighborhood Health Plan of Rhode Island (NHP RI)[2].

2) Tufts Health Public Plan (Tufts); and

3) United Health Care Community Plan (UNC)

The Table below shows the distribution of enrollment by eligibility category and by health plan as of the end of July 2021:

Managed Care Enrollment as of July 31, 2021 (By Eligibility Group)

[2] NHP_RI is the sole plan currently serving the substitute care population.

Medical Assistance Eligibility Group	NHPRI	Tufts	UHC	Total
RIte Care	104,067	7,721	53,092	164,880
Extended Family Planning	1,076	46	321	1,443
Children with Special Health Care Needs	5,240	98	1,879	7,217
Children in Substitute Care	2,627	0	0	2,627
Rhody Health Partners	7,508	770	6,373	14,651
Medicaid Expansion	53,631	8,222	35,305	97,158
Total	**174,149**[3]	**16,857**	**96,970**	**287,976**
% of Total Medicaid	**51.5%**	**5.1%**	**28.6%**	**85.2%**

This solicitation is for managed care services for all of the populations described above and summarized in the table. Under the provisions of Rhode Island's Centers for Medicare and Medicaid Services ("CMS")-approved Medicaid Section 1115 Comprehensive Demonstration Waiver, enrollment in managed care is mandatory for all populations described above.

Children in substitute care arrangements (i.e., foster homes, group homes or in other DCYF designated/approved living arrangements) are currently enrolled in one contracted health plan, Neighborhood Health Plan of Rhode Island. With this solicitation, all Bidders will be required to provide coverage for children in substitute care. All children in substitute care will be offered choice to enroll with those Health Plans that are successful Bidders and selected by the State.

Once successful Bidders have been determined as a result of this solicitation and upon successful completion of the readiness review and Agreement execution with EOHHS, EOHHS will provide all current and newly eligible members with non-biased choice counseling in order to exercise their freedom of choice to choose from all selected Contractors. EOHHS will send notices to all eligible members advising them of the open enrollment period and of their health plan options. EOHHS will work closely with HealthSource Rhode Island (HSRI), with consumer advisory groups and other stakeholders in order to ensure members are aware of their right to choose and how to be informed of their options with attention to cultural and language preferences and SDOH needs of the Member(s).

Responsibilities of the unbiased, independent choice counselors include educating Potential Enrollees and their families, guardians, or adult caregivers about:

- Managed care in general, including the option to enroll in a Health Plan;
- The way services typically are accessed under managed care;
- The role of the PCP; and Health Plan Member responsibilities.

[3] As of July 31, 2021, there were 12,768 individuals enrolled in the Rhody Health Options program administered by NHP_RI. While these individuals are included when citing RI's total managed care enrollment, this program is not included in this procurement and therefore are not included within the total managed care enrollment number in the table above.

- Benefits available through the Contractor's Health Plan, both in-plan and out-of-plan;
- Available Health Plan options, including criteria that might be important when making a choice (e.g., presence or absence of an existing PCP or other providers in a Health Plan's network, prescription coverage, additional benefits offered by a Health Plan).

If an incumbent Contractor is awarded a contract under this solicitation, and a current member does not choose to change Health Plans among all awarded Health Plans, the member will be maintained with their current Health Plan. For newly eligible beneficiaries who do not make a voluntary choice during the open enrollment period, EOHHS will follow the Default Enrollment methodology described in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.2., "Covered Populations, Enrollment and Disenrollment" of the "Model Contract" found in Appendix B, in accordance with 42 C.F.R. § 438.54. The default enrollment methodology will seek to preserve existing provider-beneficiary relationships and may also include Health Plan market share, performance on quality metrics, contract requirements including contracting with EOHHS-certified Accountable Entities (AEs), financial performance, household affiliations, previous enrollment in a Quality Health Plan (QHP), or other factors EOHHS determines are in the best interest of Members. EOHHS may implement a special default process when a new plan enters the market, or when EOHHS determines that enrollment trends or other factors indicate a need for modification (e.g., due to a significant shift in enrollments) and will notify the Health Plans and Members when a special default process will be implemented.

Once an eligible beneficiary selects or is assigned to a Health Plan they have ninety (90) days during which they can switch to another health plan. Following ninety (90) days after their initial enrollment into a Health Plan, members are restricted to that Health Plan until the next open enrollment period, unless dis-enrolled by EOHHS or meet just cause criteria established by EOHHS for plan change requests by members.

2.3 Rhode Island Health System Transformation Project ("HSTP")

The Rhode Island Health System Transformation Project ("HSTP") is a component of the State's CMS-approved Section 1115 Demonstration Waiver. HSTP aligns with the goals of the Institute for Health Care Improvement's Triple Aim: improve the member experience and quality of care, improve population health, and reduce the total cost of care. HSTP has guided significant investments and has enabled EOHHS to implement and invest in delivery system changes aimed at achieving all three goals. The HSTP provides the financial and structural support for growth and development of AEs. This solicitation furthers expectations for Bidders to build strong partnerships with AEs to improve member health while controlling health care costs and ensuring the sustainability of the AE business model when HSTP funding is no longer available.

AEs are provider organizations who are accountable for quality health care, outcomes, and the total cost of care for enrollees. Current AEs include health centers, hospitals, and primary care providers. All members that are attributed to an AE are also enrolled in a Health Plan. Children, families, and the Medicaid Expansion population account for the largest number of AE enrollees. Since implementation in 2016, and as of July 2021, the AEs serve approximately 203,699 members, accounting for approximately sixty-eight percent (68%) of managed care enrollees.

2.4 EOHHS's Goals for Procurement

EOHHS' has four (4) overarching goals for this procurement:

1. Empowering members to make informed choices about their health plans and care;
2. Improving care and service coordination and management;
3. Increasing investment in population health, focus on social determinants of health and *actual* focus on race equity; and,
4. Improving budget predictability and increased payments for improved outcomes.

These goals guided the formulation of the vision of the system of care and care continuum described in Section 2.5 of this procurement and shaped the changes incorporated into the "Model Contract" found at Appendix B, Medicaid Managed Care Model Contract ("Model Contract"). For more information on how these goals were developed, see the EOHHS Medicaid Managed Care 2021-2022 Procurement: Policy Report in the Procurement Library.

2.5 EOHHS' Vision for the System of Care and Care Continuum

In partnership with its contracted Health Plans, EOHHS' vision is to continue to deliver high quality care to members in an accessible, affordable coordinated, cost-effective manner, improving the population health of Medicaid beneficiaries, while reducing the per capita cost of health care.

Through this solicitation, EOHHS seeks qualified Bidders to deliver a system of care in which the member (or family) is at the center of all care planning and has autonomy over all care decisions, meaning that members are active participants in the development of care plans and identification of care goals. A person-centered system is holistic and integrated, meaning that a person's health is viewed inclusive of medical, behavioral health, and social needs. This system of care has the primary care team closest to the member, who acts as the primary point of contact for the member assisting them as they navigate their care. As members' needs grow in complexity, additional, tailored supports are provided as extensions of the primary care team, through AE deployed complex case management, Integrated Health Homes ("IHH") and Assertive Community Treatment ("ACT") teams, or other specialized programming for particular sub-populations.

Through this system of care and for AE-attributed members, EOHHS envisions the AE to be the primary source of referral, navigation, and coordination between primary care and other healthcare and community-based services within and outside of the AE's network. AEs are expected to coordinate closely with their contracted health plan partners to ensure that care management programming and system navigation for all attributed members are coordinated. For members that are not attributed to an AE, the Health Plan retains full accountability for providing the full continuum of care management programming. The graphic below further depicts EOHHS' vision for a comprehensive, person/family centered system of care.

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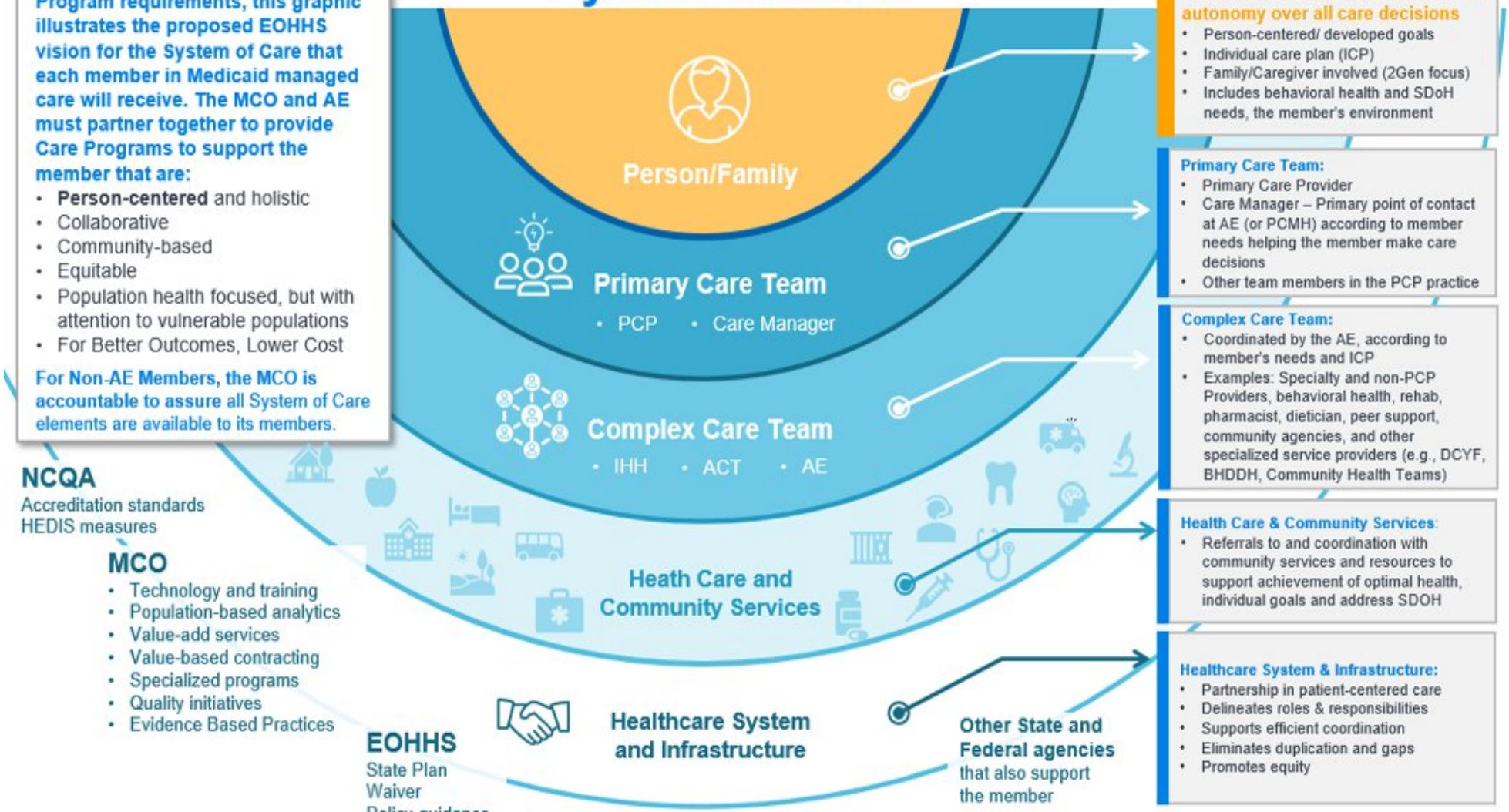
System of Care

As the foundation for its Care Program requirements, this graphic illustrates the proposed EOHHS vision for the System of Care that each member in Medicaid managed care will receive. The MCO and AE must partner together to provide Care Programs to support the member that are:

- **Person-centered** and holistic
- Collaborative
- Community-based
- Equitable
- Population health focused, but with attention to vulnerable populations
- For Better Outcomes, Lower Cost

For Non-AE Members, the MCO is accountable to assure all System of Care elements are available to its members.



NCQA
Accreditation standards
HEDIS measures

MCO
- Technology and training
- Population-based analytics
- Value-add services
- Value-based contracting
- Specialized programs
- Quality initiatives
- Evidence Based Practices

EOHHS
State Plan
Waiver
Policy guidance

Other State and Federal agencies that also support the member

The Member is at the center and has autonomy over all care decisions
- Person-centered/ developed goals
- Individual care plan (ICP)
- Family/Caregiver involved (2Gen focus)
- Includes behavioral health and SDoH needs, the member's environment

Primary Care Team:
- Primary Care Provider
- Care Manager – Primary point of contact at AE (or PCMH) according to member needs helping the member make care decisions
- Other team members in the PCP practice

Complex Care Team:
- Coordinated by the AE, according to member's needs and ICP
- Examples: Specialty and non-PCP Providers, behavioral health, rehab, pharmacist, dietician, peer support, community agencies, and other specialized service providers (e.g., DCYF, BHDDH, Community Health Teams)

Health Care & Community Services:
- Referrals to and coordination with community services and resources to support achievement of optimal health, individual goals and address SDOH

Healthcare System & Infrastructure:
- Partnership in patient-centered care
- Delineates roles & responsibilities
- Supports efficient coordination
- Eliminates duplication and gaps
- Promotes equity

2.6 Recent Developments and Disruptions to RI Health Care Landscape

In the past year, EOHHS has responded to critical developments and disruptions impacting Rhode Island's health care landscape and continues to be faced with ongoing challenges including:

- The continuing effects of the COVID-19 pandemic upon Rhode Island, its economy, and its healthcare systems.
- Racial and ethnic disparities and systemic racism within the healthcare delivery system and their effect on overall population health equity.
- The need for improved community engagement and development of health equity zones.
- A lack of behavioral healthcare service continuum, integration, and parity within the current healthcare systems.
- The need for improved children's behavioral health, for our general Medicaid population and for our child welfare population.
- The impacts of Social Determinants of Health ("SDoH") on health status and improvement opportunities.
- The need for alternative and value-based payment ("VBP") models for the investment of the State's Medicaid dollars amidst the rising costs of healthcare, focusing spending on maximizing health and reducing waste.
- The need to collect data and utilize evidenced-based practices.

Rhode Island's state-based health insurance exchange, Health Source Rhode Island (HSRI) provides individuals, families, and small employers with access to high-quality, affordable health coverage. HSRI began providing services in 2013 and has since served as a robust marketplace for Rhode Islanders to shop, compare, and purchase health insurance.

Currently, HSRI's two (2) Qualified Health Plans (QHPs) insure over 31,000 individuals and families across eighteen (18) plans in metal levels ranging from Bronze to Platinum. Of paid individual and family enrollees, eighty to eighty-five percent (80-85%) receive financial assistance, Advanced Premium Tax Credits (APTC) and/or Cost-Sharing Reductions (CSR) and fifteen to twenty percent (15-20%) receive no financial assistance.

Additionally, eighty-three percent (83%) of customers renewed their coverage during the Annual Open Enrollment period last year. According to Rhode Island's latest Health Information Survey, four percent (4%) of Rhode Islanders were uninsured in 2020 – a reduction of uninsured residents by more than two-thirds since 2013. HSRI also covers over 6,500 small business employees and dependents through the HSRI for Employers program.

Through this procurement, EOHHS seeks to align coverage for members who transition from Medicaid to Exchange coverage and from Exchange coverage to Medicaid. The purpose of aligning Health Plans offered to both RI Medicaid and Exchange customers is to promote continuity of care and minimize adverse impacts for individuals who churn between the programs as well as for mixed coverage families. Through this alignment EOHHS' goal is to promote the following advantages for Medicaid and Exchange customers:

1. Seeing similar sets of providers through continuity of provider networks between Medicaid and Exchange carriers;
2. Having a single point of contact - either through customer service or an insurer's website – to assist with navigating benefits and, in turn, reducing the complexity of coverage; and
3. Experiencing greater assistance from carriers in maintaining coverage throughout eligibility changes.

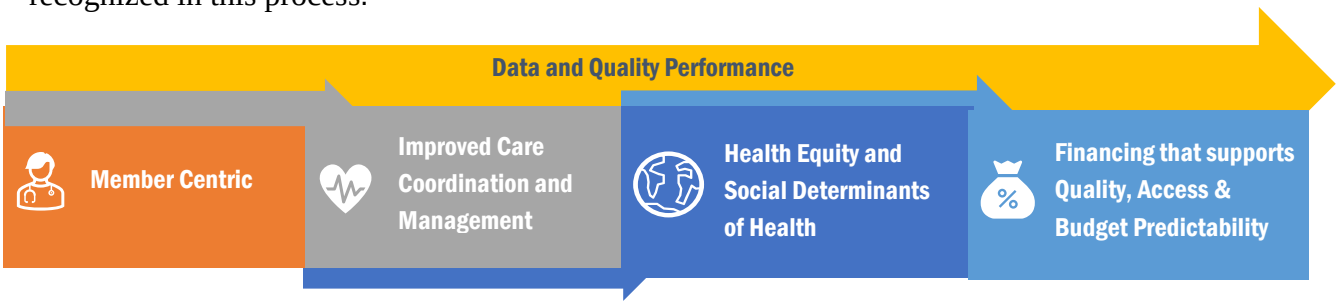
2.7 Stakeholder Information Gathering Process

To support this RFQ, EOHHS conducted an extensive stakeholder engagement process to gather feedback on the current Medicaid managed care program and explore opportunities and innovations for improvements to align with EOHHS' current initiatives and member needs. On March 2, 2021, the Rhode Island Department of Administration (DOA), on behalf of EOHHS, issued Request for Information (RFI) # 7611871 to solicit informational responses from potential Bidders and other interested parties to inform the managed care procurement for RIte Care, Rhody Health Partners, and Adult Expansion populations. DOA accepted responses through March 30, 2021. The agency received responses from nineteen (19) potential bidders, organizations, associations, and community leaders representing a cross-section of respondents. A summary of the highlights and areas of consensus from this process is noted below:

Key Area	Highlights and Areas of Consensus
Care and Service Coordination	• Deliver care management and service coordination in accordance with the consumer's choice and preferences. The most recommended approach is to pair the member with the provider who has an established relationship to the patient to optimize engagement and successful outcomes. • Establish appropriate parameters to further support transparent and timely data sharing among and between EOHHS, health plans and providers. All stakeholders should use the data flow to inform, support and track individual member, system, and programmatic performance to achieve EOHHS' policy goals for the managed care program.
Behavioral Health	• Implement systemic improvements at the state, health plans, AE, and provider levels to achieve an integrated system of whole-person care that addresses physical and behavioral health needs for children and adults. • Providers should be well-versed in evidence-based care models including trauma-informed care, adverse childhood experiences, principles of recovery and empowerment, health literacy, and harm reduction. • Service continuum assessment should address early identification, prevention and care transitions.
Social Determinants of Health (SDoH)/ Population Health/ Health Equity	• Support alignment of quality, operational, and financial incentives across health plans, AEs and other providers, including community-based organizations. Support should build on current EOHHS and RI Department of Health's Health System Transformation Program (HSTP), Rhode to Equity, Health Enterprise Zones (HEZs), Care Transformation Collaborative Rhode Island (CTC-RI) and Community Resource Platform, and other strategies. • Consider requirements for health plans to have a health equity plan developed with member input to address internal and external anti-racism, implicit and unconscious bias training, staffing, quality, and financial incentives to reflect Black, Indigenous, and Persons of Color experiences.
Value-Based Payments and APMs	• Discourage exclusivity arrangements between AEs and health plans. • Most respondents supported flexibility in value-based purchasing arrangements between health plans, AEs and other providers to achieve the required outcomes while meeting providers where they are and advancing to more sophisticated arrangements over time.
Member Enrollment	• Contract with an independent enrollment broker for unbiased member outreach and education to facilitate active member choice among all available options. Outreach and education should be tailored to RI enrollees' cultural, linguistic, and literacy levels. Most respondents suggested requiring enrollees to select a primary care provider (PCP) at the point of managed care enrollment. • Maintain members in their health plans for physical and behavioral health services when a non-dual member qualifies for long-term services and supports (LTSS) with additional requirements for coordination and communication to ensure continuity of care and coverage to ensure whole-person centered care.

Health Plan Financing and Comprehensive Risk	• Continue actuarially sound rate setting Respondents note this is a key to the successful transfer of financial risk to health plans. Health plans with demonstrated financial stability and experience should be well positioned to assume risk with additional mechanisms to recognize membership allocation and incentives for improved quality and member outcomes.
Other	• Continue telehealth flexibilities, especially for meeting behavioral and SDoH needs of members.

As a result of this feedback, the following fundamental principles and policy goals were recognized in this process:



- Empowering the member to make informed decisions
- Creating infrastructure that treats the whole person and reduces duplication and fragmentation of care and services
- Promoting social services to offer Medicaid members a benefit package that supports person-centered health care.
- Achieving greater budget predictability and use of funds to support movement to paying for value and outcomes.

EOHHS also issued a member survey that yielded over 2,300 responses and convened numerous internal, cross-agency staff workgroups to review the feedback received, the internal assessment of challenges and opportunities to make informed policy decisions for the future managed care program.

More information on the policy recommendations developed and incorporated into the "Model Contract" can be found by accessing the EOHHS Medicaid Managed Care 2021-2022 Procurement: Policy Report which can be accessed in the procurement library at https://eohhs.ri.gov/providers-partners/medicaid-managed-care/2022-medicaid-managed-care-procurement-library.

SECTION 3: SCOPE OF WORK AND REQUIREMENTS

Proposals must follow all instructions, conditions and requirement outlined within this RFQ. Appendix B to this RFQ is the stand-alone Medicaid Managed Care Model Contract ("Model Contract"), which details the scope of work for contracted Health Plans, as well as Appendix C, the "Draft Medicaid Managed Care Manual" ("Draft Medicaid Managed Care Manual") also found at the following link: https://eohhs.ri.gov/providers-partners/medicaid-managed-care/medicaid-managed-care-manual. The RFQ, incorporating the "Model Contract", "Draft Medicaid Managed Care Manual" and the Bidder's related proposal by reference, are considered the contracts to be executed between selected Bidders and the state as described in Addendum F,

"Agency Special Requirements", Attachment F-2, "General Terms and Conditions", Article 2, "Agreement Composition and Order of Precedence" of the "Model Contract".

Bidders are expected to read this RFQ in its entirety before responding. Failure to follow any of the instructions, conditions and requirements set forth in this RFQ, may result in a low-score or disqualification.

Acceptable proposals must offer all services identified in this RFQ, including the "Model Contract" in Appendix B, the "Draft Medicaid Managed Care Manual" in Appendix C, and agree to the contract conditions specified throughout the RFQ and included in Bidder's Technical Proposal response to Section 4 of this RFQ. The State reserves the right to change tasks and deliverables in the contract during the negotiation period and to amend the contract to include new populations, services, or programs, including the RIte Smiles and Rhode Island Medicare-Medicaid Plan (MMP) programs.

3.1 General Overview

This RFQ provides background information and describes the services and the system of care delivery desired by EOHHS. It describes the requirements for this procurement and specifies the contractual conditions required by the State. The RFQ solicits qualified health plans to implement new and enhanced approaches to deliver high-quality, cost-effective managed health care for Rhode Island's Medicaid members consistent with Rhode Island's Medicaid program key principles and goals, statutes, regulations, and the CMS-approved 1115 Demonstration Waiver extension in accordance with EOHHS' duties and authority as contained in Rhode Island General Laws sections 42-7.2-2, 42-7.2-5 and 42-7.2-16 and all Governing Laws and Regulations described in Addendum F, "Agency Special Requirements", Attachment F-2, "General Terms and Conditions", Article 3, "Governing Laws and Regulations" of the "Model Contract".

In response to this RFQ, as outlined in Section 4, Technical Proposal, qualified Bidder(s) must certify that they will meet all elements outlined in this Section 3, Scope of Work and Requirements, Section 4, Technical Proposal, the Managed Care "Model Contract", and the "Draft Medicaid Managed Care Manual". Bidders must provide evidence that further validates their capacity and readiness to meet all requirements contained within Appendix B, "Model Contract" and Appendix C, "Draft Medicaid Managed Care Manual" as demonstrated by their response to this RFQ.

The successful Bidder(s) must demonstrate the capacity to provide high quality services in a cost-effective manner to eligible Medicaid populations throughout the State of Rhode Island. The selected Bidder(s) must be properly licensed and have the capability to meet a defined set of program and technical standards set forth in Appendix B, the "Model Contract" and Appendix C, the "Draft Medicaid Managed Care Manual", including but not limited to the following:

- Enroll the covered population and provide the covered benefits that represent a full continuum of health and behavioral health care services;
- Maintain a robust provider network that meets Federal and State accessibility standards;
- Provide in-plan benefits and coordinate out-of-plan benefits that meet individual member needs;
- Have the capacity to provide care management to a diverse population with complex needs;
- Have the capacity to provide responsive member and provider services;

- Have the capacity to operate under a risk bearing contract and to meet financial standards;
- Maintain a viable information technology capacity and meet Federal and State reporting requirements;
- Maintain a grievance and appeals process that meets Federal and State requirements; and
- Implement alternative payment methodologies with defined quality metrics.
- Have the ability to enter into written subcontracts with EOHHS certified Accountable Entities.
- Maintain administrative and management policies and procedures in place to detect and prevent fraud, waste and abuse and the overall program integrity of the program.
- Maintain a comprehensive utilization management program plan that clearly defines the program's organizational structure, standards, and policies and procedures.

The successful Bidder(s) will also be required to meet specific terms and conditions related to contract amendments and potential contract disputes; personnel and performance standards; confidentiality of information; and other terms and conditions related to administering its contract with EOHHS.

Any successful Bidder(s) will be required to complete a readiness review conducted by EOHHS to both ensure the accuracy of information contained in the Technical Proposal and to ensure Bidder(s) preparedness to perform the requirements of this RFQ, Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 2, "Readiness Review Requirements" of the "Model Contract" found in Appendix B in accordance with 42 C.F.R. § 438.66(c)-(d). Readiness shall be conducted by EOHHS during the tentative award and contract negotiation phase. To complete the readiness review assessment, EOHHS will consider the Bidder's assurance of operational readiness, information contained in the Bidder's Proposal, and systems testing, and documentation supplied by the Bidder during Readiness Review.

EOHHS, with approval from the State Purchasing Agent, reserves the right to defer the contract start date for up to one (1) year beyond July 1, 2023. RI EOHHS or their designee will identify to the Bidder(s) areas where EOHHS does not deem Bidder(s) to be ready and able to meet its obligations under the tentative award. EOHHS shall provide reasonable opportunity for the Bidder(s) to correct such areas to remedy all deficiencies prior to the contract effective date. If, for any reason, the Bidder(s) does not fully satisfy EOHHS that it is ready and able to perform its obligations under the tentative award prior to the contract start date and EOHHS does not agree to postpone the contract start date or extend the date for full compliance with the tentative award, then EOHHS may not award a final contract.

EOHHS is seeking to enter into contracts with Health Plans that are prepared to serve the enrolled population beginning on July 1, 2023. At the same time, EOHHS will consider strong proposals with substantial evidence of both current development and concrete plans and capability to fully meet all requirements at or close to the projected start of the contract and include a timeline or project work plan that would guide a new entrant's completion of core activities needed to "go live" no later than two (2) months following this effective date.

3.2 Health Plan Licensure and Organizational Capacity

The Bidder must demonstrate that the organization meets all State general requirements as described in Section 1 and attest to all of the General Terms and Conditions set forth in

Addendum F, “Agency Special Requirements”, Attachment F-2, “General Terms and Conditions” of the “Model Contract” in its entirety.

The Bidder must certify that it has obtained and will maintain all licenses, certifications, permits, and authorizations necessary to perform its obligations under the RFQ and is in good standing with all regulatory agencies. The Bidder certifies that it is licensed in Rhode Island as an HMO under the provisions of Chapter 2741, “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 State. If Bidder is not a licensed HMO in Rhode Island, Bidder 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;
- 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

The Bidder must forward to EOHHS any complaints received from the DBR or the Rhode Island Department of Health concerning its licensure, certification, and/or accreditation within thirty (30) days of the Bidder’s receipt of a complaint.

The Bidder agrees to provide to the State, or its designees, any information requested pertaining to its licensure and/or certification including communication to and from DBR and the Rhode Island Department of Health. This provision shall apply to any subsidiary of the Bidder or any subcontractor with delegated authority for administration or oversight of covered benefits or adjudication of covered benefit claims under this Agreement. Bidder also agrees to forward to the State a copy of any correspondence sent by the Bidder to the Rhode Island Department of Business Regulation or the Rhode Island Department of Health, which pertains to the Bidder’s licensure or its contract status with any institution or provider group.

The Bidder must be accredited by the National Committee for Quality Assurance (“NCQA”) as a Medicaid managed care organization or otherwise for a newly entering plan, provide proof that it is NCQA accredited as a Medicaid managed care organization in another state and will achieve full accreditation for Rhode Island Medicaid within twelve (12) months of the execution of the award under this RFQ.

Ensuring access to high quality and cost-effective services to all Rhode Islanders is paramount; therefore, the Bidder must obtain NCQA distinction in Multicultural Health Care within twenty-four (24) months of execution of the award under this RFQ. Achievement of provisional accreditation status will require a corrective action plan within thirty (30) calendar days of receipt of the Final Report from the NCQA and may result in termination of the Agreement. Failure to obtain NCQA accreditation and Multicultural Health Care distinction within twenty-four (24) months of execution of the Agreement may result in suspension of enrollment or termination of this Agreement.

Is certified by a nationally known health utilization management organization.

In addition to providing Medicaid Managed Care services, Bidders are also highly encouraged to participate in the state's health insurance exchange, HSRI. Bidders who currently participate or intend to participate should include a plan in their response for applying for rate approval and Exchange certification, including the timeframe for participating.

3.3 Health Plan Organization and Administrative Requirements

The Bidder must maintain the organizational and administrative capacity and capabilities to carry out all duties and responsibilities under the "Model Contract" as set forth in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.1, "Contract Administration and Management" of the "Model Contract", including the required staffing capacity with the appropriate training, qualifications, and expertise for the functions they perform. The bidder must designate key management and technical personnel who will be assigned to the Contract. Key personnel include the Chief Executive Officer, Medical Director, Chief Financial Officer, Privacy Official, Security Official (see 45 C.F.R. § 164.308), Chief Diversity, Equity, and Inclusion Officer and individuals with management responsibility for the following functional areas:

- Members services;
- Provider network development and management;
- Medical management and quality assurance (including Care Program, benefit administration, utilization management, and quality assurance and improvement);
- Management Information Systems (MIS) and claims processing;
- Grievances and Appeals;
- Reporting;
- Program integrity and compliance;
- Accountable Entity Programs; and
- Special Investigative Units for Fraud, Waste, and Abuse
- Diversity, Equity and Inclusion Programs and Policies

The Bidder will not contract with or employ, either directly or indirectly:

- An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under Federal Acquisition Regulations or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing the Executive Order;
- An individual or entity that is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act;
- An individual who is an affiliate, as defined in the Federal Acquisition Regulation.

The Bidder will be responsible for performance of all duties and responsibilities under the "Model Contract", whether Subcontractors or other Representatives are used.

The Bidder is required to have an office in the Greater Providence area of Rhode Island. The Bidder may perform some administrative functions out-of-state, with the approval of EOHHS, as long as it does not affect the quality, effectiveness, and efficiency of the services or functions performed by the Bidder in the judgment of EOHHS. The Bidder is expected to have an in-state presence to conduct outreach and approved marketing activities within all the communities throughout the State and participate in EOHHS and other member advisory meetings and forums.

3.4 Fiscal and Performance Requirements

The Bidder must be financially solvent, have the capital, reinsurance, financial resources and management capability to operate under this procurement's risk-based contract that reimburses the successful Bidder with actuarially sound capitation rates. 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 as set forth in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.27, "Financial Requirements" of the "Model Contract". Bidders will be required to provide documentation on a regular basis that the Contractor is financially solvent, has the capital, reinsurance and the financial resources and management capability to operate under this risk-based contract and comply with the terms outlined in the Agreement as described in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operational Requirements", Section 3.27, "Financial Requirements" of the "Model Contract". The Bidder must demonstrate to EOHHS that it is able to meet the solvency requirements set forth through the Rhode Island Office of the Health Insurance Commissioner (OHIC). Exceptions to minimum OHIC standards will not be granted.

The Bidder agrees to provide all the information necessary for calculating benchmark levels. The Bidder also agrees to comply with corrective actions ordered by the State to address any identified deficiencies with respect to financial benchmarks.

Bidders responding to this RFQ understand and agree to be paid a fixed monthly payment per enrolled member, a capitation payment, for the provisions of all services described in the "Model Contract" included in this RFQ and set forth in Addendum F, "Agency Special Requirements", Attachments F-3.1-3.4 of the "Model Contract". Bidders will be at full risk for provision of the covered services. Bidders will be expected to have access to sufficient reserves and/or reinsurance to bear the risk of unexpected medical claims which may occur. The State and its contracted actuaries will develop actuarially sound capitation rates which will be paid to the bidder. This is a requirement of the Centers for Medicare & Medicaid (CMS) under 42 C.F.R. § 438.4. Information regarding the development and rate setting process are included in the Appendix D, "Managed Care Organization Request for Qualification: Financial Bidder Packet".

3.5 Eligibility, Enrollment and Disenrollment

The Bidder must comply with the eligibility and program enrollment requirements outlined and described in Addendum F, "Agency Special Requirements", Attachment F-1, Scope of Work, Article 3, "Operations Phase Requirements", Section 3.2, "Covered Populations, Enrollment, and Disenrollment" of the "Model Contract".

The following populations are eligible for managed care enrollment under this RFQ as described in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.2, "Covered Populations, Enrollment, and Disenrollment" of the "Model Contract":

RIteCare Eligibility Groups:

- **Families**. This group consists of persons categorically eligible for Medicaid based on RI Works or RI Works-related status or based on families with a minor child or children under age eighteen () with income specified by the State.

- **Children Under Age nineteen (19) and Under 250% FPL**. This group consists of children under age nineteen (19) living in families and with income under 250% of the FPL.
- **Pregnant Women Under 250% FPL ("SOBRA-Extension Group")**. This group consists of uninsured pregnant women living in families under 250% of the FPL. The category is referred to as the "SOBRA-Extension Group" (Sixth Omnibus Budget Reconciliation Act). The group is eligible for the full scope of Medicaid benefits, as described below, through delivery and two (2) months postpartum.
- **Extended Family Planning Group.** This group consists of women who meet the following criteria: have qualified for RIte Care; were pregnant and are now sixty (60) days postpartum or sixty (60) days post loss of pregnancy; and are subject to losing Medicaid eligibility. The group is eligible to receive a schedule of family planning-related benefits for up to twenty-four (24) months. Women who qualify for this category remain with the same Health Plan that provided coverage during pregnancy.
- **Children with Special Health Care Needs.** This group includes: (1) blind/disabled individuals up to age twenty-one (21) who are eligible for Medicaid based on SSI; (2) children eligible under Section 1902(e)(3) of the Social Security Act ("Katie Beckett" children) up to age nineteen (19); (3) individuals up to age twenty-one (21) receiving subsidized adoption assistance; (4) children in substitute care ("foster care") (enrollment in RIte Care for these children will be based on EOHHS determination of managed care eligibility) or eligible based on participation in a DCFY kinship or guardian program (whether in a home-based, residential, or institutional setting, as applicable); (5) adults between the ages of twenty-one (21) and twenty-six (26) who were previously active with the Department of Youth and Family Services (DCYF) and do not have other comprehensive coverage; and (6) youth who opt to remain in the care of DCYF up to age twenty-one (21) if they entered foster care on or after their sixteenth birthday and did not achieve permanency (i.e. adopted, reunified, etc.) and were set to age out of foster care.
- **Uninsured Children Up to Age 18 above 250% FPL.** This group consists of children up to age eighteen living in families who are uninsured and whose income is above 250% of the FPL.

o **Rhody Health Partners Eligibility Group –**
- Individual's age twenty-one (21) and older who are Categorically eligible for Medicaid;
- Not covered by other third-party health insurance (including Medicare);
- Residents of Rhode Island; and
- Not residing in an institutional facility for more than thirty (30) days.

o **Affordable Care Act (Adult Expansion) Eligibility Group –**
- Adults between the ages of nineteen (19) and sixty-four (64);
- Who are at or below the States specified FPL based on household income (using the application of a modified adjusted gross income);
- Who are not pregnant;
- Who otherwise do not qualify for Medicaid; and
- Are not eligible for or enrolled in Medicare.
- Women in the ACA Expansion group who become pregnant while enrolled are guaranteed eligibility for comprehensive services through two (2) months postpartum or post loss of pregnancy, and then are eligible for an Extended Family Planning benefit for up to an additional twenty-four (24) months.

EOHHS reserves the right to add new eligibility groups by amending the managed care contract.

The following Medicaid populations are excluded from enrollment in Rhode Island Medicaid managed care under this RFQ:

- Recipients receiving services in an Intermediate Care Facility for Intellectual or Developmental Disabilities (ICF/IID).
- Rhody Health Partners and ACA Expansion populations who have exceeded the maximum number of days in a nursing facility.

3.6 Provider Networks, Services and Access to Services

The Bidder must establish and maintain a robust geographic Provider Network designed to ensure that the full range of Covered Services including preventive care, primary care, acute care, specialty care, behavioral health care, substance use disorder and long-term services and supports (including nursing homes and home and community-based care) is available and accessible to all members in a timely manner without unreasonable delay in accordance with the Service Accessibility Standards for access and timeliness of care developed by EOHHS and set forth in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.14, "Provider Networks and Requirements, Access to Care" of the "Model Contract".

The Bidder must cover all medically necessary medical (primary and acute), behavioral healthcare service, long-term care services and supports, described in Addendum F, "Agency Special Requirements", Attachment F-3.1, "Schedule of In-Plan Benefits" and Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.3, "Covered Benefits, Service Requirements and Limitations" of the "Model Contract" in an amount, duration and scope to ensure that the services reasonable achieve the purpose for which the services are furnished. This also includes any Value-Added Services and In-Lieu of Services proposed by the Bidder and approved by EOHHS.

The Bidder is also required to coordinate out-of-plan and non-covered services, as described in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, Operations Phase Requirements", Section 3.13, "Care Program and Continuity of Care" of the "Model Contract". The out-of-plan services are included in Addendum F, "Agency Special Requirements", Attachment F-3.2, "Schedule of Out-of-Plan Benefits" of the "Model Contract".

3.7 Care Management and Coordination of Services

The Bidder must have a comprehensive Care Program to meet the framework and requirements described in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.13, "Care Program and Continuity of Care" of the "Model Contract" and Chapter 8, "Care Program and Accountable Entities" of the "Draft Medicaid Managed Care Manual" that encompasses the full continuum of care management and coordination activities and is available to all members based on their individualized needs. The overarching goal of the Care Program is to provide member's access to all services and supports needed to maximize their health, employ person-centered strategies that promote independence and quality of life, and provide coordinated and cost-effective care. At a minimum, the Care Program must address:

- Health Risk Assessments (HRAs).

- Record keeping.
- Care Program policies and procedures.
- Qualifications and location of Care Managers and Complex Care Managers.
- Supports for members' families and caretakers.
- Individualized Care Management Plans (ICPs) for members receiving Care Management and Complex Case Management.
- Requirements for coordinating care with Targeted Case Management providers, including AIDS Case Management Agencies.
- Additional Care Coordination requirements for members recently discharged from correctional institutions, including coordination with the local Reentry Councils.
- Specialized Care Coordination requirements for populations needing Complex Case Management, including members with high-risk pregnancies, members receiving services in the Neonatal Intensive Care Units, Children with Special Health Care Needs; children with complex medical needs and/or adverse childhood experiences (ACEs); people living with HIV, AIDS, Hepatitis C, severe mental illness or addiction; and people recently discharged from correctional institutions (collectively "Specialized Populations").
- Health Promotion and Wellness and member engagement activities.
- Delegation of Care Program requirements to AEs or other providers.

3.8 Provider and Member Services

The Bidder must establish and maintain a Provider services function to timely and adequately respond to Providers' questions, comments and inquiries and adequately staff and operate the Provider Services function, including a toll-free telephone line, to provide appropriate and timely responses meet the Provider Services requirements in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.14, "Provider Networks and Requirements, Access to Care" of the "Model Contract".

As part of the Member Services function, the Bidder(s) must have an ongoing program of member education that considers the multi-lingual, multi-cultural nature of the population and recognizes that some members have disabilities requiring additional supports in order to access and receive covered services.

The Bidder must establish, staff and maintain a Member Services function that meets the requirements in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.20, "Member Services "of the "Model Contract" and Chapter 6, "Critical Elements" of the "Draft Medicaid Managed Care Manual". At a minimum, the member services function must include the following:

- Member Call Center Description;
- Translator and interpreter services;
- Member education activities and opportunities;
- Developing and implementing a Member Advisory Committee; and,
- Developing Member services performance metrics to track service utilization and key performance metrics (KPIs)

3.9 Reporting Infrastructure and Requirements

The Bidder must establish and maintain the information technology capacity to meet all state and federal reporting requirements and timeframes described in Addendum F, "Agency Special

Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.25 "General Reporting Requirements" of the "Model Contract" and Chapter 11, "Reporting Calendar and Templates" of the "Draft Medicaid Managed Care Manual". The Bidder must adhere to Chapter 11 of the "Draft Medicaid Managed Care Manual", "Reporting Calendar and Templates," which includes the EOHHS reporting requirements, templates, timeframes, and submission requirements.

In addition, the Bidder must have a QM/QI system in place to review all data submissions to EOHHS, including submissions generated by the Bidder's subcontractors.

3.10 Grievance and Appeals

The Bidder must have in place an internal Grievance and Appeals Procedure that complies with relevant sections of the Social Security Act, 42 USC §1396a, 42 C.F.R. §§ 438.400 – 438.424, and 210-10-05 R.I.C.R. § 2.4 and Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.21, "Grievances and Appeals", of the "Model Contract". The Bidder must follow the timeframes for decisions, expedited decisions, notices and continuation of benefits. The Bidder must also comply with the Grievance and Appeal Notice templates, reporting requirements, timeframes and submission requirements described in Chapter 10, "Grievances and Appeals" of the "Draft Medicaid Managed Care Manual".

3.11 Alternative Payment Methodologies

EOHHS seeks to significantly reduce the use of fee-for-service payment as a payment methodology and to replace fee-for service with qualified alternative payment methodologies (APMs) that provide incentives for better quality and more efficient delivery of health services. The Bidder must develop an APM Strategy and Implementation Plan that outlines how it intends to achieve EOHHS' defined targets and describes the APM methodologies it intends to adopt. The APM Strategy shall conform to the requirements set forth in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.29, "Alternative Payment Methodology" of the "Model Contract" and Chapter 5, "Financial Requirements" of the "Draft Medicaid Managed Care Manual".

3.12 Accountable Entities

EOHHS has established the Accountable Entity Program to promote health care delivery system reform. Fundamental to this initiative is the progressive movement from volume-based to value-based payment arrangements and increased risk and responsibility for cost and quality of care. Bidders will be required to enter into written subcontracts with EOHHS certified Accountable Entities in accordance with Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 4.15, "Accountable Entities" of the "Model Contract" and the following AE program requirement documents found in Chapter 8, "Care Program and Accountable Entities" of the "Draft Medicaid Managed Care Manual" and the following documents included in the Procurement Library:

- "Accountable Entity Attribution Guidance";
- "Accountable Entity Total Cost of Care Requirements";
- "Total Cost of Care Technical Guidance";
- "Infrastructure Incentive Program: Requirements for Managed Care Organizations and Certified Accountable Entities"; and

- "Rhode Island Accountable Entity Program Total Cost of Care Quality and Outcome Measures and Associated Incentive Methodologies for Comprehensive Accountable Entities: Implementation Manual".

3.13 Program Integrity and Compliance

The Bidder (or subcontractor to the extent that the subcontractor is delegated responsibility by the Bidder for coverage of services or payment of claims under the contract), shall have administrative and management arrangements in place to detect and prevent fraud, waste and abuse.

The Bidder must have a Compliance Program, evidenced by a written Compliance Plan composed of policies, procedures and practices that demonstrates how the Contractor complies with the requirements of Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.22, "Program Integrity, Fraud, Waste and Abuse" of the "Model Contract" and all relevant State and Federal laws, regulations, policies, procedures and guidance, including updates and amendments as issued by any relevant state or federal authority.

3.14 Utilization Management

The Bidder must have in place a Utilization Management (UM) Program that is National Committee for Quality Assurance (NCQA) accredited and that facilitates the delivery of high quality, cost efficient and effective care as set forth in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.16, "Utilization Review", of the "Model Contract". The Bidder must have a written UM Program Plan that clearly defines the Program's organizational structure, standards, and policies and procedures and must include, at a minimum:

- Consistent review criteria for initial and continuing authorization decisions;
- Provisions for consultation with the requesting provider for medical services when appropriate;
- Identification of overutilization and underutilization of services and corrective action, as appropriate;
- Compliance with notice and timeliness standards in accordance with CMS regulations and the "Model Contract";
- Coverage parity assurances between mental health/substance abuse benefits and medical/surgical benefits in accordance with Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.4,"Behavioral Health Services" and the "Draft Medicaid Managed Care Manual", the Mental Health Parity Addiction Equity Act (MHPAEA) and 42 CFR §438.910(d); and,
- A mechanism to interface with the Program Integrity responsibilities under Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.22, "Program Integrity, Fraud, Waste and Abuse" of the "Model Contract".

SECTION 4: TECHNICAL PROPOSAL

A. Technical Proposal

Response to this RFQ must consist of all of the following technical proposal components. Each of these components must be separate from the others. All proposals submitted under this RFQ must address, in sufficient detail, how the Bidder will fulfill the expected goals and outcomes outlined in this RFQ and provide evidence of past or current experience showing how the Bidder's approach will meet the expected outcomes outlined in this RFQ. Data demonstrating improvements are to be provided to support the demonstrations. Bidders should be advised that simply repeating the outcomes and asserting that they will be performed will not be considered an acceptable response. The emphasis should be on completeness and clarity of content.

The Bidder must answer all components within the Technical Proposal Section in the order that they appear in each section and sub-section and must be limited to the maximum page limits. All referenced attachments, graphics, flowcharts, diagrams, and tables must be placed after the narrative response for the section or sub-section of the Mandatory Proposal Requirements responses and each evaluation category of the Technical Proposal Requirements responses. Graphics, flowcharts, diagrams, tables, and other attachments do not count toward the maximum page limits.

Any responses more than the maximum page limits will not be reviewed. Any documentation not specifically requested will not be reviewed. All responses must be in narrative format. The Bidder is to structure its proposal response identifying each of the proposal components separated by a tabbed page that includes the headings and numbering to match the corresponding RFQ Section.

Proposal Components:	**RFQ Section**
A. Table of Contents	4.0
B. Mandatory Proposal Requirements	
1. Letter of Transmittal	4.1
2. Financial Viability	4.2
3. Executive Summary	4.3
4. Bidder's Experience, Understanding and Readiness to Perform	4.4
C. Technical Proposal Requirements	
1. Service Delivery Plan	4.5
2. Population Health, Diversity, Health Equity and Inclusion	4.6
3. Quality and Performance Improvement	4.7
4. Alternative Payment Model (APM) Approach	4.8
5. Member Services and Engagement	4.9
6. Provider Network/Provider Services	4.10
7. Care Program and Coordination and Case Scenarios	4.11
8. Information Systems and Encounter Data	4.12
9. Value-Added Services and In-Lieu of Services (ILOS)	4.13

B. Mandatory Proposal Requirements

The following mandatory proposal requirements will be considered minimum requirements of the proposal and will be scored based on a pass/fail basis. Bidders that do not receive a pass score for all of the mandatory proposal requirements will be considered non-responsive and the proposal will not proceed. Page limits are included for each section; however, Bidders are

encouraged to use graphics, figures, tables etc. as appropriate to respond to the question. These visuals are excluded from the page limits.

Bidders must meet all mandatory requirements in Section 4.B. Mandatory Proposal Requirements by receiving a pass score. A Bidder's response to the RFQ must meet all mandatory proposal requirements prior to proceeding to review and evaluation of the bidder's response to the Technical Proposal Requirements. Any proposal that does not meet all Mandatory Proposal Requirements in Section 4.B. shall be rejected and will not proceed to be evaluated on the Technical Proposal Requirements identified in Section C. Technical Proposal Requirements.

4.1. Letter of Transmittal (2 Page Limit) (Pass/Fail Scoring)

Bidder shall submit a letter of transmittal signed by the owner, officer or other authorized agent of the Bidder or organization, including a statement that the Bidder has read, understands, acknowledges and accepts the terms and conditions of this RFQ. The transmittal letter must include statements regarding the following:

4.1.1 A statement that the Bidder has read, understands and accepts the conditions and limitations of this RFQ, the "Model Contract", and the "Draft Medicaid Managed Care Manual";

4.1.2. A statement that the Technical Proposal is effective from the date of submission and that the proposal remains in effect for an additional year.

4.1.3 Identification of any proposed sub-contractor(s) (excluding direct health service providers) arrangements in the proposal.

4.1.4 A statement that the Bidder attests to the accuracy and truthfulness of all information contained in the Bidder's responses to the RFQ.

4.1.5 A statement that the Bidder has read, understands, and accepts the mandatory requirements, responsibilities, and Terms and Conditions of this RFQ, the "Model Contract" and the "Draft Medicaid Managed Care Manual".

4.1.6 A statement that the Bidder accepts the State's Fiscal and Performance Requirements as set forth in Section 3.4 of the Scope of Work and the actuarial rate development and rate setting process outlined in "Managed Care Organization Request for Qualification: Financial Bidders Packet" found in Appendix D.

4.1.7 A statement that the Bidder is an HMO that is either licensed by the Rhode Island Department of Business Regulation or will receive HMO licensure or approval to conduct business in Rhode Island no later than sixty (60) days after execution of this Agreement.

4.1.8 A statement of attestation that the Bidder is in good standing with and has not been debarred from participation in any Federal or Federal/State health care programs, including Medicare, CHIP, and any state Medicaid program.

4.1.9 A statement of attestation that the Bidder is accredited by the National Committee for Quality Assurance ("NCQA") as a Medicaid managed care organization or otherwise for a newly entering plan, is NCQA accredited as a Medicaid managed care organization in another state and will achieve full accreditation for Rhode Island Medicaid within twelve (12) months of the

execution of the award under this RFQ. The Bidder must provide a copy of the NCQA Accreditation certification if currently accredited

4.1.10 A statement of attestation that the Bidder has or will obtain NCQA distinction in Multicultural Health Care within 24 months of execution of the award under this RFQ. The Bidder must provide a copy of the NCQA Certification, if the Bidder has received.

4.1.11 A statement of attestation that the Bidder and its Subcontractors have the skills, qualifications, expertise, financial resources, and experience necessary to provide the services and deliverables described in the RFQ, the Bidder's Proposal, and the "Model Contract" in an efficient, cost- effective manner, with a high degree of quality and responsiveness, and has performed similar services for other public or private entities.

4.1.12 A statement of attestation that the Bidder abides by Affirmative Action Policies and Procedures and that the Bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, sexual orientation, political affiliation, national origin, or handicap and complies with the Americans with Disabilities Act.

4.1.13 A statement of attestation that the Bidder has no moral or religious objections to providing any of the Covered Benefits described in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Section 4.3, Covered Benefits, Service Requirements and Limitations", and Attachment F-3.1, In-Plan Services and Attachment F-3.5, In-Lieu of Services, in the "Model Contract".

4.2 Financial Viability (Provide the required documents) (Pass/Fail Scoring)

4.2.1 Provide evidence of the Bidder's financial viability and solvency, as well as any adverse factors that may affect the Bidder's financial viability including but not limited to bankruptcy proceedings, major lawsuits, fines, etc. The Bidder must satisfactorily demonstrate to EOHHS that it is able to meet the solvency requirements set for through the Rhode Island Office of the Health Insurance Commissioner (OHIC). The Bidder(s) shall provide a description and/or provide evidence of financial solvency as a Health Plan operating in Rhode Island or outside of Rhode Island. Documentation to be provided by the Bidder(s) shall include the following at a minimum:

- **4.2.1.1** 2019 and 2020 Annual NAIC Financial Statements;
- **4.2.1.2** Most recent Quarterly NAIC Financial Statement;
- **4.2.1.3** 2019 and 2020 Annual Audited Financial Statements;
- **4.2.1.4** 2019 and 2020 Annual Report to Owners, Shareholders, Members, and Others;
- **4.2.1.5** Company's General Liability and Directors' and Officer's Insurance Coverages**;**
- **4.2.1.6** Claims Reinsurance Coverage and attachment points; and,
- **4.2.1.7** Where applicable, evidence that the parent Company provides 100% of subsidiary's financial backing

Bidder(s) newly entering the Rhode Island market should provide comparable documentation to demonstrate financial solvency and compliance with Rhode Island requirements.

In addition, bidder(s) newly entering the Rhode Island market should provide expected sources of capital funding to ensure financial viability to meet the solvency requirements set forth through the Rhode Island Office of the Health Insurance Commissioner (OHIC).

4.3 Executive Summary (5-page limit) (Pass/Fail)

The executive summary should demonstrate the Bidder's understanding of the service requested in this RFQ and any problems anticipated in accomplishing the work. It should include the Bidder's overall design to achieving the deliverables, solutions to the problems presented and knowledge of the requested services, including, but not limited to:

4.3.1 Bidder experience serving the Medicaid population under a risk-based contract. If the Bidder does not have specific experience in Rhode Island, the Bidder should describe its experience serving the Medicaid population in a state similar to that of Rhode Island within that past three (3) years along with a description of the size and scope of the previous engagement.

4.3.2 A demonstration of an understanding of the Rhode Island environment; the conditions surrounding this procurement and knowledge and experience with the Medicaid population. The Bidder must describe potential promising approaches to providing Medicaid services in a way that meets the unique needs of the enrolled Rhode Island Medicaid population. If the Bidder is not currently serving as a Medicaid managed care plan in Rhode Island, then the Bidder should also describe its related experience in other states.

4.3.3 A description of whether or not the Bidder currently participates on the Rhode Island Heath Insurance Exchange, HSRI. If not a current participant, the Bidders willingness to participate within 24 months of an award under this RFQ.

4.3.4 The Bidder must describe how it will establish and maintain partnerships with Rhode Island Accountable Entities in the delivery of care for Medicaid members and in assisting the State with transforming Rhode Island's healthcare system under the AE delivery model. Bidder should describe how it will establish the necessary supports and appropriate metrics to help both measure and incent progress toward the State's healthcare system transformation and Alternative Payment Methodology targets identified in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, Operations Phase Requirements", Section 3.28 "Alternative Payment Methodologies" of the "Model Contract" and Chapter 5, "Financial Requirements" of the "Draft Medicaid Managed Care Manual".

4.3.5 A description of the Bidder's ability to be ready to serve members by July 1, 2023.

4.3.6 A description of areas of capability still under development, as applicable, accompanied by realistic timeframes for completion.

4.4 Bidder's Experience, Understanding and Readiness to Perform (10 Page limit) (Pass/Fail Scoring)

4.4.1 The Bidder must provide a high-level description of its organization, including an organizational chart to reflect the reporting structure for the delivery of services requested in this RFQ and the "Model Contract" as well as a demonstration of the administrative capacity and capabilities and readiness to carry out all duties and responsibilities under this RFQ, which includes the "Model Contract" and the "Draft Medicaid Managed Care Manual". The plan should include, but is not limited to, the following components:

4.4.1.1 Staff Qualifications – Provide staff resumes/CV and describe qualifications and experience of key staff who will be involved in the delivery of services identified in this RFQ, Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, Operations Phase Requirements", Section 3.1, "Contract Administration and Management" of the "Model Contract" including their experience in the delivery of services requested in this RFQ.

4.4.1.2 Plan for Promoting Workforce Diversity, Equity and Inclusion – Provide a description of the Bidder's plan for promoting workforce diversity, equity and inclusion at all levels with its organization. The response should include the organizational goals and benchmarks that the Bidder has set to become a more inclusive and diverse organization and/or the steps the bidder has or will take to address structural racism, unconscious and implicit bias within its organization. The response should also describe how the Bidder will evaluate current organizational efforts, human resources practices, track progress and continue to improve the organizational structure, policies and processes to support workforce diversity, inclusivity and equity.

4.4.1.3 Board Members – Provide a description of the structure of the board, role of the Bidder's board members in governance and policy making, how conflicts of interests are addressed and prohibited, and how Medicaid members will be represented in an advisory and decision-making capacity for the services delivered as a result of this RFQ.

4.4.1.4. **Capability, Capacity, and Qualifications of the Bidder** - Provide a detailed description of the Bidder's experience as a Medicaid managed care organization providing the scope of services similar to those set forth in this RFQ. List a minimum of three (3) relevant client references, to include client names, addresses, contact names with emails and phone numbers, dates of service and type(s) of service(s) provided.

4.4.1.4.1 A disclosure of any sanctions imposed on the Bidder during the last three (3) years due to deficiencies in performance of contractual requirements related to a contract(s) with a Medicaid agency. Include any sanctions associated with affiliates and/or subsidiaries of the Bidder that are expected to be used in performance of a contract awarded as a result of this solicitation. For each sanction identified, provide the following:

- **4.4.1.4.1.1** Date of the sanction.
- **4.4.1.4.1.2** Brief description/reason for the sanction.
- **4.4.1.4.1.3** Actions taken to address the performance deficiency.
- **4.4.1.4.1.4** Dollar amount associated with any monetary sanction.
- **4.4.1.4.1.5** Brief description of any plan of correction enforced and resulting outcome.

C. Technical Proposal Requirements

The response to the following technical proposal requirement categories will receive a numerical score as identified in Section 5: Evaluation and Selection. The responses should demonstrate, using relevant data, the Bidder's understanding of the Rhode Island health care landscape and Medicaid population, including challenges and opportunities related to health care delivery, and unique approaches to providing Rhode Island Medicaid services to the population covered under this RFQ.

Responses should demonstrate the potential for innovation and increased value inherent in the managed care structure and not available in the fee-for-service (FFS) delivery system. These questions reflect State priorities and should address, where applicable, racial disparities, community collaboration, and person-centered design even if the question does not expressly state those themes. If the Bidder does not currently have a Medicaid managed care contract with the State, the Bidder should select a current market or product to use in the responses to questions regarding current policies, procedures, or experiences and name the market and product selected. Page limits are included for each category; however, Bidders are encouraged to include relevant data, graphics, figures, tables etc. as appropriate to supplement their response to the question. Graphics, flowcharts, diagrams, tables and other attachments do not count toward the maximum page limits.

Any responses in excess of the maximum page limits will not be reviewed. Any documentation not specifically requested will not be reviewed.

4.5 Service Delivery Plan (20-page limit; 100 Points)

The service delivery plan should describe in a clear and succinct manner the Bidder's internal business processes to effectively and efficiently operate a managed care plan to meet all of the requirements in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", of the

"Model Contract", and the "Draft Medicaid Managed Care Manual" and in the questions outlined below. The use of data, workflows, charts, and other graphics to describe business processes will be considered. The Service Delivery Plan should include, but is not limited to, the following components:

4.5.1 **Eligibility, Enrollment and Disenrollment**: Provide a summary description of the Bidder's processes for meeting the requirements set forth in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.2, Covered Populations, Enrollment and Disenrollment" of the "Model Contract", including how the bidder will receive, report, and update member information including, but not limited to, daily and monthly member enrollment and disenrollment files and other updates relating to changes in membership status, including newborns and updated member demographics.

4.5.2 **Provider Networks and Access to Services**: Provide a summary of how the Bidder uses data and other sources of information to establish and maintain a robust geographically and culturally diverse provider network to assure a complete continuum of behavioral health, physical health, and preventive services to deliver the full array of In-Plan Services as outlined in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.3, "Covered Benefits, Service Requirements and Limitations", Section 3.4, "Behavioral Health Services", Section 3.6, "Telehealth", Section 3.7, "Early and Periodic Screening, Diagnosis and Treatment", Section 3,8, "Health Homes for Children Program", Section 3.9, "Extended Family Planning Program Services", Section 3.10, "Enhanced Services", and Attachment F-3.1 and F-4, "Schedule of In-Plan Services" and Schedule of In-Lieu of Services", of the "Model Contract" that assures timely access. The response should include the Bidder's knowledge of the current Rhode Island provider landscape, including behavioral health providers, primary care providers, acute care providers, long-term services and support providers, any gaps in the current network and how the Bidder will build a sufficient Provider Network that will address identified gaps and that specifically addresses the needs of the following populations:

4.5.2.1 Individuals with mental health and/or substance abuse issues;
4.5.2.2 Children and adolescents, including those who are involved with the Rhode Island Department of Children, Youth and Families;
4.5.2.3 Persons with a comorbid physical, mental health, and substance use conditions; and
4.5.2.4 Individuals who are racially and ethnically diverse.

4.5.3. **Member Services**:

4.5.3.1 Provide a summary of the Bidder's process for engaging and communicating with members upon enrollment to include how member communications are conducted before and after July 1, 2023, including, but not limited to, Welcome letters, ID cards, provider directory and member handbook, Primary Care Provider selection, Accountable Entity education and transition of care, if indicated. The summary should describe the Bidder's

strategies to communicate with Members who are difficult to reach, including:

4.5.3.1.1 Members who speak languages other than English as their primary language;
4.5.3.1.2 Members who are deaf, blind or visually impaired; and
4.5.3.1.3 Members who are from various cultures and Black Indigenous, People of Color (BIPOC).

4.5.3.2 Describe the Bidder's approach to include use of data, to establish, staff, and maintain a member facing business unit ("Member Services Department") dedicated to responding to questions, comments, Grievances, Appeals, and inquiries from members as described in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operational Requirements", Section 3.20, "Member Services" of the "Model Contract" and Chapter 6, "Critical Elements" of the Medicaid "Draft Medicaid Managed Care Manual". The Response should include at a minimum how the Bidder will provide for (including any use of subcontractors):

4.5.3.2.1 Member Call Center functions;
4.5.3.2.2 Translation and interpreter services;
4.5.3.2.3 A Member Advisory Committee to obtain feedback and ongoing quality and process improvements based on member feedback; and,

4.5.3.3 The Bidder should include any sanctions or corrective actions imposed on the Bidder during the last three (3) years due to any deficiencies in performance of contractual requirements related any of the Member services functions as described in Addendum F, "Agency Special Requirements", Attachment F-1, Scope of Work, Article 3, Operations Phase Requirements, Section 3.20, "Member Services" of the "Model Contract".

4.5.4 **Provider Services**: Provide a summary of the Bidder's process to maintain a Provider services function to timely and adequately respond to Providers' questions, comments and inquiries and adequately staff and operate the Provider Services function, to provide appropriate and timely responses to meet the Provider Services requirements in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.14, "Provider Networks and Requirements, Access to Care" of the "Model Contract". The response shall include at a minimum a summary level description of the Providers ability to:

4.5.4.1 Operate, staff and maintain a provider services toll-free telephone line;
4.5.4.2 Develop and provide an ongoing program of Provider education concerning the benefits and the needs of the member population; and,

4.5.4.3 Develop a Provider manual and make it available to all contracted Providers

4.5.5 Quality Management and Improvement: Provide the Bidder's approach to overall quality management and quality improvement (QM/QI) and specific strategies that will be used to advance Rhode Island's Medicaid Managed Care Quality Strategy across all programs and populations, including physical health and behavioral health as set forth Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.17, "Quality Assurance" of the "Model Contract". The response should include:

4.5.5.1 The Bidder's current QM/QI organizational plan description, goals, quality committees, and schedule of QM activities;

4.5.5.2 A summary description and organizational chart of its proposed QM/QI program, including a list of the Bidder's staff dedicated to and responsible for administering and operating the Bidder's QM/QI program as described in these sections, including the role of the Medical Director;

4.5.5.3 A description of incentives that will be implemented for providers, AEs and community-based organizations and members to incentivize delivery of the right care in the right place at the right time as envisioned through the Triple Aim; and

4.5.5.4 A paragraph summary of how the Bidder will identify quality improvement plans and projects to put in place, what potential topics may be, how the Bidder will use grievance, appeal, and service authorization information and data to inform and improve the quality of care and population health for members, and how the Bidder will monitor implementation and outcomes of the activities.

4.5.6 Alternative Payment Methodologies: Describe the Bidder's strategic plan and timeframe for developing APMs that mature along the LAN continuum over the course of the contract period as set forth in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.28, "Alternative Payment Methodologies", of the "Model Contract" and Chapter 5, "Financial Requirements" of the "Draft Medicaid Managed Care Manual". At a minimum, the response should include:

4.5.6.1 Any experience or lessons learned from the Bidder's work in other state Medicaid managed care programs, Medicare, or the Commercial marketplace.

4.5.6.2 Any current work that could be leveraged or any anticipated contracting challenges that may impact, either positively or negatively the Bidder's ability to meet the APM targets described in the "Model Contract".

4.5.6.3 The Bidder's plan to educate and engage both AEs and non-AE providers

4.5.7 **Grievance and Appeals**: Provide a description of how the Bidder ensures that all components of its grievance and appeals system adhere to State and federal requirements and Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.21, "Grievances and Appeals", of the "Model Contract" regarding the handling of member grievances and appeals. Include a summary of:

4.5.7.1 The Bidders policies and processes for adjudicating grievances and appeals;

4.5.7.2 Any monitoring protocols your organization has in place to ensure that all grievances and appeals are addressed timely; and

4.5.7.3 How your organization uses data to conduct ongoing evaluations of your protocols to meet State, federal and the "Model Contract" requirements.

4.5.7.4 Any sanctions or corrective actions imposed on the Bidder during the last three (3) years due to any deficiencies in performance of contractual requirements associated with the requirements described in Addendum F, "Agency Special Requirements", Attachment F-1, Scope of Work, Article 3, Operational Requirements, Section 3.21, "Grievances and Appeals," of the "Model Contract".

4.5.8 **Care Program Framework and Protocols:** A summary of the Bidders policies and procedures to meet the Care Program Framework and Protocols set forth in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.13 "Care Program and Continuity of Care" of the "Model Contract" and Chapter 8, "Care Program and Accountable Entities" of the "Draft Medicaid Managed Care Manual". The Response should include at a minimum how the Bidder will provide for:

4.5.8.1 The Division of duties and partnership expectation between the Bidder, Accountable Entities (AEs), and other Care Program participants.

4.5.8.2 Ensuring members have ongoing sources of care appropriate to their needs and are actively involved in decisions relating to their care.

4.5.8.3 Coordinating health-related
social services for all members with identified needs (based on HRA screening)

4.5.8.4 Continuity of care, for new and existing members, second opinions, coordinating out-of-plan benefits, and self-referrals.

4.5.9 **Claims and Encounter Data:** Describe how the Bidder will ensure that Medicaid encounter claims data submitted to EOHHS are timely, accurate, complete and consistent as described in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.26, "Claims Processing and Management Information Services (MIS)" of the "Model Contract" and the "Rhode Island

Medicaid Managed Care Encounter Data Quality Measurement, Thresholds and Penalties for Non-Compliance" in Chapter 4, "Claims and MIS", of the "Draft Medicaid Managed Care Manual".

4.5.10 **Program Integrity and Compliance:** Describe how your organization will meet the requirements in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.22, "Program Integrity, Fraud, Waste and Abuse" in the "Model Contract" to prevent, detect and respond to instances of fraud, waste and abuse (FWA) by providers and members. The response should describe all relevant practices, including methods used to detect aberrant billing patterns; prevent payment on improper claims; investigate suspected FWA; impose consequences for providers responsible for FWA; report pertinent information related to FWA investigations, refer suspected fraud to the appropriate authorities.

4.5.11 Describe the Bidder's staff of the unit that investigates FWA, including, the number of staff dedicated to FWA investigations, the level of experience and/or education required for staff members, and any relevant training that staff receive from your organization. Responses to this question should include proposed program integrity practices as they relate to both providers and members. Describe innovations the Bidder has or proposes to implement to analyze and report program integrity data, including at least one example of a successful innovation implemented.

4.6 Population Health, Diversity, Health Equity and Inclusion (15-page limit; 150 Points)

EOHHS seeks to advance health equity through Medicaid managed care population health management strategies, which are designed to promote health equity and redress health disparities to achieve optimal health outcomes for all individuals receiving Medicaid. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

4.6.1 Describe the Bidder's approach to, and experience with, improving population health for Medicaid populations including how principles of a population health approach will inform and guide its managed care program in Rhode Island. The Bidder should describe its population health management strategy, program structure, population health assessment, health activities, health experience, role in local initiatives, and quality of care and delivery. The response should include at a minimum:

4.6.1.1 Sources and types of data and information collected and used by the Bidder to inform your organization's population health strategies and initiatives, including the collection and utilization of data regarding social determinants of health (SDOH);

4.6.1.2 The criteria and thresholds for risk stratification and how risk stratification informs its organization's population health strategies;

4.6.1.3 Member outreach and engagement strategies;

4.6.1.4 Collaboration, coordination, and data sharing with other entities, including community-based organizations, that impact population health; and

4.6.1.5 How the Bidder evaluates the impact of its population health strategies on health outcomes to inform the development of and updates to the Bidder's health equity strategy and quality plans as required in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, Operations Phase Requirements", Section 3.12 "Population Health" and Section 3.17 "Quality Assurance" of the "Model Contract".

4.6.2 Describe the Bidder's plan to ensure a system of care for children with serious emotional disturbances. The response should include a detailed example, including the data used by the Bidder for:

4.6.2.1 Early identification of symptoms to ensure interventions occur as soon as needs are identified;

4.6.2.2 Coordination with Early Intervention providers and programs;

4.6.2.3 Coordination of the ICP and Individualized Service/Education Plan; and

4.6.2.4 How the bidder will ensure appropriate access to a full continuum of services to prevent higher level or out of home placement.

4.6.3 Describe how the Bidder will identify and address the social determinants of health (SDOH) needs affecting its membership in the context of the Bidder's population health management strategy. Include an example of the Bidder's recent experience and success addressing SDOH to improve health equity and population health outcomes, including your organization's approach to collecting SDOH data. Include at least one (1) example that demonstrates how the Bidder used data to identify an issue impacted by SDOH, which interventions were developed, how the impacts of the interventions were assessed, and outcomes were achieved.

4.6.4 Describe the Bidder's current utilization of community health workers, peer support specialists, and doulas in any capacity within its managed care programs. The response should include how these workers are utilized and how performance is measured and evaluated.

4.6.5 Describe the Bidder's experience and successes in identifying, addressing, and mitigating racial and ethnic disparities within a Medicaid population. Include the metrics used to evaluate the program, the measurable improvements achieved and describe how long the improvements have been maintained.

4.6.6 Describe the Bidder's data collection procedures related to enrollee's race, ethnicity, language, disability status (RELD data), geography, and how such data informs the provision of culturally and linguistically appropriate services for members. If the Bidder does not currently collect some types of RELD and geographic data, describe how the Bidder plans to capture this data during the first two (2) years of the Contract award.

4.7 Quality and Performance Improvement (10-page limit; 150 Points)

4.7.1 Describe how the Bidder will further incentivize AEs and other providers, to address health disparities and the social determinant needs of members, improve health equity in access to and delivery of health care services, and improve adult and child health outcomes. Address the following items in the response:

4.7.1.1 Provide examples of the types of APM arrangements, types of Providers that participated in APM arrangements, actual or anticipated number of members served under APM arrangements and indicate whether the examples are planned or implemented.

4.7.1.2 How the Bidder assesses an AE or Provider's capacity and ability to contract under an APM arrangement and evaluates whether the AE or Provider is able to progress along the LAN framework;

4.7.1.3 How the Bidder shares quality, utilization, cost, and outcomes data with AEs and Providers participating in these arrangements, supports AEs and Providers to be successful under these reimbursement arrangements, and implements strategies to reduce AE and Provider administrative burden; and

4.7.1.4 How the Bidder evaluates the success of the APM arrangement, including the types of performance metrics and the evaluation process.

4.7.2 The Bidder must provide a table that identifies improvements it has made in quality indicators for population(s) similar to those of Rhode Island which includes, at a minimum, three (3) years of data for three (3) of the following six (6) HEDIS measures in which the Bidder has generated improvement and what activities the Bidder implemented which created those improvements. In each case the Bidder should note the state and population to which the measure results apply and include how the Bidder used data and data analysis to inform those actions/initiatives, and how the Bidder will implement those strategies in Rhode Island.

4.7.2.1 Breast Cancer Screening (BCS)
4.7.2.2 Asthma Medication Ratio (AMR)
4.7.2.3 Follow-Up After Hospitalization for Mental Illness – 7 Day
4.7.2.4 Prenatal and Postpartum Care (PPC)
4.7.2.5 Childhood Immunization Status – Combination 10
4.7.2.6 Comprehensive Diabetes Care: HbA1c control (<8.0%)

4.7.3 The Bidder is required to propose two ideas for collaborative quality improvements to improve Rhode Island Medicaid members' outcomes and reduce the cost of their care.

4.7.4 Describe at least one (1) data-driven clinical initiative that the Bidder initiated within the past twenty-four (24) months that yielded improvements in clinical care for the Medicaid population or a similar population. The response should provide sufficient detail regarding the data used to identify the need for the initiative, the process for designing, developing, and implementing the initiative, the measures used to evaluate the initiative and how the initiative will be maintained or adjusted to achieve continuous quality improvement.

4.8 Alternative Payment Model (APM) Approach (2-page limit; 100 Points)

4.8.1 Describe the Bidder's experience implementing and advancing Alternative Payment Methodology (APM) arrangements, as described in the Health Care Payment Learning and Action Network (LAN) alternative payment methodology framework, with Accountable Entities (Accountable Care Organizations), Providers, including physical health, behavioral health and community-based organizations.

4.8.2 Describe how the Bidder will engage both AEs and non-AE providers in APM arrangements and how the Bidder will ensure that payments to providers are increasingly focused on population health, appropriateness of care and other measures related to value. The response should also include how the Bidder will support providers and AEs in successful delivery system reform through these APM arrangements, including the types of technical assistance and data that the Bidder will offer to AEs and providers.

4.9 Member Services and Engagement (3-page limit; 60 Points)

4.9.1 Describe how the Bidder solicits and/or receives member feedback regarding member satisfaction, communications, service delivery, quality improvement, provider networks, and health plan operations, including how the feedback is used to improve your organization's operations. Describe efforts to use this feedback to assess how structural racism impacts member's experiences and to improve health outcomes for the Rhode Island Medicaid population.

4.9.2 Describe the Bidder's approach to member health education and health literacy. The response must include:

4.9.2.1 Demonstrated or planned strategies for conducting activities that promote and increase health literacy to members that speak languages other than English or have indicated a preference for communications in another non-English language; for persons who are deaf, blind, hard of hearing or visually impaired; and for those who cannot read;

4.9.2.2 Identification of the health education activities that are relevant given the populations covered, to include, BIPOC;

4.9.2.3 Evaluation of the effectiveness of strategies implemented and how your organization uses the information learned to make changes to its member engagement approach; and

4.9.2.4 The means of communication that will be employed to connect with members, including the use of internet, smart phone-based applications and other technologies to educate members regarding care pathways for their individual medical issues.

4.9.3 Describe the Bidder's plans to work with the Rhode Island community to engage members and Providers in a culturally appropriate way, understand the unique needs and resources within the community, and collaborate to meet the needs of members within those communities.

4.10 Provider Network/Provider Services (10-page limit; 70 Points)

4.10.1 Describe how the Bidder is working to diversify its provider network to meet the cultural and linguistic needs and preferences of the organization's

members, including how the Bidder will ensure its provider networks are reflective of the RI communities. The response should include at a minimum, an example of how the Bidder identifies the cultural, linguistic and diversity gaps in their provider network, the outreach and incentives used to formalize agreements with these providers and the process and data used by the plan to conduct ongoing evaluation of provider network diversity.

4.10.2 Describe the Bidder's experience developing its behavioral health provider network, including coordination, and contracting with local community behavioral health clinics and providers to manage services for adult members with behavioral health disorders, including those with chronic, co-occurring, and/or severe substance use disorders. Describe the services, types of providers, and approaches the Bidder will use to effectively manage the care for these members and provide evidence to show how these approaches have been successful.

4.10.3 Provide an example of an innovative approach the Bidder took within the last three (3) years for the following scenarios, the results achieved, and how you will apply this experience to Rhode Island's Medicaid managed care program:

4.10.3.1 Providing integrated behavioral and physical health services;
4.10.3.2 Advanced payment methods or incentives to co-locate services in primary care setting in support of advancing primary care.
4.10.3.3 Advancing the use of behavioral health evidence-based practices.

4.10.4 Describe the Bidder's proposed approach to offering, promoting, and supporting the appropriate and effective use of telehealth services to increase access and health equity for Rhode Island Medicaid members. The response should assume a post-pandemic environment where access would be balanced with appropriate utilization management and timely access to office-based care that meets the time, distance and availability standards included in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.14, "Provider Networks and Requirements, Access to Care" in the "Model Contract".

4.10.5 Describe the Bidder's approach to reimbursement rate development for hospitals, physicians, clinics, behavioral health providers and other providers who provide unique or are especially important to the Medicaid population.

4.10.6 Describe the Bidder's relevant experience and proposed approach for delivering behavioral health benefits to RI Medicaid managed care members in accordance with the requirements outlined in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3., "Operations Phase Requirements", Section 3.4, "Behavioral Health" of the "Model Contract". Include in your response:

4.10.6.1 Processes for ensuring compliance with the Mental Health Parity and Addictions Equity Act;
4.10.6.2 Strategies to integrate behavioral and physical health services, including proposed approach for meeting all minimum required components in the "Model Contract";

4.10.6.3 Strategies to improve coordination between AEs, primary care physicians, and MAT and behavioral health providers;

4.10.6.4 Proposed processes for crisis services; and

4.10.6.5 Any differences in your approach between adults and children/youth.

4.10.7 If the Bidder intends on subcontracting to a third party to deliver behavioral health benefits, the Bidder should identify the organization and discuss the existing relationship. The Bidder should identify the tasks to be performed by the Subcontractor and how the Bidder will perform oversight of the behavioral health Subcontractor and ensure that the subcontracted delegation does not compromise the delivery of behavioral health benefits and will further support and promote the integrated delivery of physical and behavioral health benefits.

4.11 Care Program and Coordination and Case Scenarios (20-page limit; 250 Points)

The Bidder will be responsible for developing a comprehensive Care Program that encompasses the full continuum of care management and coordination activities. The overarching goal of the Care Program is to provide members' access to all services and supports needed to maximize their health, employ person-centered strategies that promote independence and quality of life, and provide coordinated and cost-effective care.

4.11.1 Describe how the Bidder's Health Risk Assessment (HRA) will be completed for all members within ninety (90) days for newly enrolled members and annually thereafter and how the results of the HRA will be utilized. At minimum, the response should include:

4.11.1.1 How the Bidder will outreach and engage the member throughout the overall HRA process in a culturally competent way and in accordance with the members preferred language and method of communication.

4.11.1.2 How the HRA will be used to identify or stratify members who may require more intensive care management activities, services beyond the traditional medical model and that incorporates whole-person care principles.

4.11.1.3 How the Bidder will use the HRA to identify immediate service delivery needs for continuity of services (e.g., medications, assistive medical technology or supplies, ongoing relationships with providers, potential needs for prior authorizations or special arrangements to assure continuity with current providers, and potential met and unmet needs for assistance in accessing services and/or identifying providers);

4.11.1.4 How the Bidder will introduce members to the assistance provided by care management either by the Health Plan, AE, and /or an established provider or community care manager; and

4.11.1.5 How the results of the HRA and other data sources will be used to differentiate between members for whom care coordination is sufficient or for whom a more intensive level of care management and support may be necessary.

4.11.2 Describe how the Bidder will assess AE capabilities to perform delegated care program functions for AE-attributed members in accordance with NCQA delegation standards. The Bidder should describe its approach to delegation

and partnership with AEs by describing the clear delineation of roles, implementation of a joint operating structure, supports provided to aid AE led care programming (including data sharing, technical assistance, and financial support), and mechanisms for effective oversight of AEs performing Care Program activities for members.

4.11.3 Describe the Bidders approach to development of Individual Care Management Plans (ICPs) for members receiving Care Management and Complex Case Management. The response should include how the Bidder will develop the ICP with active member/family participation and reflect the results of a comprehensive assessment of care needs, including plans to mitigate impacts of social determinants of health and how the patient's cultural background, language preferences, priorities and goals will be reflected in the plan. The Bidder should provide an example of a recent experience in ICP development that demonstrated member/family engagement, how the Bidder ensured the member's understanding of the care he/she would receive, and the providers who were engaged in the development of the plan.

4.11.4 Case Scenarios

Coordination with other programs and services provided by various inter and intra-Departmental Programs are essential to ensuring that member's needs are addressed, fragmentation and duplication of services are minimized and that services are delivered cost effectively. The following case scenarios present situations that present the types of situations that Contractors awarded as part of this solicitation will have the opportunity to influence. Describe your approach to each of the following four (4) case scenarios:

4.11.4.1 <u>Scenario 1</u>

John is a thirteen (13) year-old male receiving Applied Behavior Analysis. He attends a specialized private ABA-day school and is diagnosed with Autism Spectrum Disorder. John currently resides with his birth parents and his eleven (11) year old brother at home.

John's treatment plan includes the following treatment goals: safety and behavior, expressive language, self-help skills, toileting, increasing play skills, typing skills, exercise routine, and conversation/ communication skills. A Functional Behavior Assessment was conducted, and a Behavior Intervention Plan was developed in March to address aggression, elopement, and mouthing.

One (1) year after intake: John's primary staff took a leave of absence causing a reduction in the number of hours served. Aggression increased and community outings did not occur during this period due to parent concerns about safety in the community. Dressing, bathing, toothbrushing, and toileting were put on hold per parent request while reintroducing demands after lapse in service. Parent's reported John having at least one major disturbance each night.

Two (2) years after intake: There was a decrease in shifts primarily due to lack of staff availability as well as several staff that were not a good fit for the home and parents

requested, they not return. Specifically, two (2) experienced staff were fired by parents due to personality conflicts.

During this time period, John had an increase in aggression, bolting, and disrobing. A new behavior was targeted for reduction, head banging, occurring at an average of nine (9) per session. Due to significant behavioral challenges the primary focus during this time period has been on safety and increasing appropriate behavior. Parents reported being overwhelmed and feeling that John needs a more intensive service or residential placement out of the home. Meetings were held with John's team, including DCYF and a family advocate to review needs and plan for safety while options/needs for more intensive services were explored. The clinician developed a safety protocol for head banging behavior.

John has made progress in many areas while receiving ABA services, however, his challenging behavior, while variable, has generally continued to increase with age. The increase in challenging behavior has put the safety of himself and his family increasingly more at risk. While parent's have been able to manage in the past, they have recently reported being overwhelmed and possibly incapable of managing John.

Describe the case management process for John and his family including identifying and securing treatment at the appropriate level of care consistent with his current and future treatment needs, the family support services the Bidder will put into place for this member and his family. The response should include at a minimum:

4.11.4.1.1 How Case Management will be coordinated with the local Behavioral Health Provider's Case Manager, John's ABA day-school and DCYF who have been working with the member and family;

4.11.4.1.2 How the Bidder will ensure the member's interagency service plan and ICP are coordinated and updated to reflect the services and necessary supports to meet John and his family's increasing needs and allow John to be served in the least restrictive environment;

4.11.4.1.3 How the Bidder will address staffing capacity needs of the provider network to ensure services are accessible and available as identified on the members ICP; and

4.11.4.1.4 The Bidder's process to continuously engage and communicate with the family and school to ensure that their needs are being met.

4.11.4.2 <u>Scenario 2</u>

Suzi is a nine (9) year old adopted girl currently in Bradley Hospital. Suzi has a history of abuse and neglect by her birth mother and other adults who were in and out of the home. Records also indicate that Suzi experienced severe sexual abuse as a child when she was residing with her father. At age two and a half (2 ½), Suzi's maternal uncle and aunt became her and her older brother's adoptive parents. They are loving, caring and invested in her care. Suzy's aunt and uncle have two children of their own but have been unable to handle her behaviors in their home although they still take care of her brother.

At this point, Suzy's aunt and uncle are reporting that they are not currently able to have her live with them. This family feels that they are unable to meet her needs and the safety of the other children would be compromised if Suzi returned to their home at this time unless they received considerable in-home assistance. Aunt and Uncle are both employed. He is a delivery truck driver who works the morning shift, and she works at a local motel during the afternoon shift. Neither have any physical or emotional problems nor is there any evidence of substance abuse. They own their own home which they maintain well. They have not visited Suzi consistently while she has been in Bradley but state their willingness to take her into their home 'under the right circumstances'. Suzi does well in school academically, however her school records indicate that she is boisterous, hyper, oppositional, and argumentative with peers and staff. Her peer relationships have been testy and confrontational. She has made verbal threats to hurt her peers, but she has not acted on her threats. Suzy has difficulty coping with feelings of anger, rejection, depression, and anxiety as she becomes aggressive, oppositional, and defiant. She does not injure others with her aggression, but she often destroys belongings. She has denied any thoughts of suicide. She has difficulty accepting limits and following directions of adults and authority figures. She becomes easily frustrated and will act out aggressively (e.g., by pushing chairs, slamming doors) during group activities. In addition, Suzy has poor personal boundaries, difficulty forming meaningful attachments, wetting, and soiling herself when she is angry, inappropriate touching of peers, impulsivity, low self-esteem, feels unwanted, has poor social judgment, and has conflicting feelings towards foster care which all contribute to her poor social adjustment. Her personal hygiene has been variable.

Describe the case management process for Suzi and her adoptive parents including identifying and securing treatment at the appropriate level of care consistent with her current and future treatment goals, member and family supports to address the needs for this member and her family including discharge planning, if appropriate. The response should include at a minimum:

4.11.4.2.1 How the Bidder will facilitate timely and appropriate hospital discharge for the member;

4.11.4.2.2 The Bidder's process for case management before and after the hospitalization to ensure there is no gap in transitions of care, as well as how Case Management will be coordinated with local providers, the school, and DCYF;

4.11.4.2.3 How the discharge plan will be coordinated and facilitated including linkages to treatment Providers and other providers identified on the members interagency services plan;

4.11.4.2.4 How the Bidder will facilitate the interagency service planning and ICP process for this member and family; and,

4.11.4.2.5 How the Bidder will work with DCYF Case managers to facilitate and support the timely placement of the member with her aunt and uncle.

4.11.4.3. <u>Scenario 3</u>

Janet is a twenty-five (25) year old female with a diagnosis of Major Depressive Disorder (MDD), Post Traumatic Stress Disorder (PTSD), and Anxiety with a history of

hospitalizations due to self-harm. Janet was admitted to the hospital two (2) months ago due to suicidal ideation and aggression. While hospitalized Janet has also been evicted from her apartment and lost her part-time job. Janet is clinically ready for discharge; however, she has no confirmed housing available and no stable source of income to support her discharge.

Describe the case management process for Janet including discharge planning, identifying and securing treatment at the appropriate level of care, and support services to address her housing, employment and other health related social needs upon discharge. The response should include at a minimum:

4.11.4.3.1 Case management before and after the discharge to ensure there is no gap in transitions of care, including linkages to treating Providers;

4.11.4.3.2 How Case Management will be coordinated with the local Behavioral Health Provider's Case Manager, and other community-based providers, including local housing support providers, employment and training providers, connections to other supports such as the Supplementary Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF), Social Security, etc.;

4.11.4.3.3 How to ensure the member engages in services in a timely manner and remains engaged after discharge; and,

4.11.4.3.4 Process to develop the discharge and ongoing ICP for the Janet that includes her engagement and that of the other treatment and social service providers.

4.11.4.4 <u>Scenario 4</u>

Dianna is a thirty-eight (38) year old woman, approximately sixteen (16) weeks pregnant, living in western Rhode Island. She has had two (2) previous high-risk pregnancies, which resulted in stillborn births. She does not have a PCP, and other than her previous high-risk pregnancies, she does not note any significant health issues. She is overweight and a smoker but has been trying to quit since she is pregnant. She is having difficulty finding a provider that is willing to provide prenatal care and deliver her baby due to the complexities that she experienced with her two (2) former pregnancies.
She is also homeless but has been living for the past month in a homeless women's shelter. She recently got a job as a cashier at the local superstore but is worried that being on her feet so much will not be suitable for the baby, so she is worried about losing her job as her pregnancy progresses.

Describe the approach for supporting Dianna throughout her pregnancy, delivery, and post-partum care. The response should include at a minimum:

4.11.4.4.1 How the Bidder will support Dianna getting regular primary and prenatal care;

4.11.4.4.2 How the Bidder will ensure follow up and care for Dianna's newborn, including EPSDT visits, follow up immunizations and necessary screenings;

4.11.4.4.3 What community and social supports will be provided to Dianna and her baby to ensure a healthy and stable environment for them both pre- and post-delivery; and,

4.11.4.4.4 How the Bidder will help to address Dianna's ongoing support needs, including housing, employment, and child care.

4.12 Information Systems and Encounter Data (8-page limit; 100 Points)

4.12.1 Provide a list with an explanation indicating any corrective action plans and/or sanctions imposed on the bidder in the last three (3) years related to encounter data submission and describe processes the bidder has implemented to ensure encounters pass the Rhode Island MIS validation process in compliance with 42 CFR §438.242. Include plans for working with a capitated Provider who fails to submit encounters or submits encounters without paid claims.

4.12.2 Describe the Bidder's proposed approach and experience with collecting, validating, and submitting complete and accurate encounter data in a timely manner to Rhode Island MIS.

4.12.3 Describe the Bidder's current and planned use and support for provider and member use of new and existing technology such as the state's health information exchange (HIE), CurrentCare, electronic health records (EHR), and personal health records, including incentives and strategies that will be used to promote use of EHRs and CurrentCare for providers and members.

4.12.4 Submit detailed narrative descriptions of the Bidders existing or planned systems to meet the requirements in the "Model Contract" addressing, at a minimum, the functional areas listed below. The narrative response must describe the extent to which these systems are: (i) currently implemented as opposed to planned; and (ii) integrated (or planned to be integrated) with other systems, internal and external.

4.12.4.1 Eligibility, enrollment, and disenrollment management and data exchange.

4.12.4.2 Provider Network management, certification, enrollment, notification and confirmation file exchange;

4.12.4.3 Member and Provider information;

4.12.4.4 Report generation and transmission;

4.12.4.5 Care Program and Coordination system, including HRA results, risk stratification determination, tracking, and member and provider communication;

4.12.4.6 Claims processing, edits, corrections, and adjustments due to retroactive eligibility changes or other reasons;

4.12.4.7 Claims adjudication, payment, and coordination of benefits for claims with third party liability;

4.12.4.8 Encounter submissions, correction, voiding, and resubmission; and

4.12.4.9 Financial management and accounting activities.

4.13 Value-Added Services and In-Lieu of Services (ILOS) (1-page limit; 20 Points)

4.13.1. The Bidder may propose to offer value-added services. For each service proposed, provide the following:

4.13.1.1 A description of the service(s), including information on who is eligible to receive the service, and the proposed timeframe for implementation.

4.13.1.2 Describe the expected impact in terms of cost savings, and perceived qualitative value of the service(s).

4.13.1.3 Describe the Bidder's proposed method(s) of outreach to increase member awareness and utilization of the value-added service(s).

4.13.2 In addition, the Bidder may propose to have additional services be added to the list of in-lieu of services currently listed in Addendum F, "Agency Special Requirements", Attachment F-3.4 of the "Model Contract". Upon reviewing this list, provide the following:

4.13.2.1 A description of proposed additional service(s), including information on what service the ILOS is being offered in place of.

4.13.2.2 Describe any relevant experience providing this service in other states, and perceived qualitative and quantitative value of the service(s).

4.13.2.3 Describe the Bidder's proposed method(s) of education to providers regarding offering this service and outreach to increase member awareness and utilization of the service.

D. ISBE Proposal

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

SECTION 5: EVALUATION AND SELECTION

5.1 Evaluation Committee

Proposals will be reviewed by a technical evaluation committee ("TEC") comprised of staff from State agencies. Only State personnel will serve as voting members of the Committee. The TEC first shall consider the mandatory proposal requirements in Section 4.B before the TEC will evaluate the technical proposal requirements in Section 4.C. Bidders must receive a passing score for all of the mandatory proposal requirements before the TEC will proceed to evaluate the Technical Proposal Requirements in Section 4.C.

5.2 Evaluation Process and Scoring

The State will conduct a comprehensive and impartial evaluation of all bids. The Technical Proposals will be evaluated for completeness and quality against a set of criteria based described below under the General Evaluation and Technical Scoring Requirements.

A. Minimum Score

The Bidder must receive a minimum of **750 (75%)** out of a maximum of **1000** points in Section 4.C Technical Proposal Requirements. Bidders scoring less than **750** points in Section 4.C Technical Proposal Requirements will not have the ISBE participation proposals opened or evaluated; such proposals will not receive further consideration.

As total possible evaluation points are determined, Bidder ISBE proposals will be evaluated and assigned up to 6/60 points for ISBE participation.

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

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

Mandatory Proposal Requirements	**Possible Points**
4.1. Letter of Transmittal	Pass/Fail
4.2 Financial Viability	Pass/Fail
4.3 Executive Summary	Pass/Fail
4.4 Bidder's Experience, Understanding and Readiness to Perform	Pass/Fail
Technical Proposal Requirements	
4.5 Service Delivery Plan	100
4.6 Population Health, Diversity, Health Equity and Inclusion	150
4.7 Quality and Performance Improvement	150
4.8 Alternative Payment Model (APM) Approach	100
4.9 Member Services and Engagement	60
4.10 Provider Network/Provider Services	70
4.11 Care Program and Coordination and Case Scenarios	250

4.12 Information Systems and Encounter Data	100
4.13 Value-Added Services and In-Lieu of Services	20
Total Possible Technical Points	**1000 Points**
ISBE Participation**	60 Bonus Points
Total Possible Points	**1060 Points**

Section	Mandatory Requirements Scored on Pass / Fail Basis Question	Pass	Fail
4.1.2 Letter of Transmittal			
4.1.2.1	The transmittal letter includes a statement that the Bidder has read, understands and accepts the conditions and limitations of this RFQ, the "Model Contract", and the "Draft Medicaid Managed Care Manual".		
4.1.2.2	The transmittal letter includes a statement that the Bidder's Technical Proposal is effective from the date of submission and that the proposal remains in effect for an additional year.		
4.1.2.3	The Bidder identified in the transmittal letter its proposed sub-contractor(s) (excluding direct health service providers) arrangements that will be used in performance of services in the proposal.		
4.1.2.4	The transmittal letter includes a statement that the Bidder attests to the accuracy and truthfulness of all information contained in the Bidder's response to the RFQ.		
4.1.2.5	The Bidder attests that the Bidder has read, understands, and accepts the mandatory requirements, responsibilities, and Terms and Conditions of this RFQ, the "Model Contract" and the "Draft Medicaid Managed Care Manual".		
4.1.2.6	The Bidder accepts the State's Fiscal and Performance Requirements as set forth in Section 3.4 of the Scope of Work and the actuarial rate development and rate setting process outlined in Appendix D: "Managed Care Organization Request for Qualification: Financial Bidder's Packet"		
4.1.2.7	The Bidder attest that its organization is an HMO that is either licensed by the Rhode Island Department of Business Regulation or will receive HMO licensure or approval to conduct business in Rhode Island no later than sixty (60) days after execution of an Agreement.		
4.1.2.8	The Bidder attests that the organization is in good standing with and has not been debarred from participation in any Federal or State health care programs, including Medicare, CHIP, and any state Medicaid program.		
4.1.2.9	The Bidder attests to being accredited by the National Committee for Quality Assurance ("NCQA") as a Medicaid managed care organization or otherwise for a newly entering plan, is NCQA accredited as a Medicaid managed care organization in another state and will achieve full accreditation for Rhode Island Medicaid within 12 months of the execution of the award under this RFQ and provides a copy of the NCQA Accreditation certification if currently accredited.		
4.1.2.10	The Bidder attests that the organization has or will obtain NCQA distinction in Multicultural Health Care within 24 months of execution of the award under this RFQ. If the bidder is currently holds an NCQA certificate in Multicultural Health Care Distinction a copy of the NCQA certification is provided if the Bidder has stated it has received.		
4.1.2.11	The bidder attest that its organization and its Subcontractors have the skills, qualifications, expertise, financial resources, and experience necessary to provide the services and deliverables described in the RFQ, the Bidder's Proposal, and the "Model Contract" in an efficient, cost- effective manner, with a high degree of quality and responsiveness, and has performed similar services for other public or private entities.		
4.1.2.12	The Bidder attests that it abides by Affirmative Action policies and procedures and that the Bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, sexual orientation, political affiliation, national origin, or handicap and complies with the Americans with Disabilities Act.		
4.1.2.13	The Bidder attests that it has no moral or religious objections to providing any of the Covered Benefits described in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Section 3.3, "Covered Benefits, Service Requirements and		

	Limitations", and Attachments F-3.1, "Schedule of In-Plan Benefits" and F-3.4, "Schedule of In-Lieu of Services" in the "Model Contract".		
4.2 Financial Viability			
4.2.1	The Bidder provided evidence of the Bidder's financial viability and solvency, as well as any adverse factors that may affect the Bidder's financial viability including but not limited to bankruptcy proceedings, major lawsuits, fines, etc. The Bidder has satisfactorily demonstrated to EOHHS that it is able to meet the solvency requirements set for through the Rhode Island Office of the Health Insurance Commissioner (OHIC). The Bidder(s) provided a description and/or provided evidence of financial solvency as a Health Plan operating in Rhode Island or outside of Rhode Island. The following minimum required documents were provided by the Bidder(s): **4.2.1.1** 2019 and 2020 Annual NAIC Financial Statements; **4.2.1.2** Most recent Quarterly NAIC Financial Statement; **4.2.1.3** 2019 and 2020 Annual Audited Financial Statements; **4.2.1.4** 2019 and 2020 Annual Report to Owners, Shareholders, Members, and Others; **4.2.1.5** Company's General Liability and Directors' and Officer's Insurance Coverages**;** **4.2.1.6** Claims Reinsurance Coverage and attachment points; and, **4.2.1.7** Where applicable, evidence that the parent Company provides 100% of subsidiary's financial backing If the Bidder is newly entering the Rhode Island market the bidder provided comparable documentation to demonstrate financial solvency and compliance with Rhode Island requirements. In addition, if bidder is newly entering the Rhode Island market the bidder provided expected sources of capital funding to ensure financial viability to meet the solvency requirements set forth through the Rhode Island Office of the Health Insurance Commissioner (OHIC).		
4.3 Executive Summary			
4.3.1	The Bidder included a description of its experience serving the Medicaid population under a risk-based contract. If the Bidder does not have specific experience in Rhode Island, the Bidder described its experience serving the Medicaid population in a state similar to that of Rhode Island within that past three (3) years along with a description of the size and scope of the previous engagement.		
4.3.2	The Bidder demonstrated an understanding of the Rhode Island environment; the conditions surrounding this procurement and knowledge and experience with the Medicaid population. The Bidder described potential promising approaches to providing Medicaid services in a way that meets the unique needs of the enrolled Rhode Island Medicaid population. For Bidders not currently serving as a Medicaid managed care plan in Rhode Island, the Bidder described its related experience in other states.		

4.3.3	The Bidder included a description of whether or not the Bidder currently participates on the Rhode Island Heath Insurance Exchange, HSRI. If not a current participant, the Bidder indicates whether or not the Bidder is willing to participate within twenty-four (24) months of an award under this RFQ.		
4.3.4	The Bidder described how it will establish and maintain partnerships with Rhode Island Accountable Entities in the delivery of care for Medicaid members and how it will assist the State with transforming Rhode Island's healthcare system under the AE delivery model. The Bidder described how it will establish the necessary supports and appropriate metrics to help both measure and incent progress toward the State's healthcare system transformation and Alternative Payment Methodology targets identified in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.28, "Alternative Payment Methodologies" of the "Model Contract" and Chapter 5, "Financial Requirements" of the "Draft Medicaid Managed Care Manual".		
4.3.5	The Bidder included a description of the Bidder's ability to be ready to serve members by July 1, 2023.		
4.3.6	The Bidder included a description of areas of capability still under development, as applicable, accompanied by realistic timeframes for completion.		
4.4 Bidder's Experience, Understanding and Readiness to Perform			
	The Bidder provided a high-level description of its organization, including an organizational chart to reflect overall reporting structure for the delivery of services requested in this RFQ and the "Model Contract" as well as a description of the Bidder's administrative capacity and capabilities and readiness to carry out all duties and responsibilities under this RFQ, including the "Model Contract" and "Draft Medicaid Managed Care Manual". The description included, the following components, at a minimum:		
4.4.1.1	**Staff Qualifications** – The Bidder provided staff resumes/CV and described the qualifications and experience of key staff who will be involved in the delivery of services identified in this RFQ, Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.1, "Contract Administration and Management" of the "Model Contract" including their experience in the delivery of services requested in this RFQ. Resumes including managed care experience are provided for: Chief Executive Officer (CEO); Medical Director; Chief Diversity, Equity, and Inclusion (DEI) Officer; Chief Financial Officer (CFO); Privacy Official; Security Official; and individuals with management responsibility for the following functional areas: a) Members services; b) Provider network development and management; c) Medical management and quality assurance (including Care Program, benefit administration, utilization review (UR), and quality assurance and improvement); d) MIS and claims processing; e) Grievances and Appeals; f) Reporting; g) Program integrity and compliance; h) Accountable Entity Programs; and i) Special Investigative Units for Fraud, Waste, and Abuse.		

4.4.1.2	**Plan for Promoting Workforce Diversity, Equity and Inclusion –** The Bidder provided a description of the Bidder's plan for promoting workforce diversity, equity and inclusion at all levels with its organization. The response included the organizational goals and benchmarks that the Bidder has set to become a more inclusive and diverse organization and/or the steps the bidder has or will take to address structural racism, unconscious and implicit bias within its organization. The response also described how the bidder will evaluate current organizational efforts, human resources practices, track progress and continue to improve the organizational structure, policies and processes to support workforce diversity, inclusivity and equity.		
4.4.1.3	**Board Members** – The Bidder provided a description of the structure of the organizations board, role of the Bidders' board members in governance and policy making, how conflicts of interest are addressed and prohibited, and specified the manner in which Medicaid members will be represented in an advisory and decision-making capacity for the services delivered as a result of this RFQ.		
4.4.1.4	**Capability, Capacity, and Qualifications of the Bidder** – The Bidder provided a detailed description of the Bidder's experience as a Medicaid managed care organization providing the scope of services similar to those set forth in this RFQ. The Bidder provided a list of three (3) relevant client references, including the client names, addresses, contact names with emails and phone numbers, dates of service and type(s) of service(s) provided for each of the client references.		
4.4.1.4.1	The Bidder provided a disclosure of any sanctions imposed on the Bidder during the last three (3) years due to deficiencies in performance of contractual requirements related to a contract(s) with a Medicaid agency. The Bidder included any sanctions associated with affiliates and/or subsidiaries of the Bidder that are expected to be used in performance of a contract awarded as a result of this solicitation. For each sanction identified, the bidder provided the following: **4.4.1.4.1.1** Date of the sanction. **4.4.1.4.1.2** Brief description/reason for the sanction. **4.4.1.4.1.3** Actions taken to address the performance deficiency. **4.4.1.4.1.4** Dollar amount associated with any monetary sanction. **4.4.1.4.1.5** Brief description of any plan of correction enforced and resulting outcome.		

D. Technical Proposal Scoring:

In the second step, evaluators will score each written response across the technical proposal requirement domains. Within each technical proposal requirement domain, each scored item also has a weight. The weight of each evaluated item determines the number of points available for that item. Evaluators will assign each item a score on a scale from 0 to 5. The score will determine the percentage of available points the respondent will earn for that item. Scoring a "5" will result in the respondent earning 100% of available points; scoring a "4" will result in the respondent earning 80% of the available points; and so on. One thousand points (1000) points are available across all scored items. See Rating Factor Chart on the next page.

Example:

4.11.4.3, Case Scenario 3, is worth 25 points.

- **The evaluator uses the rating factor chart and determines a response to this item meets the state's defined criteria for a score of 3.**
- **Based on this scoring, the respondent will earn 15 points of the 25 points available for this item.**

Math to Determine the Score:
25*.60 = 15
The Bidder receives 15 Points for the written response to Case Scenario 3 (Question 4.11.4.3)

Rating for Technical Proposal Requirement Categories	Rating Factor	Conversion Factor
The response goes above and beyond all aspect of the question. All elements of the question were addressed, the approach is highly desirable to EOHHS and the response included sufficient detail and demonstrates expert level knowledge and understanding of the subject matter.	**5**	**100%**
The response is good and satisfies all aspects of the question and included some benefits above the requirements. All elements of the question were addressed, and the approach is desirable to EOHHS; however, the response was lacking in detail. The response demonstrated a strong knowledge and understanding of the subject matter, but not at an expert level.	**4**	**80%**
The response is acceptable and satisfies most aspects of the question. Nearly all of the elements of the question were addressed, and the approach is acceptable to EOHHS; however, the response was lacking in detail in order to fully evaluate the approach and demonstrated a minimal knowledge and understanding of the subject matter.	**3**	**60%**
The response is minimally acceptable and satisfies some of aspects the question. Most, but not all elements of the question were addressed, and the approach was lacking details and weakness were identified in at least two areas making the approach less desirable to EOHHS. The response was ambiguous and demonstrated some knowledge and understanding of the subject matter.	**2**	**40%**
The response is poor and fails to meet all or most of aspects of the question. The response did not address all elements of the question and lacked sufficient detail to evaluate the approach and EOHHS did not find the approach desirable. The response did not demonstrate knowledge and understanding of the subject matter.	**1**	**20%**
The response is unacceptable and fails to meet all aspects of the question or no response was provided for some or all parts of the question. The response is missing, or incomplete information was provided. EOHHS found the response completely undesirable. The response demonstrated a lack of understanding, was conflicting or confusing.	**0**	**0%**

Section	Technical Proposal: Service Delivery Plan Question	Maximum Points Possible	Maximum Percentage Value
4.5 Service Delivery Plan		**100**	**10.00 %**
4.5.1	**Eligibility, Enrollment and Disenrollment**: Provide a summary description of the Bidder's processes for meeting the requirements set forth in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.2, "Covered Populations, Enrollment and Disenrollment" of the "Model Contract", including how the bidder will receive, report, and update Member information including, but not limited to, daily and monthly Member enrollment and disenrollment files and other updates relating to changes in membership status, including newborns and updated member demographics.	10	
4.5.2	**Provider Networks and Access to Services**: Provide a summary of how the Bidder establishes and maintains a robust geographically and culturally diverse provider network to assure a complete continuum of behavioral health, physical health, and preventive services to deliver the full array of In-Plan Services as outlined in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.3, "Covered Benefits, Service Requirements and Limitations", Section 3.4, "Behavioral Health Services", Section 3.6, "Telehealth", Section 3.7, "Early and Periodic Screening, Diagnosis and Treatment", Section 3,8, "Health Homes for Children Program", Section 3.9, "Extended Family Planning Program Services", Section 3.10, "Enhanced Services", and Attachments F-3.1,"Schedule of In-Plan Benefits" and F-3.4, "Schedule of In-Lieu of Services", of the "Model Contract" that assures timely access. The response should include the Bidder's knowledge of the current RI provider landscape, including behavioral health providers, primary care providers, acute care providers, long-term services and support providers, any gaps in the current network and how the Bidder will build a sufficient Provider Network that will address identified gaps and that specifically addresses the needs of the following populations: **4.5.2.1** Individuals with mental health and/or substance abuse issues; **4.5.2.2** Children and adolescents, including those who are involved with the Rhode Island Department of Children, Youth and Families; **4.5.2.3** Persons with a comorbid physical, mental health, and substance use conditions; and\ **4.5.2.4** Individuals who are racially and ethnically diverse.	10	
4.5.3	**4.5.3.1 Member Services**: Provide a summary of the Bidder's process for engaging and communicating with Members upon enrollment to include how member communications are conducted before and after July 1, 2022, including, but not limited to, Welcome letters, ID cards, provider directory and member handbook, Primary Care Provider selection,	10	

	Accountable Entity education and transition of care, if indicated. The summary should describe the Bidder's strategies to communicate with Members who are difficult to reach, including: **4.5.3.1.1** Members who speak languages other than English as their primary language; **4.5.3.1.2** Members who are deaf, blind or visually impaired; and **4.5.3.1.3** Members who are from various cultures and Black Indigenous, People of Color (BIPOC). **4.5.3.2** Describe the Bidder's approach to establish, staff, and maintain a Member facing business unit ("Member Services Department") dedicated to responding to questions, comments, Grievances, Appeals, and inquiries from Members as described in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.20, "Member Services" of the "Model Contract" and Chapter 6, "Critical Elements" of the "Draft Medicaid Managed Care Manual". The Response should include at a minimum how the Bidder will provide for: **4.5.3.2.1** Member Call Center functions; **4.5.3.2.2** Translation and interpreter services; and, **4.5.3.2.3** A Member Advisory Committee to obtain feedback and ongoing quality and process improvements based on member feedback.		
4.5.4	**Provider Services**: Provide a summary of the Bidder's process to maintain a Provider services function to timely and adequately respond to Providers' questions, comments and inquiries and adequately staff and operate the Provider Services function, to provide appropriate and timely responses to meet the Provider Services requirements in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.14, "Provider Networks and Requirements, Access to Care" of the "Model Contract". The response shall include at a minimum a summary level description of the Providers ability to: **4.5.4.1** Operate, staff and maintain a provider services toll-free telephone line; **4.5.4.2** Develop and provide an ongoing program of Provider education concerning the benefits and the needs of the member population; and **4.5.4.3** Develop a Provider manual and make it available to all contracted Providers	10	
4.5.5	**Quality Management and Improvement:** Provide the Bidder's approach to overall quality management and quality improvement (QM/QI) and specific strategies that will be used to advance Rhode Island's Medicaid Managed Care Quality Strategy across all programs and populations, including physical health and behavioral health as set forth Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.17, "Quality Assurance" of the "Model Contract". The response should include: **4.5.5.1** The Bidder's current QM/QI organizational plan description, goals, quality committees, and schedule of QM activities;	10	

	4.5.5.2 A summary description and organizational chart of its proposed QM/QI program, including a list of the Bidder's staff dedicated to and responsible for administering and operating the Bidder's QM/QI program as described in these sections, including the role of the Medical Director; and **4.5.5.3** A description of incentives that will be implemented for providers, AEs and community-based organizations and members to incentivize delivery of the right care in the right place at the right time as envisioned through the Triple Aim; and **4.5.5.4** A paragraph summary of how the Bidder will identify quality improvement plans and projects to put in place, what potential topics may be, how the Bidder will use grievance, appeal, and service authorization information and data to inform and improve the quality of care and population health for members, and how the Bidder will monitor implementation and outcomes of the activities.		
4.5.6	**Alternative Payment Methodologies:** Describe the Bidder's strategic plan and timeframe for developing APMs that mature along the LAN continuum over the course of the contract period as set forth in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.28, "Alternative Payment Methodologies", of the "Model Contract" and Chapter 5, "Financial Requirements" of the "Draft Medicaid Managed Care Manual". At a minimum, the response should include: **4.5.6.1** Any experience or lessons learned from the Bidder's work in other state Medicaid managed care programs, Medicare, or the Commercial marketplace. **4.5.6.2** Any current work that could be leveraged or any anticipated contracting challenges that may impact, either positively or negatively the Bidder's ability to meet the APM targets described in the "Model Contract". **4.5.6.3** The Bidder's plan to educate and engage both AEs and non-AE providers	10	
4.5.7	**Grievance and Appeals**: Provide a description of how the Bidder ensures that all components of its grievance and appeals system adhere to State and federal requirements and Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.21, "Grievances and Appeals", of the "Model Contract" regarding the handling of Member grievances and appeals. Include a summary of: **4.5.7.1** The Bidders policies and processes for adjudicating grievances and appeals; **4.5.7.2** Any monitoring protocols your organization has in place to ensure that all grievances and appeals are addressed timely; **4.5.7.3** How your organization uses data to conduct ongoing evaluations of your protocols to meet State, federal and the "Model Contract" requirements; and **4.5.7.4** Any sanctions or corrective actions imposed on the Bidder during the last three (3) years due to any deficiencies in performance of contractual requirements associated with the requirements described in	10	

	Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.21, "Grievances and Appeals", of the "Model Contract".		
4.5.8	**Care Program Framework and Protocols:** A summary of the Bidders policies and procedures to meet the Care Program Framework and Protocols set forth in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.13 "Care Program and Continuity of Care" of the "Model Contract" and Chapter 8, "Care Program and Accountable Entities" of the "Draft Medicaid Managed Care Manual". The Response should include at a minimum how the Bidder will provide for: **4.5.8.1** The Division of Duties and partnership expectation between the Bidder, Accountable Entities (AEs), and other Care Program participants. **4.5.8.2** Ensuring members have ongoing sources of care appropriate to their needs and are actively involved in decisions relating to their care. **4.5.8.3** Coordinating health-related social services for all members with identified health needs (based on HRA screening) **4.5.8.4** Continuity of care, for new and existing members, second opinions, coordinating out-of-plan benefits, and self-referrals.	10	
4.5.9	**Claims and Encounter Data:** Describe how the Bidder will ensure that Medicaid encounter claims data submitted to EOHHS are timely, accurate, complete and consistent as described in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.26, "Claims Processing and Management Information Services (MIS)" of the "Model Contract" and "Rhode Island Medicaid Managed Care Encounter Data Quality Measurement, Thresholds and Penalties for Non-Compliance" in Chapter 4, "Claims and MIS" of the "Draft Medicaid Managed Care Manual".	10	
4.5.10	**Program Integrity and Compliance:** Describe how your organization will meet the requirements in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.22, "Program Integrity, Fraud, Waste and Abuse" in the "Model Contract" to prevent, detect and respond to instances of fraud, waste and abuse (FWA) by providers and members. The response should describe all relevant practices, including methods used to detect aberrant billing patterns; prevent payment on improper claims; investigate suspected FWA; impose consequences for providers responsible for FWA; report pertinent information related to FWA investigations, refer suspected fraud to the appropriate authorities. Describe the Bidder's staff of the unit that investigates FWA, including, the number of staff dedicated to FWA investigations, the level of experience and/or education required for staff members, and any relevant training that staff receive from your organization. Responses to this question should include proposed program integrity practices as they relate to both providers and Members. Describe innovations the Bidder has or proposes to implement to analyze and report program integrity data, including at least one example of a successful innovation implemented.	10	

Section Number	Technical Proposal: Key Elements Section Section / Title	Maximum Points Possible	Maximum Percentage Value
4.6	**Population Health, Diversity, Health Equity and Inclusion**	**150**	**15%**
4.6.1	Describe the Bidder's approach to, and experience with, improving population health for Medicaid populations including how principles of a population health approach will inform and guide its managed care program in Rhode Island. The Bidder should describe its population health management strategy, program structure, population health assessment, health activities, health experience, role in local initiatives, quality of care and delivery. The response should include at a minimum: **4.6.1.1** Sources and types of data and information collected and used by the Bidder to inform your organization's population health strategies and initiatives, including the collection and utilization of data regarding social determinants of health (SDOH); **4.6.1.2** The criteria and thresholds for risk stratification and how risk stratification informs your organization's population health strategies; **4.6.1.3** Member outreach and engagement strategies; **4.6.1.4** Collaboration, coordination, and data sharing with other entities, including community-based organizations, that impact population health; and **4.6.1.5** How the Bidder evaluates the impact of its population health strategies on health outcomes to inform the development of and updates to the Bidder's health equity strategy and quality plans as required in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.12 "Population Health" and Section 3.17 "Quality Assurance" of the "Model Contract".	**50**	
4.6.2	Describe the Bidder's plan to ensure a system of care for children with serious emotional disturbances. The response should include a detailed example, including the use of data used by the Bidder for: **4.6.2.1** Early identification of symptoms to ensure interventions occur as soon as needs are identified; **4.6.2.2** Coordination with Early Intervention providers and programs; **4.6.2.3** Coordination of the ICP and Individualized Service/Education Plan; **4.6.2.4** How the bidder will ensure appropriate access to a full continuum of services to prevent higher level or out of home placement.	**20**	
4.6.3	Describe how the Bidder will identify and address the social determinants of health (SDOH) needs affecting its membership in the context of the Bidder's population health management strategy. Include an example of the Bidder's recent experience and success addressing SDOH to improve health equity and population health outcomes, including your organization's approach to collecting SDOH data. Include at least one (1) example that demonstrates how the Bidder used data to identify an issue impacted by SDOH, which interventions were developed, how the impacts of the interventions were assessed, and outcomes were achieved.	**20**	

4.6.4	Describe the Bidders current utilization of community health workers, peer support specialists, and doulas in any capacity within its managed care programs. The response should include how these workers are utilized and how performance is measured and evaluated.	**20**	
4.6.5	Describe the Bidder's experience and successes in identifying, addressing, and mitigating racial and ethnic disparities within a Medicaid population. Include the metrics used to evaluate the program, the measurable improvements achieved and describe how long the improvements have been maintained.	**20**	
4.6.6	Describe the Bidder's data collection procedures related to enrollee's race, ethnicity, language, disability status (RELD data), geography, and how such data informs the provision of racially, culturally and linguistically appropriate services for Members. If the Bidder does not currently collect some types of RELD and geographic data, describe how the Bidder plans to capture this data during the first two years of the Contract award.	**20**	
4.7 Quality and Performance Improvement		**150**	**15%**
4.7.1	Describe how the Bidder will further incentivize AEs and other providers, to address health disparities and the social determinant needs of Members, improve health equity in access to and delivery of health care services, and improve adult and child health outcomes. Address the following items in the response: **4.7.1.1** Provide examples of the types of APM arrangements, types of Providers that participated in APM arrangements, actual or anticipated number of members served under APM arrangements and indicate whether the examples are planned or implemented. **4.7.1.2** How the Bidder assesses an AE or Provider's capacity and ability to contract under an APM arrangement and evaluates whether the AE or Provider is able to progress along the LAN framework; **4.7.1.3** How the Bidder shares quality, utilization, cost, and outcomes data with AEs and Providers participating in these arrangements, supports AEs and Providers to be successful under these reimbursement arrangements, and implements strategies to reduce AE and Provider administrative burden; and **4.7.1.4** How the Bidder evaluates the success of the APM arrangement, including the types of performance metrics and the evaluation process.	**60**	
4.7.2	The Bidder must provide a table that identifies improvements it has made in quality indicators for population(s) similar to those of Rhode Island which includes, at a minimum, three years of data for three of the following six (6) HEDIS measures in which the Bidder has generated improvement and what activities the Bidder implemented which created those improvements. In each case the Bidder should note the state and population to which the measure results apply and include how the Bidder used data and data analysis to inform those actions/initiatives, and how the Bidder will implement those strategies in Rhode Island. **4.7.2.1** Breast Cancer Screening (BCS)	**60**	

	4.7.2.2 Asthma Medication Ratio (AMR) **4.7.2.3** Follow-Up After Hospitalization for Mental Illness – 7 Day **4.7.2.4** Prenatal and Postpartum Care (PPC) **4.7.2.5** Childhood Immunization Status – Combination 10 **4.7.2.6** Comprehensive Diabetes Care: HbA1c control (<8.0%)		
4.7.3	The Bidder is required to propose two (2) ideas for collaborative quality improvements to improve Rhode Island Medicaid members' outcomes and reduce the cost of their care.	**20**	
4.7.4	Describe at least one (1) data-driven clinical initiative that the Bidder initiated within the past twenty-four (24) months that yielded improvements in clinical care for the Medicaid population or a similar population. The response should provide sufficient detail regarding the data used to identify the need for the initiative, the process for designing, developing and implementing the initiative, the measures used to evaluate the initiative and how the initiative will be maintained or adjusted to achieve continuous quality improvement.	**10**	
4.8 Alternative Payment Model (APM) Approach		**100**	**10%**
4.8.1	Describe the Bidder's experience implementing and advancing Alternative Payment Methodology (APM) arrangements, as described in the Health Care Payment Learning and Action Network (LAN) alternative payment methodology framework, with Accountable Entities (Accountable Care Organizations), Providers, including physical health, behavioral health and community-based organizations.	**50**	
4.8.2	Describe how the Bidder will engage both AEs and non-AE providers in APM arrangements and how the Bidder will ensure that payments to providers are increasingly focused on population health, appropriateness of care and other measures related to value. The response should also include how the Bidder will support providers and AEs in successful delivery system reform through these APM arrangements, including the types of technical assistance and data that the Bidder will offer to AEs and providers.	**50**	
4.9 Member Services and Engagement		**60**	**6%**
4.9.1	Describe how the Bidder solicits and/or receives member feedback regarding member satisfaction, communications, service delivery, quality improvement, provider networks, and health plan operations, including how the feedback is used to improve your organization's operations. Describe efforts to use this feedback to assess how structural racism impacts member's experiences and to improve health outcomes for the RI Medicaid population.	**20**	
4.9.2	Describe the Bidder's approach to Member health education and health literacy. The response must include: **4.9.2.1** Demonstrated or planned strategies for conducting activities that promote and increase health literacy to members that speak languages other than English or have indicated a preference for communications in another non-English language; for persons who are deaf, blind, hard of hearing or visually impaired; and for those who cannot read;	**20**	

	4.9.2.2 Identification of the health education activities that are relevant given the populations covered, to include, BIPOC; **4.9.2.3** Evaluation of the effectiveness of strategies implemented and how your organization uses the information learned to make changes to its member engagement approach; and **4.9.2.4** The means of communication that will be employed to connect with members, including the use of internet, smart phone-based applications and other technologies to educate members regarding care pathways for their individual medical issues.		
4.9.3	Describe the Bidder's plans to work with the Rhode Island community to engage Members and Providers in a culturally appropriate way, understand the unique needs and resources within the community, and collaborate to meet the needs of Members within those communities.	**20**	
4.10 Provider Network Management/Provider Services		**70**	**7%**
4.10.1	Describe how the Bidder is working to diversify its provider network to meet the cultural and linguistic needs and preferences of the organization's members, including how the Bidder will ensure its provider networks are reflective of the RI communities. The response should include at a minimum, an example of how the Bidder identifies the cultural, linguistic and diversity gaps in their provider network, the outreach and incentives used to formalize agreements with these providers and the process and data used by the plan to conduct ongoing evaluation of provider network diversity.	**10**	
4.10.2	Describe the Bidder's experience developing its behavioral health provider network, including coordination and contracting with local community behavioral health clinics and providers to manage services for adult members with behavioral health disorders, including those with chronic, co-occurring, and/or severe substance use disorders. Describe the services, types of providers, and approaches the Bidder will use to effectively manage the care for these Members and provide evidence to show how these approaches have been successful.	**10**	
4.10.3	Provide an example of an innovative approach the Bidder took within the last three (3) years for the following scenarios, the results achieved, and how you will apply this experience to Rhode Island's Medicaid managed care program: **4.10.3.1** Providing integrated behavioral and physical health services; **4.10.3.2** Advanced payment methods or incentives to co-locate services in primary care setting in support of advancing primary care. **4.10.3.3** Advancing the use of behavioral health evidence-based practices.	**5**	
4.10.4	Describe the Bidder's proposed approach to offering, promoting, and supporting the appropriate and effective use of telehealth services to increase access and health equity for Rhode Island Medicaid members. The response should assume a post-pandemic environment where access would be balanced with appropriate utilization management and timely access to office-based care that meets the time, distance and availability standards included in Addendum F, "Agency Special Requirements", Attachment F-1, "Scope of Work", Article 3, "Operations Phase Requirements", Section 3.14, "Provider Networks and Requirements, Access to Care" in the "Model Contract".	**10**	

4.10.5	Describe the Bidder's approach to reimbursement rate development for hospitals, physicians, clinics, behavioral health providers and other providers who provide unique or are especially important to the Medicaid population.	**10**	
4.10.6	Describe the Bidder's relevant experience and proposed approach for delivering behavioral health benefits to RI Medicaid managed care members in accordance with the requirements outlined in Attachment F-1, "Scope of Work", Article 3., "Operations Phase Requirements", Section 3.4, "Behavioral Health" of the "Model Contract". Include in your response: **4.10.6.1** Processes for ensuring compliance with the Mental Health Parity and Addictions Equity Act; **4.10.6.2** Strategies to integrate behavioral and physical health services, including proposed approach for meeting all minimum required components in the Model Managed Care Agreement; **4.10.6.3** Strategies to improve coordination between AEs, primary care physicians, and MAT and behavioral health providers; **4.10.6.4** Proposed processes for crisis services; and **4.10.6.5** Any differences in your approach between adults and children/youth.	**20**	
4.10.7	If the Bidder intends on subcontracting to a third party to deliver behavioral health benefits, identify the organization and discuss your existing relationship. The Bidder should identify the tasks to be performed by the Subcontractor and how the Bidder will perform oversight of the behavioral health Subcontractor and ensure that the subcontracted delegation does not compromise the delivery of behavioral health benefits and will further support and promote the integrated delivery of physical and behavioral health benefits.	**5**	
4.11 Care Program and Coordination and Case Scenarios		**250**	**25%**
	The Bidder will be responsible to develop a comprehensive Care Program that encompasses the full continuum of care management and coordination activities. The overarching goal of the Care Program is to provide Members' access to all services and supports needed to maximize their health, employ person-centered strategies that promote independence and quality of life, and provide coordinated and cost-effective care.		
4.11.1	Describe how the Bidder's Health Risk Assessment (HRA) will be completed for all members within 90 days for newly enrolled Members and annually thereafter and how the results of the HRA will be used. At minimum, the response should include: **4.11.1.1** How the Bidder will outreach and engage the member throughout the overall HRA process in a culturally competent way and in accordance with the members preferred language and method of communication. **4.11.1.2** How the HRA will be used to identify or stratify members who may require more intensive care management activities, services beyond the traditional medical model and that incorporates whole-person care principles. **4.11.1.3** How the Bidder will use the HRA to identify immediate service delivery needs for continuity of services (e.g. medications, assistive medical technology or supplies, ongoing relationships with providers, potential needs for prior authorizations or special arrangements to assure continuity with current providers, and potential met and unmet needs for assistance in accessing services and/or identifying providers);	**50**	

	4.11.1.4 How the Bidder will introduce members to the assistance provided by care management either by the Health Plan, AE, and /or an established provider or community care manager; and **4.11.1.5** How the results of the HRA and other data sources will be used to differentiate between members for whom care coordination is sufficient or for whom a more intensive level of care management and support may be necessary.		
4.11.2	Describe how the Bidder will assess AE capabilities to perform delegated care program functions for AE-attributed Members in accordance with NCQA delegation standards. The Bidder should describe its approach to delegation and partnership with AEs by describing the clear delineation of roles, implementation of a joint operating structure, supports provided to aid AE led care programming (including data sharing, technical assistance, and financial support), and mechanisms for effective oversight of AEs performing Care Program activities for Members.	**50**	
4.11.3	Describe the Bidders approach to development of Individual Care Management Plans (ICPs) for Members receiving Care Management and Complex Case Management. The response should include how the Bidder will develop the ICP with active member/family participation and reflect the results of a comprehensive assessment of care needs, including plans to mitigate impacts of social determinants of health and how the patient's cultural background, language preferences, priorities and goals will be reflected in the plan. The Bidder should provide an example of a recent experience in ICP development that demonstrated member/family engagement, how the Bidder ensured the Member's understanding of the care he/she would receive, and the providers who were engaged in the development of the plan.	**50**	
4.11.4 Case Scenarios		**--**	**--**
	Coordination with other programs and services provided by various inter and inter-Departmental Programs are essential to ensuring that member's needs are addressed, fragmentation and duplication of services are minimized and that services are delivered cost effectively. The following case scenarios present situations that present the types of situations that Contractors awarded as part of this solicitation will have the opportunity to influence. Describe your approach to each of the following four (4) case scenarios:		
4.11.4.1 <u>Scenario 1</u>	John is a thirteen (13)-year-old male receiving Applied Behavior Analysis (ABA). He attends a specialized private ABA-day school and is diagnosed with Autism Spectrum Disorder. John currently resides with his birth parents and eleven (11)-year-old brother at home. John's treatment plan includes the following treatment goals: safety and behavior, expressive language, self-help skills, toileting, increasing play skills, typing skills, exercise routine, and conversation/ communication skills. A Functional Behavior Assessment was conducted, and a Behavior Intervention Plan was developed in March to address aggression, elopement, and mouthing. One (1) year after intake: John's primary staff took a leave of absence causing a reduction in the number of hours served. Aggression increased and community outings did not occur during this period due to parent concerns about safety in the	**25**	

	community. Dressing, bathing, toothbrushing, and toileting were put on hold per parent request while reintroducing demands after lapse in service. Parent's reported John having at least one major disturbance each night. Two (2) years after intake: There was a decrease in shifts primarily due to lack of staff availability as well as several staff that were not a good fit for the home and parents requested, they not return. Specifically, two (2) experienced staff were fired by parents due to personality conflicts. During this time period, John had an increase in aggression, bolting, and disrobing. A new behavior was targeted for reduction, head banging, occurring at an average of nine (9) per session. Due to significant behavioral challenges the primary focus during this time period has been on safety and increasing appropriate behavior. Parents reported being overwhelmed and feeling that John needs a more intensive service or residential placement out of the home. Meetings were held with John's team, including DCYF and a family advocate to review needs and plan for safety while options/needs for more intensive services were explored. The clinician developed a safety protocol for head banging behavior. John has made progress in many areas while receiving ABA services, however, his challenging behavior, while variable, has generally continued to increase with age. The increase in challenging behavior has put the safety of himself and his family increasingly more at risk. While parent's have been able to manage in the past, they have recently reported being overwhelmed and possibly incapable of managing John. Describe the case management process for John and his family including identifying and securing treatment at the appropriate level of care consistent with his current and future treatment needs, the family support services the Bidder will put into place for this member and his family. The response should include at a minimum: **4.11.4.1.1** How Case Management will be coordinated with the local Behavioral Health Provider's Case Manager, John's ABA day-school and DCYF who have been working with the member and family; **4.11.4.1.2** How the Bidder will ensure the member's interagency service plan and ICP are coordinated and updated to reflect the services and necessary supports to meet John and his family's increasing needs and allow John to be served in the least restrictive environment; **4.11.4.1.3** How the Bidder will address staffing capacity needs of the provider network to ensure services are accessible and available as identified on the members ICP; and **4.11.4.1.4** The Bidder's process to continuously engage and communicate with the family and school to ensure that their needs are being met.		
4.11.4.2 **<u>Scenario 2</u>**	Suzi is a nine (9)-year-old adopted girl currently in Bradley Hospital. Suzi has a history of abuse and neglect by her birth mother and other adults who were in and out of the home. Records also indicate that Suzi experienced severe sexual abuse as a child when she was residing with her father. At age two and a half (2 ½), Suzi's maternal uncle and aunt became her and her older brother's adoptive parents. They are loving, caring and invested in her care. Suzy's aunt and	**25**	

	uncle have two children of their own but have been unable to handle her behaviors in their home although they still take care of her brother. At this point, Suzy's aunt and uncle are reporting that they are not currently able to have her live with them. This family feels that they are unable to meet her needs and the safety of the other children would be compromised if Suzi returned to their home at this time unless they received considerable in-home assistance. Aunt and Uncle are both employed. He is a delivery truck driver who works the morning shift, and she works at a local motel during the afternoon shift. Neither have any physical or emotional problems nor is there any evidence of substance abuse. They own their own home which they maintain well. They have not visited Suzi consistently while she has been in Bradley but state their willingness to take her into their home 'under the right circumstances'. Suzi does well in school academically, however her school records indicate that she is boisterous, hyper, oppositional, and argumentative with peers and staff. Her peer relationships have been testy and confrontational. She has made verbal threats to hurt her peers, but she has not acted on her threats. Suzy has difficulty coping with feelings of anger, rejection, depression, and anxiety as she becomes aggressive, oppositional, and defiant. She does not injure others with her aggression, but she often destroys belongings. She has denied any thoughts of suicide. She has difficulty accepting limits and following directions of adults and authority figures. She becomes easily frustrated and will act out aggressively (e.g., by pushing chairs, slamming doors) during group activities. In addition, Suzy has poor personal boundaries, difficulty forming meaningful attachments, wetting, and soiling herself when she is angry, inappropriate touching of peers, impulsivity, low self-esteem, feels unwanted, has poor social judgment, and has conflicting feelings towards foster care which all contribute to her poor social adjustment. Her personal hygiene has been variable. Describe the case management process for Suzi and her adoptive parents including identifying and securing treatment at the appropriate level of care consistent with her current and future treatment goals, member and family supports to address the needs for this member and her family including discharge planning, if appropriate. The response should include at a minimum: **4.11.4.2.1** How the Bidder will facilitate timely and appropriate hospital discharge for the member. **4.11.4.2.2** The Bidder's process for case management before and after the hospitalization to ensure there is no gap in transitions of care, as well as how Case Management will be coordinated with local providers, the school, and DCYF; **4.11.4.2.3** How the discharge plan will be coordinated and facilitated including linkages to treatment Providers and other providers identified on the members interagency services plan; **4.11.4.2.4** How the Bidder will facilitate the interagency service planning and ICP process for this member and family; **4.11.4.2.5** How the Bidder will work with DCYF Case managers to facilitate and support the timely placement of the member with her aunt and uncle.		
4.11.4.3 <u>Scenario 3</u>	Janet is a twenty-five (25)-year-old female with a diagnosis of Major Depressive Disorder (MDD), Post Traumatic Stress Disorder (PTSD), and Anxiety with a history of hospitalizations due to self-harm. Janet was admitted to the hospital two (2) months ago due to suicidal ideation and aggression. While hospitalized Janet has also been evicted from her	**25**	

	apartment and lost her part-time job. Janet is clinically ready for discharge; however, she has no confirmed housing available and no stable source of income to support her discharge. . Describe the case management process for Janet including discharge planning, identifying and securing treatment at the appropriate level of care, and support services to address her housing, employment and other health related social needs upon discharge. The response should include at a minimum: **4.11.4.3.1** Case management before and after the discharge to ensure there is no gap in transitions of care, including linkages to treating Providers; **4.11.4.3.2** How Case Management will be coordinated with the local Behavioral Health Provider's Case Manager, and other community-based providers, including local housing support providers, employment and training providers, connections to other supports such as the Supplementary Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF), Social Security, etc.; **4.11.4.3.3** How to ensure the member engages in services in a timely manner and remains engaged after discharge; and **4.11.4.3.4** Process to develop the discharge and ongoing ICP for the Janet that includes her engagement and that of the other treatment and social service providers.		
4.11.4.4 **Scenario 4**	Dianna is a thirty-eight (38)-year-old woman, approximately sixteen (16) weeks pregnant, living in western RI. She has had two (2) previous high-risk pregnancies, which resulted in stillborn births. She does not have a PCP, and other than her previous high-risk pregnancies, she does not note any significant health issues. She is overweight and a smoker but has been trying to quit since she is pregnant. She is having difficulty finding a provider that is willing to provide prenatal care and deliver her baby due to the complexities that she experienced with her two former pregnancies. She is also homeless but has been living for the past month in a homeless women's shelter. She recently got a job as a cashier at the local superstore but is worried that being on her feet so much will not be suitable for the baby, so she is worried about losing her job as her pregnancy progresses. Describe the approach for supporting Dianna throughout her pregnancy, delivery, and post-partum care. The response should include at a minimum: **4.11.4.4.1** How the Bidder will support Dianna getting regular primary and prenatal care; **4.11.4.4.2** How the Bidder will ensure follow up and care for Dianna's newborn, including EPSDT visits, follow up immunizations and necessary screenings; **4.11.4.4.3** What community and social supports will be provided to Dianna and her baby to ensure a healthy and stable environment for them both pre- and post-delivery. **4.11.4.4.4** How the Bidder will help to address Dianna's ongoing support needs, including housing, employment, and child care.	**25**	
4.12 Information Systems and Encounter Data		**100**	**10%**

4.12.1	Provide a list with an explanation indicating any corrective action plans and/or sanctions imposed on the bidder in the last three (3) years related to encounter data submission and describe processes the bidder has implemented to ensure encounters pass the Rhode Island MIS validation process in compliance with 42 CFR 438.242. Include plans for working with a capitated Provider who fails to submit encounters or submits encounters without paid claims.	**25**	
4.12.2	Describe the Bidder's proposed approach and experience with collecting, validating, and submitting complete and accurate encounter data in a timely manner to Rhode Island MIS.	**25**	
4.12.3	Describe the Bidder's current and planned use and support for provider and member use of new and existing technology such as the state's health information exchange (HIE), CurrentCare, electronic health records (EHR), and personal health records, including incentives and strategies that will be used to promote use of EHRs and CurrentCare for providers and members.	**20**	
4.12.4	Submit detailed narrative descriptions of the Bidders existing or planned systems to meet the requirements in the "Model Contract" addressing, at a minimum, the functional areas listed below. The narrative response must describe the extent to which these systems are: (i) currently implemented as opposed to planned; and (ii) integrated (or planned to be integrated) with other systems, internal and external. **4.12.4.1** Eligibility, enrollment, and disenrollment management and data exchange. **4.12.4.2** Provider Network management, certification, enrollment, notification and confirmation file exchange; **4.12.4.3** Member and Provider information; **4.12.4.4** Report generation and transmission; **4.12.4.5** Care Program and Coordination system, including HRA results, risk stratification determination, tracking, and member and provider communication; **4.12.4.6** Claims processing, edits, corrections, and adjustments due to retroactive eligibility changes or other reasons; **4.12.4.7** Claims adjudication, payment, and coordination of benefits for claims with third party liability;Encounter submissions, correction, voiding, and resubmission; and **4.12.4.8** Financial management and accounting activities.	**30**	
4.13 Value-Added Services and In-Lieu of Services (ILOS)		**20**	**2%**
4.13.1	The Bidder may propose to offer value-added services. For each service proposed, provide the following: **4.13.1.1** A description of the service(s), including information on who is eligible to receive the service, and the proposed timeframe for implementation. **4.13.1.2** Describe the expected impact in terms of cost savings, and perceived qualitative value of the service(s). **4.13.1.3** Describe the Bidder's proposed method(s) of outreach to increase member awareness and utilization of the value-added service(s).	**10**	

4.13.2	In addition, the Bidder may propose to have additional services be added to the list of in-lieu of services currently listed in Addendum F, "Agency Special Requirements", Attachment F-3.4, "Schedule of In-Lieu of Services" of the "Model Contract". Upon reviewing this list, provide the following: **4.13.2.1** A description of proposed additional service(s), including information on what service the ILOS is being offered in place of. **4.13.2.2** Describe any relevant experience providing this service in other states, and perceived qualitative and quantitative value of the service(s). **4.13.2.3** Describe the Bidder's proposed method(s) of education to providers regarding offering this service and outreach to increase member awareness and utilization of the service.	**10**	
	Subtotal of Points	**1000**	100%

***********Bidders may be required to submit additional written information or be asked to make an oral presentation before the TEC to clarify statements made in the proposal. ************

5.3 Contract Award and Special Conditions

The State reserves the right to disqualify or not consider any proposal that is determined not to achieve the State goals or be in the best interest of the State. Proposals found to be technically and/or substantively non-responsive will be rejected and not further considered. The State reserves the right to send clarifying questions and to receive clarifying responses from Bidders submitting proposals, request interview and presentations, request additional financial information, contact references, and/or use other appropriate means to evaluate a proposal and the bidder's qualifications per the approval of the State Purchasing Agent.

5.4 Readiness Review

For any successful Bidder, EOHHS will conduct a readiness review prior to the Operational Start Date in accordance with 42 C.F.R. § 438.66(d)to ensure the Bidder is prepared to perform the requirements of the "Model Contract". EOHHS will provide successful Bidders with a Readiness Review Schedule with timelines for completing all Readiness Review activities. The successful Bidder must complete all Readiness Review activities to the satisfaction of EOHHS no later than sixty (60) calendar days prior to the Operational Start Date, or a delayed Operational Start Date may be required. EOHHS reserves the right to continue review activities after the Operational Start Date, at its discretion.

SECTION 6: QUESTIONS

Questions concerning this solicitation must be e-mailed to the Division of Purchases at doa.purquestions1@purchasing.ri.gov no later than the date and time indicated on page one of this solicitation. No other contact with State parties is permitted. Please reference **RFQ # 7664814** on all correspondence. Questions should be submitted in writing in a Microsoft Word attachment in a narrative format with no tables. Answers to questions received, if any, shall be posted on the Division of Purchases' website as an addendum to this solicitation. It is the responsibility of all interested parties to monitor the Division of Purchases website for any procurement related postings such as addenda. If technical assistance is required, call the Help Desk at (401) 574-8100.

SECTION 7: PROPOSAL CONTENTS

A. Proposals shall include the following:

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

2. Two (2) completed original and copy versions, signed and sealed Appendix A. MBE, WBE, and/or Disability Business Enterprise Participation Plan. Please complete separate forms for each MBE, WBE or Disability Business Enterprise subcontractor/vendor to be utilized on the solicitation. *Do not include any copies in the Technical or Cost proposals.*

3. Technical Proposal The technical proposal submitted under this RFQ must address, in sufficient detail, how the Bidder will fulfill the expected goals and outcomes outlined in this RFQ and provide evidence of past or current experience showing how the Bidder's approach will meet the expected outcomes outlined in this RFQ. Data demonstrating improvements are to be provided to support the demonstrations. Bidders

are advised that simply repeating the outcomes and asserting that they will be performed will not be considered an acceptable response. The emphasis should be on completeness and clarity of content. All referenced attachments, graphics, flowcharts, diagrams, and tables must be placed after the narrative response for the section or subsection following the instructions fond in Section 4: Technical Proposal. The technical proposal is limited to one hundred five (105) pages (this excludes any appendices, charts, graphs, and as appropriate, organization charts and resumes of key staff that will provide services covered by this request).

a. One (1) Electronic copy on a CD-R, marked "Technical Proposal - Original".
b. One (1) printed paper copy, marked "Technical Proposal -Original" and signed.
c. Eight (8) printed paper copies

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

1. Formatting of CD-Rs – Separate CD-Rs are required for the technical proposal and cost proposal. All CD-Rs submitted must be labeled with:

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

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

2. Formatting of written documents and printed copies:

    a. For clarity, the Mandatory Proposal Requirements and Technical Proposal Requirements shall be typed. These documents shall be single-spaced with 1" margins on white 8.5"x 11" paper using a font of 12-point Calibri or 12-point Times New Roman.
    b. All pages on the Mandatory Proposal Requirements and Technical Proposal Requirements are to be sequentially numbered in the footer, starting with number 1 on the first page of the narrative (this does not include the cover page or table of contents) through to the end, including all forms and attachments. The Vendor's name should appear on every page, including attachments. Each attachment should be referenced appropriately within the proposal section and the attachment title should reference the proposal section it is applicable to.
    c. If the solicitation includes a proposal template for vendor use, it shall be typed using the formatting provided in the template.
    d. Printed copies are to be only bound with removable binder clips.

SECTION 8: PROPOSAL SUBMISSION

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

Proposals should be mailed or hand-delivered in a sealed envelope marked "**RFQ# 7664814"** to:

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

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

SECTION 9: CONCLUDING STATEMENTS

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

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

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

The State's General Conditions of Purchase shall be the contractual terms and conditions between the parties upon issuance of a Purchase Order by the Division of Purchases. The State's General Conditions of Purchase can be found at https://rules.sos.ri.gov/regulations/part/220-30-00-13 and addenda can be found at https://ridop.ri.gov/rules-regulations/.

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

MBE, WBE, and/or DISABILITY BUSINESS ENTERPRISE PARTICIPATION PLAN
Bidder's Name:
Bidder's Address:
Point of Contact:
Telephone:
Email:
Solicitation No.:
Project Name:

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

Name of Subcontractor/Supplier:	
Type of RI Certification:	□ MBE □ WBE □ Disability Business Enterprise
Address:	
Point of Contact:	
Telephone:	
Email:	
Detailed Description of Work To Be Performed by Subcontractor or Materials to be Supplied by Supplier:	
ISBE Participation Rate % Commitment for this Subcontractor	
Anticipated Date of Performance:	

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

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

APPENDIX B: MODEL CONTRACT

XXX ##/##-###

AGREEMENT BETWEEN

STATE OF RHODE ISLAND

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

AND

XXXXX

FOR MEDICAID MANAGED CARE SERVICES

Name of Contractor:

Title of Agreement:

Basis for Contract:

Contract Award:

Performance Period:

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

ADDENDA

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

GC ADDENDUM A	**General Insurance Requirements**
GC ADDENDUM B	**Information Technology Requirements and/or Management Information System Requirements –** are hereby incorporated by reference into GC Addendum F
GC ADDENDUM D	**Agency Specific Federal Funding Requirements -- Provides any requirements imposed by federal partners** (All Federal Requirements are included in Addendum F and are hereby incorporated by reference into the Agreement)
GC ADDENDUM F	**Agency Special Requirements Not Otherwise Addressed in the General Conditions**

ADDENDUM A

General Insurance Requirements

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

ADDENDUM D

Agency Specific Federal Funding Requirements -- Provides Any Requirements Imposed by Federal Partners (See Addendum F for Applicable Federal Requirements, which are hereby incorporated by reference into the Agreement)

ADDENDUM F

Agency Special Requirements Not Otherwise Addressed in the General Conditions

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

ATTACHMENT F-1	**Scope of Work**
ATTACHMENT F-2	**EOHHS General Terms and Conditions**
ATTACHMENT F-3.1	**Schedule of In-Plan Benefits**
ATTACHMENT F-3.2	**Schedule of Out-of-Plan Benefits**
ATTACHMENT F-3.3	**Schedule of Non-Covered Benefits**
ATTACHMENT F-3.4	**Schedule of In Lieu of Services**
ATTACHMENT F-4	**Capitation Rates and Fiscal Assurances**
ATTACHMENT F-5	**Liquidated Damages Matrix**
ATTACHMENT F-6	**Request for Qualification (Will be Added to Final Executed Contract)**
ATTACHMENT F-7	**Contractor's Proposal (Will be Added to Final Executed Contract)**

ATTACHMENT F-1

Scope of Work

Table of Contents

1. Definitions

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

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 Member practices that result in unnecessary cost to the Medicaid program. [42 C.F.R. § 438.2 and 42 C.F.R. §455.2]

Accountable Entity (AE) is a Medicaid provider that meets EOHHS certification standards, is subcontracted with the Contractor to coordinate the full continuum of Health Care Services to the Contractor's Members who are attributed to that AE and has agreed to participate in the Accountable Entity Program.

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

Accountable Entity Incentive Pool (AEIP) is the total incentive dollars, as established by EOHHS, that may be earned during the performance year by a qualified AE that is participating in the Medicaid Infrastructure Incentive Program (MIIP).

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

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

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

Advanced Directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) that relates to the provision of health care when an individual is incapacitated.

Advanced Practice 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 such laws and regulations.

Adverse Benefit Determination means the following actions by the Health Plan or its Representatives:

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

Affiliate means any person, firm, corporation, partnership, limited liability company, joint venture, business trust, association or other entity or organization that now or in the future directly or indirectly controls, is controlled by, or is under common control with the Contractor.

Affordable Care Act (ACA) means the Patient Protection and Affordable Care Act and the Health Care and Reconciliation Act of 2010.

Agreement or **Contract** has the meaning assigned in the General Conditions of Purchase.

Affordable Care Act Eligibles or **Expansion Population** the optional Medicaid coverage group, consisting of low-income adults ages 19 or older and under 65, that Rhode Island has elected to cover under the ACA.

Alternative Payment Method (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to specific clinical conditions, care episodes, or populations.

Appeal means the MCO's review of an Adverse Benefit Determination. **[**42 C.F.R. § 438.400(b)]

Attribution refers to the identification of those Members for whom each AE is responsible pursuant to the methodology set forth in EOHHS' AE Attribution Guidance.

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

Behavioral Health Benefits includes all Mental Health Benefits and Substance Use Disorder Benefits described in this Agreement.

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

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

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

Capitation Rate means a fixed predetermined fee paid by EOHHS to the Contractor each month for each enrolled Member in a defined Rate Cell, in exchange for the Contractor arranging for or providing a defined set of Covered Services, regardless of the amount of Covered Services used by enrolled Members.

Care Coordination is defined as the deliberate 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 and supports. Care Coordination services should include connection with resources to address Social Determinants of Health (SDoH).

Care Management (CM) is a team-based, person-centered, and goal-oriented approach designed to improve the health of Members with time-limited episodes of instability, such as following an acute medical event (e.g., heart attack, sepsis), surgery, or gaining self-care skills following a new diagnosis (e.g., diabetes). Care managers shall facilitate access to services, both clinical and non-clinical, by connecting Members to resources that support them in playing an active role in the self-direction of their health care needs.

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

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

Children with Special Health Care Needs means those children with complex health conditions who are enrolled in the Managed Care Program.

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

Claim means a bill for services, a line item of service, or all services for one Member within a bill.

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

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

Cold Call Marketing means any unsolicited personal contact by the Health Plan with a Potential Enrollee for the purpose of Marketing. [42 C.F.R. § 438.104(a)]

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

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

Comprehensive Risk Contract means a Risk Contract between EOHHS and a Health Plan that covers comprehensive services, including inpatient hospital and other services described in 42 C.F.R. § 438.2.

Community Reinvestment means investments in the community that are correlated with lower health care costs and improved health care quality to materially advance the welfare of the public and address social risk factors and SDoH.

Confidential Information has the meaning assigned in the General Conditions of Purchase (Section 13.17). .

Contract or **Agreement** has the meaning assigned in the General Conditions of Purchase.

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

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

Contract Year means the period of time beginning on July 1 each year and ending on June 30 the following year.

Copayment means a cost-sharing arrangement in which a covered person pays a specific charge for a specified service. This amount is paid at the time services are rendered.

Cost Sharing means any copayment, coinsurance, deductible, or other similar charge. [42 C.F.R. §447.51]

Covered Services or **In-Plan Benefits** means the Medicaid-covered services and benefits included within the scope of this Agreement as described in Attachment F-3.1, "Schedule of In-Plan Benefits." The term also includes any Value-Added Services and In Lieu of Services offered by the Contractor.

Credible Allegation of Fraud In accordance with 42 C.F.R. §455.2, a credible allegation of fraud is an allegation that has been verified by the state, from any source, including:

1. Fraud hotline tips verified by further evidence;
2. Claims data mining;
3. Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Allegations are considered to be credible when they have indicia of reliability and EOHHS has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

Day means calendar day, which includes weekends and holidays, unless otherwise specified.

Deemed Newborn Eligibility applies to newborn babies born to Medicaid-eligible pregnant women who are residents of Rhode Island. These newborns are deemed eligible for Medicaid from the date of birth. Once deemed eligible as a newborn, the infant remains eligible for one year and, as such, is a non-MAGI eligibility pathway. Accordingly, retroactive coverage is available for periods prior to the application date if the newborn was otherwise deemed eligible.

Doula, as defined by the American College of Midwives, is a person who has been specifically trained to provide nonmedical support to women during pregnancy, childbirth, and the postpartum period.

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

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.

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

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

Emergency Medical Transportation means ambulance services for an Emergency Medical Condition.

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

Emergency Services means covered inpatient and outpatient services that are:

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

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

Enrollee or **Member** means a Medicaid beneficiary who is currently enrolled in the Contractor's Health Plan. [42 C.F.R. § 438.2]

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

EPSDT means Early and Periodic Screening, Diagnosis and Treatment, a comprehensive set of services provided to all Medicaid-eligible children under age 21 in accordance with 42 U.S.C. § 1396d(r).

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

Essential Community Provider means a provider that serves predominantly low-income, medically underserved individuals. CMS has identified six ECP categories:

1. Federally Qualified Health Centers (FQHCs) and FQHC "Look-Alike" clinics;
2. Ryan White HIV/AIDS Program Providers;
3. Family Planning Providers;
4. Indian Health Providers;
5. Hospitals; and
6. Other ECP Providers including STD clinics, TB clinics, Hemophilia treatment centers, Black Lung clinics and other entities that serve predominately low-income, medically underserved individuals.

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

Executive Office of Health and Human Services (EOHHS) is the Single State Agency for purposes of administering the Medicaid program as specified in 42 C.F.R. § 438.10.

Expansion Population or **Affordable Care Act Eligibles** means the optional Medicaid coverage group, consisting of low-income adults ages 19 or older and under 65, that Rhode Island has elected to cover under the ACA.

External Quality Review Organization (EQRO) means an organization that meets the competence and independence requirements set forth in 42 C.F.R. § 438.354, and performs external quality review, other EQR-related activities as set forth in 42 C.F.R. § 438.358, or both. [42 C.F.R. § 438.320]

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.

Family Planning Services means the voluntary process of identifying goals and developing a plan for the number and spacing of children and the means by which those goals may be achieved. These means include a broad range of acceptable and effective family planning methods and services, which may range from choose not to have sex to the use of other family planning methods and services to limit or enhance the likelihood of conception (including contraceptive methods and

natural family planning or other fertility awareness-based methods) and the management of infertility, including information about referrals for adoption. Family planning services include preconception counseling, education, and general reproductive and fertility health care, in order to improve maternal and infant outcomes, and the health of women, men, adolescents, and individuals assigned female at birth who seek family planning services, and the prevention, diagnosis, and treatment of infections and diseases which may threaten childbearing capability or the health of the individual, sexual partners, and potential future children. Family planning methods and services are never to be coercive and shall always be strictly voluntary. Family planning does not include post conception care (including obstetrics or prenatal care) or abortion as a method of family planning.

Fee for Service (FFS) Program means the traditional Medicaid payment system under which providers receive a payment for each unit of service provided to a Medicaid beneficiary.

FPL means Federal Poverty Level.

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

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

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

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

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

Health Care Acquired Conditions (HAC) means a condition occurring in any inpatient hospital setting, identified as a HAC in the Rhode Island Medicaid State Plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Social Security Act; other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Health Care Provider means:

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

Health Care Service means any Medicaid service provided pursuant to this Agreement by the Contractor in any setting**.** [42 C.F.R. § 438.320]

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

Health Equity is defined as the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically.

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

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

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

Health Plan means any organization that is licensed as a health maintenance organization ("HMO") by the Rhode Island Department of Business Regulation, and contracts with EOHHS to provide Managed Care Program services.

Health Promotion and Wellness includes innovative and evidence-based educational resources, self-management tools, and information for Members in formats that meets Members' needs, promotes self-care, and empowers Members.

Health Risk Assessment means an assessment that the Contractor or its designee shall complete for all Members through direct contact with the Member, guardian, or adult caregiver.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 (August 21, 1996), as amended or modified.

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

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

Hold Time means the duration of time spent on hold in a call center between the interactive voice response, touch tone response system, or recorded greeting before reaching a call center employee.

Home Care Services mean 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.

Home Health Care is supportive care provided in the home. Care may be provided by licensed healthcare professionals who provide medical treatment needs or by professional caregivers who provide daily assistance to ensure the activities of daily living (ADLs) are met. For patients recovering from surgery or illness, home care may include rehabilitative therapies.

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

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

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

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

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

Housing Stabilization Program means a program that assists in preventing homelessness, sheltering those for whom homelessness is unavoidable, and rapidly re-housing the homeless in stable, permanent housing.

Incentive Payment means a payment made under an Incentive Arrangement.

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

Incurred but Not Reported (IBNR) means liability for services rendered for which Claims have not been received.

Incentive Arrangement means any payment mechanism under which the Contractor may receive additional funds over and above the Capitation Payments it was paid for meeting targets specified in this Agreement. [42 C.F.R. § 438.6(a)]

Indian means an individual that:

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

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

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

In-Plan Benefits or **Covered Services** means the Medicaid-covered services and benefits included within the scope of this Agreement, as described in Attachment F-3.1, "Schedule of In-Plan Benefits." The term also includes any Value-added Services and In Lieu of Services offered by the Contractor.

Intensive Care Management Plan 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 that were identified in the course of the Member's enrollment with the Contractor.

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

Long-term Services and Support or **LTSS** means services and supports, provided to Members of all ages who have functional limitations and/or chronic illnesses, that have the primary purpose of supporting the ability of the Member to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting. [42 C.F.R. § 438.2]

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

Managed Care Organization (MCO) means an entity that has, or is seeking to qualify for, a Comprehensive Risk Contract and that is:

1. A Federally qualified HMO that meets the advance directives requirements of 42 C.F.R. Part 489, Subpart I; or
2. Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:
    a) Makes the services it provides to its Medicaid Members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.
    b) Meets the solvency standards of 42 C.F.R. § 438.116.

The terms "Managed Care Organization" and "MCO" are used interchangeably with the term "Contractor" in this Agreement. [42 C.F.R. § 438.2]

Managed Care Program means the Rhode Island managed care program that is the subject matter of this Agreement.

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

Marketing Materials means materials that:

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

Marketing Representative means a Health Plan's Representative who is engaged in a Marketing activity.

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

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

Medical Loss Ratio (MLR) Reporting Year means a period of 12 months that is consistent with the Rating Period selected by EOHHS. [42 C.F.R. § 438.8(b)]

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

Medically Necessary means medical, surgical, or other services required for the prevention, diagnosis, cure, or treatment of an injury, health related condition, disease or its symptoms including such services necessary to prevent a detrimental change in either medical or mental health status or substance use disorder or services needed to achieve age-appropriate growth and

development or to attain, maintain, or regain functional capacity. Medically necessary services shall 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. The authorization process for medically necessary services can be no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures. [CMS Checklist 1.F.6.10]

Member or **Enrollee** means a Medicaid beneficiary who is currently enrolled in the Contractor's Health Plan. [42 C.F.R. § 438.2]

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

Mental Health Parity and Addiction Equity Act or **MHPAEA** requires managed care plans that cover Mental Health Benefits or Substance Use Disorders Benefits to offer coverage for those services that is no more restrictive than the coverage for Medical/Surgical Benefits.

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

Network Provider means any provider, group of providers, or entity that has a network provider agreement with the Contractor or its Subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render Covered Services. A Network Provider is not a Subcontractor by virtue of the network provider agreement. The term Network Provider is used interchangeably with "In-Network Provider." [42 C.F.R. § 438.2]

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

Non-participating Physician or **Out-of-Network Physician** means a provider who does not sign a network provider agreement to participate in the Contractor's or its Subcontractor's provider network.

Other Provider-Preventable Condition means a condition occurring in any health care setting that meets the following criteria:

1. Is identified in the Rhode Island Medicaid State Plan;
2. Has been found by EOHHS, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
3. Has a negative consequence for the Member;
4. Is auditable; and

5. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Out-of-Plan Benefits or Out-of-Plan Services means services that are not a part of the Covered Services under this Agreement but are available to Members through the Rhode Island FFS Program.

Operational Start Date means July 1, 2023, the first Day on which the Contractor is responsible for providing Covered Services to Managed Care Program Members and all related Contract functions.

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

Party means either EOHHS or the Contractor unless the context clearly indicates otherwise.

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

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

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

financial records, educational transcripts (as defined in 45 C.F.R. § 75.2, "Protected Personally Identifiable Information").

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

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

Population Health refers to the health status and health outcomes within a group of people rather than considering the health of one person at a time. For public health practitioners, improving population health involves understanding and optimizing the health of a population broadly defined by community.

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

Post-Stabilization Care Services means covered services related to an Emergency Medical Condition that are provided after a Member is Stabilized to maintain the Stabilized condition, or, under the circumstances described 42 C.F.R. § 438.114(e), to improve or resolve the Member's condition. [42 C.F.R. § 438.114(a)]

Potential Enrollee or **Potential Member** means a Medicaid beneficiary who is not yet enrolled in a Health Plan. [42 C.F.R. § 438.2]

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

Premium means the amount an individual must pay for their health insurance every month. In addition to a premium, an individual must pay other costs for their health care, including a deductible, copayments, and coinsurance.

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

Prescription Drug Coverage means health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs means drugs and medications that, by law, require a prescription.

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

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

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

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

Private Duty Nursing means nursing services for Members who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided:

1. By a registered nurse or a licensed practical nurse;
2. Under the direction of the Member's physician; and
3. To a Member in one or more of the following locations at the option of EOHHS
    a. His or her own home;
    b. A hospital; or
    c. A skilled nursing facility. [42 C.F.R. § 440.80]

Promptly means without unreasonable delay, but no later than two Business Days unless otherwise required by EOHHS.

Protected Health Information (PHI) means individually identifiable information relating to the past, present, or future health status of an individual that is created, collected, or transmitted, or maintained by a HIPAA-covered entity in relation to the provision of healthcare, payment for

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

Provider means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services. [42 C.F.R. § 438.2] When the term is capitalized in this Agreement ("Provider"), it refers to a Network Provider.

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 Article.

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

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

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

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

Readily Accessible means electronic information and services that comply with modern accessibility standards, such as Section 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions. [42 C.F.R. § 438.10(a)]

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

Related Entity or **Related Entities** means any party related to the Contractor by common ownership or control, and:

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

Related Groups mean those groups the Contractor shall make coverage available to, although they are outside of the actual program.

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

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

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

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

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

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

Scope of Work means services and deliverables specified in this Agreement, including all attachments and documents incorporated by reference into the Agreement, and all amendments thereto.

Sensitive Information or SI means information that could be expected to have a serious, severe, or catastrophic adverse effect on organizational operations, organizational assets, or individuals if the confidentiality, integrity, or availability is lost. Further, the loss of Sensitive Information confidentiality, integrity, or availability might:
1. Cause a significant or severe degradation in mission capability to an extent and duration that the organization is unable to perform its primary functions;
2. Result in significant or major damage to organizational assets;

3. Result in significant or major financial loss; or
4. Result in significant, severe or catastrophic harm to individuals that may involve loss of life or serious life-threatening injuries.

Service Authorization Request means a managed care Member's request for the provision of a service, or a request made by a provider on the Member's request. The term is used interchangeably with "Prior Authorization request." [42 C.F.R. § 431.210]

Services Broker means an entity contracted with EOHHS to coordinate and deliver Out-of-Plan Services. Service Brokers include entities coordinating and delivering NEMT and dental services for children.

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

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

Skilled Care Services are services provided by technicians and therapists in a Member's home or in a nursing home.

Skilled Nursing Care are services from licensed nurses provided in a Member's home or in a nursing home.

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

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

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

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

Stabilized means, with respect to an Emergency Medical Condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or that the woman has delivered the child and the placenta. [42 C.F.R § 438.114 citing 42 C.F.R. § 489.24]

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

State Fair Hearing means the process set forth in 42 C.F.R. Part 431, Subpart E, regarding fair hearings for Medicaid applicants and beneficiaries. [42 C.F.R. § 438.400(b)]

Subcontractor means an individual or entity that has a contract with the Contractor that relates directly or indirectly to the performance of the Contractor's obligations under this Agreement. A Network Provider is not a Subcontractor by virtue of the network provider agreement with the Contractor. [42 C.F.R. § 438.2]

Substance Use Disorder Benefits means benefits for items or services for substance use disorders, as defined by EOHHS and in accordance with applicable Federal and State law. For purposes of this Agreement, substance use disorder benefits include the long-term care services described in Attachment F-1, Section 4.4, "Behavioral Health." [42 C.F.R. § 438.900]

Supplemental Security Income or **SSI** means a federal income supplement program funded by general tax revenues (not Social Security taxes) designed to help aged, blind, and disabled people with little or no income by providing cash to meet basic needs for food, clothing, and shelter.

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

Telecommunication Relay Service (TRS) means a telephone transmission services that provides the ability for an individual who is deaf, hard of hearing, deaf-blind, or who has a speech disability to engage in communication by wire or radio with one or more individuals, in a manner that is functionally equivalent to the ability of a hearing individual who does not have a speech disability to communicate using voice communication services by wire or radio. [47 C.F.R. § 64.601(42)]

Tip a piece of information regarding an act of Fraud, Waste or Abuse or other activity of interest to the EOHHS Office of Program Integrity. A tip, by itself, generally does not provide sufficient information to establish that Fraud, Waste or Abuse has occurred, but it might provide investigators with a direction to pursue in an investigation.

Total Cost of Care (TCOC) is an alternative payment methodology that includes a historical baseline cost of care projected forward to the end of a performance period. Actual costs during the performance period are then compared to the baseline to identify a potential shared savings or risk pool. The methodology for calculating the Total Cost of Care for the Accountable Entity Program is set forth in the Accountable Entity Total Cost of Care Requirements and Total Cost of Care Technical Guidance.

Treatment Limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under

a plan or coverage. (See 42 C.F.R. § 438.910(d)(2) for an illustrative list of nonquantitative treatment limitations.) A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition. [42 C.F.R. § 438.900]

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

Urgent Care means care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.

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 24 hours could reasonably be expected to result in:

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

Validation means the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis. [42 C.F.R. § 438.320]

Value-Added Services (VAS) means additional services the Contractor offers to Members beyond the Covered Services specified in Attachment F-3.1, "Schedule of In-Plan Benefits." Value-Added Services must be approved by EOHHS, and may be actual Health Care Services, benefits, or positive incentives that EOHHS determines will promote healthy lifestyles, address social determinants of health, or improve health outcomes among Members.

Vendor has the meaning assigned in the General Conditions of Purchase. The term is used interchangeably with "Contractor" and "Health Plan."

Waste means the inappropriate utilization of services or misuse of resources. Waste is not a criminal or intentional act but results in unnecessary expenditures to the Medicaid program that might be prevented.

Withhold Arrangement means any payment mechanism under which a portion of a Capitation Rate is withheld from a Health Plan and a portion of or all of the withheld amounts will be paid to the Health Plan for meeting targets specified in the contract. The targets for a withhold arrangement are distinct from general operational requirements under the contract. Arrangements that withhold a portion of a Capitation Rate for noncompliance with general operational requirements are liquidated damages and not a withhold arrangement. [42 C.F.R. § 438.6(a)]

1. Definitions- Document History Log	
Contract Cross-References	
Governing Requirements and Authority	• Social Security Act, Title XVIII • Social Security Act, Title XIX • 25 U.S.C. § 1603 • 42 U.S.C. § 1396(d) • Public Law 104-191 • 42 C.F.R. § 64.601 • 42 C.F.R. § 75.2 • 42 C.F.R. § 155.20 • 42 C.F.R. § 414.234 • 42 C.F.R. § 435.923 • 42 C.F.R. § 431.210 • 42 C.F.R. §§ 438.2, 438.3, 438.6, 438.8, 438.10, 438.14, 438.104, 438.114, 438.116, 438.320, 438.354, 438.358, 438.400, 438.408, 438.900, 438.910 • 42 C.F.R. §§ 440.70, 440.80, and 440.130 • 42 C.F.R. § 447.45, 447.51 • 42 C.F.R. § 455.2 • 42 C.F.R. Part 489, Subpart I and § 489.24 • OMB Memorandum M-06-19 • OMB Memorandum M-17-12 • Rhode Island General Laws, Chapter 40-8.4-12 *et. seq.*
CMS Checklist Sections	• I.F.6, Amount, Duration and Scope, Item I.F.6.10
Revision Date and Description	

2. Readiness Review Phase

2.1. Introduction (CMS Checklist I.A.1.13-.15)

This section includes the Scope of Work for the Readiness Review phase of the Agreement, which shall be completed before the Operational Start Date in accordance with 42 C.F.R. § 438.66(d). During Readiness Review, EOHHS will assess the Contractor's adherence to Readiness Review requirements and capability to assume the functions required under this Agreement. To complete the assessment, EOHHS will consider the Contractor's assurance of readiness, information contained in the Contractor's proposal, systems testing, and documentation supplied during Readiness Review.

2.2. General Requirements

2.2.1. Deficiencies Identified During Readiness Review

If the Contractor or EOHHS identify a deficiency during Readiness Review, the Contractor shall either:

2.2.1.1. Correct the deficiency within ten Days or discovering or receiving written notice of the deficiency; or

2.2.1.2. If the deficiency requires more than ten Days to correct, provide a Corrective Action Plan or Risk Mitigation Plan within the timeframe directed by EOHHS.

2.2.1.3. EOHHS may postpone the Contractor's Operational Start Date up to one year and assess contractual remedies, including termination of the Agreement or liquidated damages if the Contractor fails to correct all Readiness Review deficiencies within required timeframes. EOHHS will make all final decisions regarding the Contractor's operational readiness.

2.2.2. Desk and Onsite Reviews

2.2.2.1. EOHHS may conduct Readiness Review activities via desk reviews and onsite reviews, as well as thorough systems testing and file exchanges. A portion of the Readiness Review will be performed onsite at the Contractor's administrative office or other locations identified by EOHHS.

2.2.2.2. If the Contractor fails to provide pre-onsite materials as requested, EOHHS may choose to delay the onsite review and contractual remedies, including liquidated damages, may apply.

2.2.2.3. The Contractor shall be responsible for all travel costs incurred by EOHHS staff or designees participating in onsite Readiness Reviews.

2.2.2.4. The results of the Readiness Review will be submitted to CMS by EOHHS for CMS to make a determination that the Agreement or associated amendment is approved under 42 C.F.R. § 438.3(a).

2.2.3. Readiness Review Schedule

2.2.3.1. EOHHS will provide the Contractor with a Readiness Review Schedule with timelines for completing all Readiness Review activities.

2.2.3.2. The Contractor shall complete all Readiness Review activities to the satisfaction of EOHHS no later than 60 Days prior to the Operational Start Date, or a delayed Operational Start Date may be required. EOHHS reserves the right to continue review activities after the Operational Start Date, at its discretion.

2.2.4. Readiness Review Activities

2.2.4.1. If the Contractor identifies information needed from EOHHS to complete Readiness Review activities, the Contractor shall submit a written request for information in a manner that does not delay the schedule or work to be performed.

2.2.4.2. The Parties will work together during Readiness Review to:

a) Establish communication protocols.
b) Establish contacts with EOHHS staff and other contractors.
c) Clarify expectations for the content and format of deliverables.

2.2.4.3. The Contractor shall submit a Transition Plan and monthly progress reports by the dates identified in the Readiness Review Schedule. At a minimum, the Transition Plan shall include:

a) Staffing patterns and key personnel for all major Agreement functions identified in Section 3.1, "Contract Administration and Management."
b) Proposed schedules for Readiness Review demonstrations.
c) Other requirements identified by EOHHS.

2.2.4.4. The Contractor is required to:

a) Meet all Readiness Review timelines.
b) Be responsive to EOHHS questions and requests within designated timeframes.
c) Provide adequate space and facilities for onsite reviews.
d) Include all staff and Subcontractors responsible for the functions described in this Agreement in Readiness Review activities.

2.2.5. Changes to Key Personnel and Organization

The Contractor shall submit a report identifying:

2.2.5.1. Key Personnel meeting the requirements of Section 3.1, "Contract Administration and Management," including current resumes. Changes to Key Personnel identified in the Contractor's Proposal must be approved by EOHHS.

2.2.5.2. Job descriptions, organizational charts, and other organizational information that has changed since proposal submission.

2.2.6. Financial Readiness Review

2.2.6.1. The Contractor shall submit a Financial Report that:

a) Identifies whether the Contractor or its ultimate parent organization has experienced a material financial deterioration or change following proposal

submission. The report shall describe any changes to financial statements, including changes to net worth; cash flow; loss of contracts; credit, audit, regulatory or legal issues; and major contingencies. In addition, the report shall describe any issues regarding changes in ownership or control.

b) Includes the most recently updated financial statements for the Contractor and ultimate parent organization (internal financial statements, annual statements, and audited statements). Except for internal financial statements, the financial statements should generally include the notes, management discussion, and where appropriate, the audit letter.

c) Includes the most recent financial reports to and registration statements with the Rhode Island Department of Business Regulation; IRS Form 990; and bond or debt rating analysis. It is not necessary to submit updated SEC 10-K or 10-Q filings with the report.

2.2.6.2. The Contractor shall submit documentation demonstrating it has secured all required bonds.

2.2.6.3. If the Contractor intends to include employee bonus or incentive payments as allowable administrative expenses in financial reports, it shall furnish an Employee Bonus or Incentive Plan. The plan shall include the:

a) Criteria for establishing bonus or incentive payments.

b) Methodology to calculate payments.

c) Timing of payments.

2.2.6.4. EOHHS shall approve all substantive revisions to the Employee Bonus or Incentive Plan at least 30 Days before revisions take effect.

2.2.6.5. EOHHS reserves the right to disallow all or part of the Employee Bonus or Incentive Plan that it deems inappropriate. All bonus or incentive payments are subject to audit and shall conform with the cost reporting and financial requirements in this Agreement.

2.2.6.6. The Contractor shall submit a Third Party Liability (TPL) Policy describing how the Contractor shall conduct the following activities:

a) Cost avoidance activities;

b) Payment reductions based on third-party payments for any part of a Covered Service;

c) Payment recovery activities;

d) Identification of other forms of insurance processes and procedures;

e) Subrogation, including the analysis of the State motor vehicle accident report file data exchange required under 42 C.F.R. § 433.138(d)(4)(ii) to identify potential subrogation claims and identify Members with a legal liable third party; and

f) The analysis of the State motor vehicle accident report file data exchange required under 42 C.F.R. § 433.138(d)(4)(ii) to identify potential subrogation claims and identify Members with a legal liable third party and

methods for conducting diagnosis and trauma code editing to identify potential subrogation claims.

2.2.7. Systems Readiness Review

2.2.7.1. The Contractor shall submit descriptions of interface and data and process flow for each key business processes described in Section 3.26, "Claims Processing and Management Information System (MIS)."

2.2.7.2. The Contractor shall have clearly defined policies and procedures to support day-to-day MIS activities. During Readiness Review, the Contractor shall submit the following plans:

a) Disaster Recovery Plan.
b) Business Continuity Plan.
c) Security Plan.
d) Joint Interface Plan.
e) Risk Management Plan.
f) Systems Quality Assurance Plan.

2.2.7.3. The Business Continuity Plan and the Disaster Recovery Plan may be combined into one document.

2.2.7.4. During Readiness Review, the Contractor shall demonstrate its system capabilities and adherence to Agreement specifications, including requirements relating to claims management, encounter data submission, and Member information. EOHHS will provide the Contractor with a test plan outlining activities the Contractor shall perform prior to the Operational Start Date.

2.2.7.5. The Contractor shall have hardware, software, network and communications systems with the capability and capacity to handle and operate all MIS systems and subsystems (collectively "systems") identified in Section 3.26, "Claims Processing and MIS." For example, the MCO's MIS system shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

2.2.7.6. During Readiness Review testing:

a) The Contractor's systems shall accept all data files and information provided by EOHHS or its contractors.
b) The Contractor shall install and test all hardware, software, and telecommunications required to support the Agreement.
c) The Contractor shall identify and test systems modifications need to support the business functions of the Agreement.
d) The Contractor shall produce data extracts and receive all electronic data transfers and transmissions.
e) Provide test data files for systems and interface testing for all external interfaces (e.g., member hotline, provider support line, EOHHS administrative contractors).

f) The Contractor shall execute all systems readiness testing cycles required by EOHHS.

2.2.7.7. The Contractor shall provide documentation demonstrating its systems and facilities comply with HIPAA security requirements.

2.2.7.8. EOHHS may independently test whether the Contractor's systems have the capacity to administer the EOHHS managed care programs.

2.2.7.9. The Contractor is responsible for all costs incurred by EOHHS due to system errors, regardless of whether these errors were discovered during Readiness Review testing.

2.2.7.10. The Contractor shall provide EOHHS a summary of all recent external audit reports, including findings and corrective actions, relating to the Contractor's proposed systems, including any SSAE16 audits conducted in the prior three years.

2.2.7.11. The Contractor shall make additional information regarding the details of such system audits available to EOHHS upon request.

2.2.8. Operational Readiness Review

2.2.8.1. Within ten Days of the Agreement Effective Date, EOHHS will provide to the Contractor a readiness review tool outlining the evidence of readiness the Contractor shall provide for each element of the Operational Readiness Review.

2.2.8.2. The Contractor shall clearly define and document the policies and procedures it will follow to support day-to-day business operations, including coordination with Subcontractors and EOHHS contractors.

2.2.8.3. At a minimum, the Contractor shall submit the following documents for EOHHS review and approval during Readiness Review. The documents shall meet the Uniform Managed Care Manual specifications, where applicable:

a) Network Adequacy Plan, including a list of all contracted and credentialed providers and a description of contracting and credentialing activities to be completed before the Operational Start Date.
b) Training curriculum for Member Services staff and Network Providers.
c) Oversight and Coordination Plan documenting how the Contractor shall oversee subcontracted functions and coordinate its business activities with those performed by Subcontractors and EOHHS contractors.
d) Pre-delegation audit of subcontracted functions, including an evaluation of each Subcontractor's readiness to perform the delegated functions. The audit shall encompass all duties and responsibilities that have been delegated to Subcontractors and include a risk evaluation.
e) Draft Member and Provider materials, including the Contractor's Member Handbook, Provider Manual, Provider Directory (hard copy and online format), Member Identification (ID) card, website content, hotline scripts and messaging, and other Member and Provider materials identified by EOHHS.

f) Member Grievance and Appeals policies and procedures.
g) Program Integrity and Fraud, Waste, and Abuse Compliance Plan.
h) Utilization Management Plan and Drug Utilization Review Program policies and procedures.
i) Strategic Diversity and Inclusion Plan (to be updated annually during the Operations Phase).
j) Care Program Plan, including the Care Plan Strategy for AEs.
k) Quality Improvement Plan.
l) APM Strategy and Implementation Plan.
m) Copies of all Subcontracts and results of delegation oversight, including Accountable Entity (AE) oversight reviews.
n) Copies of all Major Subcontracts.
o) Documentation showing the Contactor has secured all required insurance coverage.
p) Proof of licensure or approval with the Rhode Island Department of Business Regulation.
q) Proof of NCQA accreditation and certification.

2.2.8.4. The Contractor shall demonstrate toll-free telephone systems and reporting capabilities for the Member Services and provider hotlines.

2.2.8.5. The Contractor shall supply copies of the Provider Directory and other materials requested by EOHHS for purposes of Member enrollment.

2.2.8.6. To the extent any Readiness Review topics or documentation relate to services provided by a Subcontractor of the Contractor, Contractor shall assure that Subcontractor staff fully comply with and participate in Readiness Review activities.

2.2.8.7. During Readiness Review, EOHHS shall provide the Contractor with one opportunity to enhance proposed Value-added Services or add new Value-added Services. EOHHS will not allow the Contractor to delete, limit, or restrict any Value-added Services included in its proposal.

2.2.8.8. At EOHHS' discretion, the Contractor may not be eligible for payment prior to meeting all Readiness Review criteria.

2.2.9. Additional Assurances

2.2.9.1. In addition to the deliverables described in this section, the Contractor shall implement all processes, MIS systems, and staffed functions prior to the Operational Start Date, and the Contractor shall successfully assume all contractual responsibilities prior to the Operational Start Date.

2.2.9.2. The Contractor shall complete the following prior to the Operational Start Date:

a) Key MCO personnel, staff, and Subcontractors are hired and trained.
b) MIS systems and interfaces are in place and functioning properly.
c) Communications procedures are in place.

d) Provider Manuals have been distributed.

e) Provider training sessions have occurred according to an EOHHS-approved schedule.

2.2.9.3. EOHHS reserves the right to request additional information, including more detailed or up-to-date information regarding the Contractor's operating procedures and documentation.

2.2.10. Waiver or Amendment of Readiness Review Requirements

EOHHS reserves the right to waive or amend one or more Readiness Review requirements in writing, and to allow incumbent vendors to modify previously approved materials.

2.2.11. Additional Readiness Review Activities

Notwithstanding its right to terminate the Agreement, EOHHS may require the Contractor to complete all or some of the Readiness Review activities described in this section at any time during the term of the Contract, including the option for a targeted annual compliance review, if the Contractor:

2.2.11.1. Exhibits evidence where it is found to be less than fully compliant regarding elements under this Contract.

2.2.11.2. Begins providing a new service or benefit.

2.2.11.3. Expands operations to new managed care programs.

2.2.11.4. Makes a change to its Major Subcontractor.

2.2.11.5. Makes a significant change to the Contractor's Provider Network,

2.2.11.6. Implements a major system change after the Operational Start Date.

2. Readiness Review Phase- Document History Log	
Contract Cross-References	• Section 3.1, Contract Administration and Management • Section 3.26, Claims Processing and Management Information System (MIS)
Governing Requirements and Authority	• 42 C.F.R. § 433.138 • 42 C.F.R. §§ 438.3, 438.66
CMS Checklist Items	I.A., Contract Completeness, Sections I.A.1.13-.15
Revision Date and Description	

3. Operations Phase Requirements

3.1. Contract Administration and Management

3.1.1 Independent Contractor

3.1.1.1. The Contractor shall be engaged as an independent contractor of the State of Rhode Island ("the State"). Nothing contained in this Agreement will be construed to create the relationship of employer and employee, principal and agent, partnership or joint venture, or any other fiduciary relationship. The Contractor and its Representatives shall not hold themselves out as, nor claim to be, officers or employees of EOHHS or the State.

3.1.1.2. The Contractor and its Representatives may not act as agent for, or on behalf of, the State or to bind the State in any manner.

3.1.1.3. The State must issue an IRS Form 1099 reflecting the Contractor's compensation and will not be responsible for federal, state, or local taxes derived from the Contractor's net income or for the withholding or payment of any federal, state, and local income, and other payroll taxes, workers' compensation, disability benefits, or other legal requirements applicable to the Contractor.

3.1.1.4. The Contractor and its Representatives shall not be entitled to benefits provided by the State to its employees.

3.1.2 Health Plan Administration

3.1.2.1 The Contractor shall maintain the organizational and administrative capacity and capabilities to carry out all duties and responsibilities under this Agreement. Personnel shall be properly trained and qualified for the functions they perform. Notwithstanding transfer or turnover of personnel, the Contractor remains obligated to perform all duties and responsibilities under this Agreement without degradation and in accordance with Agreement terms.

3.1.2.2 At its discretion and at no additional cost to the State, EOHHS may require the Contractor to implement or revise business processes or procedures that support the work described in Article 3, "Operations Phase Requirements." The Contractor shall implement such changes within 45 Days, unless otherwise indicated in EOHHS' notice.

3.1.3 Contractor's Key Personnel

3.1.3.1. As stated in the Contractor's proposal, the Contractor shall designate key management and technical personnel who will be assigned to the Contract. For the purposes of this requirement, key personnel include the Chief Executive Officer (CEO); Medical Director; Chief Diversity, Equity, and Inclusion (DEI) Officer; Chief Financial Officer (CFO); Privacy Official; Security Official (see 45 C.F.R. § 164.308); and individuals with management responsibility for the following functional areas:

a) Members services;

b) Provider network development and management;
c) Medical management and quality assurance (including Care Program, benefit administration, utilization Review (UR), and quality assurance and improvement);
d) MIS and claims processing;
e) Grievances and Appeals; and
f) Reporting;
g) Program integrity and compliance;
h) Accountable Entity Programs; and
i) Special Investigative Units for Fraud, Waste, and Abuse.

3.1.3.2. The Contractor shall supply key personnel with the resources necessary to meet all contractual requirements.

3.1.3.3. The Contractor shall ensure project continuity by notifying the EOHHS Managed Care Director in writing within three Business Days of a change in key personnel, and by replacing key personnel with persons having the requisite skills, experience, and other qualifications for the function performed. Regardless of specific personnel changes, the Contractor shall maintain the overall level of expertise, experience, and skill reflected in the key personnel job descriptions and qualifications included in the Contractor's proposal.

3.1.3.4. Notwithstanding 220-RICR-30-00-13.22(A)(11), if EOHHS determines a satisfactory working relationship cannot be established with certain key personnel, it will notify the Contractor in writing. Upon receipt of EOHHS' notice, the Parties will attempt to resolve EOHHS' concerns on a mutually agreeable basis.

3.1.4. Chief Executive Officer

3.1.4.1. The Contractor shall employ a qualified individual to serve as the CEO for the Rhode Island Medicaid Managed Care Program. The CEO shall be a full-time employee of the Contractor, primarily dedicated to Managed Care Program, and hold a senior executive or management position in the Contractor's organization. The Contractor may propose an alternate structure for the CEO position, subject to EOHHS' prior written approval.

3.1.4.2. The CEO shall act as a liaison between the Contractor and EOHHS and shall be authorized and empowered to represent the Contractor on all matters pertaining to the Agreement.

3.1.4.3. The CEO is responsible for:

a) Ensuring compliance with the terms of this Agreement, including securing and coordinating required resources.
b) Receiving and responding to EOHHS inquiries and requests.
c) Participating in regular CEO meetings or calls with EOHHS.
d) Making best efforts to promptly resolve any issues identified by the Contractor or EOHHS related to this Agreement.

e) Meeting with EOHHS representatives on a periodic or as needed basis to review the Contractor's performance and resolve compliance issues or disputes.

3.1.5. Medical Director

3.1.5.1. The Medical Director shall be licensed to practice medicine in Rhode Island and be board-certified, board-eligible, or trained in his or her field of specialty.

3.1.5.2. The Medical Director shall be:

a) Employed full-time by the Contractor.
b) Given sufficient support staff, including assistant or associate Medical Directors, to help carry out the responsibilities of the office.
c) Available to the Contractor's medical staff daily for consultation on referrals, denials, Appeals, Complaints, and problems.

3.1.5.3. The Medical Director's responsibilities shall include:

a) Development, implementation, and oversight of the Contractor's internal quality assurance program (QAP) and UM Program activities, including Prior Authorizations (PAs), concurrent reviews, and retrospective reviews. The Medical Director shall have adequate and appropriate experience in these areas.
b) Serving as the Contractor's senior clinical officer and participating in the development of Alternative Payment Methodologies (APMs) and related quality metrics. Additionally, the Medical Director shall provide clinical executive leadership as the Contractor analyzes the outcomes of quality metrics for any APMs, including APMs with Accountable Entities.
c) Participating in Medical Advisory Committee meetings with the EOHHS Chief Medical Officer.

3.1.5.4. The Medical Director is responsible for development, implementation, and oversight of:

a) The Contractor's UM and quality assurance (QA) committees.
b) Care Program activities, including Health Promotion, Care Coordination, Care Management, and Complex Case Management activities.
c) Staff education about the Contractor's policies and procedures on advanced directives.
d) The Contractor's medical policies, practice standards, and protocols, including the use of evidence-based practice guidelines.
e) Referral process for specialty and Out-of-Plan Services.
f) The investigation of all potential quality of care problems, including but not limited to Member-specific occurrences of possible Health Care-Acquired Conditions and Other Provider-Preventable Conditions or hospital acquired conditions in accordance with 42 C.F.R. § 447.26, 42 C.F.R. Chapters 447, 434, 438, and Sections 1902(a)(4), 1902(a)(6), and 1903 of the Social Security Act.

g) Recommendations regarding the development and implementation of corrective action plans for Providers.

h) Processes to ensure confidentiality of medical records, information regarding sexually transmitted infection appointments, mental health and substance use appointments, and other Confidential Information belonging to the Member.

i) Provider recruitment and credentialing activities;

j) Disease management and Population Health Management programs and strategies to educate Members about health promotion, disease prevention, and efficient and effective use of health care benefits.

k) Diversity and Health Equity initiatives.

3.1.5.5. The Medical Director shall serve as a liaison between the Contractor and its Providers and communicate regularly with Providers, addressing areas of clinical relevance including but not limited to:

a) UM and management functions, including requirements for PAs, concurrent reviews, and retrospective reviews.

b) Prescription and over-the-counter drug formulary for Medicaid Members.

c) Health Equity, promotion, and disease management programs.

d) Clinical practice guidelines.

e) Quality indicators, such as the Contractor's performance on HEDIS® and CAHPS® measures.

3.1.5.6. The Medical Director shall serve as the Contractor's representative on the EOHHS Medical Care Advisory Committee.

3.1.5.7. The Contractor shall notify the EOHHS Managed Care Director of a change in the Medical Director position and provide a transition plan no later than five Business Days after the Contractor becomes aware of the staffing change.

3.1.6. Chief Diversity, Equity, and Inclusion Officer

3.1.6.1. The Chief DEI Officer shall report to the CEO or Director of Human Resources and is responsible for managing and overseeing the Contractor's efforts to:

a) Create a diverse and inclusive workforce.

b) Identify and address potential discrimination or biases in the workforce.

c) Ensure compliance with yearly workforce trainings, such as anti-bias, anti-racist, sexual harassment, and health inequities training.

d) Launch initiatives to change culture.

e) Create a supportive environment for underrepresented Members of the organization.

f) Develop, execute, and monitor compliance with a comprehensive, organization-wide Strategic Health Equity, Diversity and Inclusion Plan.

3.1.6.2. The Chief DEI Officer shall serve as a leader in the organization and has primary responsibility for:

a) Submitting the Strategic Diversity and Inclusion Plan to EOHHS during Readiness Review, then annual reports describing Plan activities and outcomes.
b) Developing training programs for staff.
c) Reviewing and assessing the impact and effectiveness of diversity and inclusion programs.

3.1.7. Contract Administration

3.1.7.1. This Agreement will be administered for the State by EOHHS. The Contractor's CEO or his or her appointee will serve as the responsible party for all matters related to this Agreement.

3.1.7.2. The EOHHS Managed Care Director, or his or her designee, will be the Contractor's primary liaison in working with EOHHS and other state agencies. The EOHHS Managed Care Director may appoint contract managers, or liaisons, to represent EOHHS on routine communications and other administrative matters.

3.1.7.3. In no instance will the Contractor refer any matter to the Medicaid Program Director, Deputy Medicaid Program Director, or any other official in Rhode Island unless initial contact, both verbal and in writing, regarding the matter has been presented to the EOHHS Managed Care Director.

3.1.7.4. Whenever the State is required by this Agreement to provide written notice to the Contractor, such notice will be signed by the EOHHS Managed Care Director or his or her designee.

3.1.7.5. All notices regarding the failure to meet performance requirements and any assessments remedies under this Agreement will be issued by the EOHHS Managed Care Director or his or her designee.

3.1.8. Notification of Administrative Changes

The Contractor shall notify the EOHHS Managed Care Director of all changes materially affecting administration of this Agreement, including any change affecting the Contractor's ability to meet performance standards.

3.1.9. Subcontracts and Delegation of Duty (CMS Checklist I.J.3.01-.03)

3.1.9.1. All Subcontracts shall be in writing and fulfill the requirements of 42 C.F.R. § 438.230, as applicable to the service or activity delegated under this Agreement. The Contractor shall make available all Subcontracts for inspection by the EOHHS, upon request.

3.1.9.2. All Subcontracts are subject to prior approval by EOHHS. At least 30 Days before executing or amending a Subcontract, the Contractor shall provide the proposed Subcontract to EOHHS for review. The Contractor and Subcontractor shall promptly respond any questions or requests for information. Notwithstanding EOHHS' approval of a Subcontract, EOHHS reserves the right to designate the Subcontract, or any portion thereof, as unacceptable for any

reason or determine that it is otherwise incompatible with this Agreement or any aspect of law, regulation, or policy.

3.1.9.3. Failure to obtain EOHHS approval may result in contract remedies, including corrective actions plans, liquidated damages, or termination. To be eligible for approval, all Subcontractors, and employees, shall be subject to the applicable qualifications in Rhode Island state law and regulation.

3.1.9.4. The Contractor shall monitor the performance of all Subcontractors on an ongoing basis, consistent with industry standards and state and federal regulations. This includes conducting formal reviews based on a schedule established by EOHHS. The Contractor and its Representatives shall take corrective action on any identified deficiencies or areas of improvement.

3.1.9.5. The Contractor is responsible for performance of the Agreement, whether Subcontractors are used. In compliance with 42 C.F.R. §438.230(c), the Contractor shall execute a written agreement with its Subcontractors that: specifies that Contractor's right to revoke the agreement, outlines reasons for the revocation, and specifies other remedies in instances where EOHHS or the Contractor determines the Subcontractor has not performed satisfactorily. Subcontracts shall specify the Contractor may impose sanctions for inadequate performance.

3.1.9.6. A Subcontract providing delegated services that result in direct contact with a Member shall contain a provision identifying which party is responsible for providing sign language, oral interpretation, and oral translation services. Such services shall be provided at no cost to the Member. In addition, these Subcontracts shall require Subcontractors to comply with the notice requirements described in Section 3.21.4, "Adverse Benefit Determinations."

3.1.9.7. A Subcontract providing licensing and credentialing services for providers. or other services that result in the selection of providers, shall contain a provision that the Contractor retains the right to approve, suspend, or terminate any selected or approved provider by the Subcontractor.

3.1.9.8. The Contractor agrees, and shall require its Subcontractors to agree, to subrogate to EOHHS any and all claims the Contractor has or may have against any provider, including but not limited to manufacturers, wholesale or retail suppliers, sales representatives, testing laboratories, or other providers in the design, manufacture, marketing pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, durable medical equipment, or other products, in actions brought against said providers on behalf of EOHHS, through the Rhode Island Attorney General's Office. The Contractor is entitled to recoveries that are the direct result of a similar legal suit filed by the Contractor against the same party or parties that was initiated and properly filed prior to the date of a legal action initiated or joined by EOHHS or by Rhode Island Department of Attorney General.

3.1.9.9. All Subcontracts shall be consistent with the terms of this Agreement and require Subcontractors to comply with all applicable provisions of state and

federal laws. In addition, the following provisions of this Agreement shall be incorporated into all Subcontracts:

a) General Conditions of Purchases and Addendum A through E, if designated as applicable to the Contractor under this Agreement.
b) Section 3.22, "Program Integrity."
c) Section 3.24, "Security and Confidentiality."
d) Attachment F-2, Section 2.5, "Federal Approval"; Article 3, "Governing Laws and Regulations"; and Article 7, "Intellectual Property."

3.1.10. Subcontracting with Minority and Women Business Enterprises

3.1.10.1. In accordance with R.I. Gen. Laws § 37.14.1, "Minority Business Enterprise," and promulgating regulations including 220-RICR-80-10-2, the Contractor shall comply with state and federal requirements regarding participation by minority business enterprises (MBE) and women business enterprises (WBE).

3.1.10.2. The Contractor's responsibilities include, but are not limited to:

a) Complying with ISBE (MBE/WBE) requirements stated in the solicitation.
b) Notifying MBE/WBE-certified businesses of subcontracting opportunities.
c) Demonstrating good faith efforts to contract with MBE/WBE businesses to further the State's goal of awarding 10% of the dollar value of the Contract to MBE/WBE businesses.
d) Submitting reports in accordance with DOA requirements.

3.1.10.3. Additional information regarding MBE/WBE requirements is available through the DOA Office of Diversity, Equity, and Opportunity website.

3.1.11. Responsibility for Contractor Representatives

3.1.11.1. The Contractor's Representatives shall not in any way be considered employees of EOHHS or the State of Rhode Island.

3.1.11.2. Except as expressly permitted in this Agreement, neither the Contractor nor its Representatives may act in any sense as agents or representatives of EOHHS or the State of Rhode Island.

3.1.11.3. The Contractor agrees that anyone it employs to fulfill the terms of the Agreement remains under its sole direction and control.

3.1.11.4. The Contractor shall be responsible for its acts, including negligence and the acts of its Representatives.

3.1.11.5. Any claim on behalf of any person arising out of employment or alleged employment by the Contractor (including, but not limited to, claims of discrimination against the Contractor or its Representatives) is the sole responsibility of the Contractor. The Contractor shall indemnify and hold harmless EOHHS and the State from all claims asserted against EOHHS or the State arising from or related to the employment or alleged employment by the Contractor.

3.1.11.6. The Contractor understands that any person who alleges a claim arising out of employment or alleged employment by the Contractor will not be entitled to any compensation, rights, or benefits from EOHHS or the State including, but not limited to, tenure rights, medical and hospital care, sick and annual/vacation leave, severance pay, or retirement benefits.

3.1.11.7. The Contractor shall pay all damages incurred by the Contractor's Representatives within the scope of their duties under the Contract.

3.1.11.8. The Contractor shall determine the hours to be worked and duties to be performed by its Representatives.

3.1.11.9. The Contractor shall inform all Representatives that there is no right of subrogation, contribution, or indemnification against EOHHS or the State of Rhode Island for any duty owed to them by the Contractor, or any judgment rendered against the Contractor.

3.1.11.10. The Contractor understands that EOHHS and the State do not assume liability for the actions of, or judgments rendered against, the Contractor or its Representatives. The Contractor agrees that it has no right to indemnification or contribution from EOHHS or the State for any such judgments rendered against the Contractor or its Representatives.

3.1.12. Cooperation with Other Entities

3.1.12.1. The Contractor agrees to reasonably cooperate with and work with the other Health Plans, EOHHS contractors, and third-party representatives as requested by EOHHS.

3.1.12.2. The Contractor shall ensure its Representatives cooperate with EOHHS or other state or federal administrative agency personnel at no charge for purposes relating to the administration of the Managed Care Programs, including for the following purposes:

a) The investigation and prosecution of Fraud, Waste, and Abuse;
b) Audit, inspection, or other investigative purposes;
c) Testimony in judicial or quasi-judicial proceedings; and
d) The delivery of information to EOHHS or other agencies' investigators, auditors, or legal staff.

3.1.13. Employment Practices (CMS Checklist I.B.1.03, I.J.2.01)

3.1.13.1. The Contractor shall comply all applicable state and federal requirements relating to fair employment practices and agrees further to include a similar provision all Subcontracts.

3.1.13.2. The Contractor shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, sexual orientation, national origin, age (except as provided by law), marital status, political affiliation, or handicap.

3.1.13.3. The Contractor shall take affirmative action to ensure that employees and applicants for employment are treated without regard to their race, color,

religion, sex, national origin, age (except as provided by law), marital status, political affiliation, disability, or handicap. Such action shall be taken in areas including: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship.

3.1.13.4. The Contractor shall comply with the requirements of the following laws and regulations:

a) Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.);
b) Rehabilitation Act of 1973, as amended (29 U.S.C. 794);
c) Title IX of the Education Amendments of 1972 (regarding education programs and activities) (20 U.S.C. 1681 et. seq.);
d) Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et. seq.);
e) Age Discrimination Act of 1975;
f) Section 1557 of the Patient Protection and Affordable Care Act (ACA);

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

3.1.13.6. The Contractor shall comply with all other state and federal laws, rules, or regulations that are or may be applicable to employment practices but not specifically mentioned in this section.

3.1.14. Employment of State Personnel

3.1.14.1. Unless authorized in writing by the EOHHS Managed Care Director, the Contractor and its Representatives may not recruit, employ, or otherwise engage EOHHS staff, consultants, or other state augmentation contractors to work on the subject matter related to this Agreement and who, in the 12-month period prior to employment or engagement, either:

a) Participated in the design, development, evaluation, or oversight of the managed care procurement resulting in this Agreement.
b) Worked on projects relating to, or had oversight responsibility for, projects relating to the Rhode Island Medicaid managed care program.

3.1.14.2. The penalty for violating the above conditions shall result in an administrative sanction of:

a) $2,500 per employee, consultant, or contractor.
b) An added $2,500.00 penalty per month if the Contractor or its Representative fails to terminate the employee, consultant, or contractor after receiving written notice of the violation.

3.1.15. RI Works Participants

3.1.15.1. The State operates a worker training and employment assistance program known as the RI Works. As part of its hiring practices, the Contractor agrees to consider qualified RI Works individuals for employment openings.

3.1.15.2. The Contractor agrees to make good faith efforts to fill at least 50% of their new or open positions related to this Agreement with RI Works participants, providing they are qualified for the positions.

3.1.16. Payments to Institutions or Entities Located Outside of the U.S. (CMS Checklist I.L.6.08)

In compliance with 42 C.F.R. § 438.602(i), the Contractor shall be located within the U.S. The Contractor shall make no payments to a Network Provider, Out-Of-Network provider, Subcontractor, or financial institution located outside of the U.S. The Contractor shall issue no payments for items or services to providers, provider bank accounts or business agents located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. The Contractor is prohibited from making payments to telemedicine providers and pharmacies located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa.

3.1.17. Prohibited Affiliations (CMS Checklist I.I.1.04-.09, I.I.2.17-.37)

3.1.17.1. In accordance with 42 C.F.R. § 438.610, the Contractor may not knowingly contract with or employ, either directly or indirectly:

a) An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under Federal Acquisition Regulations or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing the order.

b) An individual or entity that is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act.

c) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in Section 3.1.17.1(a).

3.1.17.2. The relationships described in this Section are as follows:

a) A director, officer, or partner of the Contractor.

b) A Network Provider, employee, consultant, or other Subcontractor of the Contractor, as governed by 42 C.F.R. § 438.230.

c) A person with beneficial ownership of five percent or more of the Contractor's equity.

d) A person with employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this Contract.

3.1.18. Disclosure of Contractor's Ownership and Control Interest (CMS Checklist I.I.2.06-.12, I.I.2.14-.16, I.L.6.07)

3.1.18.1. In accordance with 42 C.F.R. § 455.104, the Contractor shall submit, for EOHHS review, forms documenting full and complete disclosure of the Contractor's ownership and controlling interest, as specified in Chapter 11 of

the Managed Care Manual, "Reporting Calendar and Templates." Disclosures shall be due at any of the following times:

a) When the Contractor submits the proposal in accordance with the State's procurement process.
b) Upon execution, renewal, or extension of the Agreement.
c) Within 35 Days after any change in the Contractor's ownership.

3.1.18.2. The Contractor shall disclose the following information, based on 42 C.F.R. § 455.104:

a) The name and address and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity or managed care entity. The address for corporate entities shall include as applicable business address, every business location, and P.O. Box address.
b) Date of birth and Social Security Number (in the case of an individual);
c) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or managed care entity) or in any Subcontractor in which the disclosing entity (or managed care entity) has a five percent or more interest.
d) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or managed care entity) is related to another person with an ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling;
e) Whether the person (individual or corporation) with an ownership or control interest in any Subcontractor in which the disclosing entity (or managed care entity) has a five percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
f) The name of any other disclosing entity (or managed care entity) in which an owner of the disclosing entity (or managed care entity) has an ownership or control interest.
g) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or managed care entity).

3.1.18.3. The Contractor shall keep and submit copies of completed disclosure forms to the Secretary of the United States Department of Health and Human Services (DHHS) or to EOHHS within 35 Days of a written request.

3.1.18.4. The information described in this Section shall be submitted concurrently with a certification from the Contractor's CEO, CFO, or a direct report of the CEO or CFO with delegated authority to sign on their behalf. The certification shall attest, based on best information, knowledge, and belief that the data, documentation, and information are accurate, complete, and truthful.

3.1.18.5. In accordance with 42 C.F.R. § 438.602, the Contractor shall post on its website the name and title of individuals included in 42 C.F.R. § 438.604(a)(6). This requirement applies only to any individual or entity that has a contract with the

Contractor that relates directly or indirectly to the performance of the Contractor's obligations under this Agreement, not including a network provider.

3.1 Contract Administration and Management- Document History Log	

Contract Cross-References	• General Conditions of Purchases and Addendum A through E
	• Attachment F-2, General Terms and Conditions
	  ○ Section 2.5, Federal Approval
	  ○ Article 3, Governing Laws and Regulations
	  ○ Article 7, Intellectual Property
	• Section 3.1, Contract Administration and Management
	• Section 3.21, Grievances and Appeals
	• Section 3.22, Program Integrity, Fraud, Waste, and Abuse
	• Section 3.24, Security and Confidentiality
	• Managed Care Manual Chapter 11, Reporting Calendar and Templates

Governing Requirements and Authority	• Americans with Disabilities Act, Civil Rights Act of 1964, • Vocational Rehabilitation Act of 1973 • Age Discrimination Act of 1975 • Patient Protection and Affordable Care Act • Social Security Act Title XI • Social Security Act Title XIX • 20 U.S.C. 1681 • 29 U.S.C. 794 • 42 U.S.C. 12101 *et. seq.*; 2000d *et. seq.* • 42 C.F.R. Chapters 447, 434, 438 • 42 C.F.R. §§ 431.55, 438.3, 438.100; 438.230, 438.602, 438.604, 438.606, 438.608, 438.610, 438.808, 447.26, 455.104, 1001.1901, 1002.3 • 45 C.F.R. § 164.308 • State Medicaid Director Letters 6/12/08 and 1/16/09 • Executive Order 12549 • R.I. Gen Law § 37.14.1 • 220-RICR-80-10-2
CMS Checklist Items	• I.B.1, No Discrimination, Section I.B.1.03 • I.I.1, Exclusions, Sections I.I.1.04 -.09 • I.I.2, Requirements, Procedures, and Reporting, Sections I.I.2.06 -.12, I.I.2.14 -.37 • I.J.2, Compliance with State and Federal Laws, Section 1.J.2.01 • I.J.3, Subcontractors, Sections I.J.3.01-.03 • I.L.6, Program Integrity, Sections I.L.6.07-.08
Revision Date and Description	

3.2. Covered Populations, Enrollment, and Disenrollment

3.2.1. General Information and Requirements (CMS Checklist I.B.1.01-.05 and I.B.3)

3.2.1.1. The Medicaid managed care eligibility determinations, redeterminations, and enrollment functions are the responsibility of EOHHS.

3.2.1.2. The Contractor shall accept all beneficiaries assigned to its Health Plan by EOHHS.

3.2.1.3. The Contractor acknowledges enrollment in managed care is mandatory except in the case of voluntary enrollment programs that meet the conditions of 42 C.F.R. § 438.50(a) (see Section 3.2.6, regarding Voluntary Managed Care Populations).

3.2.1.4. The Contractor shall comply with the requirements of 42 C.F.R. § 438.3(d) by:

a) Accepting all Potential Enrollees in the order in which they apply without restriction, up to the limits set under this Contract;

b) Not discriminating against Potential Enrollees based on race, color, national origin, sex, or disability, or using any policy or practice that has the effect of discriminating on these grounds.

c) Not discriminating in enrollment, disenrollment, or reenrollment based on health status or need for Health Care Services.

3.2.1.5. The Contractor shall have written policies and procedures for receiving, reporting, and updating the following Member information:

a) Receive daily and monthly updates from EOHHS regarding Members enrolled in, or disenrolled from, the Contractor's Health Plan and other updates relating to membership. The Contractor shall incorporate these updates into its MIS within one Business Day.

b) Identify any change in a Member's status that may impact the Member's eligibility or managed care enrollment and notify EOHHS of such changes no later than five Business Days of identification. Examples of changes in status include changes in family size, changes in residence, or death.

c) Electronically report newborn births to EOHHS on a weekly basis. The Contractor is responsible for Medicaid newborns as of the date of birth, provided the mother was actively enrolled or retroactively enrolled as of the date of birth.

d) Perform outreach calls to determine a Member's most recent and accurate address telephone number. The Contractor shall ensure its Subcontracts include flow-down provisions requiring all Subcontractors to report changes in a Member's demographic information to the Contractor. The Contractor shall follow the EOHHS policy and procedures outlined in the "EOHHS Medicaid Managed Care Organization (MCO) Requirements for Medicaid Member Demographic Changes" in Managed Care Manual Chapter 11, "Reporting Calendar and Templates."

3.2.1.6. The Contractor's Member Handbook shall include a notice that changes in status shall be reported to EOHHS, including family size, residence, births, and deaths.

3.2.2. RIte Care Eligibility Groups

3.2.2.1. Qualification for RIte Care eligibility is based on a combination of factors; including family composition, income level, insurance status, and/or pregnancy status, depending on the aid category. Enrollment procedures, scope of benefits, and program cost-sharing vary by aid category as described below.

3.2.2.2. The RIte Care population is a mandatory Managed Care Program population that consists of the following five eligibility groups, or aid categories. These defined groups represent a consolidation of various aid categories:

a) **Families.** This group consists of persons categorically eligible for Medicaid based on RI Works or RI Works-related status or based on families with a minor child or children under age 18 with income specified by the State.

b) **Children Under Age 19 and Under 250% FPL**. This group consists of children under age 19 living in families and with income under 250% of the FPL.

c) **Pregnant Women Under 250% FPL** ("SOBRA-Extension Group"). This group consists of uninsured pregnant women living in families under 250% of the FPL. The category is referred to as the "SOBRA-Extension Group" (Sixth Omnibus Budget Reconciliation Act). The group is eligible for Medicaid Covered Services through delivery and two months postpartum.

d) **Extended Family Planning Group.** This group consists of women who meet the following criteria: have qualified for RIte Care; were pregnant and are now 60 Days postpartum or 60 Days post loss of pregnancy; and are subject to losing Medicaid eligibility. The group is eligible to receive a schedule of family planning-related benefits for up to 24 months, as described in the "Extended Family Planning Program Requirements" in Managed Care Manual Chapter 2, "Medicaid Services." Women who qualify for this category remain with the same Health Plan that provided coverage during pregnancy.

e) **Children with Special Health Care Needs**. This group includes: (1) blind/disabled individuals up to age 21 who are eligible for Medicaid based on SSI; (2) children eligible under Section 1902(e)(3) of the Social Security Act ("Katie Beckett" children) up to age 19; (3) individuals up to age 21 receiving subsidized adoption assistance; (4) children in substitute care ("foster care") (enrollment in RIte Care for these children will be based on EOHHS determination of managed care eligibility) or eligible based on participation in a DCFY kinship or guardian program (whether in a home-based, residential, or institutional setting, as applicable); (5) adults age 21-26 who were previously active with the Department of Youth and Family Services (DCYF) and do not have other comprehensive coverage; and (6) youth who opt to remain in the care of DCYF up to age 21 if they entered foster care on or after their 16th birthday and did not achieve permanency

(i.e. adopted, reunified, etc.) and were set to age out of foster care. Children with Special Health Care Needs may be eligible for home and community-based LTSS as Out-of-Plan Benefits through the Rhode Island Medicaid FFS Program, but receive all In-Plan Benefits through the Managed Care Program.

f) **Uninsured Children Up to Age 18 above 250% FPL**. This group consists of children up to age 18 living in families who are uninsured and whose income is above 250% of the FPL.

3.2.3. Rhody Health Partners Eligibility

3.2.3.1. Individuals who meet the following criteria are eligible for Rhody Health Partners, and are included in the Managed Care Program as a mandatory population:

a) Age 21 and older;
b) Categorically eligible for Medicaid;
c) Not covered by other third-party health insurance (including Medicare);
d) Residents of Rhode Island; and
e) Not residing in an institutional facility for more than 30 Days.

3.2.3.2. These individuals may be eligible for home and community-based LTSS as Out-of-Plan Benefits through the Rhode Island Medicaid FFS Program, but receive all In-Plan Benefits through the Managed Care Program.

3.2.4. Affordable Care Act (ACA) Eligible Population

3.2.4.1. Individuals who meet the following criteria qualify for ACA Expansion group eligibility, and are included in the Managed Care Program as a mandatory population:

a) Adults between the ages of 19 and 64;
b) Who are at or below the State's specified FPL based on household income (using the application of a modified adjusted gross income);
c) Who are not pregnant;
d) Who otherwise do not qualify for Medicaid; and,
e) Are not eligible for or enrolled in Medicare.

3.2.4.2. Members in the ACA Expansion group who become pregnant while enrolled are guaranteed eligibility for comprehensive services through 2 months postpartum or post loss of pregnancy, and then are eligible for an Extended Family Planning benefit for up to an additional 24 months.

3.2.5. New Eligibility Groups

EOHHS reserves the right to add new eligibility groups by amending this Agreement.

3.2.6. Voluntary Managed Care Population

Eligible Indian populations are subject to voluntary enrollment in the Managed Care Program and may choose to opt out of the program.

3.2.7. Excluded Managed Care Populations

The following Medicaid populations are excluded from enrollment in the Managed Care Program:

3.2.7.1. Recipients receiving services in an Intermediate Care Facility for Intellectual or Developmental Disabilities (ICF/IID).

3.2.7.2. Rhody Health Partners and ACA Expansion populations who have exceeded the maximum number of Days in a nursing facility as defined in Section 3.2.14 of this Agreement. See Section 3.2.14 for a description of the managed care disenrollment process.

3.2.8. No Guaranteed Eligibility

Except as provided above, there are no eligibility guarantees for RIte Care, Rhody Health Partners, and ACA Expansion group Members. EOHHS has the sole authority to determine whether an individual meets managed care eligibility and enrollment criteria, as well as the individual's cost sharing requirements, if applicable.

3.2.9. Non-Biased Enrollment Counseling (CMS Checklist I.C.1.12)

3.2.9.1. At the time of initial eligibility determination or re-certification, EOHHS will make available non-biased enrollment counseling ("Choice Counselors") to Potential Enrollees. Responsibilities of the Choice Counselors include educating Potential Enrollees and their families, guardians, or adult caregivers about:

a) Managed care in general, including: the option to enroll in a Health Plan; the way services typically are accessed under managed care; the role of the PCP; and Health Plan Member responsibilities.

b) Benefits available through the Contractor's Health Plan, both in plan and out of plan.

c) Available Health Plan options, including criteria that might be important when making a choice (e.g., presence or absence of an existing PCP or other Providers in a Health Plan's Network).

3.2.9.2. To facilitate enrollment counseling, the Contractor shall provide enrollment packet materials to EOHHS annually, or more frequently if the Contractor makes substantive changed to the materials. All materials for Potential Enrollees shall be written at no higher than a sixth-grade level, in a format and manner that is easily understood in accordance with 42 C.F.R. § 438.10(c).

3.2.10. Selection of Health Plan by Applicants and Beneficiaries

EOHHS will offer applicants or beneficiaries the opportunity to select a Health Plan at the time of enrollment, when a Health Plan leaves the market or is terminated, during designated plan change opportunity periods, and at other times determined by EOHHS.

3.2.11. Default Enrollment

3.2.11.1. EOHHS will open the plan change opportunity at the start of the new contract period; all beneficiaries will have the opportunity to select or change their current Health Plan.

3.2.11.2. EOHHS will offer all beneficiaries the opportunity to select or change their current Health Plan on a yearly basis (Plan Change Opportunity). A Member of an incumbent Health Plan who does not make a Health Plan selection will remain in the same Health Plan.

3.2.11.3. If an eligible applicant or beneficiary does not select a Health Plan, EOHHS will assign one in accordance with 42 C.F.R. § 438.54.

3.2.11.4. EOHHS's default enrollment methodology will seek to preserve existing provider-beneficiary relationships. The default enrollment methodology also may include market share, quality metrics, Health Plan performance on contract requirements including contracting with EOHHS-certified AEs, Health Plan financial performance, household affiliations, previous enrollment in a Qualified Health Plan (QHP), or other factors EOHHS determines are in the best interest of Members.

3.2.11.5. EOHHS reserves the right to implement a special default process at any time.

3.2.12. Automatic Reassignment Following Resumption of Eligibility (CMS Checklist I.B.4)

Beneficiaries who are disenrolled from a Health Plan due to loss of eligibility, and who regain eligibility within 60 Days of disenrollment, may select a Health Plan of their choice. Beneficiaries who do not make a Health Plan selection will be automatically assigned to their previous Health Plan upon reinstatement of their Medicaid eligibility. If more than 60 Days have elapsed and the beneficiary does not make a Health Plan selection at the time eligibility was reinstated, the beneficiary will be assigned to a Health Plan based on the default enrollment process described in Section 3.2.11.

3.2.13. Health Plan Lock-In

After 90 Days of initial enrollment in a Health Plan, Members will be restricted to that Health Plan until the next open enrollment period, unless disenrolled under one of the conditions described in Section 3.2.14.

3.2.14. Member Disenrollment (CMS Checklist I.B.5.01-.16 and I.B.6.01-.02)

3.2.14.1. EOHHS has sole authority to disenroll Members from contracted Health Plans, subject to the conditions described below. The Contractor is prohibited from processing a Member's request to disenroll from the Health Plan and will direct Members to file the request directly with EOHHS, or its delegate, for a disenrollment determination.

3.2.14.2. EOHHS will disenroll Members from a Health Plan for any of the following reasons:

a) Loss of Medicaid eligibility;
b) Loss of program eligibility;
c) Death;
d) Relocation out-of-state;
e) Adjudicative actions;
f) Change in eligibility status;

g) Placement in a nursing facility for more than 30 consecutive Days (Rhody Health Partners and ACA Expansion Members only);

h) Placement in an institution for mental disease or institutional long-term care facility, such as Eleanor Slater or Tavares;

i) A long-term stay in an out-of- state hospital;

j) Eligibility determination error; or,

k) For cause, as determined by EOHHS.

3.2.14.3. EOHHS will determine whether cause exists for disenrollment on an individual basis in accordance with 42 C.F.R. § 438.56(d)(2). Circumstances constituting cause include:

a) Poor quality of care;

b) Lack of access to Providers experienced in dealing with the Member's health needs;

c) The Contractor does not cover a service because of moral or religious ground; and

d) The Member's service needs (e.g., cesarean section and a tubal ligation) are not available within the network, and the Member's Primary Care Provider or another provider determines that not receiving the services will subject the Member to unnecessary risk.

3.2.14.4. A Member has the right to disenroll for cause, as described in Section 3.2.14.3, at any time.

3.2.14.5. A Member may request disenrollment from EOHHS or the Contractor either in writing or orally. The Contractor shall refer the request to EOHHS within one Business Day and Contractor shall provide member with information on how to disenroll from Health Plan, including disenrollment form.

3.2.14.6. A Member may request disenrollment without cause:

a) During the 90 Days following the date of the recipient's initial enrollment with the Contractor and at least once every 12 months thereafter;

b) Upon automatic reenrollment under 42 C.F.R. § 438.56(g), if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity; and

c) When EOHHS imposes an intermediate sanction upon the Contractor, as identified in 42 C.F.R. § 438.702(a)(4).

3.2.14.7. In accordance with 42 C.F.R. § 438.56(b)(2), the Contractor may not request disenrollment of a Member because of an adverse change in the Member's health status, or because of the Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the Member's special needs (except when the Member's continued enrollment in the Health Plan seriously impairs the Health Plan's ability to furnish services to either the particular Member or other Members).

3.2.14.8. The Contractor shall submit written disenrollment policies and procedures to EOHHS for approval. If an exception applies, the Contractor shall request the disenrollment in writing and provide justification for the request. All disenrollments are subject to approval by EOHHS.

3.2.15. Effective Date of Disenrollment (CMS Checklist 1.B.6.03-.04)

3.2.15.1. EOHHS will process a Member's request for disenrollment in accordance with the timeframe specified in 42 C.F.R. § 438.56(e), no later than the first Day of the second month following receipt (the "processing deadline"). Requests processed after this timeframe will be effective as of the processing deadline.

3.2.15.2. EOHHS will notify the Contractor of a Member's effective date of disenrollment, which normally will be effective at midnight on the last date of the month in which notice was received.

3.2.15.3. The Contractor agrees to have written policies and procedures for complying with State disenrollment orders.

3.2.16. Retroactive Enrollment and Disenrollment

In special circumstances identified by EOHHS, the Contractor shall retroactively enroll or disenroll a Member. The Contractor is required to coordinate with EOHHS and the Member's prior Health Plan, if applicable, to successfully transition the Member to the Contractor's Health Plan, and to work with EOHHS to reprocess any necessary claims.

3.2.17. Reporting Demographic Changes

3.2.17.1. The Contractor shall report address changes, including Members who report out-of-state address changes, to EOHHS in accordance with the EOHHS Medicaid Managed Care Organization Requirements for Medicaid Member Demographic Changes.

3.2. Covered Populations, Enrollment, and Disenrollment- Document History Log	
Contract Cross-References	• Managed Care Manual Chapter 11, Reporting Calendar and Templates
Governing Requirements and Authority	• Section 1903(m)(2)(A)(v) of the Social Security Act (42 U.S.C. § 1396b) • 42 C.F.R. §§ 438.3, 438.10, 438.50, 438.54, 438.56, 438.702
CMS Checklist Items	• I.B.1, No Discrimination, Sections I.B.1.01-.05 • I.B.3, Opt Out, Section I.B.3.01 • I.B.4, Reenrollment, Section I.B.4.01 • I.B.5, Disenrollment, Sections I.B.5.01-.16 • I.B.6, Disenrollment Request Process, Sections I.B.6.01-.04 • I.C.1, Language and Format, Section I.C.1.12
Revision Date and Description	

3.3. Covered Benefits, Service Requirements, and Limitations

3.3.1. General Requirements (CMS Checklist I.F.6.10-.13)

The Contractor shall cover all Covered Services in Attachment F-3.1, "Schedule of In-Plan Benefits," so long as the service is Medically Necessary for the Member. In accordance with 42 C.F.R. § 438.210(a)(5), the Contractor shall apply Medical Necessity criteria in a manner that:

3.3.1.1. Is no more restrictive than Rhode Island's Medicaid Fee-for-service (FFS) Program, taking into account Quantitative and Non-Quantitative Treatment Limits indicated in Rhode Island's State Plan or other state law or regulation.

3.3.1.2. Provides Members access to services that address the prevention, diagnosis, and treatment of diseases, conditions, or disorders that result in health impairments or disabilities.

3.3.1.3. Provides Members access to services that allow then to achieve age-appropriate growth and development.

3.3.1.4. Allows Members access to services needed to attain, maintain, or regain a Member's functional capacity.

3.3.2. Failure to Provide Covered Benefits (CMS Checklist I.J.5)

If the Contractor fails to provide any Covered Services, or approved In Lieu of Service, as outlined by this Agreement, EOHHS may impose contractual remedies, including civil monetary penalties up to $25,000 for each failure to provide services. EOHHS may also:

3.3.2.1. Appoint temporary management to the Contractor.

3.3.2.2. Grant Members the right to disenroll from the plan without cause.

3.3.2.3. Suspend all new enrollments after the date the Secretary or the state notifies the Contractor of a determination of a violation under this Section of the Agreement.

3.3.2.4. Suspend the payments for new Members until CMS or EOHHS is satisfied the Contractor has taken remedial measures and the noncompliance is not likely to recur.

3.3.3. Amount, Duration, and Scope, Caps and Limitations (CMS Checklist I.F.6.01-.09)

The Covered Services described in Attachment F-3, "Services," must comply with the following requirements.

3.3.3.1. Each Covered Service shall be provided in an amount, duration, and scope that is no less than the amount, duration, and scope for the same service under Rhode Island's fee-for-service Medicaid program.

3.3.3.2. The Contractor shall ensure that Covered Services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which they are furnished.

3.3.3.3. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of Covered Services solely because of the diagnosis, type of illness, or condition of the Member.

3.3.3.4. Covered Services are subject to the benefit limits described in the Rhode Island Medicaid State Plan. The Contractor may place appropriate limits on Covered Services based on Medical Necessity or for the purpose of utilization control.

3.3.3.5. The Contractor shall ensure, notwithstanding any utilization controls:

a) Services can reasonably achieve their purpose.
b) Services are authorized a manner to reflect a Member's ongoing need for services and supports, taking into account Members with ongoing or chronic conditions.
c) Family planning and women's health services are provided in a manner that maintains the Member's freedom of choice as required in Sections 3.14.38 and 3.14.39 of this Agreement.

3.3.4. In-Lieu of Services (CMS Checklist I.F.6.16-.20)

3.3.4.1. The Contractor may offer In-Lieu of Services (ILOS), as approved by EOHHS, in accordance with the policies and procedures outlined in Chapter 2 of the Managed Care Manual, "Medicaid Services." ILOS may be substituted for a Rhode Island Medicaid State Plan service when all of the following conditions are met:

a) EOHHS, in its sole discretion, determines the alternative service or setting is a medically appropriate substitute for the Covered Service or setting under the Rhode Island Medicaid State Plan.
b) EOHHS, in its sole discretion, determines the alternative service or setting is a cost-effective substitute for the Covered Service or setting under the State Plan.
c) The approved ILOS is listed in the Attachment F-3.4, "In-Lieu of Services."

3.3.4.2. In its approval of the ILOS, EOHHS will designate a CPT code and fee schedule rate and other billing and coding guidelines, as appropriate.

3.3.4.3. The Contractor shall submit claims for ILOS using the designated code and rate. Further the Contractor shall follow all EOHHS billing and coding guidelines applicable to that ILOS

3.3.4.4. The Contractor may not offer an ILOS until EOHHS has submitted a written notice of approval of the ILOS and its CPT code and rate and notified the Member as outlined in this Section.

3.3.4.5. The Contractor may not require the Member to receive the ILOS in place of the Rhode Island Medicaid State Plan service.

3.3.4.6. The Contractor shall inform Members of any newly approved ILOS on its website, in accordance with Section 3.19.11, "Contractor Website," and in an update to the Member Handbook. All updates shall be posted no later than 30 Days after EOHHS's approval of the ILOS.

3.3.4.7. If the Contractor seeks to provide an ILOS that is not listed in Attachment F-3.4, it shall receive EOHHS' prior approval to delivery of the ILOS in accordance with Chapter 2 of the Managed Care Manual.

3.3.5. Termination of an In-Lieu of Service

EOHHS, in its sole discretion, may terminate an ILOS if it determines the service is not cost effective or may be harmful to Members. EOHHS will provide notice to the Contractor of its decision to terminate.

3.3.5.1. The Contractor may terminate its offer of an ILOS after receiving approval from EOHHS to do so. The Contractor shall submit their intent to terminate an ILOS in accordance with Managed Care Manual Chapter 2, "Medicaid Services."

3.3.5.2. The Contractor shall notify Members of an ILOS termination, regardless of whether EOHHS or the Health Plan initiated the termination. The Contractor shall post notice on its website, in accordance with Section 3.19, "Member Materials," and in an update to the Member Handbook. All updates shall be posted no later than 30 Days in advance of the termination date.

3.3.5.3. The Contractor shall develop a transition plan for Members receiving the terminated ILOS and ensure Subcontractors and Providers follow the transition plan or otherwise maintain continuity of care for Members.

3.3.6. Out-of-Plan Benefits

The Contractor is not responsible for directly providing or reimbursing Out-of-Plan Benefits as outlined in Attachment F-3.2 of this Agreement.

3.3.6.1. Out-of-Plan Benefits are not available to all of following populations:

a) SOBRA-extension group Members who have an income above 250% of the federal Poverty Level.
b) Members receiving Extended Family Planning Benefits.

3.3.7. Contractor Responsibilities

Notwithstanding the foregoing, the Contractor shall provide coordination for Out-of-Plan Benefits or otherwise ensure the Out-of-Plan Benefit is accessible to the Member. This includes:

3.3.7.1. Educating Members and Providers about the availability of these services (via the Member Handbook, Provider Handbook, outreach, and education materials, etc.).

3.3.7.2. Ensuring the Member's Primary Care Provider or specialty Provider refers the Member to the Out-of-Plan Service, as appropriate.

3.3.7.3. Facilitating communication and information sharing between Network Providers and out-of-network providers, brokers, and other state agencies for access to Out-of-Plan Services.

3.3.7.4. Verifying whether Members are receiving these services.

3.3.7.5. Ensuring the Member's Primary Care Provider, Case Manager, Primary Care Case Manager, or other entity creating the Member's plan of care is integrating Out-of-Plan Services when creating and executing the Member's Plan of Care.

3.3.7.6. Coordinating all Out-of-Plan Benefits with the In-Plan Benefits in the Member's Plan of Care.

3.3.8. Value-Added Services

3.3.8.1. The Contractor may offer Value-Added Services to its Members, as approved by EOHHS in accordance with Chapter 2 of the Managed Care Manual.

3.3.8.2. EOHHS will not factor Value-Added Service into its calculation of the Contractor's Capitation Rate, meaning the Contractor is responsible for the cost of all Value-Added Services.

3.3.8.3. The Contractor shall include a description of the Value-Added Services offering in all Member Materials as described in 3.19 of this Agreement.

3.3.8.4. The Contractor may include use Value-Added Services offerings as a Marketing tool and include the service array in Marketing Materials.

a) The Contractor shall share a description of the Value-Added Services offerings with EOHHS contracted entities providing Choice Counseling to help ensure Choice Counselors are accurately explaining the Value-Added Services in their communication with Members and Potential Members.

3.3.9. Terminating a Value-Added Service

3.3.9.1. The Contractor, in its sole discretion, may choose to discontinue a Value-Added Service.

3.3.9.2. Prior to terminating a Value-Added Service, the Contractor shall notify the following entities:

a) The Contractor shall notify EOHHS no later than 60 Days in advance of the proposed effective date of termination if the Contractor is choosing to terminate a Value-Added Service. Further, the Contractor shall provide EOHHS with a plan to have all Members receiving the Value-Added Service complete their course of treatment at a clinically appropriate point and refer Members to an alternative service if medically appropriate and available under the benefit package.

b) The Contractor shall notify the Choice Counselors no later than 30 Days in advance of the proposed effective date of termination.

c) The Contractor shall notify all Members no later than 30 Days in advance of the proposed effective date of termination. The notification shall be on the Member facing page of the Contractor's website as described in 3.19 of this Agreement and in an updated version of all Member Materials. The Contractor should make a best effort to communicate directly with Members receiving the Value-Added Service.

3.3. Covered Benefits, Service Requirements, and Limitations- Document History Log	
Contract Cross-References	• Attachment F-3, Services • Section 3.14, Provider Networks and Requirements, Access to Care • Section 3.19, Member Materials • Managed Care Manual Chapter 2, Medicaid Services
Governing Requirements and Authority	• 42 C.F.R. § 438.210
CMS Checklist Items	• I.F.6, Amount, Duration, and Scope, Sections I.F.6.01-.13, and I.F.6.16-.20 • I.J.5, Sanctions, Section I.J.5.01
Revision Date and Description	

3.4. Behavioral Health Benefits

3.4.1. General Requirements

3.4.1.1. The Contractor shall provide the full continuum of Behavioral Health Benefits described in this Agreement, including Mental Health Benefits and Substance Use Disorder Benefits for children and adults. These benefits are described at a high level in this section. For additional information regarding Behavioral Health Benefits, see Attachment F-3 ("Services"), Chapter 2 of the Managed Care Manual, "Medicaid Services," the Rhode Island Medicaid Provider Manual's Chapter on "Rehabilitative Services," and the Rhode Island Medicaid State Plan.

3.4.1.2. Recognizing that Members' behavioral health needs may change over time, the Contractor shall implement a stepped approach to providing Behavioral Health Benefits that addresses all levels of need. Members can enter the continuum at any step and shall receive care and treatment based on their individual needs and acuity levels.

3.4.1.3. The Contractor's behavioral health program shall include strategies to promote early diagnosis, intervention, and treatment. These strategies shall include early screening and referral practices, to ensure treatment is provided at the right time and setting, thereby reducing the need for inpatient, emergency room (ER), and other high-cost settings.

3.4.1.4. The Contractor shall comply with the Rhode Island Medicaid State Plan, Rhode Island Medicaid Provider Manual's Rehabilitative Services Coverage Guidelines, and EOHHS Certification Standards as they relate to coverage of Behavioral Health Benefits, benefit limits, and authorized provider types.

3.4.1.5. Subject to the requirements of Sections 3.4.2, "Behavioral Health Workgroup" and 3.4.13, "Mental Health Parity Requirements," the Contractor is responsible for develop its own claims billing guidelines and level of care (LOC) and UR criteria for Behavioral Health Benefits. These guidelines and criteria shall be approved by EOHHS prior to implementation and any subsequent substantive revision.

3.4.1.6. In accordance with Sections 3.14.28 and 3.20.7, the Contractor's Provider and Member education programs shall include descriptions of covered Behavioral Health Benefits, Out-of-Plan Behavioral Health Benefits, and how to access these services.

3.4.1.7. In accordance with Section 3.14.23, "Self-Referrals" the Contractor shall have written policies and procedures allowing Members to self-refer for in-network Behavioral Health Benefits, as appropriate to the type of service.

3.4.1.8. The Contractor shall comply with reporting requirements regarding behavioral health quality metrics and outcomes, as described in Chapter 9 of the Managed Care Manual, "Quality Programs." The Contractor is subject to contractual remedies, including liquidated damages and payment withholds, for failure to report on or meet performance targets.

3.4.2. Behavioral Health Workgroup

3.4.2.1. The Contractor shall participate in an ongoing workgroup with EOHHS, BHDDH, DCYF, health plans, AEs, Member advocates, and other stakeholders and interested parties identified by EOHHS. The purpose of the workgroup is to identify:

a) Practices and protocols to promote health equity and access to integrated and coordinated physical health, behavioral health, SUD, and social determinants of health (SDoH) services.
b) Opportunities to reduce provider burden through streamlined and standardized claims billing guidelines; LOC criteria; and prior authorization, retrospective review, and other UM processes.
c) Standardized screening and assessment tools to promote early diagnosis and treatment of behavioral health conditions for all Members, including Members with developmental delays, and to identify SDoH and other risk factors that impact behavioral health outcomes.
d) Standardized and evidence-based provider education and training tools to address workforce challenges, early diagnosis and intervention, health equity, and SDoH. When appropriate, trainings should be designed to meet continuing education requirements for maintaining provider licensure or certification.
e) Standardized tool to support evidence-based practices, including technical bulletins, certification standards, and program guidelines.
f) Standardized transition of care protocols, including discharge planning protocols for Members following inpatient psychiatric or residential treatment services.

3.4.2.2. Examples of standardized screening and assessment tools the workgroup may consider include:

a) Child and Adolescent Needs and Strengths Assessment (CANS);
b) Adult Needs and Strengths Assessment (ANSA);
c) Screening, Brief Intervention, and Referral to Treatment (SBIRT);
d) National Institute of Mental Health suicide screening tools;
e) Adverse Childhood Experiences (ACEs);
f) Brief Questionnaire for Initial Placement (BQuIP);
g) The Level of Care Utilization System (LOCUS); and
h) Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE).

3.4.2.3. The following table includes examples of standardized and evidence-based provider education and training activities the workgroup may consider:

Adult Specific	Child/Adolescent Specific	All Populations
• SAMHSA Assertive Community Treatment (ACT) • Cognitive Behavioral Therapy (CBT) and Cognitive Processing Therapy (CPT) • SAMHSA Illness Management and Recovery (IMR) • SAMHSA Integrated Treatment for Co-occurring Disorders • SAMHSA Supported Employment and Permanent Supportive Housing • Housing First • "SAMHSA Medication Assisted Treatment (MAT)"	• Nurturing Parent Training • Trauma Focused CBT • Case Management using the NWIC Wraparound model, when indicated	• Screening, Brief Intervention, and Referral to Treatment (SBIRT) Model • Motivational Interviewing • Person-Centered Recovery Planning • Patient Activation • Seeking Safety • Cultural Competency and Implicit Bias

3.4.2.4. The workgroup will provide a report with preliminary recommendations no later than six months after the Operational Start Date and will continue to meet on a quarterly basis as directed by EOHHS.

3.4.2.5. All workgroup recommendations are subject to EOHHS review and final approval. Policies and procedures developed through workgroup activities will be added to the Managed Care Manual as needed.

3.4.3. Behavioral Health Network

3.4.3.1. The Contractor is responsible for maintaining and promoting access to a robust Provider network. The network shall include a broad mix of Providers, including:

a) Qualified Clinicians – including Rhode Island Department of Health licensed psychiatrists, psychologists, mental health counselors, marriage and family therapists, chemical dependency providers, and social workers with the requisite skills and training for the services provided and the Members served. In some cases, providers working toward licensure can provide services under the supervision of a licensed provider.

b) Psychiatric hospitals and acute care hospital with units designated as psychiatric facilities under R.I. Gen. Laws § 40.1-5;

c) BHDDH-licensed: inpatient psychiatric facilities for SUD services; inpatient psychiatric facilities; Medication Assisted Treatment (MAT) providers; substance use treatment programs and facilities; Community Mental Health Centers (CMHCs); Community Residential Service providers and facilities; and Adult Day Health Service providers; and

d) Peer Recovery Specialists ("Recovery Coaches") and Family Youth Support Peer Program providers meeting EOHHS certification standards.

e) Other community-based providers meeting the education and qualification standards for the services provided.

3.4.3.2. For the provider types identified above, refer to Section 3.14, "Provider Networks and Requirements, Access to Care," for additional information regarding provider network and access standards. The Contractor shall monitor the behavioral health access standards to promote parity and geographic accessibility, and to ensure the full continuum of behavioral health needs is met on a timely basis.

3.4.3.3. Unless otherwise noted in the Contract or Managed Care Manual, the Contractor is responsible for negotiating reasonable reimbursement rates with behavioral health Network Providers, and for reaching the EOHHS performance targets regarding APMs described in Section 3.28, "Alternative Payment Model Methodologies."

3.4.4. General Rehabilitative Services

3.4.4.1. The Contractor is responsible for providing child and adult Member access to the full continuum and array of behavioral health rehabilitative Covered Services.

3.4.4.2. The primary purpose of rehabilitative services is to provide diagnosis, treatment, or rehabilitation of a mental disorder, or a dysfunction related to a mental disorder. Rehabilitative services also include clinical diagnostic and treatment services for individuals with behavioral health disorders. These services typically include:

a) Assessment and diagnostic evaluation;
b) Psychological and neuropsychological assessment and evaluation;
c) Developmental evaluation;
d) Psychological testing;
e) Individual, family, couple, and group therapy;
f) Crisis intervention, including mobile crisis intervention through a community mental health center; and
g) Medication treatment, evaluation, and management.

3.4.4.3. Rhode Island Medicaid also provides specialized rehabilitative behavioral health Covered Services to children and adults with complex needs. These services are described below.

3.4.5. Mental Health Targeted Case Management

3.4.5.1. Targeted Case Management (TCM) includes services provided by qualified mental health providers for the purpose of monitoring and assisting clients in maintaining their overall wellbeing. This includes gaining access to needed medical, social, educational, and other services necessary to meet basic human needs. TCM services may include:

a) Maintaining up-to-date assessments and evaluations necessary for establishing eligibility for Behavioral Health Benefits.

b) Participating in the treatment planning process and monitoring client progress in meeting the goals and objectives of the individualized treatment plan.
c) Locating, coordinating, and monitoring all necessary medical, educational, vocational, social, and psychiatric services.
d) Assisting in the development and execution of an individualized treatment plan that supports income maintenance.
e) Assisting in the development of appropriate social networks and natural supports.
f) Assisting with other activities necessary to maintain behavioral health stability in a community-based setting.

3.4.5.2. To qualify for TCM, Members shall meet the eligibility criteria for "target groups" described in the Rhode Island Medicaid State Plan.

3.4.5.3. The Contractor shall ensure child and adult Members in the following target groups have access to TCM as a Covered Service:

a) Severely Mentally Disabled: children, adolescents, and adults with severe and/or persistent mental or emotional disorders.
b) DCYF Children: children between the ages of one Day and five years in DCYF care or custody, who have or are at risk of acquiring human immunodeficiency virus (HIV).
c) Children Receiving Early Intervention: children ages of one and three receiving early interventions services due to developmental delays or other established conditions.
d) Victims of Incest, Sexual Molestation, and Sexual Assault: child and adolescent victims.
e) Children in the Lead Program: children under the age of 21 with elevated screening or blood levels, or under the age of 6 with developmental delays.
f) HIV/AIDS Program: children, adolescents, or adults with HIV or Acquired Immune Deficiency Syndrome (AIDS).
g) Children at Risk of Developmental Disabilities (DD): children under the age of 21 who are either at risk of developing a developmental disability due to specific medical conditions, such as genetic disorders, birth defects, inborn diseases of metabolism or are demonstrating developmental delays.

3.4.5.4. Members in other target groups also may receive TCM as an Out-of-Plan Benefit if they meet the eligibility criteria described in the Rhode Island Medicaid State Plan. These Members include:

a) Members participating in the Adolescent Parenting Program;
b) Children ages 3-21 receiving special education services;
c) Homebound adults ages 65 and over;
d) Blind or visually impaired children and adults; and
e) Children under age 21 who are involved in the juvenile justice system.

3.4.5.5. The Contractor shall develop and implement strategies to coordinate care with all TCM providers, whether delivering TCM as a Covered Service or an Out-of-Plan Benefit. Coordination efforts shall include strategies to:

a) Share data;
b) Identify and address Social Determinants of Health (SDoH);
c) Coordinate Out-of-Plan Benefits, including out-of-plan TCM; and
d) Verify Members receive services and supports not covered by Medicaid from community-based organizations following referrals to these entities (i.e., "close the loop on referrals").

3.4.5.6. The Contractor shall implement UR strategies and Care Plan protocols to ensure that Members receiving TCM services do not receive duplicate services through other Medicaid programs, such as the Health Homes for Children program (also called "Cedar Health Homes") and Assertive Community Treatment/Integrated Health Homes programs for adults.

3.4.6. Home and Community Based Services for Children

3.4.6.1. The Contractor is responsible for providing home and community-based services (HCBS) to children with complex needs. These specialized services are intended to meet the needs of children with serious or chronic health needs and allow them to attain their fullest potential while remaining as independent as possible in their home communities.

3.4.6.2. HCBS include:

a) Applied Behavior Analysis (ABA);
b) Adolescent Residential Substance Use Treatment;
c) Personal Assistance Services and Supports (PASS); and,
d) Respite Services.

3.4.6.3. HCBS shall be provided through a holistic, person and family-centered approach, and should be designed to improve Member outcomes by integrating mental health, physical health, SUD, and SDoH health needs.

3.4.6.4. The Contractor shall ensure HCBS comply with Evidence-Based Practices (EBP) treatment modalities specific to each service.

3.4.6.5. The Contractor shall provide HCBS in accordance with EOHHS and federal HCBS settings requirements, including 42 C.F.R. Part 441.

3.4.6.6. For child Members with behavioral health conditions, developmental delays and/or at risk of DD who receive HCBS as Out-of-Plan Benefits, the Contractor is responsible for overseeing all Care Program activities, including coordination of In-Plan Benefits and Out-of-Plan HCBS.

3.4.7. Intermediate Services

3.4.7.1. The Contractor is responsible for providing intermediate services for child and adult Members requiring alternatives to, or step-down from, hospitalization and other acute services described in Section 3.4.8, "Acute Services."

3.4.7.2. Intermediate services include:

a) Partial Hospitalization (PHP)/Day Treatment Program/Intensive Outpatient Treatment (IOP) (for children and adults);
b) Enhanced Outpatient Services (EOS) (for children)/Community Psychiatric Supported Treatment (CPST) (for adults);
c) Assertive Community Treatment (ACT) (for adults);
d) Health Homes for Children services (for children);
e) Peer Recovery Specialist services (for adults) and Family Support services (for children);
f) Integrated Dual Diagnosis Treatment for SUD Services (for adults);
g) Center of Excellence Program (COE) Medications (for adults).

3.4.7.3. Most COE Program services are Out-of-Plan Benefits reimbursed by Medicaid FFS; except for medications (table or films), which shall be included on the Contractor's formulary as the Pharmacy Services In-Plan Benefit.

3.4.8. Acute Services

3.4.8.1. The Contractor shall provide acute Behavioral Health Benefits for children and adults. Acute services represent the highest level of service intensity based on the Member's need for either a locked or staff secured 24-hour clinical setting that offers full behavioral health management and supervision.

3.4.8.2. Acute services include:

a) Inpatient Acute Hospitalization;
b) Acute Residential Treatment Services (ARTS);
c) Observation/Crisis Stabilization; and
d) Emergency Service Intervention; including mobile crisis response services.

3.4.9. Long Term Residential Programs

3.4.9.1. The Contractor shall provide long term residential program services to adult Members who meet clinical criteria described in Managed Care Manual Chapter 2, "Medicaid Services." Long term residential program services include:

a) SSTAR Birth Residential Program;
b) Mental Health Psychiatric Rehabilitative Residence (MHPRR); and
c) Supportive Mental Health Psychiatric Rehabilitative Residence Apartments (MHPRR-A).

3.4.9.2. Providers must meet state licensure or certification standards, as appropriate to the service provided.

3.4.9.3. The Contractor shall coordinate with these Providers on discharge planning, to ensure Members have the medical and community supports needed to successfully transition to the community.

3.4.10. Opioid Treatment Program Health Home

3.4.10.1. The Contractor shall provide Opioid Treatment Program (OTP) Health Home (HH) program services to adults with opioid dependence who meet the clinical criteria for program service (e.g., co-occurring chronic conditions or risk of chronic conditions), as described in Managed Care Manual Chapter 2, "Medicaid Services."

3.4.10.2. The OTP HH program includes comprehensive Care Coordination, health promotion, chronic condition management, population management, transitional care, individual and family support services, and other services described in Managed Care Manual Chapter 2, "Medicaid Services."

3.4.10.3. The Contractor shall provide the following oversight and support activities for OTP Health Home Providers:

a) Provide reports to Providers to facilitate coordination of medical and behavioral health care.
b) Use utilization data (inpatient admissions, readmissions, ER visits, and pharmacy reports) and predictive modeling to identify Members with new health risks and share this information with Providers.
c) Provide technical support and assistance to Providers regarding quality and data reporting, and submission of HIPAA compliant claims data.
d) Oversee Provider performance, including HIPAA compliant claims submission for OTP HH bundles, and withhold payments as needed and in accordance with the Reporting Calendar in Managed Care Manual Chapter 11, "Reporting Calendar and Templates."
e) Work with Network Providers and Out-of-Network Providers to ensure Members receive coordinated care and can maintain relationships with established treating providers.

3.4.11. Court Ordered Behavioral Health Benefits

3.4.11.1. The Contractor shall provide Behavioral Health Benefits ordered by a Court with jurisdiction over behavioral health and SUD matters (e.g., drug, mental health, and family law courts), and services required by other state officials or bodies (e.g., probation officers, the Rhode Island State Parole Board) in accordance with applicable Rhode Island laws and regulations. The Contractor shall not require Prior Authorization for such services, nor controvert their Medical Necessity in retrospective reviews.

3.4.11.2. The Contractor is required to cover court-ordered services provided by Out-of-Network Providers.

3.4.12. Care Coordination and Discharge Planning

3.4.12.1. The Contractor shall require PCPs to have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health or SUD conditions or disorders. PCPs may provide any clinically appropriate behavioral health or SUD service within the scope of their practice.

3.4.12.2. The Contractor shall provide training to network PCPs on:

a) How to screen and identify behavioral health disorders.
b) The Contractor's referral processes for Behavioral Health Benefits.
c) The Contractor's clinical care coordination requirements.

3.4.12.3. The Contractor shall educate behavioral health Providers on processes to refer Members with known or suspected and untreated physical health problems or disorders to their PCPs for examination and treatment.

3.4.12.4. The Contractor is responsible for developing operational processes with Providers to ensure they are aware when Members visit emergency departments or admitted to inpatient levels of care.

3.4.12.5. Prior to discharge from an inpatient psychiatric setting, all Members receiving inpatient psychiatric services shall be scheduled for an outpatient follow-up visit with a mental health practitioner no later than seven Days after discharge. In addition, Members who are clinically assessed in an ER setting and are not admitted to an inpatient LOC shall receive a follow up visit with a mental health practitioner within seven Days of ER discharge. The Contractor may fulfill these requirements by either:

a) Contracting with Network hospitals or other Providers.
b) Using the Contractor's own or delegated Care Managers or Care Coordinators for outreach.
c) Contracting with another Care Coordination entity in the community.

3.4.12.6. The Contractor shall develop policies and procedures to ensure discharge plans are shared with the Member's behavioral health provider, PCP, AE, or other care coordinating entity (as applicable) within three Business Days of discharge.

3.4.12.7. The Contractor shall work with hospital delivery systems to develop:

a) Transition of care protocols for Members discharged from the hospital, including clear documentation of each party's roles and responsibilities. The protocols will also address processes and procedures to coordinate with DCYF for children in DCYF care or custody.
b) Develop strategies to provide integrated and coordinated care to Members who may present with primary medical conditions who also have underlying behavioral health issues, such as alcohol or substance use related disorders, anxiety disorders, or mood disorders.
c) The Contractor's Network Provider Agreement with behavioral health Providers must require Providers to contact Members with missed appointments within 24 hours to reschedule appointments.

3.4.13. Mental Health Parity Requirements (CMS Checklist I.F.4.05, I.F.6.15, I.F.12.01-.08, I.G.3.06)

3.4.13.1. The Contractor shall comply with the Mental Health Parity Addiction Equity Act (MHPAEA) requirements and establish coverage parity between Mental Health Benefits and Substance Use Disorder Benefits (collectively "Behavioral Health Benefits") and Medical/Surgical Benefits. The Contractor shall cover

Behavioral Health Benefits in a manner that is no more restrictive than the coverage for Medical/Surgical Benefits.

3.4.13.2. Attachment F-3.1, "Schedule of In-Plan Benefits" regarding "Behavioral Health Benefits for Children and Adults," identifies the types and amount, duration, and scope of services and is consistent with EOHHS' parity analysis. The Contractor may cover additional services necessary to comply with the requirements for parity in Behavioral Health Benefits in 42 C.F.R. Part 438, Subpart K; however, the Contractor shall provide advance written notice to and receive prior written approval from the EOHHS Managed Care Director when it believes this requirement is triggered.

3.4.13.3. The Contractor shall not:

a) Impose treatment limitations on Behavioral Health Benefits that are more restrictive than the predominant treatment limitations applied to substantially all Medical/Surgical Benefits.

b) Develop separate treatment limitations that only apply to Behavioral Health Benefits.

c) Use UR (Prior Authorization, retrospective reviews, etc.) or other medical management techniques for Behavioral Health Benefits that are not comparable to, or applied more stringently than, those applied Medical/Surgical Benefits. In accordance with 42 C.F.R. § 438.910, the Contractor's UR requirements shall comply with parity requirements.

d) In accordance with Managed Care Manual Chapter 11, "Reporting Calendar and Templates," the Contractor shall submit reports documenting the number of Prior Authorization requests received for Behavioral Health Benefits and Medical/Surgical Benefits and the outcomes of these requests.

e) If EOHHS implements cost-sharing requirements or lifetime or annual benefit limits for managed care benefits, the Contractor shall comply with all state and federal laws and regulations regarding parity as they relate to financial requirements, including the MHPAEA and 42 C.F.R. §§ 438.905 and 438.910.

3.4.13.4. The Contractor shall provide EOHHS with copies of all Non-Quantitative Treatment Limitations (NQTL) assessment tools, surveys, or corrective action plans related to compliance with MHPAEA.

3.4.13.5. The Contractor shall publish its MHPAEA policy and procedure on its website, including the sources used for documentary evidence.

3.4.13.6. The Contractor shall publish any processes, strategies, evidentiary standards, or other factors (collectively "factors") used in applying NQTL to Behavioral Health Benefits on its website and in its Provider Manual, and shall ensure the classifications are comparable to, and are applied no more stringently than, the factors used in applying the limitation for Medical/Surgical Benefits in the classification. The Contractor shall provide Behavioral Health Benefits in every classification in which it provides Medical/Surgical Benefits (e.g., inpatient, outpatient, emergency care, prescription drugs).

3.4.13.7. The Contractor shall ensure its NQTL for Behavioral Health Benefits shall not be more restrictive, nor applied more stringently, than NQTL for its commercial population. This includes policies and procedures for medical necessity determination, prior approval, and concurrent and retrospective review.

3.4.13.8. The Contractor shall use processes, strategies, evidentiary standards, or other factors in determining access to Out-of-Network Providers of Behavioral Health Benefits that are comparable to and applied no more stringently than those used to determine access to Out-of-Network Providers of Medical/Surgical Benefits.

3.4.13.9. At EOHHS' request, the Contractor shall assist with claims reviews and audits regarding parity.

3.4.13.10. The Contractor shall provide EOHHS with its analysis ensuring parity compliance:

a) When new services are added as an In-Plan Benefits for Members; or
b) Prior to implementing changes to NQTL.
c) In the event of a suspected parity violation, the Contractor shall direct Members to its internal Complaint, Grievance, and Appeals process as appropriate. If the matter is not resolved to the Member's satisfaction through this process and forum, the Contractor shall instruct the Member that he or she may file an external medical review and/or a State Fair Hearing in accordance with their rights under Section 3.21, "Grievances and Appeals."

3.4.13.11. The Contractor shall track and trend Complaints and Grievances related to parity in accordance with Managed Care Manual Chapter 10, "Grievances and Appeals."

3.4.14. Behavioral Health Innovation Plan

3.4.14.1. To promote seamless transitions through the care continuum and expanded capacity for services, the Contractor shall develop programs to support and promote practice transformation and coordinated care for Members with co-occurring physical health, behavioral health, SDoH, and/or substance use disorder needs.

3.4.14.2. No later than 30 Days after the Contract Effective Date, the Contractor shall update the Behavioral Health Innovation Plan (Plan) submitted with its proposal. The revised Plan is subject to EOHHS approval and shall, at a minimum, include the Contractor's implementation strategy and timelines for the following Plan activities:

a) Promoting Integrated Care Delivery Systems through evidence-based integration models and other strategies in collaboration with AEs, PCPs, TCM and other behavioral health providers. This section of the Plan shall include the Contractor's strategies and activities to further the state's goal of providing integrated and coordinated whole-person care. Examples of evidence-based integration models include:

Evidence-Based Integration Model	Description
Collaborative Care Model	Supported American Psychiatric Association (APA) and Academy of Psychosomatic Medicine (APM), which focuses on primary care settings.
Integrated Care Models	Promoted by the SAMHSA-HRSA Center for Integrated Health Solution for behavioral health providers and PCPs.
Health Homes	Also known as "Medical Health Homes" under Section 2703 of the Affordable Care Act. Features a team-based clinical approach, links to community support and resources, and coordinated physical and behavioral health care for people with multiple chronic illnesses.
Patient-Centered Medical Homes	Recognized by the National Committee for Quality Assurance (NCQA) or other nationally recognized programs.
Certified Community Behavioral Health Clinics (CCBHC)	Authorized under Section 223 of the Protecting Access to Medicare Act (PAMA) and subsequent legislation. Focuses on coordinated physical health, behavioral health, and SUD services.

b) Addressing Gaps in the Care Continuum: at a minimum, the Plan shall include specific Member and Provider education and contracting strategies to increase access for child and adult Members to:
   - Behavioral Health Benefits for individuals with mild to moderate needs, including early screenings and interventions to promote access to care.
   - Behavioral Health Benefits for individuals with cognitive and intellectual disabilities.
   - Intermediate Services, including IOP.
   - Emergency Services Interventions, including interventions for children in DCYF out-of-home care (e.g., residential placement settings, the child's home, police stations, and other community settings).
   - Observation/Crisis Stabilization/Holding Beds and Respite, including services for children in DCYF care or custody.
   - Mobile Crisis Response services.
   - Home-based therapeutic services, life skills training, and other evidence-based practices.
   - The Contractor may also propose In Lieu of Services (ILoS) for EOHHS' consideration to address potential service gaps.

c) Strategies to promote coordinated and seamless transitions between care settings.

d) Promoting Health Equity by implementing processes to identify specific populations (i.e., racial/ethnic, geographic, etc.) that have experienced disproportionately poor health outcomes, then developing a methodology to improve outcomes and Health Equity and access to Behavioral Health Services for these populations. This section should include strategies to train Contractor staff, Network Providers, and Provider offices on DEI topics, such as cultural competency and implicit bias.

e) Fostering Partnerships with AEs, PCPs, TCM and other behavioral health providers, SUD providers, I/DD Providers, Primary Prevention entities, criminal justice systems, school-based behavioral health providers, and community-based organizations to address gaps in care and improve care

coordination. Communication and data-sharing are key to these partnerships. The Contractor shall develop strategies to identify and address barriers to data sharing, and develop clear processes for care planning, referrals to behavioral health treatment and community supports, and mechanisms to share information (such as sharing clinical data between electronic medical record systems).

f) Training and Technical Support for Network Providers and office staff on plan requirements and activities.

g) Telemedicine strategies to expand care across the behavioral health continuum of care.

h) APMs that support Plan activities, foster innovation and integrated care, and promote access to the full care continuum of Behavioral Health Benefits. APM methodologies shall be submitted to EOHHS for review and approval prior to implementation, in accordance with Managed Care Manual Chapter 5.

i) After the Operational Start Date, the Contractor shall provide quarterly reports, in a format approved by EOHHS, describing Behavioral Health Innovation Plan activities and outcomes. The Contractor is subject to contractual remedies, including liquidated damages and payment withholds, for failing to report on or complete plan activities.

3.4. Behavioral Health Benefits- Document History Log	
Contract Cross-References	• Attachment O, Mental Health, Substance Use and Developmental Disability Services for Children • Attachment P, Behavioral Health and Substance Use Services for Adults • Attachment F-3.1, Schedule of In-Plan Benefits • Section 3.14, Provider Networks and Requirements, Access to Care • Section 3.20, Member Services • Section 3.21, Grievances and Appeals • Section 3.28, Alternative Payment Model Methodologies • Managed Care Manual Chapter 2, Medicaid Services • Managed Care Manual Chapter 5, Financial Requirements • Managed Care Manual Chapter 9, Quality Programs • Managed Care Manual Chapter 10, Grievances and Appeals • Managed Care Manual Chapter 11, Reporting Calendar and Templates • Rhode Island Medicaid Provider Manual, Rehabilitative Services • Rhode Island Medicaid State Plan
Governing Requirements and Authority	• Mental Health Parity Addiction Equity Act (MHPAEA) • 42 C.F.R. Part 438, Subpart K, Parity in Mental Health and Substance Use Disorder Benefits • 42 C.F.R §§ 438.905 and 438.910 • 42 C.F.R. Part 441 • 42 C.F.R. § 440.230 • R.I. Gen. Laws section 40.1-5, Mental Health Law
CMS Checklist Items	• I.F.4, Delivery Network, Section I.F.4.05 • I.F.6., Amount, Duration and Scope, Section I.F.6.15 • I.G.F.12, Parity in Mental Health and Substance Use Disorder (MH/SUD) Benefits, Sections I.F.12.01-.08 • I.G.3, Authorization and Utilization Management, Section I.G.3.06
Revision Date and Description	

3.5. Pharmacy Services

3.5.1. Comprehensive Pharmacy Benefits (CMS Checklist I.F.11.01)

3.5.1.1. The Contractor shall provide comprehensive inpatient and outpatient pharmacy benefits for Members, including all categories of prescription and non-prescriptions drugs, biological products, and supplies identified in Attachment F-3.1, "Schedule of In-Plan Benefits," the EOHHS Pharmacy Provider Manual, and the "Medicaid Managed Care Services Pharmacy Benefit Plan Protocols" ("PBM Protocols") in Chapter 2 of the Managed Care Manual.

3.5.1.2. The Contractor shall also provide the pharmacy products and supplies identified in the PBM Protocols, including glucometers, continuous glucose monitors, syringes, test strips, lancet and lancet devices, alcohol swabs, calibration fluid, and other miscellaneous supplies.

3.5.1.3. The Contractor shall ensure coverage of outpatient drugs meets the standards of Section 1927(a) of the Social Security Act [42 U.S.C. 1396r-8], as applied to Medicaid managed care in 42 C.F.R. § 438.3(s).

3.5.2. Generics First Program

3.5.2.1. The Contractor shall comply with EOHHS' Generic First Program. This program promotes the use of generic products or the lowest net cost alternative products. The program is described in further detail described in PBM Protocols

3.5.3. Formulary and Preferred Drug List (CMS Checklist I.C.5.01-.03)

3.5.3.1. The Contractor may establish its own drug formulary, provided the formulary meets the requirements of this Section and Section 1927(d) of the Social Security Act (42 U.S.C. 1396r-8).

3.5.3.2. The formulary shall be limited to drug products manufactured by pharmaceutical companies that have signed a federal rebate agreement pursuant to Section 1927(a) of the Social Security Act unless an exception under the Act applies.

3.5.3.3. The Contractor shall provide:

a) Information in electronic or paper form about which generic and name brand medications are covered on the Contractor's formulary.
b) Information in electronic or paper form about what tier each medication is on.
c) Formulary lists on the Contractor's website in a machine-readable file and format as specified the Secretary of the United States Department of Health and Human Services.

3.5.3.4. The formulary cannot include the drugs, biologic products, or supplies:

a) Identified in PBM Protocols as "excluded drugs," or
b) Otherwise excluded from coverage under the Rhode Island Medicaid State Plan or state or federal law.

3.5.3.5. The PBM Protocols include a list of brand name therapeutic classes of drugs/single agents the Contractor shall include on its formulary. Within each class, the Contractor may maintain its own preferred drug list (PDL). Brand name drugs that are neither on the Contractor's PDL nor in one of the listed therapeutic classes identified in the PBM Protocols are considered non-preferred. The Contractor shall cover non-preferred drugs on a case-by-case basis as described in the PBM Protocols. Such coverage shall be based on Medical Necessity and a demonstrated lack of efficacy of a preferred or generic drug for an individual patient.

3.5.4. Non-Prescription Drugs

3.5.4.1. Some over the counter (OTC) drugs are Covered Services when prescribed by a physician or other authorized Provider.

3.5.4.2. Examples of OTC drugs covered under the Generics First Program are:

a) Emergency contraception;
b) Nicotine cessation supplies;
c) Nutritional supplements.

3.5.4.3. At a minimum, the Contractor shall cover the OTC agents and classes included in the EOHHS Medicaid FFS Program (see the "OTC Listing" in the Medicaid Pharmacy Provider Manual).

3.5.5. Drug Utilization Review Program

3.5.5.1. The Contractor shall operate a Drug Utilization Review Program (DUR) that complies with all of the requirements contained in Section 1927(g) of the Social Security Act and all of the requirements contained in 42 C.F.R. Part 456, Subpart K, as if the requirements applied to the Contractor instead of the State. The program shall:

a) Assure that prescriptions are appropriate, Medically Necessary, and not likely to result in adverse medical results.
b) Be designed to educate Providers and pharmacists to identify and reduce the frequency of patterns of Fraud, Abuse, gross overuse, or inappropriate or medically unnecessary care.
c) Include, at minimum, prospective DUR, retrospective DUR, and an educational program.

3.5.5.2. The Contractor can apply reasonable clinical review criteria to all Pharmacy Benefits, as necessary to demonstrate a Member meets medical and clinical criteria ("clinical Prior Authorizations"). In addition, the Contractor can apply Prior Authorization requirements to drugs that are not on the Contractor's PDL based on their non-preferred status ("PDL Prior Authorizations").

3.5.5.3. The Contractor shall submit changes to all clinical prior authorization and PDL prior authorization criteria to EOHHS for approval at least 30 Days before they are adopted or revised.

3.5.5.4. The Contractor shall comply with the SUPPORT for Patients and Communities Act, Title 1, Section 1004 (2018), as codified in Sections 1902(oo)(1)(A)(i)(I) and 1932(i) of the Social Security Act, which mandates that the Contractor has the capacity to and engages in the following Utilization Review processes:

a) Automating DUR safety edits for opioid refills.
b) Automating claims review process to identify refills in excess of state limits.
c) Monitoring of concurrent prescribing of opioids, benzodiazepines and/or antipsychotics (Including children's antipsychotics).
d) Establishing maximum daily morphine equivalent safety edits.
e) Activating concurrent utilization alerts for beneficiaries concurrently prescribed opioids and benzodiazepines and/or antipsychotics.

3.5.5.5. The Contractor shall provide annual reports on DUR Program activities as specified in Reporting Calendar in Managed Care Manual Chapter 11, "Reporting Calendar and Templates."

3.5.5.6. The Contractor shall comply with EOHHS' "Treatment of Hepatitis C Prior Authorization Guidelines," in Managed Care Manual Chapter 2, "Medicaid Services."

3.5.6. Prior Authorization and 72-Hour Emergency Fills

3.5.6.1. In accordance with 42 C.F.R. § 438.3(s)(6) and Section 1927(d)(5) of the Social Security Act, the Contractor shall respond to a request for prior authorization of a covered outpatient drug that is received by telephone or other telecommunication device within 24 hours of the request.

3.5.6.2. Unless prohibited under state or federal laws, such as the Controlled Substances Act (P.L. 91-513), the Contractor shall allow a 72-hour emergency supply to be dispensed any time a Prior Authorization is not available, and the prescribed drug shall be filled. If the prescriber cannot be reached or is unable to request the Prior Authorization, the Contractor shall allow the pharmacy to submit and fill an emergency 72-hour prescription. The Contractor shall allow pharmacists to use their professional judgment regarding whether there is an immediate and urgent need every time the 72-hour option is used. The 72-hour emergency procedure should not be used for routine and continuous overrides.

3.5.7. Pharmaceutical and Therapeutics Committee

3.5.7.1. The Contractor shall maintain a Pharmaceutical and Therapeutics (P&T) Committee, or a similar entity, to develop Prior Authorization criteria. The P&T Committee shall:

a) Represent the needs of all of the Contractor's Members, including Members with special health care needs.
b) Allow Network physicians, pharmacists, behavioral health Providers and other specialists to participate in the approval of criteria for clinical prior authorizations.

c) Consist of at least six committee members, including at least three Network Providers not employed by the Contractor nor its Subcontractors. The Contractor's Medical Director shall participate in all P&T meetings.

d) Meet at least semi-annually in Rhode Island. Meetings shall be open to public comment before the P&T Committee votes on any PDL or prior authorization items. The Contractor shall keep written minutes of all P&T meetings.

3.5.7.2. The Contractor shall notify the EOHHS when its P&T Committee meeting has been scheduled and include official notification of the meeting on its Provider website and through other applicable avenues, such as Provider training and newsletters.

3.5.8. EOHHS Pharmacy Benefit Review Committee

3.5.8.1. The EOHHS Medicaid Managed Care Services Prescription Drug Benefit Review Committee will meet at least annually to:

a) Review and update the allowed list of brand name therapeutic classes of drugs and single agents,

b) Review criteria for case-by-case exceptions described in the PBM Protocols.

c) Develop recommended protocols for communicating changes.

3.5.8.2. The Contractor's Medical Director or his or her designee shall represent the Contractor on the committee and provide support to EOHHS as needed.

3.5.9. Drug Rebate Reporting

3.5.9.1. The Contractor shall report data that EOHHS determines is necessary to bill manufacturers for rebates in accordance with section 1927(b)(1)(A) of the Social Security Act no 45 Days after the end of each quarterly rebate period, pursuant to 42 C.F.R. 438.3(s)(2). Such utilization information shall include, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code of each covered outpatient drug dispensed or covered by the Contractor.

3.5.9.2. Covered outpatient drugs dispensed to Medicaid Members from covered entities purchased at 340B prices, which are not subject to Medicaid rebates, should be excluded from the Contractor's reports to EOHHS.

3.5.9.3. To ensure that drug manufacturers will not be billed for rebates of drugs purchased and dispensed under the 340B Drug Pricing Program, the Contractor shall have mechanisms in place to clearly identify these drugs and exclude the reporting of this utilization data to EOHHS to prevent duplicate discounts on these products.

3.5.9.4. Covered outpatient drugs are not subject to the rebate requirements if such drugs are both subject to discounts under 340B and dispensed by Health Plans, including Medicaid MCOs.

3.5.10. Patient Protection and Affordable Care Act

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

3.5.10.2. The Contractor shall provide EOHHS with quarterly pharmacy claims information with respect to Drug Rebate Equalization in a format that is compliant with CMS published guidelines and approved by EOHHS.

3.5.11. Cost and Pricing Transparency

3.5.11.1. The Contractor shall ensure full transparency when administering the pharmacy services and benefits described in this Section.

3.5.11.2. The Contractor shall implement safeguards to prohibit PBMs or other Subcontractors from engaging in activities that may result in undisclosed or excess profits, or errors in Medical Loss Ratio reporting.

3.5.11.3. If the Contractor subcontracts all or a portion of the pharmacy services described in this section to a PBM or another Subcontractor, the Contractor shall ensure the PBM or other Subcontractor comply with all requirements in this section.

3.5.11.4. Within five Business Days of an EOHHS request, the Contractor and its Subcontractors shall provide EOHHS unredacted copies of or access to all books, records, contracts, and rebate agreements with pharmaceutical manufacturers, intermediaries, PBM, other Subcontractors, wholesalers, or other third parties related to this Agreement.

3.5.11.5. As specified in the Reporting Calendar in Managed Care Manual Chapter 11, "Reporting Calendar and Templates," the Contractor shall provide EOHHS a quarterly report itemizing:

a) All amounts received, by National Drug Code (NDC) number and manufacturer, for rebates, discounts, credits, fees, or other payments that are based on actual or estimated utilization of a covered drug, or price concessions based on the effectiveness of a covered drug (collectively "rebates");
b) Amounts of rebates paid to the Contractor, PBM, or another Subcontractor;
c) The share of rebates attributable to the Contractor, PBM, Subcontractors, or other participants in a rebate arrangement;
d) The timeframes when the rebates were received.

3.5.11.6. Within five Business Days of EOHHS' request, the Contractor shall provide the following information:

a) The Wholesale Acquisition Cost (WAC), Maximum Allowable Cost (MAC), Average Wholesale Price (AWP), or any other reimbursement construct utilized by the Contractor, PBM, or anther Subcontract at any point in time for each covered drug purchased pursuant to this Agreement.

b) The dollar amount of any reimbursements the Contractor, PBM, or another Subcontractor pays to contracted pharmacies and dispensing fees for each Covered Drug purchased under this Agreement.

c) The net cost of all brand name drugs that are eligible for non-federal rebates.

3.5.11.7. In accordance with Section 3.23, "Records Retention, Audits, and Inspections," EOHHS or its designee has the right to audit all financial aspects of the Contractor's business associated with claims, administrative fees, dispensing fees, rebates, pricing, or any other financial term or revenue source that results from the Contractor's Members' utilization under this Agreement. In addition, EOHHS or its designee has the right to audit all legal, contractual, and operational aspects of the Contractor's business.

3.5.12. Reports of Out-of-State Activities

3.5.12.1. The Contractor shall provide monthly reports on out-of-state pharmacy activity in accordance with the reporting template in Managed Care Manual Chapter 11, "Reporting Calendar and Templates."

3.5.12.2. For Members who routinely use out-of-state pharmacies, the Contractor shall conduct research as necessary to determine whether there is a pattern suggestive of out-of-state residency (e.g., the Member picks up maintenance medication at an out-of-state pharmacy for three consecutive months).

3.5.13. Prohibition on Restocking and Double Billing Prescription Drugs

To conform to Section 1903(i)(10) of the Social Security Act, payment shall not be made with respect to any amount expended for reimbursement to a pharmacy for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment (other than with respect to a reasonable restocking fee for such drug).

3.5.14. Pharmacy Lock-In Program

3.5.14.1. In accordance with 42 C.F.R. § 440.230, EOHHS has established a pharmacy lock-in program to restrict Members whose utilization of prescription drugs is documented inappropriate or excessive. The program is intended to prevent Medicaid beneficiaries from obtaining inappropriate or excessive quantities of prescribed drugs through visits to multiple providers and pharmacies.

3.5.14.2. In accordance with EOHHS guidance in Managed Care Manual Chapter 7, "Program Integrity," the Contractor shall develop policies and procedures to implement a pharmacy Lock-in Program.

3.5.14.3. The policies and procedures shall:

a) Provide that any Member identified as having engaged in inappropriate or excessive utilization of one or more prescription drugs will be required to designate a primary physician and pharmacy and will be restricted to that physician and pharmacy to obtain or fill prescriptions for a minimum of 15 months from the date of enrollment in the Lock-in Program.

b) Identify the criteria to be used to identify Members who are engaged in excessive or inappropriate prescription drug utilization. Such criteria shall

be based upon current medical and pharmacological references as identified by EOHHS.

c) Provide for written notice to any Member who has been identified as engaged in inappropriate or excessive use of prescription drugs at least 30 days prior to the proposed implementation of the restriction. The notice shall inform the Member:

- Of the specific basis for finding the Member has engaged in inappropriate or excessive utilization of one or more prescription drugs.
- That he or she has 30 Days to designate a primary physician and pharmacy as a single source of medical care.
- That if the Member fails to designate a primary physician and pharmacy in accordance with the notice, the Contractor will make the designation for the Member based upon the Member's previous use and geographic location.
- That the Member has the right to request a State Fair Hearing within 30 Days of the date of the notice if he or she disagrees with the Contractor's findings.
- That he or she may request a change of his or her primary physician/pharmacy for reasonable cause by notifying the Contractor and choosing a new primary physician/pharmacy.

3.5.14.4. Once a Member has been enrolled in the Pharmacy Lock-in Program, the Contractor shall monitor the Member's drug-usage profile. If after 15 months, the review establishes that the Member's drug utilization is appropriate and not excessive, the Contractor shall remove the restriction. If the restriction is not removed after the initial 15 months, the Contractor shall continue to monitor the Member's drug-usage profile and review whether it should continue or be removed not less often than every 12 months.

3.5.14.5. The Contractor is responsible for ensuring its Network pharmacies that are designated as primary pharmacies understand and are compliant with the requirements of the Pharmacy Lock-In program, including the requirement to:

a) Exercise sound professional judgement when dispensing drugs in order to prevent inappropriate drug utilization.

b) Notify the prescribing physician (or practitioner) to verify the authenticity and accuracy of any prescription whenever the pharmacist reasonably believes the Member is attempting to obtain excessive drugs through duplicate or altered prescriptions or other inappropriate means.

3.5.14.6. Pharmacies that are found on review to be dispensing drugs in a manner that is inconsistent with professional standards may be subject to administrative sanction including the recovery of Overpayments or a referral to the RI OIG.

3.5. Pharmacy Services- Document History Log	
Contract Cross-References	• Attachment F-3.1, Schedule of In-Plan Benefits • Section 3.23, Records Retention, Audits, and Inspections • Managed Care Manual, Chapter 2, Medicaid Services • Managed Care Manual Chapter 11, Reporting Calendar and Templates • EOHHS Pharmacy Provider Manual
Governing Requirements and Authority	• Social Security Act Title XIX • Patient Protection and Affordability Care Act (PPACA) • SUPPORT for Patients and Communities Act, Title 1, Section 1004 (2018), as codified in Sections 1902 (oo)(1)(A)(i)(I) and 1932 (i) of the Social Security Act • 42 C.F.R. §§ 438.3 and 438.10 • 42 C.F.R. § 440.230 • 42 C.F.R. Part 456 Subpart K
CMS Checklist Items	• I.C.5, Formulary, Sections I.C.5.01-.03 • I.F.11, Outpatient/Prescription Drugs, Section I.F.11.01
Revision Date and Description	

3.6. Telemedicine

3.6.1. Definitions

For purposes of this section, the following terms are defined in accordance Rhode Island General Laws, Chapter 27-81, the "Telemedicine Coverage Act" to mean:

3.6.1.1. **Clinically Appropriate** means care that is delivered in the appropriate medical setting [RI Gen. Laws 27-81-3].

3.6.1.2. **Distant Site** means a site at which a Healthcare Provider is located while providing Healthcare Services by means of telemedicine [RI Gen. Laws 27-81-3].

3.6.1.3. **Healthcare Facility** means an institution providing Healthcare Services or a healthcare setting, including, but not limited to hospitals and other licensed, inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory and imaging centers; and rehabilitation and other therapeutic-health settings [RI Gen. Laws 27-81-3].

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

3.6.1.5. **Healthcare Provider** means a Healthcare Professional or a Healthcare Facility [RI Gen. Laws 27-81-3].

3.6.1.6. **Healthcare Services** means any services included in the furnishing to any individual of medical, podiatric, or dental care, or hospitalization, or incident to the furnishing of that care or hospitalization, and the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability [RI Gen. Laws 27-81-3].

3.6.1.7. **Medically Necessary** 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 [RI Gen. Laws 27-81-3].

3.6.1.8. **Originating Site** means a site at which a patient is located at the time Healthcare Services are provided to them by means of telemedicine, which can be include a patient's home where Medically Necessary and Clinically Appropriate [RI Gen. Laws 27-81-3].

3.6.1.9. **Store-and-forward Technology** means the technology used to enable the transmission of a patient's medical information from an Originating Site to the Healthcare Provider at the Distant Site without the patient being present [RI Gen. Laws 27-81-3].

3.6.1.10. **Telemedicine** means the delivery of clinical Healthcare Services by use of real time, two-way synchronous audio, video, telephone-audio-only communications or electronic media or other telecommunications technology including, but not limited to: online adaptive interviews, remote patient monitoring devices,

audiovisual communications, including the application of secure video conferencing and store-and-forward technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, counseling and prescribing treatment, and care management of a patient's health care while such patient is at an Originating Site and the Healthcare Provider is at a Distant Site, consistent with applicable federal laws and regulations. "Telemedicine" does not include an email message or facsimile transmission between a Provider and patient, or an automated computer program used to diagnose and/or treat ocular or refractive conditions [RI Gen. Laws 27-81-3].

3.6.2. General Requirements

3.6.2.1. Telemedicine is an approved mode of delivering a Healthcare Service when:

a) The Service is a Medically Necessary Covered Service under this Agreement; and
b) It is Clinically Appropriate to provide the service via Telemedicine.

3.6.2.2. The Contractor shall comply with the requirements of Section 3-27-81-4 of the Rhode Island Telemedicine Coverage Act, which prohibits the Contractor from:

a) Excluding a Healthcare Service from coverage solely because it is provided through Telemedicine and not via in-person consultation or contact.
b) Reimbursing Network PCPs, registered dietician nutritionists, and behavioral health Providers for Telemedicine services at rates lower than services delivered by the same Provider in person.
c) Imposing a deductible, copayment, or coinsurance requirement for a Healthcare Service delivered via Telemedicine above what would normally be charged for an in-person service (applicable if EOHHS implements cost-sharing requirements for Medicaid Members).
d) Imposing Prior Authorization or other UM requirements for a Telemedicine service that are more stringent than those required for the same in-person service.
e) Imposing more stringent medical or benefit determination requirements for a Telemedicine service than those required for the same in-person service.
f) Imposing restrictions on specific technologies used to deliver Telemedicine services, unless authorized by state or federal law, EOHHS guidance, or other applicable state regulatory requirements.

3.6.2.3. The Contractor is also prohibited from imposing restrictions on Originating Sites or Distant Sites for Telemedicine services, unless authorized by state or federal law, EOHHS guidance, or other applicable state regulatory requirements.

3.6.2.4. Section 27-81.7 of the Rhode Island Telemedicine Coverage Act requires the Contractor to submit reports to the Office of the Health Insurance Commissioner (OHIC) regarding its telemedicine policies, practices, and experience. The Contractor shall provide EOHHS copies of all such OHIC reports within three Business Days of filing.

3.6.2.5. In accordance with Section 3.4.14, "Behavioral Health Innovation Plan," the Contractor's Behavioral Health Innovation Plan shall include strategies to expand access to services across the behavioral health continuum through Telemedicine.

3.6.2.6. The Compliance Plan described in Section 3.22.2, "Compliance Program," shall include the Contractor's policies and procedures for demonstrating compliance with this Section and the Telemedicine Coverage Act. The Contractor shall assist EOHHS and the officials and entities described in Section 3.23.4, "Audits of Services and Deliverables" with audits or reviews of payment parity, utilization management, and other telemedicine requirements.

3.6.3. Provider Requirements

3.6.3.1. The Contractor shall ensure Healthcare Providers meet state, federal, and EOHHS requirements for:

a) Participating in the Medicaid program;
b) Coding Telemedicine claims, as descried in Chapter 4 of the Managed Care Manual, "Claims/MIS"; and
c) Prescribing medications via Telemedicine, including the 21 U.S.C. § 829 and Drug Enforcement Administration (DEA) restrictions on prescribing controlled substances.

3.6.3.2. Any Healthcare Professional providing Healthcare Services via Telemedicine shall be subject to the same standard of care or practice standards as applicable to in-person settings.

3.6.3.3. As specified in Section 3.1.16, "Payments to Institutions or Entities Located Outside of the U.S." and 42 C.F.R. § 438.602(i), the Contractor is prohibited from making payments to Telemedicine providers located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Marina Islands and American Samoa.

3.6.3.4. In accordance with Section 3.14.31, "Provider Manual," the Contractor's Provider Manual shall include clear instructions on how to:

a) Request Prior Authorization for Telemedicine Services.
b) Submit claims for Telemedicine Services.
c) Direct Members to in-person care when Telemedicine services are not Medically Necessary or Clinically Appropriate.

3.6.4. Member Education

3.6.4.1. In accordance with Section 3.20.7, "Member Education," the Contactor shall educate Members about the availability of Telemedicine services and include clear instructions on how to access Healthcare Services through Telemedicine on the Contractor's website and in the Member Handbook.

3.6. Telemedicine- Document History Log	
Contract Cross-References	• Section 3.1, Contract Administration and Management • Section 3.4, Behavioral Health • Section 3.14, Provider Networks and Requirements, Access to Care • Section 3.20, Member Services • Section 3.22, Program Integrity, Fraud, Waste, and Abuse • Section 3.23, Records Retention, Audit, and Inspection • Managed Care Manual Chapter 4, Claims and MIS
Governing Requirements and Authority	• Ryan Haight Online Pharmacy Consumer Protection Act • Controlled Substances Act (21 U.S.C. § 829) • 42 C.F.R. § 438.602 • Telemedicine Coverage Act, RI Gen. Laws Chapter 27-81
CMS Checklist Items	
Revision Date and Description	

3.7. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

3.7.1. Coverage of EPSDT Benefits (CMS Checklist I.F.6.10-.14)

3.7.1.1. The EPSDT program provides comprehensive and preventative Health Care Services for Medicaid Members under age 21.

3.7.1.2. EPSDT Benefits include screening, diagnostic, and treatment services, such as:

a) Physician and hospital services;
b) Home care services (including personal care and private duty nursing);
c) Medical equipment and supplies;
d) Rehabilitative service, including Behavioral Health Benefits;
e) Vision care;
f) Hearing services, and
g) Dental services.

3.7.1.3. EPSDT Benefits also include other Medically Necessary measures described in Section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses or conditions discovered through screenings, even if the services are not listed in the Rhode Island Medicaid State Plan. If a Member under age 21 requires a Medically Necessary service that is not listed in Attachment F-3.1, "In Plan Benefits," or the Rhode Island Medicaid State Plan, the Contractor shall consult with the EOHHS Managed Care Director before authorizing or denying the service, to verify the service meets federal coverage criteria.

3.7.1.4. The Contractor is responsible for providing the full range of EPSDT Benefits, with the exception of Out-of-Plan Benefits described in Attachment F-3.2.

3.7.1.5. The need for EPSDT Benefits is based on Medical Necessity and the Contractor cannot limit the volume, scope, or duration of EPSDT Benefits, regardless of established limitations in Attachment F-3.1 "Schedule of In-Plan Benefits," the Rhode Island Medicaid State Plan, or regulation. The Contractor may place reasonable UM protocols in place for EPSDT Benefits, such as Prior Authorization requirements, which take into consideration the availability of other medically appropriate, cost-effective alternatives.

3.7.2. EPSDT Periodicity Requirements

3.7.2.1. The Contractor shall work with Network Providers to deliver EPSDT Benefits in accordance with the Rhode Island EPSDT Periodicity Schedule in Attachment D and Chapter 2 of the Managed Care Manual, "Medicaid Services."

3.7.2.2. The Contractor shall provide EOHHS a list of all established CPT/HCPC codes used to identify all billable services included in the EPSDT Periodicity Schedule.

3.7.2.3. The Contractor's claims and billing procedures shall require providers to code EPSDT billable services with established CPT/HCPC codes in accordance with the EPSDT Periodicity Schedule.

3.7.3. EPSDT Education and Outreach Activities (CMS Checklist I.C.2.04-.05)

3.7.3.1. In accordance with Sections 3.14.28, "Provider Materials," and 3.19.5, "Member Handbook," the Contractor's Provider Manual, Member Handbook, and EPSDT educational programs shall include information regarding:

a) EPSDT Benefits covered by the Contractor and how to access these services.
b) The Rhode Island EPSDT Periodicity Schedule.
c) How and where Members can access Out-of-Plan EPSDT Benefits.

3.7.3.2. The Contractor shall have an established process for reminders, follow-ups, and outreach to Members and Providers that includes:

a) Written notification to Members of upcoming or missed appointments.
b) Telephone protocols to remind Members of upcoming visits and follow-up on missed appointments.
c) Protocols for conducting outreach with non-compliant Members, such as telephone calls, emails, home visits, and other acceptable forms of communication with Members under state and federal law.
d) Protocols for addressing access barriers such as arranging transportation, interpreters, and connections with multi-lingual/multi-cultural service providers.

3.7.3.3. The processes described above shall consider:

a) Members' literacy capabilities.
b) The multi-lingual, multi-cultural nature of the Medicaid population in Rhode Island.
c) Other unique characteristics of this population, such as a greater frequency of changes of address and absence of telephones.

3.7.4. PCP Reports

3.7.4.1. The Contactor shall provide reports to each PCP in the Contractor's Network, on at least a quarterly basis, with a list of Members assigned to the PCP who have not had an encounter during the past year and/or have not complied with the EPSDT Periodicity Schedule.

3.7.4.2. Either the Contractor or the PCP shall contact these Members to arrange an appointment and document outreach efforts in accordance with Managed Care Manual Chapter 2, "Medicaid Services."

3.7.5. EPSDT Screening and Related Services

3.7.5.1. The Contractor shall work with Network Providers to conduct EPSDT screens to identify health and developmental problems. Screening must be conducted in accordance with the EPSDT Periodicity Schedule in Managed Care Manual

Chapter 2; however, the Contractor shall cover additional EPSDT screens as Medically Necessary.

3.7.5.2. At a minimum, EPSDT screens must include:

a) A comprehensive health and developmental history including assessments of both physical and mental health development. As described in Section 3.7.1, "Coverage of EPSDT Benefits," EPSDT services also include all diagnostic and treatment services that are Medically Necessary to correct or ameliorate a physical or mental condition identified during a screening visit.

b) Appropriate immunizations according to age, health history and the EOHHS Periodicity Schedule or the schedule established by Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines. The Contractor and its Providers must adjust for periodic changes in recommended types and schedule of vaccines. Immunizations must be reviewed at each screening examination and during acute care visits and necessary immunizations must be administered when not contraindicated. The Contractor shall require Providers to document deferral of vaccine administration for any reason.

c) A comprehensive unclothed physical examination including vision and hearing screening; dental inspection; and nutritional assessment.

d) Laboratory tests including lead toxicity, TB, and newborn screenings as medically indicated.

e) Vision testing that, at a minimum, includes diagnosis and treatment for defects in vision, including eyeglasses. Vision screening in an infant means, at a minimum, eye examination and observation of responses to visual stimuli. In an older child, screening for distant visual acuity and ocular alignment shall begin at age three.

f) Hearing testing.

g) Dental screening oral examination by PCP as part of a comprehensive examination required before age one.

h) Health education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention).

i) Referral for further diagnosis and treatment or follow-up of all abnormalities that are treatable/correctable or require maintenance therapy uncovered or suspected (referral may be to the provider conducting the screening examination, or to another provider, as appropriate.)

j) Lead screening and testing, in accordance with the Contractor's screening program. The program shall provide for screening for the presence of lead toxicity in children and shall consist of two components: verbal risk assessment and blood lead testing as described in Managed Care Manual Chapter 2, "Medicaid Services."

k) All other medically indicated screening services.

3.7.6. EPSDT Diagnosis and Treatment Services (CMS Checklist I.F.6.10-.14)

3.7.6.1. Under EPSDT requirements, if a suspected problem is detected by a screening examination, the Member must be evaluated as necessary for further diagnosis and treatment needs.

3.7.6.2. EPSDT coverage includes all follow-up diagnostic and treatment services deemed Medically Necessary to correct or ameliorate a problem discovered during an EPSDT screen. Subject to the process described in Section 3.7.1, the Contractor shall provide all such diagnostic and treatment services, regardless of whether they are covered by the State Medicaid Plan, if they are Medicaid-Covered Services as defined in Sections 1905(a) and (r) of Social Security Act.

3.7.7. Tracking

The Contractor shall establish a tracking system that provides up-to-date information on compliance with EPSDT service requirements in the following areas:

3.7.7.1. Initial visit for newborns. The initial EPSDT screen will be the newborn physical examination at the place of birth.

3.7.7.2. Preventive pediatric visits in accordance with the Rhode Island EPSDT Periodicity Schedule.

3.7.7.3. Diagnosis and/or treatment, or other referrals in accordance with EPSDT screen results.

3.7.8. Minimum Performance Standards for EPSDT and Lead Screening

3.7.8.1. The Contractor is subject to remedies, including liquidated damages and corrective action, for failure to achieve the following annual performance standards for EPSDT and lead screening services:

a) Well-child Visits: at least 75% of Members under age 21 shall receive well-child visits in accordance with the EOHHS Periodicity Schedule.
b) Immunizations: at least 100% of children in DCYF substitute care, and 75% of other child Members under age 21, shall receive immunizations in accordance with the EOHHS Periodicity Schedule.
c) Lead Screening: at least 65% of Members under age 21 shall receive blood lead testing in accordance with the EOHHS Periodicity Schedule.

3.7.8.2. Attachment F-5, “Liquidated Damages,” includes additional information regarding calculation of these measures.

3.7.8.3. EOHHS will not impose liquidated damages for the first two years a Health Plan participates in the Rhode Island Medicaid managed care market but reserves the right to impose other contractual remedies at its discretion.

3.7. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)- Document History Log	
Contract Cross-References	• Attachment F-3.3, Services • Attachment F-5, Liquidated Damages Matrix • Section 3.14, Provider Networks and Requirements, Access to Care • Section 3.19, Member Materials • Managed Care Manual Chapter 2, Medicaid Services
Governing Requirements and Authority	• Social Security Act Title XIX • 42 C.F.R. §§ 438.10(g) and 438.210(a)(5)
CMS Checklist Items	• I.C.2 Beneficiary Notification, Sections I.C.2.04-.05 • I.F.6 Coverage, Sections I.F.6.10-.14
Revision Date and Description	

3.8. Health Homes for Children Program

3.8.1. Contracting with Certified Providers

3.8.1.1. The Contractor shall enter into a Network Provider agreement with any willing Cedar Family Center certified by EOHHS as a Health Home provider. These providers are known as "Cedar Health Homes" or "CHHs," and are designated providers of Health Homes services under the Rhode Island Medicaid State Plan (see TN# 18-0009).

3.8.1.2. The purpose of Cedar Health Homes is to provide children with special health care needs and their families a structured system to:

a) Assess their need for medical and community-based services and supports.
b) Refer them to providers and entities that offer these services and supports.

3.8.2. Eligibility for Health Homes Services

3.8.2.1. Members under age 21 are eligible for Health Homes services if they meet at least one of the following criteria:

a) Suspected of having a severe mental illness or severe emotional disturbance.
b) Suspected of having two or more of the following chronic conditions: mental health condition, asthma, diabetes, DD, Down Syndrome, mental retardation, or seizure disorders.
c) Have one of the chronic conditions listed above and are at risk for developing a second.

3.8.2.2. The Contractor shall allow families to access a Cedar Health Homes provider through self-referral or by other referral sources, including the Contractor's Care Program staff, PCPs, or other providers.

3.8.2.3. The Contractor shall ensure that Members who meet eligibility criteria can:

a) Choose their Health Homes provider from any EOHHS-certified provider; or
b) Opt out of receiving Health Homes services at any time.

3.8.3. Description of Health Homes Services

3.8.3.1. Through Cedar Health Homes, the Contractor shall provide family-centered, intensive care management and coordination services to children, including:

a) Comprehensive Care Management;
b) Care Coordination;
c) Referral to community and social support services (formal and informal);
d) Individual and family support services;
e) Comprehensive transitional care; and
f) Health promotion.

3.8.3.2. These services are defined in further detail in the Rhode Island Medicaid State Plan (see TN# 18-0009).

3.8.4. Health Homes Service Requirements

3.8.4.1. Through Cedar Health Homes, the Contractor shall deliver Health Homes services to children, within the following parameters:

a) The services shall focus on providing enhanced guidance and psychoeducation to promote health and wellness by helping families understand their child's clinical needs, health conditions, medical needs, and/or risk and protective factors.

b) The care coordination shall include in-home, hands-on support and coaching that build a family's skills to successfully navigate systems of care and advocate for their children and family to ensure access and participation in services that meet the child and/or family needs.

c) Services shall be delivered by providers who have experience in delivering health homes in a family's place of residence/community and are trusted members of the communities in which the Member resides.

3.8.5. Other Requirements

3.8.5.1. The Contractor shall educate Cedar Health Home providers about their responsibility to:

a) Contact a family within ten Days of referral.

b) Document attempts to reach the family.

c) Respond to referral sources.

d) Provide a copy of the Cedar Screening Tool to the Contractor no later than five Business Days after completion.

3.8.5.2. The Contractor shall have policies and procedures to:

a) Educate Members and Providers about the availability of Health Homes services in accordance with the Member Education requirements in Section 3.20.7.

b) Facilitate communication, coordination, and data sharing between Cedar Health Homes providers and the Contractor's Care Program staff.

c) Provide technical assistance and support to Cedar Health Homes providers as needed.

3.8. Health Homes for Children Program- Document History Log	
Contract Cross-References	Section 3.20, Member Services
Governing Requirements and Authority	Rhode Island Medicaid State Plan, TN# 18-0009
CMS Checklist Items	
Revision Date and Description	

3.9. Extended Family Planning Program Services

3.9.1. Program Description

3.9.1.1. The Extended Family Planning Program provides family planning services and supplies to Members of childbearing age who lose Medicaid eligibility 60 Days post-partum or 60 Days following a birth or loss of pregnancy.

3.9.1.2. EOHHS will determine eligibility in accordance with the EOHHS "Extended Family Planning Program Requirements" in Chapter 2 of the Medicaid Managed Care Manual, "Medicaid Services."

3.9.2. Covered Services

3.9.2.1. Covered Services are limited to family planning services and supplies identified in the EOHHS Extended Family Planning Program Requirements

3.9.2.2. The Contractor shall coordinate Covered Services for Extended Family Program Members and make referrals for primary care, social support, and other Health Care Services not covered by the program.

3.9.2.3. The Contractor shall have written policies and procedures to inform Members of Extended Family Planning benefits.

3.9.2.4. In accordance with Section 3.19.5, the Contractor's Member Handbook shall include information about the program, Covered Services, and how to request the Contractor's help finding non-covered services.

3.9. Extended Family Planning Program Services- Document History Log	
Contract Cross-References	• Section 3.19, Member Materials • Managed Care Manual Chapter 2, Medicaid Services
Governing Requirements and Authority	
CMS Checklist Items	
Revision Date and Description	

3.10. Enhanced Services

In addition to the services provided under the traditional Medicaid FFS model, the Contractor shall provide the enhanced Services and benefits described in this section. The Contractor shall deliver these Services and benefits in a manner that considers the unique social, cultural, and linguistic needs of the Rhode Island Medicaid population.

3.10.1. General Tracking, Follow-up, and Outreach

The Contractor shall have written policies and procedures to promote primary and preventative care, including tracking, follow-up, and outreach activities. These policies and procedures shall extend beyond the EPSDT program requirements described in Section 3.7 and shall include:

3.10.1.1. Member education about how to access services, the role of the PCP, Prior Authorization requirements, and after-hours access requirements;

3.10.1.2. Member education about preventative visit and screening recommendations;

3.10.1.3. Tracking systems to verify all Members have received an initial visit with a PCP;

3.10.1.4. Tracking systems to measure Member compliance with the Rhode Island EPSDT Periodicity Schedule for children, U.S. Preventative Services Task Force recommendations for adults, and Centers for Disease Control recommendations for immunizations for children, adolescents, and adults. The systems should also measure Member compliance with referral recommendations that result from preventive visits;

3.10.1.5. Processes to remind Members about and support Care Coordination for upcoming preventive visits, screenings, and appointments;

3.10.1.6. Processes for follow-up and outreach with Members who miss visits, using mail, telephone, home visits, and other outreach methods as appropriate;

3.10.1.7. Processes to identify and resolve barriers to preventive care such as language or transportation barriers;

3.10.1.8. Provider contracting, outreach, and education, activities to assure compliance with EPSDT screening; and

3.10.1.9. Processes to track EPSDT and other primary and preventative care services, including appropriate CPT/HCPC codes.

3.10.2. Prenatal Tracking, Follow-up, and Outreach

3.10.2.1. The Contractor shall have written policies and procedures for educating Members about the importance of early prenatal care.

3.10.2.2. The Contractor is encouraged to offer Value-Added Services as incentives to Members who seek prenatal care during their first trimester of pregnancy and who complete the requisite number of prenatal visits, as specified in the American College of Obstetricians and Gynecologists' guidelines for routine prenatal care.

3.10.2.3. The Contractor shall:

a) Perform appropriate clinical and social risk assessment of pregnant Members;
b) Allow pregnant Members to meet with the child's PCP (if known) prior to delivery;
c) Require PCPs or prenatal care Providers to schedule post-partum visits no more than six weeks after delivery, and verify visits are completed; and
d) Ensure family planning counseling is provided and, if appropriate, the Extended Family Planning benefit explained during the last trimester of pregnancy and at the six week post-partum visit.

3.10.3. Tobacco Cessation

3.10.3.1. The Contractor shall have written policies and procedures to assess Members for smoking behavior, particularly adolescents, pregnant Members, and persons with chronic medical conditions.

3.10.3.2. The Contractor shall offer tobacco cessation programs and services to all Members at convenient times and in accessible locations.

3.10.3.3. The Contract shall cover tobacco cessation supplies specified in Attachment F-3.1, "Schedule of In-Plan Benefits."

3.10.4. Nutrition Services

3.10.4.1. The Contractor shall implement policies and procedures to ensure:

a) Comprehensive nutrition assessments, education, and counseling is incorporated into preventive medical care, including prenatal and preventive pediatric visits.
b) Referrals are made to licensed dietitians or nutritionists for therapeutic nutrition counseling in accordance with EOHHS Nutrition Standards.

3.10.4.2. EOHHS Nutrition Standards are included in Chapter 2 of the Managed Care Manual, "Medicaid Services."

3.10.5. Transportation (CMS Checklist I.C.2.07)

3.10.5.1. The Contractor shall provide emergency transportation for Members when Medically Necessary, including out-of-state transportation.

3.10.5.2. In accordance with Section 3.3.6, "Schedule of Out-of-Plan Benefits," services provided by non-emergency transportation (NEMT) brokers are Out-of-Plan Benefits.

3.10.5.3. The Contractor's Member Handbook and Provider Manual shall include descriptions of the emergency transportation benefit, the non-emergency transportation Out-of-Plan Benefits provided by NEMT brokers, and how Members can access these services.

3.10.5.4. The Contractor shall help Members experiencing transportation barriers access these services through NEMT brokers. Depending on the Member's need and circumstances, the Contractor shall contact the NEMT broker on the Member's

behalf or help the Member reach the broker via a warm handoff to the NEMT call center staff.

3.10.6. Dental Services

3.10.6.1. The Contractor is responsible for providing the following dental benefits:

a) Services to diagnose and treat an oral health condition in either an inpatient or outpatient hospital setting;

b) Services to diagnose or treat an emergency oral health condition in a hospital emergency department;

c) Medically Necessary oral surgery services, including anesthesia; and

d) A complete list of In-Plan Benefits for oral health is found in Attachment F-3.1.

3.10.6.2. In accordance with Attachment F-3.2, "Out-of-Plan Benefits," children receive routine and preventative dental services as Out-of-Plan Benefits through RIte Smiles MCOs (also called "dental maintenance organizations," or "DMOs"). Adults receive a more limited set of dental services as Out-of-Plan benefits through Medicaid FFS. Additional information regarding Out-of-Plan dental benefits is available on the EOHHS website in the "Dental Services Coverage Manual."

3.10.6.3. The Contractor's Member Handbook and Provider Manual shall include a description of covered dental services, Out-of-Plan dental benefits, and how to access these services.

3.10.6.4. The Contractor shall help Members experiencing challenges accessing Out-of-Plan dental services schedule these services. Depending on the Member's need and circumstances, the Contractor shall either contact the RIte Smiles children's dental vendor, or Medicaid FFS vendors on the Member's behalf or help the Member reach these entities via a Warm Handoff to call center staff.

3.10. Enhanced Services- Document History Log	
Contract Cross-References	• Attachment F-3.1, Schedule of In-Plan Benefits • Attachment F-3.3, Schedule of Out-of-Plan Benefits • Section 3.3, Covered Benefits, Service Requirements, and Limits • Section 3.7, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) • Managed Care Manual Chapter 2, Medicaid Services
Governing Requirements and Authority	
CMS Checklist Items	I.C.2, Enrollee Handbook, Section I.C.2.07
Revision Date and Description	

3.11. Other Requirements for Covered Services

3.11.1. Anti-gag (CMS Checklist I.E.4.01-.05)

3.11.1.1. In accordance with Section 1932(B)(3)(A) and 42 C.F.R. § 438.102(a)(1), the Contractor shall not prohibit or restrict a Health Care Provider, acting within the lawful scope of practice, from advising or advocating on behalf of a Member about:

a) The Member's health status, medical care, or treatment options including any alternative treatment that may be self-administered.
b) Any information the Member needs to decide among all relevant treatment options.
c) The risks, benefits, and consequences of treatment or non-treatment.
d) The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

3.11.1.2. Furthermore, as specified in 42 C.F.R. 438.410(b) and Section 3.21.3 "Appeals," the Contractor is prohibited from taking punitive action against a Provider who either requests an expedited resolution or supports a Member's Grievance or Appeal.

3.11.2. Advance Directives (CMS Checklist I.F.14.01-.03)

3.11.2.1. The Contractor shall maintain written policies and procedures for Advance Directives that comply with all federal and state requirements, including 42 C.F.R. §§ 422.128 and 438.3 and 489 Subpart I, Chapters 23-4.10 and 4.11 of RI General Laws.

3.11.2.2. The Contractor is prohibited from conditioning the provision of care or otherwise discriminating against an individual based on whether a Member has executed an Advance Directive.

3.11.2.3. The Contractor's policies and procedures shall identify staff, Subcontractors, or Network Providers responsible for providing Member education on Advance Directives.

3.11.2.4. The Contractor shall educate all staff, Subcontractors, and Network Providers regarding its Advance Directive policies and procedures. Those responsible for educating Members about Advance Directives shall receive additional instruction regarding:

a) Situations in which Advance Directives may be of benefit to Members.
b) How to educate Members about Advance Directives.
c) How to help Members make use of Advance Directives.

3.11.2.5. As specified in Section 3.19, "Member Materials," the Contractor's Member Materials and Member Handbook shall include information about Advance Directives, including Member's ability to direct their care through Advance Directives. In accordance with 42 C.F.R. § 438.3(j)(4), the Contractor shall

update this information no later than 90 Days after the effective date of a change in state law.

3.11.2.6. The Contractor shall provide annual notice to Members of their right to request information regarding Advance Directives, in accordance with Section 3.19.8, "Distribution of Member Materials."

3.11.3. Moral Objections (CMS Checklist I.B.5.13, I.C.2.08-.09, I.C.8.09, I.F.5.01-.02, I.F.15.01, and I.L.1.02)

3.11.3.1. The Contractor affirms the assurance made in its Proposal that it does not object to providing any Covered Services based on moral or religious objections (see Attachment F-7, "Contractor's Proposal").

3.11.3.2. The Contractor therefore cannot refuse to provide Covered Services based on these grounds.

3.11. Other Requirements for Covered Services- Document History Log	
Contract Cross-References	• Attachment F-7, Contractor's Proposal • Section 3.19, Member Materials • Section 3.21, Grievances and Appeals
Governing Requirements and Authority	• Social Security Act, Section 1932(b) • 42 C.F.R. §§ 422.128, 438.3, 438.10, 438.56, 438.102, 438.228, 438.406, and 438.410 • 42 C.F.R. Part 489, Subpart I • RI General Laws, Chapters 23-4.10 and 4.11
CMS Checklist Items	• I.B.5, Disenrollment, Section I.B.5.13 • I.C.2, Enrollee Handbook, Section I.C.2.08-.09 • I.C.8, General Information Requirements, Section I.C.8.09 • I.E.4, Anti-gag, Sections I.E.4.01-.05 • I.F.5, Services Not Covered Based on Moral Objections, Sections I.F.5.01-.02 • I.F.14, Advance Directives, Sections I.F.14.01-.03 • I.F.15, Moral Objections, I.F.15.01 • I.L.1, Enrollee and Potential Enrollee Information, Section I.L.1.02
Revision Date and Description	

3.12. Population Health

3.12.1. Purpose

3.12.1.1. EOHHS seeks to advance Health population health management strategies. Strategies should be designed to promote equity, redress health disparities, and achieve optimal health outcomes for all Medicaid Members.

3.12.1.2. Achieving Health Equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and disparities.

3.12.2. Health Equity Strategy

3.12.2.1. The Contractor shall participate in and support EOHHS's efforts to achieve Health Equity by reducing health disparities and social risk factors. The Contractor shall develop and implement a Health Equity, Diversity and Inclusion Plan and strategy that complies with this Agreement.

3.12.2.2. The Contractor's Health Equity, Diversity and Inclusion Plan and strategy shall:

a) Be developed in consultation with the Contractor's subcontracted AEs.
b) Reflect specific Member populations, communities, languages spoken and sociocultural dynamics.
c) Identify disparities in health care access, service provision, satisfaction and outcomes and the factors that drive those outcomes including social risk factors.
d) Prioritize the Health Equity outcomes that align with EOHHS' priorities and are most meaningful to the Contractor's Members.
e) Establish measurable targeted reductions for specified health disparities.
f) Identify programs, strategies and interventions to meet established targets to reduce disparities and address social risk factors.
g) Set near and long-term goals to incorporate Health Equity measures into the Contractor's value-based payment arrangements with its Subcontractors and Network Providers in accordance with guidance issued by EOHHS.
h) Solicit engagement and feedback from a representative group of Members to ensure that Contractor's Health Equity, Diversity and Inclusion Plan and strategy reflects the ethnic and cultural diversity of Members.
i) Identify and help coordinate community services and resources that can be offered to Members to address SDoH needs and demonstrate working relationships with community organizations to refer to and support provision of those service.
j) Identify how the Contractor, its Subcontractors and Network Providers will engage and support the State's broader Health Equity initiatives, including those involving sister agencies such as the Department of Health.

3.12.2.3. The Contractor's Health Equity, Diversity and Inclusion Plan and strategy shall be submitted for review and approval by EOHHS during Readiness Review, annually thereafter, and upon modification.

3.12.2.4. The Contractor shall monitor progress toward implementing its Health Equity, Diversity and Inclusion Plan and strategy and shall submit quarterly reports to EOHHS that include:

a) A narrative description of activities undertaken.
b) Quantitative progress toward meeting the measurable targets and goals identified in the plan and strategy.

3.12.3. Health Risk Assessment

The Contractor is responsible for ensuring that:

3.12.3.1. A Health Risk Assessment (HRA) is conducted on every enrolled Member in accordance with EOHHS Care Program Protocols in Managed Care Manual Chapter 8, "Care Program and Accountable Entities."

3.12.3.2. Data from the HRA shall be stratified by Member characteristics including race, ethnicity, language, disability and by attributed AE.

3.12.3.3. Whether conducted by the Contractor, a subcontracted entity or a Provider, the HRA used must be approved by EOHHS.

3.12.3.4. All staff, including the staff of subcontracted AEs and Providers shall participate in anti-bias workshops as part of mandatory staff training no less than annually.

3.12.3.5. The Contractor's data system shall have sufficient IT infrastructure and data analytics capacity to support EOHHS' vision and goals for quality improvement, measurement and evaluation, including the capability to:

a) Identify service access, utilization, health outcomes, intervention effectiveness, social risk factors, and survey (e.g., CAHPS) results by Member characteristics including race, ethnicity and language, disability, and by attributed AE; and
b) Employ advanced analytic methods such as hot spotting and predictive analytics and modeling to improve the identification of Members and Member communities disproportionately impacted by or at risk for poor health outcomes and social risk factors.
c) Support the monitoring and comparison of process and outcome measures over time to inform disparity reduction efforts.

3.12.4. Quality Measurement

The Contractor is responsible for:

3.12.4.1. Collecting and reporting data to EOHHS on select quality measures as identified by EOHHS that can be stratified based upon Members' age, race, ethnicity, language, disability, or other characteristics as specified by EOHHS and by attributed AE, if applicable.

3.12.4.2. Requiring that when AEs and Providers report data on quality measures that such data captures information and can be stratified based upon Members' age,

race, ethnicity, language, disability, or other characteristics as specified by EOHHS.

3.12. Care Coordination- Document History Log	
Contract Cross-References	• Section 3.1, Contract Administration and Management • Section 3.17, Quality Management, Quality Improvement • Managed Care Manual Chapter 8, Care Program and Accountable Entities, Care Program Protocols
Governing Requirements and Authority	
CMS Checklist Items	
Revision Date and Description	

3.13. Care Program and Continuity of Care

The Contractor shall develop a comprehensive Care Program that encompasses the full continuum of care management and coordination activities.

3.13.1. Care Program Framework and Protocols

3.13.1.1. Managed Care Manual Chapter 8, "Care Program and Accountable Entities," includes the EOHHS Care Program Protocols, including minimum requirements for Care Program activities, including:

a) Division of duties and partnership expectation between Health Plans, AEs, and other Care Program participants.
b) The care continuum framework.
c) Key components of the Care Program, including program design and planning; HRAs; Care Coordination, Care Management (CM), and Complex Case Management (CCM).
d) Qualifications and location of Care Managers and Complex Care Managers.
e) Individualized Care Plans (ICPs) for Members receiving CM and CCM.
f) Requirements for coordinating care with Targeted Case Management providers, including AIDS Case Management Agencies
g) Additional Care Coordination requirements for Members recently discharged from correctional institutions, including coordination with the local Reentry Councils.
h) Specialized Care Coordination requirements for populations needing CCM (collectively "Specialized Populations,") including:

- Members with high-risk pregnancies.
- Members receiving services in the Neonatal Intensive Care Units (NICUs).
- Children with Special Health Care Needs.
- Children with complex medical needs or adverse childhood experiences.
- People living with HIV, AIDS, Hepatitis C, severe mental illness or addiction.
- People recently discharged from correctional institutions.

3.13.1.2. EOHHS reserves the right to modify the Care Program Protocols at any time, as described in Attachment F-2, Section 4.7, "Modification to the Managed Care Manual."

3.13.2. Care Program Plan Requirements (CMS Checklist I.G.2.01-.04, I.G.2.08-.13)

3.13.2.1. The Contractor shall make Care Program services available to all Members based on their individualized needs. Key components of the Care Program are described in EOHHS Care Program Protocols, and include:

Component	Brief Description
Care Program Design and Planning	• Includes activities to coordinate Care Program functions with and delegate Care Program functions to AEs and other program participants. • Also includes activities to identify Members needing Care Program services, including data analytics, HRAs, and referrals.
Health Promotion and Wellness	• Includes strategies for wellness care and immunizations, general health promotion and prevention, and behavioral health rehabilitation and recovery. • The Contractor shall work with AEs and other Providers to integrate health education, wellness, and preparation training into Member care.
Health Risk Assessment (HRA)	• The HRA is used to determine Members' needs for and access to medical and health-related social services and supports; to coordinate care; and to determine whether risk factors indicate a need for CM or CCM.
Care Coordination	• The deliberate organization of Members' care activities between two or more participants (including the Member) involved in a Member's care to facilitate the appropriate delivery of Health Care Services and supports. • Care Coordination participants can include Members, their families, and caregivers; AEs; patient-centered medical homes, health homes, community health teams; Targeted Case Management providers; and providers of community and social supports.
Care Management (CM)	• A team-based, person-centered approach designed to improve Members' health and situational health-related needs (as documented in an ICP) by facilitating access to clinical and non-clinical services. • Situational health care needs include time-limited episodes of instability, such as following an acute medical event (e.g., heart attack, sepsis, surgery, high-risk pregnancy) or gaining self-care skills following a new diagnosis (e.g., diabetes).
Complex Case Management (CCM)	• Builds on Care Management requirements and includes evidence-based coordination services for Members with multiple or complex conditions in accordance with NCQA standards. • Delivered to the highest risk Members with complex conditions and high-risk populations. • CCM functions include a comprehensive initial assessment and development of an ICP with Member/family input; delineation of available services and resources; ongoing monitoring and follow-up by care team.

3.13.2.2. The Contractor shall develop and implement a Care Program Plan. As described in Article 2, "Readiness Review Phase,' the Care Program Plan shall be approved by EOHHS prior to the Operational Start Date. EOHHS approval is also required any time the Contractor makes substantive revisions to the Care Program Plan.

3.13.2.3. To the extent the Contractor delegates Care Program responsibilities to AE, other Subcontractors, or Providers, the Contractor shall maintain overall responsibility for ensuring compliance with the terms of this Agreement and the Care Program Plan. The Contractor shall identify delegated functions in the Care Plan. See Section 3.15, "Accountable Entity Program," for a description of Care Program activities that can be delegated to qualified Accountable Entity partners.

3.13.2.4. The Contractor's Care Program Plan shall include policies and procedures to:

a) Operate the Care Program, including all key components described in Section 3.13.2.1, above, and the EOHHS Care Program Protocols.

b) Implement standardized procedures or methodologies for predictive modeling and risk stratification to identify Members to include in the Care Program, including processes for self-referral and regular reviews of claims, utilization data, and information collected through HRAs.

c) Ensure Members have ongoing sources of care appropriate to their needs and are actively involved in decisions relating to their care.

d) Implement the requirements described in Section 3.15, "Accountable Entity Program," including a Care Plan Strategy specific to AEs. The strategy shall include minimum requirements described in the EOHHS Care Program Protocols, such as how the Contractor shall assess AE's capacity to perform delegated functions, identify which functions are delegated to AEs, and the Contractor's framework for financing Care Program activities as more responsibilities are delegated to AEs over time.

e) Oversee and actively monitor all delegated Care Program activities, including activities delegated to AEs.

f) Complete HRA tools approved by EOHHS within 90 Days of enrollment for new Members. The HRA should address health inequities and SDoH (e.g., housing instability, transportation needs, food insecurity), and comply with other requirements in the EOHHS Care Program Protocols. Results of HRA assessment should be shared with EOHHS and AEs as requested to prevent duplication of efforts.

g) Develop ICPs for Members who qualify for CM or CCM. ICPs shall be updated annually or more frequently as needed to address changes in Members' medical conditions or needs. Members, their families, and caregivers should be active participants in ICP development.

h) Coordinate health-related social services for all Members with identified needs (based on HRA screening), including:

- Documenting in ICP any positive/social needs.

- Referring to social service Providers and/or providing enhanced services de-signed to meet the Member's social needs.
- "Closing the loop" by ensuring services were received and documented in the Member's records
- Monitoring the level of Member engagement and utilization of these services.
- EOHHS reserves the right to require Contractor to use electronic community resource platform procured by EOHHS, AEs, or other Providers to coordinate tasks noted above.

i) Designate a person or entity with primary responsibility for coordinating Member services and Care Program activities and notify Members how to contact this person or entity.

j) Ensure staff and delegates who provide Care Coordination, CM, and CCM meet minimum qualifications identified in the EOHHS Care Program Protocols.

k) Provide additional supports to Specialized Populations during times of transition (e.g., between care settings, from child to adult services, etc.), as described in the EOHHS Care Program Protocols.

l) Coordinate Care Coordination activities with TCM programs (e.g., HIV) and provide additional support if the Member has unmet needs. Care Coordination activities can include participating in Member case conferences, data sharing, and other strategies.

m) Implement continuity and transition of care policies consistent with 42 C.F.R. 438.62(b), 42 C.F.R. § 438.206(b), and Sections 3.13.3 and 3.13.4, below. The Contactor's Member Handbook shall educate Members about their rights under these policies.

n) Facilitate coordination of services between care settings, including appropriate discharge planning from hospitals, residential treatment facilities, and institutional care. Facilitation shall include processes and procedures to share data regarding admissions, discharges, transfers, and prescription drugs with Members' PCPs and behavioral health providers (see also Section 3.13.4, regarding "Care Transitions").

o) Coordinate and collaborate on Out-of-Plan and other health and social services, as described in Section 3.13.7, below.

p) Use information systems to support monitoring and management of ICPs and electronic community resource platforms to coordinate and track referrals to community-based services.

q) Ensure the Contractor, Subcontractors, and Providers use and disclose individually identifiable health information, including Member records, in accordance with confidentiality requirements in 45 C.F.R. Parts 160 and 164 and applicable federal and state laws, rules, regulations, and professional standards.

r) Ensure Members are not held responsible for costs of transferring medical records to Providers.

3.13.3. Continuity of Care for New Members (CMS Checklist I.G.2.06)

3.13.3.1. The continuity of care requirements described herein are intended to ensure the seamless transfer of clinical care, and that services are not interrupted or disrupted for new Members. This includes Members who move from the FFS Medicaid Program to the Managed Care Program or from one Health Plan to another.

3.13.3.2. The Contractor shall allow newly enrolled Members to continue seeing Out-of-Network Providers and honor existing Prior Authorizations for Medically Necessary Covered Services until the shorter of:

a) Six months after enrollment in the Contractor's Health Plan;
b) Expiration of the Prior Authorization period; or
c) The Contractor has completed the HRA for the new Member and either:
- Issued or denied a new Prior Authorization for the service; or
- Transitioned the Member's medical records to a Network Provider with comparable or greater expertise in treating the Member's needs. The Contractor shall ensure Members are not charged for transferring medical records.

3.13.3.3. The Contractor shall extend the timeframes described above when the Member has Appealed an Adverse Benefit Determination and has requested benefits continue pending resolution ("Aid Pending"), as described in Section 3.21.5, "Continuation of Benefits."

3.13.4. Continuity and Transition of Care for Existing Members

3.13.4.1. The Contractor shall allow the following Members to receive Medically Necessary Covered Services from Out-of-Network Providers:

a) Pregnant Members past the 24th week of pregnancy can remain under their current obstetrician's/gynecologist's care through the post-partum checkup.
b) Members diagnosed with and receiving treatment for a terminal illness can remain with established providers for up to nine months.
c) Members with chronic or acute medical, behavioral health, or substance Abuse conditions whose providers leave the Contractor's Network can remain with these providers for up to 6 months.

3.13.4.2. Upon expiration of the above-referenced continuity periods, the Contractor shall help Members transition to qualified Network Providers and have policies to ensure, at a minimum:

a) Transitions do not create a lapse in services;
b) Necessary information exchange (including transferring Member records);
c) Compliance with patient confidentiality requirements; and
d) Members can request additional changes in Network Providers.

3.13.5. Services Not Available in Network (CMS Checklist I.F.4.03)

The Contractor shall allow Members to receive services from Out-of-Network Providers when Medically Necessary Covered Services are not available from a qualified Network Provider within the appointment availability standards described in 3.14.34. These services shall be made available at no cost to Members.

3.13.6. Additional Requirements for Out-of-Network Providers

3.13.6.1. Out-of-Network Providers shall satisfy all EOHHS and state requirements, including standards for enrollment, licensure, accreditation, or certification, as appropriate to the Covered Service provided.

3.13.6.2. The Contractor shall reimburse an Out-of-Network Provider of Emergency Medical Services, Emergency Services, Emergency Room Care, or Early Intervention services at 100% of the Medicaid FFS rate. In all other circumstances where the Contractor is required to cover services provided by an Out-of-Network Provider, the Contractor shall reimburse the Provider at a rate equal to the Contractor's usual and customary rate, or another rate agreed to in writing with the Provider.

3.13.7. Coordination with Out-of-Plan Medicaid Services and Other Health/Social Services (**CMS Checklist I.G.2.05-.07)**

3.13.7.1. EOHHS supports various federal, state, and community programs targeted to persons who may be covered the Managed Care Program. These services are significant to promote the health of Members and their families.

3.13.7.2. The Contractor is not obligated to provide or pay for Out-of-Plan Medicaid Services as described in Attachment F-3.2, "Schedule of Out-of-Plan Benefits," or other non-plan, non-capitated services. To avoid service fragmentation, however, the Contractor's Care Program Plan shall include policies and procedures to:

a) Educate Members and Providers about the availability of these services (via the Member Handbook, Provider Handbook, outreach and education materials).
b) Make referrals to and help Members access these services.
c) Coordinate these services with In-Plan Benefits.
d) "Close the loop" by verifying Members are receiving these services.

3.13.7.3. The Contractor is encouraged to coordinate and partner with Rhode Island Department of Health (RIDOH) on disease management programs including diabetes education, asthma, tobacco cessation, nutrition.

3.13.7.4. Examples of Out-of-Plan Medicaid Services, state programs, and community supports are described below, but this list is not exhaustive.

a) Non-Emergency Transportation.
b) Dental Services for Children and Young Adults (RIte Smiles).

c) Long-term Services and Supports provided to Medicaid-only Members through the Medicaid Fee-for-Service Program (including services provided through consumer/self-directed and agency/provider delivery models).
d) Special Education services.
e) Services provided through Department of Behavioral Health, Developmental Disabilities and Hospitals, Rhode Island Department of Human Services, and Rhode Island Department of Health Services.
f) Lead Program.
g) Department of Children, Youth and Families/Department of Health/Rhode Island Executive Office of Health and Human Services Special Programs.
h) Adolescent Self-Sufficiency Collaborative (ASSC).

3.13.7.5. The Contractor shall coordinate and collaborate with the Recovery Navigation Program. Coordination shall include assistance with discharge planning to appropriate inpatient detox and outpatient services as they relate to behavioral health treatments.

3.13. Care Program and Continuity of Care- Document History Log	
Contract Cross-References	• Article 2, Readiness Review Phase • Attachment F-2, Section 4.7, Modification to the Managed Care Manual • Attachment F-3.3 Out-of-Plan Benefits • Section 3.12, Population Health • Section 3.14, Provider Networks and Requirements, Access to Care • Section 3.15 Accountable Entity Program • Section 3.21, Grievances and Appeals • EOHHS Attachment Q, Introduction • Managed Care Manual Chapter 8, Care Program and Accountable Entities
Governing Requirements and Authority	• 42 C.F.R. §§ 438.62(b), 438.206(b), 438.208(b), and 438.224 • 45 C.F.R. Parts 160 and 164
CMS Checklist Sections	• I.F.4, Delivery Network, Section I.F.4.03 • I.G.2, Care Coordination, Sections I.G.2.01-.13
Revision Date and Description	

3.14. Provider Networks and Requirements, Access to Care

3.14.1. General Requirements

The Contractor shall establish and maintain a robust geographic Provider Network providing the full range of Covered Services described in Attachment F-3, "Services." This includes preventive, primary, acute, behavioral health, substance use, and other specialty care, as well as long-term services and supports (including nursing home and community-based care). Covered Services shall be available and accessible to all Members in a timely manner without unreasonable delay in accordance with the access standards described in this Section.

3.14.2. Accessibility (CMS Checklist I.E.1.04, I.E.5.07)

3.14.2.1. The Contractor shall participate in the State's efforts to promote the delivery of Covered Services in a culturally competent manner to all Members including those with Limited-English Proficiency and diverse cultural and ethnic backgrounds, disabilities and regardless of sex.

3.14.2.2. The Contractor shall ensure its Network Providers provide physical access, reasonable accommodations, accessible equipment and language assistance for Members who have Limited-English Proficiency or physical or mental disabilities.

3.14.2.3. To the extent possible and appropriate, Members shall have the opportunity to choose their Network Primary Care Provider, Women's Health Provider, or Family Planning Provider before the Contractor assigns them to such Providers.

3.14.3. Qualifications of Network Providers- General

Network Providers must meet the qualifications described in this Section 3.14, "Provider Networks and Requirements, Access to Care."

3.14.4. Licensure

All Network Providers must be appropriately licensed, certified, or registered in accordance with all applicable Rhode Island General Laws and Regulations or, if located in another jurisdiction outside of Rhode Island, in accordance with the health occupations regulatory requirements in the jurisdiction where the Provider practices.

3.14.5. Enrollment as a Medicaid Provider (CMS Checklist I.I.2.38)

All Network Providers, including ordering and referring providers, must be enrolled with the state as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. §§ 455, Subpart B, Subpart E, and 42 C.F.R. § 438.608(b). This provision does not require the Network Provider to render services to FFS beneficiaries.

3.14.6. Credentialing (CMS Checklist I.E.3.03, I.E.3.10)

All Network Providers must be credentialed and recredentialed in accordance with the policies and procedures in this Section.

3.14.7. Credentialing Process (CMS Checklist I.E.3.03-.04)

3.14.7.1. The Contractor shall have a documented process for credentialing and recredentialing Network Providers that, at minimum meets the following requirements:

a) Is supported by written policies and procedures.

b) Prohibits discrimination against particular Providers including those that serve high-risk populations or specialize in conditions that require costly treatment.

c) Includes sufficient safeguards and screening mechanisms to ensure the Contractor neither employs nor contracts with a provider who has been excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

3.14.7.2. If the Contractor declines to include an individual or groups of providers in its Network, the Contractor shall provide the applicant provider written notice of the reason for its decision and the right to appeal the decision to the Contractor.

3.14.8. Written Agreement (CMS Checklist I.E.1.01-.06, I.E.4.01-.04, I.E.8.01-.02)

3.14.8.1. The Contractor shall execute written agreements with all Network Providers.

3.14.8.2. When the Contractor contracts with Providers, it shall:

a) Not execute Provider agreements with Providers who have been debarred, suspended, or otherwise excluded from participation in Medicaid, CHIP or Medicare programs pursuant to § 1128 or § 1156 of the Social Security Act or who are not in good standing with RI Medicaid.

b) Not discriminate for the participation, reimbursement, or indemnification of Providers acting within the scope of their license or certification as defined by state law, solely on the basis of that license or certification.

c) Have policies and procedures to ensure Network Providers and office staff comply with the requirements of Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000D et seq.); Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 79420 U); Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.); Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et. seq.); and all other federal and state laws that prohibit discrimination.

d) Require that each individual or group Provider in the Network is assigned a unique identifier.

e) Not prohibit or restrict a Provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member regarding:

- The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
- Any information the Member needs to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.

- 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.
- Take no punitive action against a Provider who either requests an expedited resolution or supports a Member's Grievance or Appeal.

f) Encourage Providers to use the State's Health Information Exchange ("CurrentCare"), including the hospital alert system and help high utilizing patients to enroll in CurrentCare.

3.14.8.3. The Contractor shall offer a contract to any willing Provider in the following classes that agrees to the terms of the Contractor's Network Provider Agreement, including the payment terms:

a) Federally Qualified Health Centers (FQHCs);
b) Rural Health Centers (RHCS);
c) All Medicaid enrolled BHDDH-licensed substance use disorder Providers;
d) All Medicaid enrolled DCYF Providers; and
e) Community Mental Health Centers.

3.14.8.4. All physician incentive plan arrangements, as defined by 42 C.F.R. § 438.3(i) and 42 C.F.R. § 422.208(a), shall be in writing and included in the Network Provider Agreement. The Contractor is only allowed to operate physician incentive plans if payments do not incentivize Providers to reduce or limit Medically Necessary Covered Services. Incentive arrangements that place Providers at substantial financial risk shall include adequate stop-loss protections.

3.14.8.5. All Network Provider Agreements must conform to and be consistent with the provisions of the EOHHS Medicaid Provider Agreement.

3.14.9. School-Based Clinics

3.14.9.1. The Contractor shall include all state-approved school-based clinics in its Network and allow these clinics to provide all Medicaid Covered Services available through the clinics.

3.14.9.2. The Contractor's Network Provider Agreements with school-based clinics shall be executed no later than the Effective Date of this Agreement.

3.14.10. Related Providers

The Contractor is prohibited from entering into an exclusive Provider agreement with any Provider entity that is associated with the Contractor through any form of common ownership, control, or investment. This prohibition applies when the related-party arrangement is carried out through one or more unrelated parties.

3.14.11. Provider Terminations

3.14.11.1. The Contractor shall comply with EOHHS' requirements for "Provider Terminations and Network Changes," in Managed Care Manual Chapter 11, "Reporting Calendar and Templates."

3.14.11.2. In accordance with the EOHHS requirements, the Contractor shall provide EOHHS prompt written notice of any actions undertaken to terminate or suspend a Network Provider due to Fraud, Waste, Abuse, or quality or program integrity concerns.

3.14.12. Network Changes

3.14.12.1. The Contractor shall create written policies and procedures to address any Network Provider terminations and any changes to the Network that negatively impact Network composition or Members' ability to access Covered Services.

3.14.12.2. These policies and procedures shall comply with EOHHS' Provider Terminations and Network Changes Policy.

3.14.13. Notification to EOHHS

3.14.13.1. Section 3.14.19 describes the Member to PCP ratio applicable to this Agreement. The Contractor shall submit a monthly report on Member to PCP ratio and any changes in its Network composition. The Contractor shall take corrective action if the report indicates it does not comply with the required Member to PCP ratio.

3.14.13.2. The Contractor shall notify EOHHS of any Provider termination, regardless of whether the Provider or Contractor initiated the separation. This notification shall be submitted in writing, via email, and no later than three Days from the date of notification of the Provider termination.

3.14.13.3. The Contractor shall complete all applicable forms described in the EPHHS Provider Terminations and Network Changes Policy no later than 30 Days from the Provider termination notice.

3.14.13.4. The Contractor shall submit a Member Transition Plan to address changes in Network composition no later than 15 Days before the effective date of a Network Provider termination. The plan shall comply with the continuity of care requirements in Section 3.13, "Care Program and Continuity of Care."

3.14.14. Notification to Members (CMS Checklist I.C.6.01)

3.14.14.1. The Contractor shall make a good faith effort to give written notice of a Provider termination to all impacted Members regardless of whether the Provider or Contractor initiated the termination.

3.14.14.2. For purposes of this Section, and "impacted Members" include Members:

a) Attributed to a PCP, or

b) Who were seen on a regular basis by the Provider, as evidenced by receiving at least one Covered Service from the Provider within the preceding 12 months.

3.14.14.3. Upon request, the Contractor shall provide a Member an EOHHS Plan Change Request Form, including translated versions of the form, free of charge.

3.14.14.4. The Contractor shall document all Member outreach related to a Provider termination or Network change in accordance with EOHHS' "Provider

Terminations and Network Changes Policy." The Contractor shall begin the Member outreach no later than 15 Days before the Provider's effective date of termination.

3.14.15. Network Development Plan (CMS Checklist 1.B.2.02)

The Contractor shall develop and maintain a Network Development Plan that contains all of the following elements:

3.14.15.1. Addresses continuous recruitment and retention of new Providers.

3.14.15.2. Considers the importance of developing a diverse Provider Network that reflects the demographics and language preferences of the population served and has the capacity to provide services in a culturally competent manner to all Members.

3.14.15.3. Monitors Network adequacy against the standards set forth in this Agreement and the needs of Members.

3.14.15.4. Includes strategies to address identified gaps when Network adequacy falls below standards or is inadequate to meet Members' needs.

3.14.15.5. The Contractor shall allow Members to choose their Network Providers to the extent possible and appropriate.

3.14.16. Network Considerations

In establishing and maintaining the network, the Contractor shall consider the following:

3.14.16.1. Anticipated number of Members enrolled in the Contractor's Health Plan.

3.14.16.2. Expected utilization of Covered Services, taking into consideration the characteristics and health care needs of Members for which the Contractor is, or will be, responsible.

3.14.16.3. The characteristic and health care needs of specific Medicaid populations including children, adults, medically underserved beneficiaries, children and adults with serious chronic and/or complex health conditions, physical and/or mental disabilities and persons with Limited English Proficiency.

3.14.16.4. The number of Network Providers accepting new patients, and whether there are a sufficient number of PCPs and other providers accepting new patients to comply with this Section's access to care requirements.

3.14.16.5. The Network's ability to provide all Medicaid managed care children and adults the full continuum of Behavioral Health Benefits, including Substance Use Disorder Benefits.

3.14.16.6. A sufficient number of subspecialists or specialty Providers experienced in sexual abuse, domestic violence, rape, and dual diagnosis (mental health and substance use disorder) to meet the needs of the population served in a timely manner.

3.14.16.7. A sufficient number of Providers experienced in serving low-income populations, persons with polypharmacy and dual diagnosis in sufficient numbers to meet the needs of the population served in a timely manner.

3.14.16.8. Numbers and types (in terms of training, experience, and specialization) of Network Providers, specifically specialty Providers, required to furnish all Covered Services.

3.14.16.9. Geographic location of Providers and Members, considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities.

3.14.16.10. Ability of Network Providers to communicate with Members with Limited English Proficiency in their preferred language and provide Culturally competent care and services to all Members regardless of race, ethnicity, gender, or background.

3.14.16.11. Ability of Network Providers to support the health and wellness of people with disabilities through their disability knowledge, experience, and expertise.

3.14.16.12. Availability of triage lines or screening systems and the use of telemedicine or other evolving and innovative technological solutions.

3.14.17. Documentation (CMS Checklist I.E.1.06-.08)

3.14.17.1. The Contractor shall submit documentation to support that is has established an adequate Provider Network, including a Network Development Plan demonstrating the Contractor:

a) Has the capacity to meet expected enrollment in accordance with the service accessibility requirements described in this Section 3.14, "Provider Networks and Requirements, Access to Care."

b) Offer an appropriate range of preventative, primary care, and specialty care that is adequate for the anticipated number of Members.

c) Maintain a Network that is sufficient in number, mix and geographic distribution to meet the anticipated number of Members.

3.14.17.2. Such documentation shall be provided to EOHHS for review and approval during Readiness Review, in accordance with the timeframes described in EOHHS' Readiness Review Schedule.

3.14.18. Primary Care Providers (PCPs)

3.14.18.1. The Contractor shall ensure every Member has a PCP who serves as the Member's primary point of contact with the Contractor's Provider Network.

3.14.18.2. The Contractor shall have policies and procedures for assigning Members who have not selected a PCP at the time of enrollment to a PCP. The Contractor's assignment methodology shall consider the provider's panel size and established relationship with the Member or the Member's household, the proximity of the provider's office to the Member's home, the Member's language needs, and other demographic information. Where possible, the Contractor shall select a NCQA accredited Patient Center Medical Home. In addition, for Members with Special Health Care Needs, the Contractor's assignment methodology shall consider the provider's ability to accommodate the Member's needs.

3.14.18.3. The Contractor shall submit its proposed assignment methodology to EOHHS for review and approval during Readiness Review and at least 30 Days prior to modification.

3.14.18.4. The Contractor shall promptly notify the Member in writing or by phone with the following PCP information:

a) Name;
b) Location;
c) Office telephone number; and
d) How to change PCPs.

3.14.19. Member to PCP Ratio

The Contractor agrees to maintain a ratio of PCPs to assigned Members of no more than 1,500 Members to a single PCP.

3.14.20. Physical and Behavioral Health Integration

3.14.20.1. In accordance with Section 3.4.14, "Behavioral Health Innovation Plan," the Contractor shall develop strategies to promote integrated physical and behavioral health care through Network Providers.

3.14.20.2. The Contractor's strategies should promote Provider education, training, and incentives to increase screening, identification, and referral for behavioral health conditions commonly identified in primary care settings.

3.14.21. Patient-Centered Medical Homes (PCMH)

The Contractor shall include NCQA certified PCMHs in its Provider Network.

3.14.22. Self-Referrals

3.14.22.1. The Contractor shall allow Members to self-refer for the following Covered Services. Unless otherwise noted, the Contractor is not required to allow self-referral to Out-of-Network Providers:

a) Women's health/gynecological/family planning services -- one annual and up to five GYN/Family Planning visits annually (includes Out-of-Network Providers).
b) Behavioral Health Benefits.
c) Substance Use Disorder Benefits.
d) Abortion services (includes Out-of-Network Providers).

3.14.22.2. The Contractor's Member Handbook shall notify Members of the right to access these services without a referral from a PCP.

3.14.22.3. The Contractor's Care Program Plan shall include processes and procedures to coordinate self-referred care with PCPs.

3.14.23. Public Health Reporting

To assist in monitor and reporting of lead poisoning and other reportable diseases throughout the State, the Contractor shall:

3.14.23.1. Require Network Providers to submit to the RI Department of Health (RIDOH) State Health Laboratories specimens for HIV testing and mycobacteria (TB) analysis as well as blood lead samples as described in the Reporting and Testing of Infectious, Environmental, and Occupational Diseases (216-RICR-30-05-01).

3.14.23.2. Submit specimens from suspected cases of measles, mumps, rubella and pertussis or other infection diseases when required by the state to facilitate investigations of outbreaks.

3.14.23.3. Comply with all other directives of the Rhode Island Department of Health.

3.14.24. Equal Access to Network Providers

3.14.24.1. Contractors who offer commercial or other health insurance products in Rhode Island shall have policies and procedures to ensure the following:

a) Network Providers may not treat Medicaid Members differently than other patients who are enrolled in non-Medicaid products.

b) A Network Provider who refuses to accept a referral of a new Medicaid Member must be considered closed for all referrals and may not receive referrals of new patients insured through the Contractor's other insurance products.

3.14.24.2. A Network Provider must not provide separate office space, examination rooms or otherwise segregate Medicaid Members in any way from other persons receiving services.

3.14.25. Networks Related to Native Americans (CMS Checklist I.B.7.02, I.D.5.01-.03)

3.14.25.1. The Contractor is required to:

a) Demonstrate that there are sufficient IHS, Tribal, and Urban Indian (ITU) Providers in the Network to ensure timely access to services available under the contract for Native American Members who are eligible to receive services from such Providers.

b) Ensure that ITU Providers enrolled in Medicaid as federally Qualified Health Centers (FQHCs) but are not participating in the Contractor's Network are paid an amount equal to the amount the Contractor would pay a FQHC that is Network Provider but is not an ITU, including any supplemental payment from the state to make up the difference between the amount the Contractor pays and what the ITU FQHC would have received under the FFF Program.

c) Ensure that ITU Providers that are not enrolled in Medicaid as a FQHC, regardless of whether they participate in the Contractor's network, has the right to receive its applicable encounter rate published annually in the federal Register by the Indian Health Services (IHS), or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State's FFS payment methodology.

d) Make timely payment to all I/T/U Providers in its Network in accordance with Section 3.26.7, "Timely Payment."

3.14.25.2. Permit any Native American who is enrolled in a non-Native American MCO and eligible to receive services from a participating I/T/U Provider to:

a) Choose to receive covered services from that I/T/U Provider, and
b) If that I/T/U Provider participates in the Network as a PCP, to choose that I/T/U as his or her PCP, as long as that Provider has capacity to provide the services.

3.14.26. Provider Services Department and Hotline

3.14.26.1. The Contractor shall stablish, maintain, and appropriately staff a Provider Services Department, or similar organizational structure, and a toll-free Provider Services Hotline.

3.14.26.2. The Provider Services Hotline shall be available to respond to Providers' questions, comments, and inquiries. This includes proving appropriate and timely responses regarding the following:

a) Eligibility and Benefits.
b) Prior Authorizations, referral requirements, Care Coordination and Network questions.
c) Assisting with Grievance and Appeals made on behalf of Members, and an escalation path, if requested.
d) Assisting Providers with questions concerning Member eligibility status.
e) Assisting Providers with Prior Authorization and referral procedures.
f) Assisting Providers with claims payment procedures and appeals.
g) Handling Provider complaints.
h) Assisting with Care Program requirements.

3.14.26.3. The Contractor shall operate the Provider Services Hotline at least during regular business hours.

3.14.26.4. The Contractor shall develop policies and procedures that address staffing, training, hours of operations, access, response standards, and monitoring of the Provider Services Hotline that comply with EOHHS call center performance standards.

3.14.26.5. The Contractor shall produce and disseminate a quarterly newsletter for Network Providers.

3.14.26.6. The Contract shall timely communicate changes in Covered Services, Member's rights and responsibilities, and other programmatic changes to Network Provider.

3.14.27. Provider Training

3.14.27.1. The Contractor shall have an ongoing Provider education and training program that at a minimum, addresses the following topics:

a) Network access and services accessibility requirements.
b) The equal access to treatment requirements described in Section 3.14.25.

c) An overview of EPSDT.
d) The Contractor's policies on Advance Directives.
e) Billing.
f) Utilization Management and Prior Authorization.
g) Fraud, Waste and Abuse.
h) The Contractor's Health Equity Plan.
i) Cultural Competency, and the unique needs of Medicaid Members.
j) Provider reporting requirements.
k) Privacy and confidentiality.
l) Anti-bias workshops as outlined in Section 3.12.3, "Health Risk Assessment."
m) Member rights and responsibilities.

3.14.27.2. The Contractor shall attend and require Providers to attend additional trainings as directed by EOHHS.

3.14.27.3. The Contractor shall conduct initial education and training for Network Providers at least 30 Days before the Operational Start Date and within 30 Days of a Provider joining the Contractor's Network.

3.14.28. Provider Contact Information

The Contractor shall require Providers to report any changes in demographic information, including addresses and telephone numbers, within five Business Days of a change.

3.14.29. Provider Practice Changes

The Contractor shall require Providers to comply with the notice requirement in the EOHHS Network Changes or Provider Termination Policy, including sale, dissolution, and other changes in provider practices.

3.14.30. Provider Manual

3.14.30.1. The Contractor shall develop a Provider Manual and make it available to all Network Providers.

3.14.30.2. The Contractor may distribute the Provider Manual electronically (i.e., via website) as long as Providers are notified about how to obtain the electronic copy and how to request a hard copy at no charge.

3.14.30.3. At a minimum, the Provider Manual shall contain the following information:

3.14.30.4. Description of the RI Medicaid Program and Covered Services.

3.14.30.5. Medical Necessity standards and clinical practice guidelines.

3.14.30.6. PCP responsibilities.

3.14.30.7. Care Program requirements, including coordination and transition of care expectation.

3.14.30.8. Prior Authorization and referral requirements.

3.14.30.9. Members' rights and responsibilities.

3.14.30.10. Reporting suspected Fraud, Waste, and Abuse.

3.14.30.11. Medical record standards.

3.14.30.12. Claims submission requirements and payment policies.

3.14.30.13. Important phone numbers.

3.14.30.14. The Contractor's or the Contractor service standards (access and availability).

3.14.30.15. 24-hour coverage requirements.

3.14.31. Network Adequacy and Access to Care (CMS Checklist I.E.5.01, I.E.5.04-.06)

3.14.31.1. Pursuant to 42 C.F.R. § 438.68, the Contractor shall ensure the Provider Network adheres to the time and distance standards established by EOHHS, published on the EOHHS website, and outlined in this Section 3.14, "Provider Networks and Requirements, Access to Care."

3.14.31.2. The Contractor shall create policies and implement procedures to monitor its compliance with all access and service availability standards. The Contractor shall submit these policies and procedures during Readiness Review, annually thereafter, and upon modification. The Contractor's policies shall comply with EOHHS' Provider Terminations and Network Changes Policy.

3.14.31.3. The Contractor shall take correction action to correct all Network deficiencies.

3.14.31.4. The Contractor shall comply with any requests for data from EOHHS' EQRO regarding access-related focused studies.

3.14.31.5. EOHHS has the right to review network adequacy and access to care standards at any time. Upon determination that a Contractor has failed to meet such requirements, EOHHS may require a correction action plan or impose other remedies, including imposing liquidated damages or suspending enrollment.

3.14.32. Time and Distance Standards (Checklist I.E.5.08-.33; I.E.5.37-.47)

3.14.32.1. The Contractor shall ensure every Member has access to Providers meeting either the time or distance standard in this Section.

3.14.32.2. Members, in their sole discretion, may select a Provider located further away than the standards require.

3.14.32.3. The time and distance standards in the following table apply statewide.

Provider Type	Time and Distance Standard *Provider office located within*
Primary Care Provider - adult & pediatric	20 minutes or 20 miles from the Member's home
OB/GYN Specialty Care	45 minutes or 45 miles from the Member's home
Outpatient behavioral health- adult prescriber	30 minutes or 30 miles from the Member's home
Outpatient behavioral health- pediatric	45 minutes or 45 miles from the Member's home

Provider Type	Time and Distance Standard *Provider office located within*
prescriber	
Outpatient behavioral health- adult non-prescriber	20 minutes or 20 miles from the Member's home
Outpatient behavioral health- pediatric non-prescriber	20 minutes or 20 miles from the Member's home
Outpatient substance Abuse treatment-prescribers	30 minutes or 30 miles from the Member's home
Outpatient substance Abuse treatment- non-prescribers	20 minutes or 20 miles from the Member's home
Top Five Adult Specialties- by total claims volume	30 minutes or 30 miles from the Member's home
Top Five Pediatric Specialties- by total claims volume	45 minutes or 45 miles from the Member's home
Hospital	45 minutes or 45 miles from the Member's home
Ambulatory Surgery Center	45 minutes or 45 miles from the Member's home
Imaging	45 minutes or 45 miles from the Member's home
Dialysis	30 minutes or 30 miles from the Member's home
Pharmacy	10 minutes or 10 miles from the Member's home

3.14.33. Appointment Availability

3.14.33.1. The Contractor is responsible for ensuring Members can schedule appointments within the standards outlined in this Section.

3.14.33.2. Network Providers must maintain hours of operation comparable to business hours under the Medicaid Program and no less than the business hours available to patients with commercial coverage.

3.14.33.3. The appointment accessibility standards in the following table apply statewide.

Appointment	Access Standard
Routine Care Appointment	Within 30 Days
Physical Exam	180 Days
EPSDT Appointment	Within 6 weeks
New Member Appointment	Within 30 Days
Non-Emergent or Non-Urgent Mental Health or Substance Use Services	Within 0 Days
Emergency Care	Immediately or referred to an emergency facility
Urgent Care Appointment	Within 24 hours

3.14.34. Exceptions to Network Adequacy Standards (CMS Checklist I.E.5.49)

3.14.34.1. The Contractor may seek an exception to the network adequacy standards described in this Section 3.14, "Provider Networks and Requirements, Access to Care," by submitting a request and supporting evidence to EOHHS in writing.

3.14.34.2. EOHHS may, in its sole discretion, grant the Contractor's request for the exception. The Managed Care Director shall provide written notice of such acceptance.

3.14.34.3. All EOHHS-approved exceptions will expire one year after they are granted unless otherwise specified in EOHHS' written notice. Exceptions will not automatically renew. The Contractor shall reapply for the exception at the end of each exception term and include supporting evidence in its application.

3.14.34.4. If EOHHS grants an exception, EOHHS will monitor access to that Provider type and may require the Contractor to comply with additional Network adequacy reporting requirements.

3.14.34.5. EOHHS will not grant an exception to the Network adequacy requirements for PCPs or for the network adequacy standards for primary care Providers or for any appointment availability standards as defined in Section 3.14.33, above.

3.14.35. Twenty-Four Hour Coverage

3.14.35.1. The Contractor shall ensure Medically Necessary Covered Services are available through Network Providers 24 hours a Day, 7 Days a week. The Contractor can satisfy this requirement by requiring PCPs to assume primary responsibility for 24/7 after hours and on call services.

3.14.35.2. PCPs may have on-call arrangements with other qualified Providers for urgent or emergent care, consistent with the Member Services Phone Line and Urgent and Emergent Phone Line outlined in Section 3.20 of this Contract. After-hours calls cannot be answered by an automated answering service.

3.14.35.3. The Contractor shall educate Members on how to access services after regular business hours and on weekends. In addition, the Contractor shall have written policies and procedures on how Members can reach their Primary Care Providers for Emergency Medical Conditions and Urgent Medical Conditions.

3.14.36. Emergency Medical Services (CMS Checklist I.F.1.01-.06; I.F.1.08-.10)

3.14.36.1. In accordance with 42 C.F.R. § 438.114, the Contractor shall cover Emergency Medical Services for Members, including Emergency Medical Services related to a behavioral health or substance use disorder conditions. The Contractor cannot limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

3.14.36.2. Emergency Medical Services must be available 24 hours a Day, 7 Days a week and delivered upon Member presentation.

3.14.36.3. In covering and reimbursing for Emergency Medical Services, the Contractor shall:

a) Cover Emergency Medical Services regardless of whether that Provider is a contracted Provider. However, the Contractor may not reimburse out-of-network providers above the Medicaid FFS Program rate for the Emergency Medical Services.

b) Not deny payment for treatment when the Member has an Emergency Medical Condition or when a Representative of the Contractor instructs the Member to seek Emergency Medical Services.

c) Not deny payment for Emergency Medical Services because the Provider, hospital, or fiscal agent failed to notify the Contractor of the Member's screening and treatment within 10 Days of presentation for Emergency Services.

d) Cover subsequent screening and treatment needed to diagnose or stabilize the Member's condition.

3.14.36.4. The Contractor shall share the federal and state requirements governing Emergency Services with Members in a clear, accurate, and standardized form at the time of enrollment and annually thereafter in accordance with the Member's Annual Notification as outlined in Managed Care Manual Chapter 6, "Critical Elements."

3.14.37. Post-Stabilization Care Services (CMS Checklist I.F.1.02; I.F.1.11-.22)

3.14.37.1. The Contractor shall cover Post-Stabilization Care Services in accordance with 42 C.F.R. § 438.114(e) and 42 C.F.R. § 422.113(c)(3). Post-Stabilization Care Services must be available to meet the needs of Members following delivery of Emergency Medical Services and a hospital admission for an Emergency Medical Condition.

3.14.37.2. Generally, a Provider must obtain Prior Authorization for Post-Stabilization Care Services. The Contractor may either pre-approve such services or authorize services in accordance with Chapter 2 of the Managed Care Manual, "Medicaid Services."

3.14.37.3. Notwithstanding the foregoing, the Contractor is responsible for paying for Post-Stabilization Care Services without Prior Approval, regardless of whether the services were delivered by a Network Provider or out-of-network provider, when the services maintain, improve, or resolve the Member's stabilized condition and the Contractor:

a) Did not respond to a request for Prior Authorization within one hour;

b) Could not be contacted; or

c) Utilization Management representative and the treating physician could not reach an agreement concerning the Member's care and the Contractor's Medical Director or his or her designee was not available for consultation.

3.14.37.4. The Contractor is no longer financially responsible for non-prior-approved Post Stabilization Care Services provided by an out-of-network provider when:

a) A Network physician with privileges at the treating hospital assumes responsibility for the Member's care;

b) A Network physician assumes responsibility for the Member's care through transfer;

c) The Contractor's Utilization Management representative and the treating physician reach an agreement concerning the Member's care; or

d) The Member is discharged from the hospital.

3.14.37.5. The Contractor may not reimburse an out-of-network providers for Post Stabilization Care Services at a rate higher than the Contractor would use if the Member obtained services through the Medicaid FFS Program.

3.14.37.6. The Contractor shall share the federal and state requirements governing Post Stabilization Care Services with Members in a clear, accurate, and standardized form at the time of enrollment and annually thereafter in accordance with the Member's Annual Notification as outlined in Managed Care Manual Chapter 6, "Critical Elements."

3.14.38. Family Planning Services (CMS Checklist I.E.1.05; I.F.2.01)

3.14.38.1. The Contractor shall demonstrate its Network includes sufficient family planning Providers to ensure timely access to Family Planning Services.

3.14.38.2. In accordance with 42 C.F.R. § 431.51(b)(2), the Contractor shall provide Members freedom of choice among family planning Providers, including access to these services from out-of-network providers.

3.14.38.3. If a Member selects a out-of-network provider to deliver Family Planning Services, the Contactor shall cooperate with that Provider by establishing a relationship for accepting referrals from them for continued medical care and management and exchange of Member information. The Contractor may not deny the coverage of Family Planning Services for a covered diagnostic, preventative, or treatment service solely on the basis that the diagnosis was made by an out-of-network provider.

3.14.39. Women's Health Services (CMS Checklist I.F.4.01)

3.14.39.1. In accordance with 42 C.F.R. § 438.206(b)(2), the Contractor shall provide female and assigned female at birth Members with direct access to a Network women's health specialist for covered care necessary to provide women's routine and preventative Health Care Services. This Provider will be in addition to the Member's PCP, if the PCP is not a women's health specialist.

3.14.39.2. The Contractor shall provide Members freedom of choice among women's health Providers, including access to these services from out-of-network providers.

3.14.39.3. The following Provider types are considered women's health specialists:

a) Obstetricians;

b) Gynecologists;

c) Certified nurse midwives;

d) Nurse Practitioners;

e) Doulas; and

f) Any other qualified health care professional specializing in women's health.

3.14.40. Services for Members with Special Needs

3.14.40.1. The Contractor shall allow Members with Special Healthcare Needs, as identified in 42 C.F.R. § 438.208(c)(1) and defined in this Agreement, direct access to specialists as medically appropriate. The Contractor may Prior Authorize the specialty care through a standing referral or an approved number of visits.

3.14.40.2. To facilitate Care Coordination, the Contractor shall require ongoing communication and collaboration between specialty Providers and the Member's PCP.

3.14.41. Reporting Out-of-Network Services

3.14.41.1. The Contractor is responsible for building a Network sufficient to provide all Covered Services. If the Contractor is not able to provide a Covered Service trough Network Providers, it must provide the service through an out-of-network provider in accordance with the requirements described in Section 3.13, "Care Program and Continuity of Care."

3.14.41.2. The Contractor shall report Out-Of-Network utilization by provider type as part of the monthly access reporting to EOHHS.

3.14.42. Second Opinions (CMS Checklist I.F.4.02)

3.14.42.1. The Contractor shall ensure Members have access to second opinions regarding the use of any Medically Necessary Covered Service. Members shall be allowed to access second opinion from Out-of-Network Providers if a Network Provider is not available to the Member in accordance with 42 C.F.R. § 438.206(b)(3).

3.14.43. Provider Satisfaction Report

The Contractor shall collect Provider satisfaction data for all lines of business through an annual survey of a representative sample of the Contractor's Network Providers.

3.14. Provider Networks and Requirements, Access to Care- Document History Log	
Contract Cross-References	• Attachment F-3, Services • Section 3.4, Behavioral Health • Section 3.12, Population Health • Section 3.13, Care Program and Coordination of Care • Section 3.20, Member Services • Section 3.26, Claims and MIS Requirements • Managed Care Manual Chapter 2, Medicaid Services • Managed Care Manual Chapter 6, Critical Elements • Managed Care Manual Chapter 11, Reporting Calendar and Templates
Governing Requirements and Authority	• Sections 1128, 1128A, 1156 of the Social Security Act • 216-RICR-30-05-01 • 230-RICR-20-30-9.7 • Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000D *et seq.)* • Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 79420 U) • Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 *et seq.)* • Americans with Disabilities Act of 1990 (42 U.S.C. 12101 *et. seq*.) • 42 C.F.R. § 59.2 • 42 C.F.R. § 414.234(a) • 42 C.F.R. §422.113(c) • 42 C.F.R. § 431.51(b) • 42 C.F.R. §§ 438.2, 438.10(a), 438.14(b), 438.68, 438.114, 438.206(b), 438.208(c), 438.214, 438.404(c), 438.608(b) • 42 C.F.R. §§ 447.45 and 447.46 • 42 C.F.R. §§ 455 Parts B and E, 455.100-.106, 455.400-.470
CMS Checklist Items	• I.B.2, Choice of Doctor, Section I.B.2.02 • I.B.7, Special Rules for American Indians, Section I.B.7.02 • I.C.6, Provider Terminations and Incentives, Section I.C.6.01 • I.D.5, Payments for Indian Health Care Providers (ICHP), Sections I.D.5.01-.03 • I.E.1, Network Adequacy, Sections I.E.1.01-.08 • I.E.3, Provider Selection I.E.3.03-.04, I.E.3.10 • I.E.4, Anti-gag I.E.4.01-.04 • I.E.5, Network Adequacy Standards, Sections I.E.5.01, I.E.5.04-.33, I.E.5.37-.47, I.E.5.49 • I.E.8, Physician Incentive Plan, Sections I.E.8.01-.02 • I.F.1, Emergency and Post-Stabilization Services, Sections I.F.1.01-.06; I.F.1.08-.22 • I.F.2, Family Planning, Section I.F.2.01 • I.F.4, Delivery Network, Sections I.F.4.01-.02 • I.I.2, Requirements, Procedures and Reporting, Section I.I.2.38
Revision Date and Description	

3.15. Accountable Entity Program

EOHHS has established the Accountable Entity (AE) Program to promote health care delivery system reform. Fundamental to this initiative is the progressive movement from volume-based to value-based payment arrangements and increased risk and responsibility for cost and quality of care. The program therefore requires certified AEs to enter APMs with managed care partners in accordance with EOHHS defined requirements.

3.15.1. Contractor's Responsibilities

3.15.1.1. The Contractor is required to enter into written Subcontracts with EOHHS certified AEs in accordance with the EOHHS "Accountable Entity Program Requirements" in Managed Care Manual Chapter 8, "Care Program and Accountable Entities." The Subcontracts shall, at minimum:

a) Support the AE Program by promoting APMs that pay for quality, not volume.
b) Include Total Cost of Care (TCOC) shared shavings and shared risk arrangements.
c) Incorporate a uniform set of quality measures, as defined by EOHHS.
d) Delineate Contractor responsibility for administration of the AE Incentive Program.
e) Include Contractor and AE responsibility for Attribution of Members to the AE.
f) Delineate Contractor and AE data sharing responsibilities, including those described in Section 3.15.1.6 below.
g) Establish a uniform performance period that coincides with the EOHHS Contract Year.
h) Set forth the Contractor's roles and responsibilities with respect to the AE Program and the AE or AEs with which the Contractor contracts.
i) Include a clear delineation of what Care Program responsibilities have been delegated to the AEs, what remain the sole responsibility of the Contractor, and what responsibilities are shared.
j) Include a description of the agreed upon financial terms to support the administration of delegated Care Program responsibilities. EOHHS reserves the right to set minimum payment rates that the Contractor shall pay for Care Program responsibilities delegated to AEs.
k) Include a description of the Joint Operating Committee and meeting schedule that the Contractor and AE shall establish as a shared management structure to promote communication, support collaborative activities, problem-solving, and ongoing review of progress toward performance goals.
l) Be submitted to EOHHS in prior to execution (as a base contract) in accordance with the EOHHS' timetable included in the EOHHS Accountable Entity Program Requirements. In addition, the Contractor shall submit all substantive revisions to AE Subcontracts to EOHHS. EOHHS

reserves the right to require revisions to Subcontracts that do not comply with the terms of this Agreement.

3.15.1.2. Notwithstanding any provision of the arrangement between the Contractor and the AE, including delegation of Care Management or other responsibilities, the Contractor is responsible for ensuring that all elements of the EOHHS-defined system of care are available and accessible for Members and for ensuring appropriate utilization of services. With respect to access to care, the Contractor shall:

a) Ensure that AE attributed Member have access to services from Providers not affiliated with the AE.
b) Ensure that Participating AE Providers are permitted to make referrals to any Provider, as appropriate, regardless of the Providers' affiliation with the AE.
c) Prohibit additional requirements for referrals to Providers who are not Affiliated Providers.
d) Maintain attributed Members' access to and freedom of choice of Providers.
e) Maintain open access to Medically Necessary services, including from Providers not affiliated with an AE.
f) Ensure that AE Attributed Members may obtain emergency services from any Provider, regardless of its affiliation with the AE.
g) Ensure that all Members receive all Medically Necessary Care Coordination and Care Management services.

3.15.1.3. Upon enrollment, the Contractor is responsible for attributing each enrolled Member to contracted AEs and reconciling AE attribution on a quarterly basis, in accordance with the AE Attribution requirements in Managed Care Manual Chapter 8, "Care Program and Accountable Entities." On a monthly basis, the Contractor shall provide the contracted AEs and EOHHS with electronic lists of attributed Members.

3.15.1.4. The Contractor shall develop a Care Plan Strategy for AEs that at a minimum reflects the priorities and range of services and requirements described in the "EOHHS Care Program Protocols" in Managed Care Manual Chapter 8, "Care Program and Accountable Entities." The Care Plan Strategy for AEs shall be submitted to EOHHS for review and approval during Readiness Review, annually thereafter, and upon modification.

3.15.1.5. The Contractor shall delegate care program responsibilities to the AE based upon an assessment of the AE's capacity to perform the delegated functions in compliance with NCQA delegation standards and the EOHHS Care Program Protocols.

3.15.1.6. The Contractor and AE shall enter into a data sharing agreement. The Contractor shall provide the AE with data as needed or requested to fulfill delegated responsibilities as described in the Accountable Entity Program Requirements. Before sharing data with the AE, the Contractor shall complete necessary quality checks and review data privacy to ensure data integrity. At minimum and on a monthly basis, the Contractor shall provide the following:

a) MCO Member attribution lists.
b) Comprehensive analytic profile of the AEs' attributed population.
c) High utilizers registries – collaborative data sharing arrangements.
d) Monthly Member-specific utilization and cost data. Data must identify high risk, high utilizer Members, Provider outlier analysis of high/low performing Providers within an AE panel.
e) Individual level data files for AE Outcome Measures.
f) Any additional files as prescribed by EOHHS in the AE Quality and Outcome Implementation Manual.
g) Monthly Provider Roster.
h) Other data reports as mutually agreed upon.

3.15.2. Monitoring and Oversight of AE Performance

The Contractor is responsible for:

3.15.2.1. Performing oversight and monitoring of delegated functions and contractual expectations.

3.15.2.2. Ensuring AEs comply with Member beneficiary protections, including notices and Appeal rights, and requirements relating to Marketing, Member communications, and Member choice.

3.15.2.3. Calculating performance on quality and outcome measures, as prescribed in the AE Quality and Outcome Implementation Manual in Managed Care Manual Chapter 8, "Care Program and Accountable Entities."

3.15.2.4. Determining performance with respect to the achievement of milestones and metrics tied to incentive payments in accordance with Managed Care Manual Chapter 8, "Care Program and Accountable Entities."

3.15.2.5. Submitting historical base data and attribution to support EOHHS calculations to establish total cost of care targets, in accordance with the Managed Care Manual Chapter 8, "Care Program and Accountable Entities."

3.15.2.6. Submitting total cost of care performance data and attribution on a quarterly and final/annual basis to support EOHHS calculations to determine AE total cost of care performance, in accordance with the Accountable Entity Program Requirements.

3.15.3. AE Capacity Building

3.15.3.1. The Contractor shall support AEs in efforts to build capacity to assume responsibility for Care Management and other delegable functions through direct support, technical assistance, and other means.

3.15.3.2. The Contractor shall develop and disseminate information and support tools pertaining to evidence-based practices to its subcontracted AEs and Providers at the point of care, including information on how to address initiatives that lack a connection to evidence-based practice.

3.15.3.3. The Contractor shall develop an AE Support Plan that outlines activities the Contractor shall undertake to partner with and support the AEs to continue to grow their capabilities. The AE Support Plan shall include:

a) The content and schedule of data sharing to occur.
b) How the Contractor shall facilitate coordination between AE and behavioral health Providers;
c) How the Contractor shall advance Health Equity and support AEs in addressing SDoH;
d) Technical assistance that shall be used to improve and increase delegated functions and data analytics.
e) Education activities for AE staff and AE Providers.
f) The Contractor's strategy for sharing best practices.

3.15.3.4. The Contractor shall submit the AE Support Plan to EOHHS annually for review and approval.

3.15.3.5. The Contractor shall implement the Medicaid Infrastructure Incentive Program (MIIP) in compliance with the Accountable Entity Program Requirements.

3.15.3.6. The Contractor shall:

a) Make timely payment to its contracted AEs for delegated services, including payments for shared savings distributions.
b) Make timely and accurate incentive payments to AEs to support AEs in developing and enhancing the capacity and tools required for effective system transformation and for achieving quality and performance outcomes in accordance with the requirements of the MIIP.

3.15.3.7. Upon request and in accordance with the format and timetable in Managed Care Manual Chapter 11, "Reporting Calendar and Template," the Contractor shall furnish EOHHS reports regarding the financial and quality performance of contracted AEs.

3.15.3.8. In accordance with its written Subcontract with the Contractor, as set forth in Section 3.15.1.1. above, a qualified AE must be accountable for all delegated functions identified within said agreement.

3.15.4. Joint Operating Agreement

3.15.4.1. Upon execution of the Subcontract with a qualified AE, the Contractor shall undertake activities in support of a collaborative approach to program operation and management. These activities may include implementation of a shared management structure, including but not limited to:

a) A Joint Operating Committee that meets regularly but not less than bi-monthly to ensure ongoing communication, support of collaborative activities, problem solving, and ongoing review of progress in performance areas.
b) A Joint Operating Agreement that documents the agreed upon structure and approach to managing program operations, clarifies roles with respect to

delegated and shared functions, and identifies the method and content of reports the AE shall submit to the Contractor, The Joint Operating Agreement shall be included within the AE Subcontract, per Section 3.15.1.1 above, and shall be submitted to EOHHS in accordance with Managed Care Manual Chapter 8, "Care Program and Accountable Entities."

3.15. Accountable Entity Program- Document History Log	
Contract Cross-References	• Managed Care Manual Chapter 8, Care Program and Accountable Entities • Managed Care Manual Chapter 11, Reporting Calendar and Templates
Governing Requirements and Authority	
CMS Checklist Items	
Revision Date and Description	

3.16. Utilization Management

3.16.1. UM Program and Plan (CMS Checklist I.G.3.01-.06, I.G.3.08)

3.16.1.1. The Contractor shall have a Utilization Management (UM) Program in place that includes written policies and procedures for processing requests for initial and continuing authorizations of services. The UM Program shall be National Committee for Quality Assurance (NCQA) accredited and facilitate the delivery of high quality, cost efficient and effective care.

3.16.1.2. The UM Program shall follow a written UM Program Plan that clearly defines the Program's organizational structure, standards, and policies and procedures. An electronic copy of the UM Program Plan shall be submitted to EOHHS for review and approval during Readiness Review, annually thereafter, and upon modification.

3.16.1.3. At a minimum, the UM Program Plan shall include policies and protocols to:

a) Ensure consistent review criteria for authorization decisions, and that required services are not arbitrarily denied or reduced in amount, duration, or scope solely because of diagnosis, type of illness, or condition of the Member.

b) Ensure each Member's record includes the information described in 42 C.F.R. § 456.111.

c) Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the Member's medical, behavioral health, or long-term service and support needs.

d) Provide for consultation with the requesting Provider for medical services when appropriate.

e) Identify overutilization and underutilization of services and take corrective action, as appropriate.

f) Ensure compliance with notice and timeliness standards in accordance with CMS regulations and this Agreement.

g) Ensure any LTSS covered by this Agreement are based on the Member's current needs assessment and consistent with the person-centered service plan.

h) Ensure coverage parity between Mental Health/Substance Abuse benefits and Medical/Surgical benefits in accordance with Section 3.4.13, "Mental Health Parity Requirements."

i) Provide for a mechanism to interface with the Contractor's Program Integrity responsibilities under Section 3.22.

3.16.2. UM Program Structure

3.16.2.1. As described in Section 3.1.5.3, "Medical Director," the Contractor's Medical Director is responsible for development, implementation, and oversight of the Contractor's UM Program.

3.16.2.2. The UM Program shall include a UM Committee that is responsible for:

a) Reviewing and approving the UM Program Plan including its policies and procedures.
b) Monitoring the UM Program on an ongoing basis in accordance with the requirements of Section 3.16.3, below.
c) Monitoring for updates to EOHHS clinical coverage criteria, evidence-based nationally recognized Medical Necessity guidelines, and other professional literature to inform and update the Contractor's clinical coverage policies and criteria.
d) Evaluating and updating the UM Program requirements at least annually.
e) Ensuring that staff responsible for rendering UM decisions are appropriately licensed with sufficient clinical expertise to review and render Prior Authorization decisions and are supervised by appropriately licensed clinical professionals.

3.16.3. UM Program Monitoring

3.16.3.1. The Contractor is responsible for ongoing monitoring and oversight of its UM Program and making necessary updates when deficiencies are identified.

3.16.3.2. Monitoring activities shall include:

3.16.3.3. Reviewing the timeliness of service authorizations.

3.16.3.4. Monitoring for consistency in the application of service authorization criteria.

3.16.3.5. Assessment of whether the Contractor's Prior Authorization procedures unreasonably limit Member access to Covered Services.

3.16.3.6. Reviewing services subject to Prior Authorization to determine if there is ongoing need for Prior Authorization to ensure appropriate utilization of services.

3.16.3.7. Using Provider feedback to identify opportunities to standardize and streamline service authorization processes to reduce administrative burden for Providers.

3.16.4. Standard Authorization Decisions (CMS Checklist I.G.3.07).

3.16.4.1. For standard authorization decisions, the Contractor shall provide notice to the Member or their Authorized Representative, and the requesting or treating Provider, as expeditiously as the Member's condition requires but no later than 14 Days following the receipt of the request for services.

3.16.4.2. The timeframes for standard authorization decisions may be extended by 14 Days if the Member requests an extension or the Contractor justifies a need for additional information and the Contractor can demonstrate how the extension is in the Member's interest.

3.16.5. Expedited Service Authorization Decisions (CMS Checklist I.G.3.08)

3.16.5.1. In accordance with Section 3.21.3.4, if following the timeframe for a standard service authorization would seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

3.16.5.2. The Contractor shall make an expedited authorization decision and provide notice to the Member and the requesting or treating provider as expeditiously as the Member's health conditions requires but no later than 72 hours after the receipt of the request for services.

3.16.5.3. The Contractor may extend the 72-hour time period by up to 14 Days if the Member requests an extension or the contractor justifies to the EOHHS a need for additional information and how the extension is in the Member's best interest.

3.16.6. Denials for Out-of-Network Services

The Contractor shall send formal written notice to Members, their Authorized Representative, and their Provider for denials of Out-of-Network services if the services were delivered six months after the Member's enrollment into the Health Plan and there is no existing Prior Authorization requiring the Contractor to extend the six-month transition of care period.

3.16.7. Compensation Arrangements (CMS Checklist I.G.3.10)

The Contractor shall demonstrate to EOHHS that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Covered Services to any Member.

3.16.8. Behavioral Health Service Authorizations

The Contractor shall have policies and procedures for conducting utilization review for Behavioral Health Services, including SUD services and Adult Day Health Services, that comply with EOHHS policy as set forth in Managed Care Manual Chapter 2, "Medicaid Services," and Section 3.4.11, "Court Ordered Behavioral Health Benefits."

3.16.9. Services Requiring Prior Authorization

When notifying a Member, their Authorized Representative, and the Provider of a service authorization, include an Adverse Benefit Determination, the Contractor shall:

3.16.9.1. Comply with all timely and adequate notice requirements as specified in this Agreement and 42 C.F.R. § 438.404(c).

3.16.9.2. Ensure notices and the content thereof are accessible to individuals with Limited English Proficiency and to people with disabilities in accordance with the requirements of 42 C.F.R. § 438.10(a).

3.16. Utilization Management- Document History Log	
Contract Cross-References	• Section 3.1, Contract Administration and Management • Section 3.4, Behavioral Health • Section 3.14, Provider Networks and Requirements, Access to Care • Section 3.21, Grievances and Appeals • Section 3.22, Program Integrity • Managed Care Manual Chapter 2, Medicaid Services
Governing Requirements and Authority	• Social Security Act, Sections 1902(oo)(1)(A)(i)I), 1927(b)(1)(A), 1927(k), 1932(i) • 42 C.F.R. §§ 438.3, 438.210(b), (d) and (e); 438.219(b); 438.910(d) • 42 C.F.R. § 456, Subpart K
CMS Checklist Items	• I.G.3, Authorization and Utilization Management, Sections I.G.3.01-.08. and I.G.3.10
Revision Date and Description	

3.17. Quality Assurance

3.17.1. General Requirements (CMS Checklist I.G.4.01-.05, I.G.5.01)

3.17.1.1. The Contractor shall develop and implement an ongoing, comprehensive Quality Program and Performance Improvement Program (QAPI) for services it furnishes to its Members, regardless of payor source or eligibility category.

3.17.1.2. The QAPI align with the objectives of Rhode Island's Medicaid Managed Care Quality Strategy (Quality Strategy), as amended or updated and found on the EOHHS website at: QUALITY-STRATEGY.DRAFT.5.3.19.pdf (ri.gov) and any priorities identified by EOHHS, including the goals of advancing Health Equity and promoting value-based, high-quality care for all Rhode Island residents.

3.17.1.3. The Contractor's Quality Management and Quality Improvement (QM/QI) and Quality Assessment and Performance Improvement (QAPI) programs shall align with EOHHS' priorities, goals and objectives as detailed in the Quality Strategy.

3.17.1.4. The Contractor shall deliver quality care that enables Members to stay healthy, prevent poor outcomes and manage chronic illnesses or disabilities. Quality care refers to:

a) Clinical quality of physical health care.
b) Clinical quality of behavioral health care focusing on recovery, resilience, and rehabilitation
c) Access and availability of primary, behavioral health, and specialty care Providers and services.
d) Continuity and coordination of care across settings and care transitions.
e) Mechanisms to assess the quality and appropriateness of care provided to Members at risk for health disparities due to race, ethnicity, sex, primary language and sexual orientation.
f) Member experience with respect to all of the quality indicators described above.

3.17.1.5. The Contractor shall apply the principles of continuous quality improvement (CQI) to all aspects of the Contractor's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:

a) Quantitative and qualitative data collection with data-driven decision-making.
b) Up-to-date evidence-based practice guidelines consisting of explicit criteria developed by professional societies or, where evidence-based practice guidelines do not exist, consensus of professionals in the field. The guidelines shall:
   - Be based on valid and reliable clinical evidence or a consensus of providers in the particular field.
   - Consider the needs of Members.

- Be adopted in consultations with Network Providers.
- Reviewed and updated periodically as appropriate.
- Consistent with the Contractor's decisions regarding Utilization Management, Member education, coverage of services, and other areas covered by the guidelines.

c) Feedback provided by Members and Providers in the design, planning, and implementation of CQI activities.

d) Issues identified by EOHHS, the Contractor, or AEs.

e) QM/QI requirements of this Agreement applied to the delivery of both physical health and behavioral health services.

3.17.2. Reporting

The Contractor shall measure and report to the EOHHS on its performance, using the standard measures required by the EOHHS, and submit data to the EOHHS according to the schedule described in the Managed Care Manual Chapter 11, "Reporting Calendar and Templates."

3.17.3. Quality Program Basic Elements (CMS Checklist I.G.5.02-.06)

3.17.3.1. The Quality Program shall be specific to the Managed Care Program requirements, guided by the current NCQA standards and Guidelines for the Accreditation of Health Plans, and shall align with the Contractor's Health Equity and Utilization Management strategies as required by Sections 3.12.2 and 3.16.

3.17.3.2. In accordance with 42 C.F.R. § 438.330, the Quality Program shall include a well-defined Quality Assessment and Performance Improvement (QAPI) Program that includes all of the following:

a) The systematic collection, submission, and evaluation of performance measurement data, including any required by EOHHS, CMS, and nationally validated initiatives and frameworks.

b) A mechanism to detect both the underutilization and overutilization of services.

c) A mechanism to assess the quality and appropriateness of physical health and behavioral health care furnished to Members with special health care needs, as defined by EOHHS and the RI Medicaid Managed Care Quality Strategy.

d) Performance Improvement Projects (PIPS), that meet the requirements of Section 3.17.6, below, including any required by EOHHS or CMS that focus on clinical and non-clinical areas.

e) Implementation of system interventions to remediate identified problems and achieve improvement in quality.

f) A process to evaluate the effectiveness of interventions.

g) Planning and initiation of activities for increasing or sustaining improvement.

h) A mechanism to interpret and disseminate data pertaining to quality to Subcontractors and Network Providers.

3.17.4. Quality Program Structure

3.17.4.1. The Contractor shall maintain a well-defined organizational structure for its Quality Program.

3.17.4.2. In accordance with Section 3.1.5, the Contractor's Medical Director is responsible for QAPI development, implementation, an oversight.

3.17.4.3. At a minimum the Quality Program shall be:

a) Implemented organization-wide, with clear lines of accountability within the organization that establish that the Contractor's Board of Directors and Executive Management are ultimately accountable for the effectiveness of the QAPI Program and the quality of care provided the Contractor's Members.

b) Include a set of functions, roles, and responsibilities for the oversight of QAPI Program activities that are clearly defined and assigned to appropriate individuals and meet the requirements of this Section.

3.17.5. Quality Management/Quality Improvement Committee

3.17.5.1. The Contractor shall have a Quality Management/Quality Improvement (QM/QI) Committee that shall be responsible for informing the development and providing oversight of the Contractor's Quality Program.

3.17.5.2. The QM/QI Committee shall include. at a minimum:

a) The Contractor's Medical Director shall serve as the chairperson for the QM/QI Committee and have experience in successful QAPI Programs.

b) A Behavioral Health Director.

c) Medical, behavioral health, and clinical Provider representation.

3.17.5.3. Committee Responsibilities include:

a) Identifying benchmarks and setting achievable performance goals for improvement initiatives.

b) Ensuring quality improvement activities take place throughout the Contractor's organization and ensuring the Contractor's subcontracted AEs and Network Providers are involved in the QAPI Program, even though they are not formal members of the Committee.

c) Reviewing and evaluating results of the QM/QI activities, recommend policy decisions, and suggesting new or improved QM/QI activities.

d) Directing task forces/committees to identify, review, and address areas of concern in the provision of Health Care Services to Members including instituting needed action and ensuring that appropriate follow up occurs.

e) Designating evaluation and study design procedures.

f) Reviewing Provider network performance, including individual PCP, AEs, specialized behavioral health Providers, and practice quality performance measure profiling to identify and address patterns.
g) Directing and analyze periodic reviews of Members' service utilization patterns.
h) Recommend needed corrective actions and ensure that appropriate follow-up occurs.
i) Providing progress reports to the Contractor's leadership.
j) Disseminating information to the Contractor's Subcontractors and Network Providers.
k) Formulating recommendations to advance quality objectives changes in policy and procedures including the adoption of evidence-based practices.
l) Providing the results of any quality improvement studies/projects and Medicaid HEDIS® and CAHPS® results to EOHHS within 30 Days of their presentation to the Contractor's QM/QI Committee.
m) Periodically updating Provider manuals and other relevant clinical content as determined by the Medical Director.

3.17.5.4. The QM/QI Committee shall:

a) Meet at least quarterly.
b) Maintain written minutes of all Committee and subcommittee meeting minutes and submit meeting minutes to EOHHS. A copy of the signed and dated written minutes for each meeting shall be available after the minutes are approved and shall be available for review upon request and during NCQA accreditation and EQRO reviews.
c) Provide the EOHHS' Chief Medical Officer advance notice of all regularly scheduled meetings of the QM/QI committee within ten Days. To the extent allowed by law, the EOHHS' Chief Medical Officer or his/her designee may attend the QM/QI Committee at his/her option.

3.17.6. Performance Improvement Plans (CMS Checklist I.G.5.10-.15)

3.17.6.1. On an annual basis, the Contractor shall conduct not less than four performance improvement projects (PIPS) that focus on both clinical and non-clinical areas.

3.17.6.2. EOHHS may require the Contractor to perform up to two additional projects for a maximum of six projects.

3.17.6.3. EOHHS, in consultation with CMS and other stakeholders, may require specific performance measures and PIP topics. The Contractor shall report the status and results of each PIP as specified in Managed Care Manual Chapter 9, "Quality Programs." If CMS specifies a PIP, the Contractor shall participate, and this shall count toward the EOHHS-approved projects.

3.17.6.4. Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, high-volume services, high risk services, health care disparities, and continuity and coordination of care. Non-clinical PIPs include

projects focusing on availability, accessibility, interpersonal aspects of care, Appeals and Grievances and other opportunities for improvement.

3.17.6.5. The focus areas may be established by EOHHS: however, for Contractor initiated PIPs, the Contractor shall submit PIP proposals in to EOHHS in accordance with Managed Care Manual Chapter 9, "Quality Programs."

3.17.6.6. The Contractor shall ensure CMS protocols for PIPs are followed and that all steps outlined in the CMS protocols for PIPs are documented.

3.17.6.7. The Contractor shall, in collaboration with EOHHS, identify benchmarks and set achievable performance goals for each of its PIPs. The Contractor shall identify and implement intervention and improvement strategies for achieving the performance goal set for each PIP to promote sustained improvements.

3.17.6.8. Each PIP shall be designed to achieve significant, measurable improvement, sustained overtime, in health outcomes and Member satisfaction, and shall be completed in a reasonable time period so as to allow information on the success of PIPs in the aggregate to produce new information on quality of care every year. Each PIP shall include the following elements:

a) Measurement of performance using objective quality indicators.
b) Identification of benchmarks and set achievable performance goals for each of the PIPS.
c) Identification and implementation of interventions for achieving the performance goals set for each PIP and promoting sustained improvements.
d) Evaluation of the effectiveness of the interventions based on the objective quality indicators identified in this Section.
e) Planning and initiation of activities for increasing or sustaining improvement.

3.17.6.9. The results of each PIP shall be able to be validated.

3.17.6.10. The Contractor shall report the status and results of each PIP to EOHHS or its designees, as requested, but at least 30 Days following presentation to the Contractor's QM/QI Committee.

3.17.6.11. Each project shall be completed in a reasonable time period to allow information on the success of PIPs in the aggregate to produce new information on quality of care every year.

3.17.7. Written Work Plan

3.17.7.1. The Quality Program shall be included in a written document that clearly describes its organizational structure, processes, and includes an Annual Work Plan that identifies the objectives, performance goals, and quality improvement activities that will be undertaken that year. The Contractor shall submit a copy of the written Quality Program and Annual Work Plan during Readiness Review, annually thereafter, and upon modification.

3.17.7.2. The Annual Work Plan, at a minimum, shall:

a) Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results.
b) Include processes to evaluate the impact and effectiveness of the QAPI Program.
c) Include a description of the Contractor staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities.
d) Describe the role of its Providers in giving input to the QAPI Program.
e) Be specific to the Rhode Island Managed Care Program and not contain documentation from other state Medicaid programs or product lines operated by the Contractor.
f) Describe the methods for ensuring data collected and reported to EOHHS is valid, accurate, and reflects Providers' adherence to clinical practice guidelines as appropriate.

3.17.8. QAPI Reporting (CMS Checklist I.G.5.09)

3.17.8.1. In accordance with the standards, reporting formats, and timetables established by EOHHS as set forth in the Medicaid Managed Care Manual, the Contractor shall measure and report at least annually its performance on:

a) EOHHS specified quality measures.
b) EOHHS specified measures associated with the EOHHS Pay for Performance Program.
c) CMS specified quality measures.
d) HEDIS® measures that support the EOHHS Comprehensive Quality Strategy.
e) Health disparity results including the methodology utilized to collect this data.
f) CAHPS® results.
g) PIP results.
h) Recommended new or improved QI activities.
i) Results of the evaluation of the impact and effectiveness of the QAPI Program.

3.17.8.2. EOHHS reserves the right to request additional reports as deemed necessary.

3.17.8.3. The Contractor shall provide data reports, including ad-hoc reports and reports for special populations using the specifications and format approved by EOHHS and required in the EOHHS Reporting Calendar in Managed Care Manual Chapter 11. The Contractor shall submit the reports based on the agreed upon dates established by the Contractor and EOHHS if not provided in the Reporting Calendar.

3.17.9. Additional Quality Assurance Reporting Requirements

3.17.9.1. The Contractor shall make internal quality assurance reports available to EOHHS upon request.

3.17.9.2. The Contractor shall perform medical record abstracts in selected quality assurance areas for use in external quality reviews.

3.17.9.3. At a minimum, the Contractor shall provide:

a) Four selected quality assurance areas for RIte Care, including one related to Children with Special Health Care Needs,
b) One quality assurance area for Rhody Health Partners; and
c) Others as requested by EOHHS.

3.17.9.4. EOHHS will provide the precise methodology for these abstracts. The Contractor shall work cooperatively with EOHHS in developing and implementing this methodology.

3.17.9.5. The Contractor shall provide the results of any quality improvement studies/projects and Medicaid HEDIS® and CAHPS® results no later than 30 Days after presentation to the Contractor's Quality Improvement Committee.

3.17.10. Reporting Accuracy, Completeness and Timeliness

3.17.10.1. Performance measures reported by the Contractor shall be accurate, complete, and timely. Failure to comply with these requirements may result in contractual remedies, including liquidate damages.

3.17.10.2. The Contractor shall cooperate fully with EOHHS or its designees in any efforts to validate PIPs or quality reporting.

3.17.10.3. The Contractor shall participate in joint quality improvement projects, as selected by EOHHS, involving Health Plans, AEs, and EOHHS.

3.17.11. Member Satisfaction

The Contractor shall collect Member satisfaction data for adults and children, or other populations or sub-populations as identified by EOHHS through an annual survey of a representative sample of its Members using a tool approved by EOHHS.

3.17.12. Provider Satisfaction

The Contractor shall collect Provider satisfaction data through an annual survey of a representative sample of the Contractor's Providers using a tool approved by EOHHS.

3.17.13. Mandatory Meetings

The Contractor shall attend monthly oversight meetings with EOHHS staff to review contract performance, compliance, quality assurance, continuous quality improvement.

3.17.14. Clinical Data Exchange

The Contractor shall contract with a state-approved vendor to ensure the appropriate and timely exchange of clinical data related to their quality performance (i.e., HEDIS®).

3.17.15. External Quality Review (CMS Checklist I.G.1.01)

3.17.15.1. The Contractor is subject to annual, external independent review of the quality, timeliness and access to services covered under its contract and to external validation of its performance improvement plans.

3.17.15.2. The Contractor shall:

a) Cooperate fully with EOHHS or its designated EOHHS' EQRO in any efforts to independently review the Contractors' performance or validate performance improvement projects.
b) Comply with any requests for data from the EOHHS' EQRO in the conduct of any independent review or access-related focused studies.

3.17.16. EOHHS Pay for Performance Program

3.17.16.1. The Contractor shall participate in the EOHHS Pay for Performance Program as set forth in Managed Care Manual Chapter 9, "Quality Programs."

3.17.16.2. The Pay for Performance Program is designed to support the transformation of the Rhode Island Medicaid program from one that pays for volume to one that pays for value and aligns with EOHHS Quality Strategy. As a requirement of participation, the Contractor shall:

a) Collect and accurately report data to EOHHS for all specified measures on a timetable and in a format specified by EOHHS in the Medicaid Managed Care Manual.
b) Factor in Health Equity into the Contractors decision making, its impacts on health and social outcomes for Members and opportunities for culturally competent care delivery.
c) Participate in all required training and information sharing sessions pertaining to the Quality Incentive Program.
d) Collaborate with EOHHS to support improvements to the Pay for Performance Program.
e) Implement changes to the Pay for Performance Program as directed by EOHHS.

3.17. Quality Assurance- Document History Log	
Contract Cross-References	• Section 3.1, Contract Administration and Management • Section 3.12, Population Health • Section 3.16, Utilization Management • Managed Care Manual Chapter 9, "Quality Programs" • Managed Care Manual Chapter 11, "Reporting Calendar and Templates"
Governing Requirements and Authority	• 42 C.F.R. §§ 441.302 and 441.730(a), • 42 C.F.R. § 438.330(a)-(d), 438.340, 438.350
CMS Checklist Items	• I.G.1, External Quality Review, Section I.G.1.01 • I.G.4, Staffing Training, Sections I.G.4.01-.05 • I.G.5, Quality, Sections I.G.5.01– 06, I.G.5.09-.15.
Revision Date and Description	

3.18. Marketing Requirements

3.18.1. General Requirements

3.18.1.1. The Contractor shall comply with 42 C.F.R. § 438.10 and § 438.104 and the EOHHS guidelines regarding Marketing, as set forth in Managed Care Manual Chapter 3, "Marketing Policies and Procedures."

3.18.1.2. The Marketing Policies and Procedures including requirements regarding:

a) Material submissions, review, and approval processes;
b) Marketing activities;
c) Marketing activities by Marketing Representatives and Subcontractors;
d) Choice Counselors;
e) Prohibited Marketing activities;
f) Marketing claims; and
g) Marketing Materials.

3.18.2. Health Plan Marketing (CMS Checklist I.C.7.01-.03; I.J.5.07)

3.18.2.1. In accordance with the federal requirements at 42 C.F.R. § 438.104(b), the Contractor shall:

a) Submit an initial Marketing Plan during Readiness Review and annual updates thereafter in accordance with Managed Care Manual Chapter 11, "Reporting Calendar and Templates." The Contractor shall submit amendments to the Marketing Plan to reflect new Marketing Materials and Marketing events during the year.
b) Distribute all Marketing Materials statewide.
c) Market the Medicaid Managed Program separately from the Contractor's private insurance products. The Contractor shall not seek to influence enrollment in its Health Plan in conjunction with sale or offering of private insurance.
d) Provide all Marketing Materials in a format that is consistent with content and language requirements as defined in Section 3.18.6.1, below.

3.18.2.2. If the Contractor distributes Marketing Materials that have not been approved by EOHHS or that contain false or misleading information, either directly or indirectly through any Representative, EOHHS may impose contractual remedies, including civil monetary penalties up to $25,000 for each distribution.

3.18.3. Allowable Marketing Activities

3.18.3.1. Any individual, whether employed, subcontracted, or otherwise engaged by the Contractor, that is performing Marketing activities shall be considered a Marketing Representative for purposes of this Agreement.

3.18.3.2. The Contractor and its Marketing Representatives may engage in the following Marketing activities:

a) Distribute general information through mass media (i.e., newspapers, magazines and other periodicals, radio, television, the Internet, public transportation advertising, billboards and other media outlets) in keeping with prohibitions as detailed in the EOHHS Marketing Policies and Procedures.

b) Targeted Marketing efforts, including having Marketing Representatives answering questions by phone or in-person from Members or Potential Enrollees. In conducting targeted Marketing efforts, the Contractor shall comply with all guidance on prohibited Marketing activities, including a prohibition on Cold Call Marketing.

c) Marketing efforts to engage the community more broadly, including hosting events (Marketing Events), participating in community health education programming (Community Events), or advertising at or otherwise supporting a community event or health education program (Sponsorship).

- The Contractor shall get prior written approval from EOHHS for participating in any press or media events or activities that includes the Contractor acting as a sponsor of the event.
- EOHHS reserves the right to require the Contractor to discontinue or modify any Marketing or Member education events after approval.

d) Respond to verbal or written requests for information made by Potential Enrollees, in keeping with the response plan outlined in the Marketing Plan approved by EOHHS.

3.18.3.3. The Contractor shall ensure all Marketing Representatives complete Marketing activities in a non-discriminatory manner and uphold the mission and goals of the Rhode Island Medicaid Program.

3.18.3.4. The Contractor shall create and oversee a Marketing focused training required for all Marketing Representatives. The training shall include all critical elements as defined in Managed Care Manual Chapter 3, "Marketing Policies and Procedures."

3.18.3.5. In any instance where an allowable activity as defined by the Contractor's Marketing guidance conflicts the EOHHS Marketing Policies and Procedures, the EOHHS Marketing Policies and Procedures shall prevail.

3.18.4. Marketing Activities by Providers

3.18.4.1. For purposes of this Section, any reference to a Provider also includes AEs.

3.18.4.2. The Contractor shall provide Marketing guidance in Provider training materials and is responsible for any Marketing Activities engaged in by contracted Providers. The Contractor shall prohibit Providers from distributing any Marketing Material this is not approved by EOHHS.

3.18.4.3. In addition to the Marketing guidelines in Managed Care Manual Chapter 3, the Contractor shall ensure Providers comply with the following Marketing policies. The Contractor may include the following language in its Network Provider Agreements as a means to preventing prohibiting Marketing activities:

a) Providers must distribute or display Marketing Materials for all Health Plans participating in the Managed Care Program or choose not to distribute or display for any Health Plans. The Provider may choose which Marketing Materials to distribute or display so long as the Provider does not give the appearance of supporting one Managed Care Organization over another.

b) Providers may inform Members and Potential Enrollees which Health Plans they contract with.

c) Providers may educate Members and Potential Enrollees of the benefits and services, including Value-Added Services, that each contracted Health Plan offers.

d) Providers must not recommend one Health Plan over another, provide any other commentary on or comparison between Health Plans, offer Members or Potential Enrollees incentives to select a particular Managed Care Organization, or assist the Member or Potential Member in deciding to select a particular Health Plan.

e) If a Member or Potential Enrollee requests contact information for a Health Plan or assistance with the Medicaid application, the Provider may distribute that information or refer the Potential Enrollee to Health Source Rhode Island or navigators. The Contractor and its employees, Subcontractors, and Providers are strictly prohibited from assisting a Potential Enrollee with the application.

3.18.4.4. The Contractor, in its sole discretion, may institute additional policies around Marketing and Marketing Materials, so long as those policies do not conflict with this Agreement or the Managed Care Manual. The Contractor is responsible for educating contracted Providers of and enforcing those additional policies and procedures.

3.18.4.5. The Contractor is subject to contractual remedies, including Liquidated Damages in accordance with Attachment F-5, for failure to ensure Provider compliance with Marketing requirements.

3.18.5. Prohibited Marketing Activities by the Contractor (CMS Checklist I.C.7.04-.07; I.J.5.07)

3.18.5.1. The Contractor and its Subcontractors are prohibited from engaging in the following activities:

a) Cold Call Marketing.

b) Distributing Marketing Materials or making any statement (written or verbal) that EOHHS determines to be inaccurate, false, confusing, misleading, or intended to defraud Potential Enrollees or EOHHS. This includes statements that:

- Mislead or falsely describe Covered Services.
- Mislead or falsely describe membership or availability of Providers and qualifications and skills of Providers.

- Assert a Potential Enrollee must enroll in a specific Health Plan, including the Contractor's Health Plan, to obtain or not lose benefits.
- Assert or otherwise lead the Potential Enrollee to believe the Contractor is endorsed by CMS, the federal or state government, or a similar entity.

c) Marketing to Potential Enrollees in state offices or any location where a Potential Enrollee may receive an eligibility determination.

d) Marketing or distributing Marketing Materials, including Member handbooks, and soliciting Potential Enrollees in any other manner, inside, at the entrance, or within 50 feet of check cashing establishments, public assistance offices, DHS eligibility offices for the Supplemental Nutrition Assistance Program (SNAP), Provider locations (including health care facilities, freestanding urgent care centers, store-based clinics), pharmacies, Medicaid Eligibility Offices, or certified Medicaid Application Centers without prior approval from EOHHS.

e) Influencing enrollment in conjunction with the sale or offering of any private insurance or Medicare Advantage Plan

f) Using terms that would influence, mislead, or cause Potential Enrollees to contact the Health Plan, rather than the EOHHS-designated Choice Counselor, for enrollment.

3.18.5.2. The Contractor is subject to contractual remedies, including Liquidated Damages in accordance with Attachment F-5, for violations of Marketing requirements.

3.18.6. Marketing Materials (CMS Checklist I.B.1.01-.05; I.C.1.01, I.C.1.04-.06; I.C.1.12-.16)

3.18.6.1. EOHHS must approve all Marketing Materials before the Contractor may distribute them to Members or Potential Enrollees. Materials shall comply with 42 C.F.R. §§ 438.10(d)(6) and 438.104 and shall not contain any prohibited Marketing Claims as outlined in Section 3.18.5, above. The Contractor shall:

a) Provide information to Members and Potential Enrollees in a manner and format that may be easily understood and is readily accessible by such Member and Potential Enrollees. This includes drafting all Marketing Materials in an easily understood language and format.

b) Make available Marketing Materials in alternative formats upon request of the Member or the Potential Enrollees. The alternative formats should consider special needs of Members and Potential Enrollees with disabilities or Limited English Proficiency.

c) Include taglines in the prevalent non-English languages in the state as well as in large print. The taglines should community the availability of written translation, oral interpretation, or TTY/TDY to understand the information provided.

d) Provide all written Marketing Materials in a conspicuously visible font size.

3.18.6.2. Marketing Materials shall not contain any language or other indication that the Contractor would discriminate against individuals eligible to enroll on the basis of their health status, need for Health Care Services, race, color, national origin, sex, sexual orientation, gender identity, or disability.

3.18.6.3. The Contractor shall obtain specific EOHHS approval of any materials, regardless of whether they are produced by the Contractor, that features the Contractor's logo. This includes Member and Potential Enrollee facing materials produced by other Health Plans and Accountable Entities.

3.18.6.4. All Marketing Materials shall contain the EOHHS logo as appears in Managed Care Manual Chapter 3, "Marketing Policies and Procedures." The MCO may not alter or modify the EOHHS logo but may change the size so long as the logo remains visible and legible in all Marketing Materials. EOHHS, in its sole discretion, may move, resize, or otherwise alter the use of its logo as part of its approval of Market Materials.

3.18. Marketing Requirements- Document History Log	
Contract Cross-References	• Attachment F-5, Liquidated Damages Matrix • Managed Care Manual Chapter 3, "Marketing Policies and Procedures" • Managed Care Manual Chapter 11, "Reporting Calendar and Templates"
Governing Requirements and Authority	• 45 C.F.R. § 155.20 • 42 C.F.R. §§ 438.2, 438.10, 438.104
CMS Checklist Items	• I.B.1, No Discrimination, Sections I.B.1.01-.05 • I.C.1, Language and Format, Sections I.C.1.01, I.C.1.04-.06, I.C.1.12-.16 • I.C.7, Marketing, Sections I.C.7.01-.07 • I.J.5, Sanctions, Section I.J.5.07
Revision Date and Description	

3.19. Member Materials

3.19.1. General Requirements (CMS Checklist I.C.8.01-.06)

3.19.1.1. The Contractor shall design and distribute Member Materials, including identification cards, a Member Handbook, a Provider Directory, and other resources described in Managed Care Manual Chapter 6, "Critical Elements."

3.19.1.2. In designing Member Materials, the Contract shall:

a) Use a format that is readily accessible.

b) Create a permanent landing page for Member Materials on the Health Plan's website that is prominent and readily accessible.

c) Create all electronic materials in a searchable, downloadable, and savable format.

d) Notify all Members that Member Materials are available in paper form upon request.

e) Provide paper materials, upon request, within five Business Days of the request and at no charge to the Member.

3.19.2. State Approval

3.19.2.1. In accordance with the process in Managed Care Manual Chapter 3, "Marketing Policies and Procedures." Contractor agrees to submit all Member Materials, including substantive changes to approved materials, to EOHHS prior to use.

3.19.2.2. The Contractor shall submit all initial versions of Member Materials to EOHHS during Readiness Review, in accordance with Section 2.2.8, "Operational Readiness Review."

3.19.3. Contractor Review

3.19.3.1. The Contractor shall review all Member Materials at least annually for any needed revisions. Further, Contractor shall communicate revisions to EOHHS for approval before incorporating into the Member Handbook or other Member Materials.

3.19.4. New Member Materials

3.19.4.1. The Contractor shall issue Member ID cards to Members for their use in obtaining Medicaid In-Plan Benefits. The Contractor's ID cards must look similar for all Members. Each ID card must include a unique Medicaid identification number that is not the Member's Social Security Number. The ID card must also contain an alpha or numeric indicator to designate RIte Care, Rhody Health Partners, or ACA Expansion Population eligibility.

3.19.4.2. The Contractor shall also distribute a New Member Packet to all new Members.

3.19.4.3. The Contractor shall distribute the Member's New Member Packet within three Business Days of receiving notification from EOHHS of the Member's enrollment.

3.19.5. Member Handbook (CMS Checklist I.C.2.01-.21, I.C.2.29-.46)

3.19.5.1. The Contractor shall create a Member Handbook based on Rhode Island's Model Member Handbook.

3.19.5.2. The Contractor shall publish Member Handbook in a searchable, downloadable, and savable format on the Contractor's website for all Members and Potential Enrollees to access. The Member Handbook shall comply with all language and format requirements as outlined in Section 3.19.9, below, and 42 C.F.R. § 438.10 (c)-(d).

3.19.5.3. The Contractor's Member Handbook shall cover, at a minimum, the following topics:

a) An overview of the how to effectively use the Managed Care Program.
b) How to access In-Plan Benefits, including after-hours care and emergency services.
c) The amount, duration, and scope of In-Plan Benefits.
d) How to access Out-of-Plan Benefits, including dental services for children and medical transportation.
e) Member's freedom of choice to access Out-of-Network Providers for family planning and women's health services
f) Accessing Non-Covered Benefits, including the Member's payment responsibilities for such services.
g) Transition of care policies for Members and Potential Enrollees.
h) Selecting and changing a Member's PCP.
i) Services available to Members under Section 3.20, "Member Services."
j) Advance Directives as outlined in Section 3.11.12 and 42 C.F.R. §438.3(j).
k) Grievances and Appeals processes.
l) Fraud, Waste, and Abuse.
m) How to disenroll from the Contractor's Health Plan.

3.19.5.4. Unless otherwise directed by EOHHS, the Contractor shall provide Members notice of any substantive changes to the Member Handbook at least 30 Days before the effective date of the change. The Contractor shall publish notice of substantive changes on its website in the same location as the Member Handbook.

3.19.6. Member Bill of Rights (CMS Checklist I.C.2.22-.28)

3.19.6.1. Contractor shall include the Member Bill of Rights in the Member Handbook. The Member Bill of Rights shall cover, at a minimum, the Member's right to:

a) Obtain available and accessible health care Services as covered under this Contract.
b) Receive information on beneficiary and plan information.
c) Be treated with respect and with due consideration for their dignity and privacy.

d) Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.
e) Participate in decisions regarding their health care, including the right to refuse treatment.
f) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
g) Request and receive a copy of their medical records and request they be amended or corrected.

3.19.7. Provider Directory (CMS Checklist I.C.4.01-.11)

3.19.7.1. Contractor shall maintain an electronic Provider directory that contains an online, searchable database. The database shall profile each contracted Provider including the following Provider information:

a) Demographics, including name, group affiliations, street address, telephone number, and if applicable website URL.
b) Specialties, as appropriate.
c) Whether the Provider is accepting new Members.
d) Cultural and linguistic capabilities, including American Sign Language and whether the Provider has completed cultural competency training.
e) Office information, including available accommodations for Members with physical disabilities, including offices, exam rooms, and equipment.

3.19.7.2. The Contractor shall incorporate any changes to the paper directory on a monthly basis and to the electronic directory no later than 30 Days of receiving the Provider's updated information.

3.19.8. Distribution of Member Materials (CMS Checklist I.C.3.01)

3.19.8.1. In accordance with 42 C.F.R. § 438.10(g)(3), the Contractor may distribute Member Materials, except for the Member ID through any of the following methodologies:

a) Mail as a printed copy of to the Member's mailing address.
b) Email to the Member after obtaining the Member's permission to contact them via email.
c) Post on the Health Plan's website and advise Members in paper or electronic form where the information is available and of the option to request Member Materials in an alternative format at no charge to the Member.
d) Any other method that can reasonably be expected to result in a Member receiving the Member Materials.

3.19.8.2. The Contractor shall mail each Member a hard copy of the ID card within ten Business Days of enrollment within the Health Plan. The Contractor may choose to share a downloadable version of the ID card in addition to the mailed version.

3.19.8.3. The Contractor shall annually redistribute all Member Materials. If the Contractor has made any changes to the Member Materials, including the Member Handbook or Provider Directory, the Contractor shall include a summary of the changes alongside the updated materials.

3.19.9. Language and Format (CMS Checklist I.C.1.01, I.C.1.05-.08; I.C.1.12-.16; I.C.2.23-.44)

3.19.9.1. In accordance with 42 C.F.R. §438.10, the Contractor shall publish all materials in a manner and format easily understood and readily accessible by Members and Potential Members.

3.19.9.2. EOHHS requires literature to be in at least a twelve-point font and at a sixth-grade reading level.

3.19.9.3. All written materials should include taglines in the prevalent non-English languages in the state and in large print explaining the availability of written translations, oral interpretation, auxiliary aids, and TTY/TDY telephone numbers for Members to use to understand Member Materials at no cost to the Member.

3.19.10. Alternative Format (CMS Checklist I.C.1.03-.04)

3.19.10.1. Members may request paper, audio, or translated versions of any Member Material by contacting the Contractor's Member Services Department. If the Member Material is readily available, the Contractor shall provide the requested Member Materials within five Business Days at no cost to the Member.

3.19.10.2. Spanish and Portuguese Member Materials shall be readily available. If a Member requests materials translated in another language, the Contractor shall provide a native translation of the Member Material, in accordance with Section 3.20.4.4.(b) of this Contract, with no cost to the Member.

3.19.11. Contractor Website

3.19.11.1. The Contractor shall maintain Rhode Island specific Member facing webpage. The site may be navigable through its main website or at a standalone domain name. The webpage shall either directly display or provide hyperlinks to all Member Materials, the Contractor's formulary as described in Section 3.5.3, and other critical elements as outlined in Managed Care Manual Chapter 6, "Critical Elements."

3.19.11.2. The Contractor shall reserve the main webpage for the most critical information for Members, including:

a) All Call Center phone lines and their hours of operation.
b) Links to all Member Materials, including the Provider Directory.
c) Instructions to replace a lost or stolen Member ID Card.
d) A description of In-Plan Benefits.
e) The meeting schedule and information for the Member Advisory Committee established under Section 3.20.5.
f) Instructions to file an Appeal and request a State Fair Hearing.

g) Instructions to file a complaint with the Contractor and to contact the Office of Program Integrity's Tip Line to report an alleged Provider committing Medicaid Fraud or Abuse to the state.

3.19.11.3. The Contractor shall ensure that the hyperlink language accurately and concisely describes the material linked and the hyperlink itself leads directly to the described material. Hyperlinks should be organized by topic where material is not dispersed among several hyperlinks.

3.19.11.4. The Contractor's webpage shall follow all readability and accessibility requirements contained in 3.19.9 of this Section. This includes having all default fonts be at least size 12 and all materials written at no higher than a sixth grade reading level.

a) All webpages on the Provider's website should have an option to link to a translated version of that page.

3.19. Member Materials- Document History Log	
Contract Cross-References	• Article 2, Readiness Review Phase • Section 3.11, Other Requirements • Section 3.20, Member Services • Section 3.3 Covered Benefits, Service Requirements, and Limits • Managed Care Manual Chapter 3, "Marketing Policies and Procedures" • Managed Care Manual Chapter 6, "Critical Elements"
Governing Requirements and Authority	• 42 C.F.R. § 438.3(j); §438.10(c)-(d) and (g), 438.100, 438.400-.424 • 42 C.F.R. § 447.51
CMS Checklist Items	• I.C.1, Language and Format, Sections I.C.1.01, I.C.1.03-.08, I.C.1.12-.16 • I.C.2, Enrollee Handbook, Sections I.C.2.01-.46 • I.C.3, Enrollee Handbook Dissemination, Section I.C.3.01 • I.C.4, Network Provider Directory, Sections I.C4.01-.11 • I.C.8, General Information Requirements, Sections I.C.8.01-.06
Revision Date and Description	

3.20. Member Services

3.20.1. General Requirements

3.20.1.1. The Contractor shall establish, staff, and maintain a Member Services Department dedicated to responding to questions, comments, Grievances, Appeals, and inquiries from Members and Providers.

3.20.1.2. The Member Services Department shall oversee the following areas of Health Plan operations:

a) Member Call Center;
b) Translation and interpreter services;
c) Member education;
d) Member Advisory Committee; and
e) Other areas identified by the Contractor.

3.20.2. Member Call Centers

3.20.2.1. The Contractor shall develop policies and procedures for the Member Services Department, including staffing, training, hours of operations, and access and response standards for calls to the Member and Provider phone lines ("Call Center."

3.20.2.2. The Contractor shall operate Call Center during regular business hours of at least 8 a.m. to 6 p.m. EST, including lunch hours, on all Business Days, in alignment with the State of Rhode Island's holiday schedule on the Rhode Island Secretary of State's website.

3.20.2.3. All calls with Members shall be recorded and the Call Center shall inform the Member that the call is being recorded for quality assurance.

3.20.2.4. In addition to the requirements in contained Section 3.20.2.1, above, the Contractor shall operate an Urgent and Emergent Phone Line. that is available for urgent care and emergency calls from Members 24 hours per Day, 7 Days per week.

3.20.2.5. Member ID cards shall contain each Member Services phone line and the dedicated purpose of the phone line, as appropriate.

3.20.2.6. The Contractor shall operate a toll-free telephone line or telephone lines for Member use ("Member Services Phone Line"). The Contractor shall staff the line with trained and knowledgeable Call Center representatives.

3.20.2.7. Members may use the Member Services Phone Line to address questions, comments, Grievances, Appeals, and inquiries related to all aspects of the managed care system.

3.20.2.8. The Contractor shall train staff to provide culturally competent, appropriate, and timely responses to questions regarding:

a) Health Plan operations, including coordination with PCPs.
b) In-Plan Benefits and access to services.

c) Coordinating and accessing Out-of-Plan Services.
d) Making appointments to obtain services.
e) Referrals and the process for receiving authorization for procedures or services.
f) Accessing care in an emergency or urgent situation.
g) Selecting a PCP.
h) Providers in a particular specialty or geographic area.
i) Accessing Member Materials as described in Section 3.19.
j) Arranging interpreter services described in Section 3.20.4.
k) Member Grievances, Appeals, and State Fair Hearings.
l) Updating Member addresses, phone numbers, emails, and other contact information EOHHS following the process in Managed Care Manual Chapter 6, "Critical Elements."
m) Other topics identified by the Contractor.

3.20.2.9. The Contractor shall ensure that the Member Services Phone Line and the Urgent and Emergent Phone Line have properly trained staff and equipment to communicate with callers with Limited English Proficiency or disabilities, including speech and hearing disabilities. The Contractor shall ensure that the translation and interpreter services referenced in Section 3.20.4 are available to all Members using the Member Services Phone Line and Urgent and Emergent Phone Line.

3.20.3. Call Center Performance Standards

3.20.3.1. The Contractor shall implement a Telecommunication Relay Service (TRS) system to, in part, evaluate the Call Center's performance using the criteria outlined in this Section. The Contractor shall report on the following performance metrics to EOHHS on or before the last Day of each month.

a) Answer at least 95% of incoming Member information telephone line calls within 30 seconds.
b) Daily average Hold Time shall be two minutes or less during regular business hours as defined in Section 3.20.2.1, above. For purposes of this Agreement, a Member is considered on hold when they are waiting for a call center representative after navigating the interactive voice response (IVR) system and when a customer service representative places the Member on hold.
c) Maintain call abandonment rate of less than 5%.

3.20.3.2. If the Contractor fails to meet one or more of its performance standards, the Contactor shall promptly notify the EOHHS Managed Care Director.

3.20.3.3. In the event of a service outage or other operational failure, the Contractor shall notify EOHHS no later than 30 minutes of becoming aware of the issue, including the root cause of the issue and the Contractor's mitigation plan.

3.20.3.4. EOHHS reserves the right to impose contractual remedies, the including liquidated damages described in Attachment F-5, if the Contractor fails to meet the performance standards described above or fails to provide timely notification of service outages or other operational failures.

3.20.4. Interpreter and Translation Services (CMS Checklist I.C.1.09-.11)

3.20.4.1. The Contractor shall offer oral and written translation and interpreter services, including auxiliary aids such as TTY/TDD and American Sign Language, at no cost to the Member or the Member Representative. The Contractor may use in-person, telephone-based, or TRS for the oral translation and interpreter services.

3.20.4.2. The Contractor shall make available interpreter services to Contracted Providers treating Members with Limited English Proficiency at no charge to the Provider or Member. The Contractor may coordinate with Rhode Island Commission for the Deaf and Hard of Hearing for interpretation services.

3.20.4.3. The Contractor shall ensure that written Marketing Materials and Member Materials are readily available in, at a minimum, English, Spanish, and Portuguese. If EOHHS provides the Contractor with notice of an additional prevalent non-English language in Rhode Island, the Contractor shall provide a translation of its Marketing Materials and Member Materials within 45 Days of receiving notification from EOHHS.

3.20.4.4. The Contractor shall provide translated Marketing Materials and Member Materials to Potential Enrollees and Members.

a) If a Member requests translated Marketing Materials or Member Materials in Spanish or Portuguese, the Contractor shall send the translated Member Materials in the format the requested to the Member within five Business Days of the request, and at no cost to the Member.

b) If the Member requests translated Marketing Materials or Member Materials in other languages, the Contractor shall translate and distribute the materials in a format requested within seven Business Days of the request, and at no cost to the Member.

3.20.4.5. In delivering translation and interpreter services, the Contractor shall comply with all applicable guidelines and requirements under Title VI of the Civil Rights Act and under the Americans with Disabilities Act. This includes offering in-person interpreter services.

3.20.5. Auxiliary Aids (CMS Checklist I.C.1.07, I.C.1.11, I.C.1.15-.16, I.C.2.39, I.C.3, I.H.1.03)

In accordance with 42 C.F.R. § 438.10(d) and Section 3.20.4, "Interpreter and Translation Services," the Contractor shall:

3.20.5.1. Notify Members that auxiliary aids and services are available upon request to Members with disabilities at no cost.

3.20.5.2. Make written Member Materials available through auxiliary aids and services in a manner that considers the special needs of Members with disabilities.

3.20.5.3. Include information on the Contractors website and in all written Member Materials, including the Member Handbook, on how to request and access auxiliary aids and services, including materials in alternative formats.

3.20.5.4. As described in Section 3.21, "Grievances and Appeals," the Contractor shall provide Members with any reasonable assistance needed to complete forms and other procedural steps related to the Grievance and Appeals process. This includes providing auxiliary aids and services and interpreter services upon request.

3.20.6. Member Advisory Committee

3.20.6.1. The Contractor shall establish a Member Advisory Committee where Members discuss and evaluate their experiences at the Health Plan.

3.20.6.2. The Member Advisory Committee shall meet at least on a quarterly basis. To call a meeting to order, the Member Advisory Committee shall have at least five currently enrolled Members or Member Representatives in attendance, plus representation from the Contractor. Meeting attendees may participate either virtually or in-person. Advocacy organization staff or Member advocates may attend meetings, but the Member Advisory Committee may not consider their attendance for purposes of establishing a meeting quorum.

a) Participating in the Member Advisory Committee is not a paid position; however, the Contractor may offer compensation to Members as it relates to attending a meeting. This can include reimbursement for transportation to and from an in-person meeting or food at in-person meetings. The Contractor is not required to compensate advocacy organization representatives or other non-Member participants.

b) The Contractor recognizes the importance of getting a well-rounded understanding of the Member experience and shall make an effort to engage a diverse representation of Members to participate in the Member Advisory Committee. Contractor shall provide interpreter services at a meeting if requested by a Member, provided the Member requests the interpreter reasonably in advance of the designated meeting time.

3.20.6.3. The Contractor shall ensure the Member Advisory Committee creates and maintains the following documents:

a) A Member Advisory Committee charter.

b) Meeting minutes for each meeting.

c) A reporting structure under which the Member Advisory Committee shares an annual report with Contractor leadership and escalates significant Member issues as soon as reasonably possible.

3.20.6.4. The Contractor shall make a good faith effort to publicize Member Advisory Committee meetings in advance, including social media, direct consumer outreach, and sharing updates on Contractor website of methods to participate in Committee.

3.20.7. Member Education

The Contractor agrees to maintain an ongoing support system program. The program shall cover topics including proper utilization of benefits and services, with an emphasis on screenings and preventative services, Behavioral Health Benefits, appropriate prescription drug use, health education, Fraud, Waste, Abuse, and other topics the Contractor deems appropriate.

3.20.8. Member Satisfaction Report

The Contractor shall collect Member satisfaction data for all lines of business through an annual survey of a representative sample of its Members, in accordance with NCQA standards, and provide copies of the results to EOHHS in accordance with Managed Care Manual Chapter 11, "Reporting Calendar and Templates."

3.20. Member Services- Document History Log	
Contract Cross-References	• Attachment F-5, Liquidated Damages Matrix • Section 3.19, Member Materials • Section 3.21, Grievances and Appeals • Managed Care Manual Chapter 3, Marketing Policies and Procedures • Managed Care Manual Chapter 11, Reporting Calendar and Templates
Governing Requirements and Authority	• Title IV Civil Rights Act; • Americans with Disabilities Act • 42 C.F.R. § 435.923 • 42 C.F.R. §§ 438.10 and 438.026 • 47 C.F.R. § 64.601(42)
CMS Checklist Items	• I.C.1, Language and Format, Sections I.C.1.07, 1.09-.11, .15 and .16 • I.C.2, Enrollee Handbook, Section I.C.2.39 • I.C.3, Enrollee Handbook Dissemination, Section I.C.3.01 • I.G.6, Cultural Competence, Section I.G.6.01 • I.H, Grievances and Appeals, Section I.H.1.03 • I.J.5, Sanctions, Section I.J.5.10
Revision Date and Description	

3.21. Grievances and Appeals

3.21.1. Generally (CMS Checklist I.E.6.01-.05, I.H.1.-.03, I.H.1.05-.09, I.H.10.01 and I.H.10.09)

3.21.1.1. In accordance with 42 C.F.R. §438.402(c)(2)(i), Members have a right to file a Grievance with the Contractor at any time. The Contractor shall also extend that same right to Providers and Authorized Representatives acting on behalf of a Member.

3.21.1.2. The Contractor shall have an internal Grievance and Appeals Procedure in place that complies with relevant sections of the Social Security Act, 42 U.S.C. §1396a, 42 C.F.R. Subpart F, and 210-10-05 R.I.C.R. § 2.4. Components of the Grievance and Appeals Procedure shall include:

a) A Grievance process.
b) An Appeal process that includes only one level (i.e., does not require multiple levels of Appeal).
c) A process to access the State's Fair Hearing process.

3.21.1.3. The Grievance and Appeals Procedure shall include the following criteria:

a) The right to a State Fair Hearing, how to obtain a hearing, and the right to representation at a hearing.
b) The right to file Grievances and Appeals and their requirements and timeframes for filing.
c) The availability of assistance in the filing process, including auxiliary aids and services (upon Member request) such as interpreter services and toll-free numbers with TTY/TTD and interpreter capabilities.
d) The toll-free numbers that Members can use to file a Grievance or Appeal by phone.
e) All notices provided to Members shall be provided in formats and languages that, at a minimum, meet applicable notification standards in 42 C.F.R. § 438.10.
f) The Member's right to request continuation of Covered Benefits during an Appeal or State Fair Hearing within the timeframes specified for filing; and the Member may be liable for the cost of any continued benefits while the Appeal is pending if the final decision is adverse to the Member.

3.21.1.4. The Contractor shall create written materials to educate Members, Providers, and Subcontractors of the Grievance and Appeals processes, including applicable forms for Grievances, Appeals, and State Fair Hearings. The Contractor shall post these materials alongside Member Materials on its website and provide alternate versions to the Member upon request, at no cost to the Member. All written materials and associated auxiliary aids shall meet the requirements of 42 C.F.R. § 438.10(d)(3)-(4).

3.21.1.5. The Contractor shall ensure that any decision makers in the Grievance and Appeals processes are not:

a) Involved in any previous level of review or decision-making; or
b) Subordinates of any individual who was involved in a previous level of review or decision-making.

3.21.1.6. Further, the Contractor shall ensure that the decision makers are individuals with appropriate clinical expertise, as determined by EOHHS, in treating the Member's condition or disease if the decision involves:

a) An Appeal of a denial based on lack of Medical Necessity;
b) A denial of an Expedited Appeal; or
c) A Grievance or Appeal involving clinical issues.

3.21.2. Grievances (CMS Checklist I.H.1.04, I.H.4.01, I.H.4.03, I.H.10.01-.07, I.H.10.09)

3.21.2.1. A Member, or Provider or Authorized Representative acting on behalf of the Member, may file a Grievance at any time with the Contractor either orally or in writing. The right to file a Grievance only applies to filing with the Contractor and does not extend to filing a Grievance directly with EOHHS.

3.21.2.2. The Contractor shall acknowledge receipt of each Grievance filed within five Business Days of receipt.

3.21.2.3. The Contractor shall resolve each Grievance and provide written notice of the resolution as expeditiously as the Member's health condition requires but not to exceed 90 Days from the date it received the Grievance.

3.21.2.4. Notwithstanding the foregoing, the Contractor may extend the timeframe for resolution of a Grievance by 14 Days if the Member, the Member's representative or the Provider request an extension or the Contractor can show (to the satisfaction of EOHHS, upon EOHHS' request) that there is need for additional information and that the extension is in the Member's interest. If the Contractor extends the timeframes not at the request of the Member, it shall:

a) Make reasonable efforts to give the Member prompt oral notice of the delay; and
b) Within two Days, give the Member written notice of the reason for decision to extend the timeframe and inform the Member of the right to file a Grievance if they disagree with that decision. The notification shall be provided in a format and language that, at a minimum, meets the standards at 42 C.F.R. §438.10.

3.21.3. Appeals (CMS Checklist I.H.4.01, I.H.4.03, I.H.5.01-.03, I.H.6.01-.10, I.H.7.01-.12, I.H.8.01-.05)

3.21.3.1. A Member or Provider or Authorized Representative acting on behalf of the Member, may file an Appeal with the Contractor either orally or in writing, within 60 Days from the date of the notice of Adverse Benefit Determination.

a) For oral requests, the date the Contractor received the oral request shall be considered as the filing date. An oral request for an Appeal shall be followed by a written, signed request, unless the Member, Provider, or Authorized Representative requests an Expedited Appeal.

b) If any party other than the Member or the Member's guardian is filing the Appeal on the Member's behalf, the Member must provide written or oral consent of the Appeal filing. The Contractor shall complete an Authorized Representative Consent Form.

c) The Contractor shall issue a written acknowledgement of an Appeal within five Business Days of receipt.

3.21.3.2. For resolution of each standard Appeal, the Contractor shall provide written notice of the disposition within 30 Days from the time the Contractor receives the Appeal. If the Contractor does not provide notice within 30 Days, the Member is deemed to have exhausted the Appeal process and may initiate a State Fair Hearing.

3.21.3.3. Resolving a Standard Appeal

a) Parties to an Appeal may include the Member, the Member's Authorized Representative, or the legal representative of a deceased Member's estate, as appropriate.

b) The Contractor shall provide the Member with a reasonable opportunity, both in person and in writing, to present evidence and testimony and make legal and factual arguments. The Contractor shall inform the Member of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals as specified in 42 C.F.R. §§438.408(b) and (c) in the case of expedited resolution.

c) Additionally, the Contractor shall provide the Member and their representative with a copy of the Member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor (or at the direction of the Contractor) in connection with the Appeal of the Adverse Benefit Determination. This information shall be provided free of charge and sufficiently in advance of the resolution timeframe for Appeals as specified in 42 C.F.R.§§438.408(b) and (c).

d) Each written notice of determination shall be provided in a format and language that, at minimum meets the standards at 42 C.F.R. §438.10 and shall include the following:

- 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 an external Appeal at no cost to the Member; the right to request a State Fair Hearing, and how to do so; the right to request to receive benefits while the hearing is pending, and how to make such a request; and that the Member may not be held liable for the cost of those benefits if the hearing decision upholds the Contractor's notice of Adverse Benefit Determination.
- Information on how to contact the Contractor either in writing or telephone regarding the Appeal process

e) In resolution of an expedited Appeal, the Contractor shall make a reasonable effort to provide oral notice of the resolution in addition to the written notice outlined in this Section.

3.21.3.4. Timelines for Resolving an Expedited Appeals

a) An expedited review is permitted when the Contractor determines (for a request from a Member) or the Provider indicates (in making the request on the Member's behalf or supporting the Member's request) that taking time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
   - The Contractor shall ensure that punitive action is not taken against a Provider who requests an expedited resolution or who supports a Member's request.

b) The Member may submit a verbal request for an expedited resolution of Appeal. The Member does not need to follow an oral request for an expedited resolution of Appeal with a written request. The Contractor shall inform the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person and in writing, in the case of an expedited resolution.

c) Expedited appeals shall be resolved within 72 hours of receipt.

d) If the Contractor denies the request for an Expedited Appeal, it shall transfer the appeal to the timeframe for standard resolution, make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two Days with a written notice.

3.21.3.5. Extending a Standard or Expedited Appeal

a) Notwithstanding the resolution timelines outlined in this Section, the Contractor may extend the timeframe for resolution of a standard or expedited Appeal by 14 Days if the Member, the Member's Authorized Representative, or the Provider request an extension or the Contractor can show (to the satisfaction of EOHHS, upon EOHHS' request) that there is need for additional information and that the extension is in the Member's interest. If the Contractor extends the timeframes not at the request of the Member, it shall:
   - Make reasonable efforts to give the Member prompt oral notice of the delay.
   - Within two Days give the Member's written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision.
   - Resolve the Appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.

3.21.4. Adverse Benefit Determinations (CMS Checklist I.H.2.01-.06, I.H.3.01-.12)

3.21.4.1. Notice of Adverse Benefit Determination

a) The notice of Adverse Benefit Determination shall include all of the following:
   - An explanation of the Adverse Benefit Determination the Contractor has made or intends to make.
   - The reasons for the Adverse Benefit Determination, including the right of the Member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Member's Adverse Benefit Determination.
   - The Member's right to request an Appeal of the Contractor's Adverse Benefit Determination, including information on exhausting the Contractor's one level of appeal as described at 42 C.F.R.§ 438.402(b) and the Member's right to request a State Fair Hearing consistent with 42 C.F.R.§ 438.402(c).
   - The procedures for exercising the right to file an Appeal or request a State Fair Hearing.
   - The circumstances under which an expedited resolution of the Adverse Benefit Determination is permitted and how to request it.
   - The Member's right to have benefits continue pending resolution of the Appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the Member may be required to pay the costs of these services provided during the pendency of the Appeal.
   - The toll-free number to file oral Grievances and Appeals.

b) If the Contractor does not reach a service authorization decision within the applicable timeframes, as outlined in Section 3.16, Utilization Management, it shall provide notice to the Member that a decision has not been reached.

3.21.4.2. Timelines for a Notice of Adverse Benefit Determination

a) The Contractor shall mail a Notice of Adverse Benefit Determination termination, suspension, or reduction of previously authorized Medicaid-Covered Services, at least ten Days before the date of Action as specified in 42 C.F.R. § 431.211.

b) Notwithstanding the foregoing, the Contractor may shorten the period of Notice of Adverse Benefit Determination to five Days before the date of Action if:
   - The Contractor has facts demonstrating that Action should be taken because of probable Fraud by the Member, and
   - The facts have been verified, if possible, through secondary sources.

c) In accordance with the requirements contained in 42 C.F.R. § 438.210(d)(1), the Contactor may have one possible extension of up to 14 additional Days if:
   - The Member or the Provider requests an extension; or

- With the agreement of the Member the Contractor provides justification to EOHHS upon request upon request a of the need for additional information and that the extension is in the Member's best interests.

d) If the Contractor exercises its option to extend the Notice of Adverse Benefit Determination, it shall provide the Member with a written notice of the reason for the extension and inform the Member of the right to file a Grievance if he or she disagrees with the Contractor's decision.

e) Under the extended timeframe, the Contractor still shall carry out its determination as expeditiously as possible as the Member's health condition requires and no later than the date the extension expires.

3.21.4.3. Expedited Notice of Adverse Benefit Determination

a) In accordance with 42 C.F.R. § 438.210(d)(2), if a provider indicates following the standard timeframe for authorization decisions will seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision. The Contractor shall provide notice as expeditiously as the Member's health conditions requires but no later than 72 hours after the receipt of the request for services. The Contractor may extend the 72-hour response time by up to 14 Days if the Member requests an extension or the Contractor justifies to the EOHHS a need for additional information and how the extension is in the Member's best interest.

3.21.4.4. Special Circumstances for Mailing a Notice of Adverse Benefit Determination on the Date of Action

a) The Contractor may mail the notice of Adverse Benefit Determination on the date of Action only under the following circumstances:

- The Contractor has factual information confirming the Member's death.
- The Contractor receives a clear written statement signed by a Member that:
  - They no longer want to receive services; or
  - The Member has provided information that requires termination or reduction of services and indicates he or she understands the Adverse Benefit Determination is the result of supplying this information.
- The Member has been admitted to an institution and is ineligible under the Managed Care Program for further services.
- The Member's whereabouts are unknown and the post office returns Contractor mail directed to them indicating no forwarding address.
- A change in the level of medical care is prescribed by the Member's physician.
- The notice involves an Adverse Benefit Determination with regard to preadmission screening requirements under §1919(e)(7) of the Social Security Act.

- The transfer or discharge from a facility will occur in an expedited fashion.

b) The Contractor shall give notice of the Adverse Benefit Determination on the date of the determination when the Action is a denial of payment.

3.21.5. Continuation of Benefits (CMS Checklist I.H.9.01-.06)

3.21.5.1. Under the following circumstances, the Contractor shall continue covering benefits for a Member while an Appeal is in process:

a) The Member files a request for an Appeal within 60 Days following the date of the Notice of Adverse Benefit Determination.

b) The Appeal involves the termination, suspension, or reduction of a previously authorized, but unexpired, service as ordered by an authorized provider.

c) The request for the continuation of benefits is filed on or before the later of the following:

- Within ten Days of the Contractor sending a Notice of Adverse Benefit Determination; or
- The intended effective date of the Contractor's proposed Adverse Benefit Determination.

d) If the Contractor either elects to continue a Member's benefits or provides continued benefits, the benefits shall continue until:

- The Member withdraws the Appeal or request for a State Fair Hearing;
- The Member does not request a State Fair Hearing and continuation of benefits within ten Days from the date the Contractor sent the notice of an adverse Appeal resolution; or
- EOHHS issues an adverse State Fair Hearing determination.

3.21.5.2. Payment for Continued Services

a) In the event of a reversed Adverse Benefit Determination, the Contractor shall pay for the continued services provided during a pending Appeal or State Fair Hearing, unless Rhode Island law or regulation requires EOHHS to cover the costs.

b) In the event of an affirmed Adverse Benefit Determination, The Contractor may recover the cost of continued services provided during a pending Appeal or State Fair Hearing, so long as the Contractor recovers costs consistent with Rhode Island policy.

3.21.6. Restoring Benefits

3.21.6.1. The Contractor shall authorize the continued services as promptly and expeditiously as the Member's health condition requires, but no later than 72 hours from the date it reverses or receives notice of a reversed Adverse Benefit Determination, if the services were not furnished during a pending Appeal or State Fair Hearing.

3.21.7. External Medical Review (CMS Checklist I.H.4.02)

3.21.7.1. Members may seek an external Appeal (external medical review), which is offered by the Contractor through a contracted independent external medical reviewer under the external Appeal procedural requirements pursuant to RI.Gen. Laws section 27-18.9-8 of the Benefit Determination and Utilization Review Act.

3.21.8. Grievance and Appeals Reporting

3.21.8.1. The Contractor shall submit quarterly Grievances, and Appeals reports in accordance with Managed Care Manual Chapter 10, "Grievances and Appeals."

3.21.8.2. Each record of a Grievance or Appeal shall include:

a) The Member's name.
b) A general description of the reason for the Grievance or Appeal.
c) The date received.
d) The date of each review or, if applicable, review meeting.
e) Resolution information for each level of the Grievance or Appeal, if applicable; and
f) The date of resolution at each level, if applicable.

3.21.8.3. The Contractor is subject to contractual remedies, including liquidated damages, if it fails to meet the following performance standards:

a) 98% of Grievances resolved within 90 Days of receipt.
b) 98% of Appeals resolved within 30 Days of receipt.

3.21.9. Grievance and Appeals Records Retention (CMS Checklist I.H.11.01-.08, I.J.1.07)

3.21.9.1. The Contractor shall maintain a complete and accurate record of all Grievances and Appeals for ten years.

3.21.9.2. The Contractor shall maintain and make Grievance and Appeal records available upon request by EOHHS and CMS. The record of each Grievance and Appeal shall contain, at a minimum:

a) A General description of the reason for the Grievance or Appeal and the date the Grievance or Appeal was received.
b) The date of each review, or if applicable, review meeting.
c) Resolution information for each level of the Grievance or Appeal, if applicable, including the date of the resolution.
d) The name of the Member for whom the Grievance or Appeal was filed.

3.21.9.3. The Contractor shall log, track, and trend all Grievances, regardless of the degree of seriousness or whether the Member expressly requests filing the concern.

3.21. Grievances and Appeals- Document History Log	
Contract Cross-References	• Section 3.16, Utilization Management • Managed Care Manual Chapter 10, Grievances and Appeals
Governing Requirements and Authority	• 42 C.F.R. § 431.211 • 42 C.F.R. §§ 438.10, 438.210(d), 438.402, 438.408(b) and (c), 438.414 • 42 C.F.R. Subpart F • Social Security Act, 42 U.S.C. §1396a • §1919(e)(7) of the Social Security Act. • 210-10-05 R.I.C.R. § 2.4. • RI.Gen. Laws section 27-18.9-8
CMS Checklist Items	• I.E.6, Provider Notification of Grievance and Appeals Rights, Sections I.E.6.01-.05 • I.H.1, Grievance and Appeals System, Sections I.H.1.01-.09 • I.H.2, Notice of Adverse Benefit Determination Requirements, Sections I.H.2.01-.06 • I.H.3, Notice of Adverse Benefit Determination Timing, Sections I.H.3.01-.12 • I.H.4, Who May File Appeals and Grievances, Sections I.H.4.01-.03 • I.H.5, Timeframes for Filing Appeals, Sections I.H.5.01-.03 • I.H.6, Process for Filing an Appeal or Expedited Appeal Request, Sections I.H.6.01-.10 • I.H.7, Timeframes for Resolving Appeals and Expedited Appeals, Sections I.H.7.01-.12 • I.H.8, Notice of Resolution for Appeals, Sections I.H.8.01-.05 • I.H.9, Continuation of Benefits, Sections I.H.9.01-.06 • I.H.10, Grievances, Sections I.H.10.01-.07, I.H.10.09 • I.H.11, Grievance and Appeal Recordkeeping Requirements, Sections I.H.11.01-.08 • I.J.1, Inspection, Section I.J.1.07
Revision Date and Description	

3.22. Program Integrity

3.22.1. General Requirements

In accordance with 42 C.F.R. §§ 456.3, 456.4, 456.23 and 42 C.F.R. § 438.608(a), the Contractor and its Subcontractors shall have administrative and management arrangements in place to detect and prevent Fraud, Waste, and Abuse. The administrative and management arrangements shall include all of the requirements in this Section.

3.22.2. Compliance Program (CMS Checklist I.I.5.01-.07)

3.22.2.1. The Contractor shall have a Compliance Program, evidenced by a written Compliance Plan. The plan must include policies, procedures and practices that demonstrates how the Contractor complies with the requirements of this Agreement, including all Governing Requirements.

3.22.2.2. The Contractor shall submit an electronic copy of the Compliance Plan to EOHHS during Readiness Review, annually thereafter and at least 30 Days before the effective date of any substantive modifications.

3.22.2.3. EOHHS, at its sole discretion, may require that the Contractor modify its Compliance Plan.

3.22.2.4. The Compliance Plan shall, at a minimum, include all of the following elements:

a) The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with this Agreement. The Compliance Officer shall report directly to the CEO and the Board of Directors.

b) A Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's Compliance Program.

c) A system of effective training and education for the Compliance Officer, the organization's senior management, and the organization's employees on the requirements of this Agreement. For existing employees, such training shall be conducted at least annually, and new hire training shall be conducted within 30 Days of the date of hire. The Compliance Plan shall also include a description of how the Contractor monitors and audits Provider and subcontractor training.

d) Effective lines of communication between the Compliance Officer and the Contractor's employees.

e) Enforcement of program integrity standards through well-publicized disciplinary guidelines for employees.

f) Establishment and implementation of procedures and a system with adequate dedicated staff and resources for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement

agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Agreement.

g) Policies and procedures for verifying with Members, by sampling or other means, whether services billed by providers and vendors have been received. Verification processes can include Explanation of Benefit (EOB) notices and other strategies.

h) Written policies and procedures for conducting announced and unannounced site visits and field audits of Providers to ensure services are rendered and billed correctly.

i) Establishment of a well-publicized email address and phone number for the dedicated purpose of reporting Fraud, Waste, and Abuse. This phone number and email address shall be made available to Members, Providers, Contractor employees and the public on the Contractor's website. The Contractor shall implement procedures to review complaints filed in the Fraud, Waste, and Abuse reporting email account at least weekly and investigate and act on such complaints as warranted.

3.22.3. Staffing

3.22.3.1. The Contractor shall have sufficient and dedicated staff in a Special Investigations Unit (SIU) and/or auditing unit.

3.22.3.2. The Contractor shall, at minimum, have one full time investigator physically located within Rhode Island for every 50,000 members or fraction thereof. This full-time position is in addition to the Compliance Officer and shall be physically located in the State of Rhode Island. EOHHS may approve written requests with detailed justification to substitute another SIU position in place of an investigator position.

3.22.3.3. As required by Section 3.1.3, "Contractor's Key Personnel," the Contractor shall provide EOHHS and the Office of Program Integrity the name and contact information of the designated individual within their SIU with whom the state and the Office of Program Integrity may:

a) Communicate directly, and

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

3.22.4. Contractor Overpayments (CMS Checklist I.I.5.08, I.I.2.39)

3.22.4.1. The Contractor shall promptly provide notice to EOHHS when it has identified or recovered capitation payments or other payments in excess of amounts specified in the Network Provider Agreement. The notice shall identify Overpayments and recoveries due to potential Fraud, Waste, or Abuse.

3.22.4.2. The Contractor shall repay Overpayments within 60 Days and include the amount of the Overpayment and the amount repaid in the monthly Program Integrity Report submitted to EOHHS in accordance with Section 3.22.15, below.

3.22.5. Provider Overpayments (CMS Checklist I.I.5.08, I.I.6.04)

3.22.5.1. The Contractor shall have a mechanism for a Network Provider to promptly report when it has received an Overpayment and to return the Overpayment to the Contractor within 60 Days of identification.

3.22.5.2. The reporting mechanism shall include a process to notify the Contractor in writing of the reason for the Overpayment, including potential Fraud, Waste, or Abuse.

3.22.5.3. Provider Overpayments and recoveries shall be reported in accordance with Section 3.22.15.

3.22.6. Retention of Recoveries (CMS Checklist I.I.6.01)

The Contractor may retain recoveries related to Overpayments, including Overpayments due to Fraud, Waste or Abuse except in the following circumstances:

3.22.6.1. The Medicaid Fraud Control and Abuse Unit (MFCU) has notified the Contractor that is has begun recovery efforts or the improperly paid funds have already been recovered.

3.22.6.2. The funds were recovered by EOHHS, the state, or federal agencies from a Provider through an action under the Federal False Claims Act.

3.22.7. Written Policies for Employees and Representatives (CMS Checklist I.I.5.13)

3.22.7.1. The Contractor shall disseminate written policies for all of its employees and Representatives that provide detailed information about the role of federal and state 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, including:

a) The False Claims Act established under sections 3279 through 3733 of Title 31, United States Code.

b) Administrative remedies for false claims and statements established under Chapter 38 of Title 31, United States Code.

c) Any state laws pertaining to civil and criminal penalties for false claims and statements and whistleblower protections under such laws.

3.22.7.2. The written policies may be on paper or in electronic form but must be readily available to all of the Contractor's employees and Representatives.

3.22.8. Information on Whistleblower Protections

The Contractor shall include a specific discussion of the laws described in the written policies required in 3.22.7 of this Section and the rights of employees to be protected as whistleblowers in the employee handbook. The employee handbook shall also include a specific discussion of the Contractor's policies and procedures for preventing and detecting Fraud, Waste, and Abuse.

3.22.9. Prohibition Against Retaliation

The Contractor shall have policies and procedures to ensure that no individual who reports Contractor, Subcontractor, or provider violations or suspected Fraud, Waste or Abuse is retaliated against and that the confidentiality of individuals reporting violations is protected.

3.22.10. Internal Monitoring and Auditing (CMS Checklist I.I.5.12)

The Contractor shall have mechanisms for internal monitoring and auditing of claims to detect and prevent Medicaid program violations and to identify possible Fraud, Waste and Abuse including provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by Network Providers were received by Members and the application of such verification processes on a regular basis. Other methods include but shall not be limited to: data matching, trending, statistical analysis, monitoring of service and billing patterns, monitoring claims edits and other data mining techniques.

3.22.11. Investigations

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

3.22.12. Program Integrity Referrals (CMS Checklist I.I.5.14)

3.22.12.1. The Contractor shall refer all potential Fraud, Waste, or Abuse cases that the Contractor identifies to EOHHS/Office of Program Integrity using the State's secure electronical portal in accordance with the following timeframes and procedures.

a) Suspected cases of Provider or vendor Fraud, Waste or Abuse involving an incident or concern related to the safety or well-being of a Member shall be referred to EOHHS and any other state agency as required under Rhode Island law within 24 hours of receipt.

b) Suspected cases of Provider or vendor Fraud, Waste or Abuse that do not involve an incident or concern related to the safety or well-being of a Member shall be referred to EOHSS/Program Integrity and the MFCU not later than 24 hours following the close of a preliminary investigation if, after preliminary investigation, the Contractor has concluded the referral involves a Credible Allegation of Fraud.

3.22.12.2. If a credible allegation of Fraud has not been established, the referral can be made not later than five Business Days following the close of the investigation.

3.22.12.3. After making a referral to EOHHS/Program Integrity Unit involving Fraud, Waste or Abuse, the Contractor shall not:

a) Contact the subject of the referral about any matters related to the referral or the investigation.

b) Enter into or attempt to negotiate any settlement or agreement regarding the referral.

c) Accept any money or other valuable consideration offered by the subject of the referral.

3.22.12.4. After receiving the Contractor's referrals, the EOHSS/Program Integrity Unit shall conduct any additional investigation necessary to establish or confirm that a Credible Allegation of Fraud exists.

3.22.13. Payment Suspension (CMS Checklist I.I.5.15))

In accordance with 42 C.F.R. § 455.23, Medicaid payments to a Provider shall be suspended after a determination that there is credible allegation of Fraud for which an investigation is pending under the Medicaid program unless good cause has been found not to suspend payments or to suspend payments only in part.

3.22.13.1. If, after preliminary investigation, the contractor determines that a credible allegation of Fraud exists, the Contractor shall consult immediately with EOHHS/Program Integrity and if good cause not to suspend in whole or in part is not established, initiate payment suspension in accordance with 42 C.F.R. §455.23. The contract shall immediately notify EOHHS regarding its actions and the basis therefore.

3.22.13.2. In the case of a payment suspension initiated by EOHHS/Program Integrity:

a) EOHHS/Program Integrity Unit shall send notice to the Contractor that payments to the Provider have been suspended and the Contractor shall also suspend payments in accordance with the notice within one Business Day.

b) The payment suspension shall remain in place until such time as EOHHS/Program Integrity Unit provides notice that the payment suspension has been lifted.

c) The Contractor shall respond to the notice that the payment suspension has been lifted within three Business Days and inform EOHHS/Program Integrity of the action taken.

3.22.13.3. All information regarding on-going payment suspensions shall be reported monthly on the EOHSS Monthly Program Integrity Report in accordance with Section 3.22.15.

3.22.13.4. If the Contractor does not suspend payments to the Provider, or the Contractor does not correctly report the amount of the payments held, EOHHS may impose contractual or other remedies in accordance with Attachment F-2, Article 9, "Performance Standards, Remedies, and Disputes."

3.22.14. Audits (CMS Checklist I.I.2.40)

3.22.14.1. In accordance with 42 C.F.R. §438.242 and 438.602(e), EOHHS, or its designees will conduct no less than once every three years, with reasonable notice, any and all audit functions necessary to verify proper invoicing by the Contractor for provision of services, proper payments by EOHHS to the Contractor, and proper identification of TPL in accordance with this Agreement.

3.22.14.2. 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 the Contractor, EOHHS may either:

a) Make a demand for repayment of Overpayment amount within 30 Days.

b) Offset the amount of Overpayment payments.

3.22.14.3. EOHHS may also 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.

3.22.14.4. If audits discover underpayment to the Contractor, EOHHS will process a corrective payment within 30 Days.

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

3.22.14.6. In accordance with Section 3.27.9, "Financial Data Reporting," the Contractor shall submit audited financial reports specific to the Medicaid contract on an annual basis. The audit shall be conducted in accordance with generally accepted accounting principles (GAAP) and generally accepted auditing standards.

3.22.15. Reporting Requirements (CMS Checklist I.I.6.02-.04)

3.22.15.1. The Contractor shall submit monthly reports to EOHHS/Office of Program Integrity using EOHHS's MCO Program Integrity Report template and the Reporting Calendar in Managed Care Manual Chapter 11.

3.22.15.2. The Contractor's monthly report shall include:

a) The ongoing monthly running totals of recoveries associated with individual cases including payment of recoveries of Overpayments to the state in situations where the Contractor is not permitted to retain some or all of the recoveries of Overpayment. The monthly Program Integrity Report serves as the mechanism for reporting the total recoveries for all cases annually, including:
   - All audits or other cases involving suspected or confirmed Provider Waste and Abuse, including Overpayment determinations and recoupments.
   - All complaints, tips and cases that warranted a preliminary investigation and the disposition of those cases, including whether the case resulted in a Credible Allegation of Fraud and payment suspension investigations.
   - Information pertaining to payment suspensions.

b) Providers removed from the Contractor's Network, either for cause or at the request of the Provider.

c) As indicated in 42 C.F.R. § 455.17,the number of complaints of Fraud, Waste, and Abuse that warranted preliminary investigation. For each case of suspected provider Fraud, Waste, or Abuse that warrants a full investigation, the report also shall include:
   - The Provider's name and ID number;
   - The source of the complaint;
   - Type of Provider;
   - Nature of the complaint; Approximate range of dollars involved;
   - Legal and administrative disposition of the case including actions taken by law enforcement officials to whom the case has been referred.

d) Other information as requested by EOHHS/Office of Program Integrity.

3.22.15.3. In addition to the requirements described above, the Contractor shall submit an annual report on recoveries made by type of overpayment (to Subcontractors or providers), and recoveries made due to Fraud, Waste, and Abuse.

3.22.15.4. The Contractor shall notify EOHHS in writing no later than ten Days after it takes action to terminate or suspend a Provider based on Fraud, Waste, Abuse, or program integrity or quality concerns.

3.22.16. Notification of Changes in Enrollee Eligibility (CMS Checklist I.I.5.09)

3.22.16.1. The Contractor shall promptly notify EOHHS when it receives information about changes in a Member's eligibility including changes in residence or death.

3.22.17. Notification of Changes in Provider Eligibility (CMS Checklist I.I.I5.11)

The Contractor shall promptly notify the EOHHS using the EOHSS Provider Termination/Network Change Template when it receives information about a change in a Network Provider's circumstances that may affect the Network Provider's eligibility to participate in the Managed Care Program, including the termination of the Network Provider Agreement with the Contractor.

3.22.18. Mechanisms for Confidential Reports

The Contractor shall establish mechanisms, such as a hotline, for the confidential reporting of Contractor, Subcontractor, or Provider noncompliance including allegations of Fraud, Waste and Abuse and a clearly designated individual, such as the Chief Compliance Officer, to receive them. The Contractor shall create several independent reporting paths to report Fraud, Waste and Abuse so that such reports cannot be diverted by supervisors or other personnel.

3.22.19. Required Disclosures

3.22.19.1. As part of the program integrity function, the Contractor shall comply with the disclosure and reporting requirements described in Sections 3.1.17, "Prohibited Affiliations," and 3.1.18, "Disclosure of Contractor's Ownership and Control Interest." American Rescue and Recovery Act Notifications

3.22.19.2. The Contractor shall refer promptly to the Rhode Island Department of Administration, Department of Purchases, any credible evidence that a principal, employee, agent, contractor, sub grantee, Subcontractor, or other person has committed a criminal or civil violation of state or federal laws and regulations in connection with funds appropriated under American Rescue and Recovery Act.

3.22.20. Cooperation

As described in Section 3.23, "Records Retention, Audits, and Inspections," the Contractor shall cooperate and assist the State and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected Fraud, Waste or Abuse.

3.22. Program Integrity- Document History Log	
Contract Cross-References	• Attachment F-2, Article 9, Performance Standards, Remedies, and Disputes • Section 3.1, Contract Administration and Management • Section 3.23, Records Retention, Audit, and Inspection • Section 3.27, Financial Requirements • Managed Care Manual Chapter 11, Reporting Calendar and Templates
Governing Requirements and Authority	• Social Security Act §§ 1128, 1128A, 1128B • False Claims Act Sections 3279 through 3733 of Title 31, U.S.C • Chapter 38 of Title 31, U.S.C • 42 C.F.R. §§ 438.3(n), 438.242, 438.602(e), 438.608, 438.609, and 438.610 • 42 C.F.R. § 433.304 • 42 C.F.R. §§ 455.2, 455.17, 455.23, and 455.100-.104 • 42 C.F.R. §§ 456.3, 456.4, 456.23 • RI General Laws Section 40-8.2-22
CMS Checklist Items	• I.I.2. Requirements, Procedures and Reporting, Section I.I.2.39-.40 • I.I.5. Compliance Program, Sections I.I.5.01-.09, I.I.5.11-.15 • I.I.6. Treatment of Recoveries, Sections I.I.6.01-04
Revision Date and Description	

3.23. Records Retention, Audits, and Inspections

3.23.1. Records Retention (CMS Checklist I.J.1.06-.07, I.J.3.07)

3.23.1.1. The Contractor shall maintain all records relating to the administration of this Agreement, including documents and electronically stored information (collectively "Contract Records"). Contract Records include:

a) All financial statements and records relating to expenditures or transactions made pursuant to this Agreement.
b) Reports to EOHHS and source information used to prepare the reports.
c) Medical records.
d) Member and Provider materials.
e) Records relating to claims adjudication, payments, disputes, and appeals.
f) Records relating to Prior Authorization, clinical reviews, and other UM activities.
g) Records relating to quality of care.
h) Records relating to Member Grievances and Appeals.
i) MLR records.
j) Subcontracts and purchase orders.
k) Prescription files.

3.23.1.2. The Contractor shall have written policies and procedures for storing Contract Records.

3.23.1.3. The Contractor shall comply with all state and federal standards for record keeping, including:

a) 42 C.F.R. § 438.5(c), regarding base rate data.
b) 42 C.F.R. § 438.8(k), regarding MLR reports.
c) 42 C.F.R. § 438.416, regarding Member Grievance and Appeals records.
d) 42 C.F.R. §§ 438.604 through 438.610, regarding program integrity safeguards.

3.23.1.4. In accordance with 42 C.F.R. § 438.3(h), the Contractor shall preserve, maintain, and provide EOHHS and the entities described in Section 3.23.2.2 access to all Contract Records until ten years after the later:

a) The termination or expiration of this Agreement, or
b) The resolution of all litigation, claims, financial management reviews, or audits relating to the Agreement.

3.23.2. Access to Information (CMS Checklist I.C.9.01, I.J.1.01, I.J.01.04-.05, I.J.3.05)

3.23.2.1. Upon reasonable notice, the Contractor shall provide prompt, reasonable, and adequate access to all Contract Records. Requests may be for any purpose, including examination, audit, investigation, inspection, contract administration, or the making of copies, excerpts, or transcripts.

3.23.2.2. Access to Contract Records shall be provided to EOHHS or the following officials or entities, or their designees, at any time:

a) DHHS and the DHHS Inspector General;
b) Government Accountability Office;
c) CMS;
d) Comptroller General of the United States;
e) State Department of Health;
f) MFCU of the Rhode Island Department of Attorney General;
g) EOHHS Office of Program Integrity and Medicaid Compliance Unit;
h) A state or federal law enforcement agency;
i) The Auditor General of Rhode Island;
j) A special or general investigative committee of the Rhode Island Legislature; and
k) Any other entity identified in writing by EOHHS.

3.23.2.3. The Contractor shall provide access to Contract Records wherever they are maintained and in reasonable comfort. The Contractor shall provide furnishings, equipment, and other conveniences EOHHS deems reasonably necessary to fulfill the purposes described in this Section.

3.23.2.4. The Contractor shall provide the entities described in this Section access to and copies of Contract Records free of charge.

3.23.2.5. Upon request by a Member, the Contractor shall make available any reports provided to EOHHS or other agencies regarding transactions between the Contractor and parties in interest.

3.23.3. Inspections (CMS Checklist I.J.1.03, I.J.3.05, I.J.3.06)

3.23.3.1. The officials and entities described in Section 3.23.2 or their designees shall, during normal business hours, have the right to enter the Contractor's premises, physical facilities, or any place where duties under this Agreement are being performed, to audit, inspect, monitor, or otherwise evaluate the work being performed.

3.23.3.2. Inspections may include CMS or state-mandated operational and financial Health Plan reviews, determinations of compliance with this Agreement, and CMS or state-mandated independent evaluations. All inspections and evaluations will be performed in a manner that does not unduly interfere with or delay work.

3.23.4. Audits of Services and Deliverables (CMS Checklist I.J.1.06, I.J.3.06)

3.23.4.1. Upon reasonable notice from EOHHS, the Contractor shall provide the officials and entities described in Section 3.23.2 access to:

a) Service locations, facilities, or installations.
b) Contract Records, including the records of all Representatives.
c) Computers, electronic systems, software, and equipment.

3.23.4.2. The access described in this Section will be for the purpose of examining, auditing, investigating, or inspecting:

a) Contractor's capacity to bear the risk of potential financial losses.
b) The services and deliverables provided by Contractor.
c) Information relating to the Contractor's Members.
d) A determination of the amounts payable under this Agreement.
e) A determination of whether the costs reported under this Agreement are allowable.
f) An examination of Subcontract terms or transactions
g) An assessment of financial results under this Agreement.
h) Detection of Fraud, Waste, or Abuse.
i) Other purposes EOHHS deems necessary to perform its oversight function or enforce this Agreement.

3.23.4.3. The Contractor shall provide any assistance such officials and entities require to complete examinations, audits, investigations, or inspections.

3.23.4.4. EOHHS will notify the Contractor of payment errors and overcharges and is entitled to offset payments to the Contractor or to collect such funds directly from the Contractor.

3.23.4.5. Contractor shall return funds owed to EOHHS within 30 Days after receiving notice of an error or overcharge, or interest will accrue on the amount due. EOHHS will calculate interest at 12% per annum, compounded daily. If the interest rate stipulated hereunder is found by a court of competent jurisdiction to be outside the range deemed legal and enforceable, then the rate hereunder will be adjusted as little as possible so as to be deemed legal and enforceable.

3.23.4.6. If an audit reveals that errors in reporting by the Contractor have resulted in errors in payments to the Contractor, the Contractor shall indemnify EOHHS for any losses resulting from such errors, including the cost of audit.

3.23.5. Compliance with Audit Findings

3.23.5.1. The Contractor shall take corrective action with respect to any finding of noncompliance or deficiency contained in any audit, review, or inspection conducted under this Section. This action shall include Contractor's delivery to EOHHS, for EOHHS' approval, of a Corrective Action Plan that addresses noncompliance or deficiency findings within 30 Days of the close of the audit, review, or inspection.

3.23.5.2. The Contractor shall bear the expense of noncompliance or deficiency findings and corrective actions, including the cost of additional audit, review, or inspection activities EOHHS determines are necessary due to the noncompliance or deficiency.

3.23.5.3. The Contractor shall provide EOHHS a copy of the portions of the Contractor's and its Representative's internal audit reports relating to the services and

deliverables provided under this Agreement no later than five Business Days after the reports are complete.

3.23.6. Application to Representatives and Network Providers (CMS Checklist I.J.1.02, I.J.1.07, I.J.3.08)

3.23.6.1. The Contractor shall require Representatives and Network Providers to comply with this Article and include appropriate flow-down provisions in Subcontracts and Network Provider Agreements.

3.23.6.2. Contracts between the Contractor and Representatives shall provide that EOHHS and the entities described in Section 3.23.2 may inspect, evaluate, or audit the Representative at any time.

3.23.6.3. Contracts between the Contractor and any Subcontractor or other Representative shall require that if EOHHS, CMS or the DHHS Inspector General determines there is a reasonable possibility of Fraud or similar risk, EOHHS, CMS, or the DHHS Inspector General may inspect, evaluate, or audit the Subcontractor or Representative at any time.

3.23. Record Retention, Audits, and Inspections- Document History Log	
Contract Cross-References	Section 3.23, Records Retention, Audit, and Inspection
Authority	• 42 C.F.R. §§ 438.3(h), (k), and (u); 438.5(c); 438.8(k); 438.230(b) and (c); 438.416; 438.604; 438.606; • 42 C.F.R. § 439.610
CMS Checklist Items	• I.C.9, Sales and Transactions, Section I.C.9.01 • 1.J.1, Inspection, Sections I.J.1.01-.07 • 1.J.3, Subcontracts, Sections I.J.3.05-.08
Revision Date and Description	

3.24. Security and Confidentiality

3.24.1. Definitions

The following definitions apply to Section 3.24, "Security and Confidentiality:"

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

3.24.1.2. "Incident" is defined by OMB Memorandum M-17-12, "Preparing for and Responding to a Breach of Personally Identifiable Information" (January 3, 2017), as an occurrence that:

a) Actually or imminently jeopardizes, without lawful authority, the integrity, confidentiality, or availability of information or an information system; or

b) Constitutes a violation or imminent threat of violation of law, security policies, security procedures, or acceptable use policies.

3.24.1.3. "Confidential Information" means information that Contractor receives or has access to under this Agreement, including but not limited to; PII; SI; PHI; Return Information; other information (including electronically stored information) or records sufficient to identify an applicant for or recipient of government benefits; preliminary draft, notes, impressions, memoranda, working papers and work product of state employees; any other records, reports, opinions, information, and statements required to be kept confidential by state or federal law or regulation, or rule of court; any statistical, personal, technical and other data and information relating to the State's data; or other such data protected by state and federal laws, regulations.

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

mother's maiden name, criminal, medical and financial records, educational transcripts (as defined in 45 C.F.R. § 75.2, "Protected Personally Identifiable Information").

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

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

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

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

3.24.2. General Requirements

The Contractor shall take security measures to protect against the improper use, loss, access of and disclosure of any Confidential Information it may receive or have access to under this Agreement as required by this Agreement, or which becomes available to the Contractor in carrying out this Agreement. The Contractor agrees to comply with and require all Subcontractors and other Representatives to comply with, all state and federal requirements for safeguarding Confidential Information. All such information shall be held in strict confidence and protected by the Contractor from unauthorized use and disclosure using same or more effective procedural requirements as are applicable to the State.

3.24.3. Use and Disclosure of Individually Identifiable Information (CMS Checklist I.G.2.12)

The Contractor shall ensure its Representatives use and disclose individually identifiable health information, such as medical records and any other health or enrollment information that identifies a particular Member, in accordance with the confidentiality requirements described in this 3.24.2 of this Section and 45 C.F.R. Parts 160 and 164.

3.24.4. Privacy and Security Safeguards and Obligations (CMS Checklist I.J.2.02)

For all Confidential Information under this Agreement, the Contractor shall comply with the following privacy and security requirements and obligations:

3.24.4.1. Ensure that its Representatives implement the appropriate administrative, physical, and technical safeguards to protect Confidential Information received by Contractor under this Agreement from loss, theft or inadvertent disclosure.

a) Contractor shall advise all users who will have access to the Confidential Information of its confidential nature, the safeguards required to protect the Confidential Information, and the civil and criminal sanctions for noncompliance contained in applicable federal laws.

b) Contractor shall store the Confidential Information in an area that is physically and technologically secure from access by unauthorized persons during duty hours, as well as non-duty hours or when not in use (e.g., door locks, card keys, biometric identifiers, etc.). Only authorized personnel will transport the Confidential Information. Contractor shall establish appropriate safeguards for such Confidential Information, as determined by a risk-based assessment of the circumstances involved.

c) Contractor agrees that the Confidential Information exchanged under this Agreement shall be processed under the immediate supervision and control of authorized personnel, and to protect the confidentiality of the Confidential Information in such a way that unauthorized persons cannot retrieve any such Confidential Information by means of computer, remote terminal, or other means. Contractor personnel shall enter personal identification information when accessing Confidential Information on the State's systems. Contractor shall strictly limit authorization to those electronic Confidential Information areas necessary for authorized persons to perform his or her official duties.

d) Contractor shall advise all users that they are responsible for safeguarding Confidential Information at all times, regardless of whether or not the Contractor employee, subcontractor, or agent is at their regular duty station.

e) Contractor shall ensure laptops and other electronic devices/media containing Confidential Information that constitutes PII are encrypted and/or password protected.

f) Contractor shall ensure emails containing Confidential Information that constitutes PII are encrypted and sent to and received by email addresses of persons authorized to receive such information. In the case of FTI,

Contractor employees, subcontractors, and agents shall comply with IRS Publication 1075's rules and restrictions on emailing return information.

g) Contractor shall restrict access to the Confidential Information only to those authorized Contractor Representatives who need such Confidential Information to perform their official duties in connection with purposes identified in this Agreement; such restrictions shall include, at a minimum, role-based access that limits access to those individuals who need it to perform their official duties in connection with the uses of Confidential Information authorized in this Agreement ("Authorized Users"). Contractor shall not use or access Confidential Data for independent projects unrelated to the purposes identified in this Agreement. Further, the Contractor shall advise all Authorized Users who will have access to the Confidential Information provided under this Agreement of the confidential nature of the Confidential Information, the safeguards required to protect the Confidential Information, and the civil and criminal sanctions for noncompliance contained in the applicable federal laws. The Contractor shall require its Representatives and all contractors, agents, and all employees of such Representatives who are Authorized Users to comply with the terms and conditions set forth in this Agreement, and not to duplicate, disseminate, or disclose such Confidential Information unless authorized under this Agreement

h) For receipt of FTI, the Contractor agrees to maintain all return information sourced from the IRS in accordance with IRC § 6103(p)(4) and comply with the safeguards requirements set forth in IRS Publication 1075, which is the IRS published guidance for security guidelines and other safeguards for protecting return information pursuant to 26 C.F.R. § 301.6103(p)(4)-1.

3.24.4.2. The Contractor shall:

a) Establish a central point of control for all requests for and receipt of Return Information and maintain a log to account for all subsequent disseminations and products made with/from that information, and movement of the information until destroyed, in accordance with IRS Publication 1075.

b) Establish procedures for secure storage of return information consistently maintaining two barriers of protection to prevent unauthorized access to the information, including when in transit, in accordance with IRS Publication 1075.

c) Consistently label return information obtained under this Agreement to make it clearly identifiable and to restrict access by unauthorized individuals. Any duplication or transcription of return information creates new records which shall also be properly accounted for and safeguarded. Return information should not be commingled with other records unless the entire file is safeguarded in the same manner as required for return information and the FTI within is clearly labeled in accordance with IRS Publication 1075.

d) Restrict access to return information solely to Representatives whose duties require access for the purposes of carrying out this Agreement. Prior to access, the Contractor shall evaluate which personnel require such access on

a need-to-know basis. Authorized Users may only access return information to the extent necessary to perform services related to this Agreement, in accordance with IRS Publication 1075.

e) Prior to initial access to FTI and annually thereafter, the Contractor shall ensure Representatives that will have access to Return Information receive awareness training regarding the confidentiality restrictions applicable to the return information and certify acknowledgement in writing that they are informed of the criminal penalties and civil liability provided by sections 26 U.S.C. §§ 7213, 7213A, and 7431 for any willful disclosure or inspection of return information that is not authorized by the Internal Revenue Code, in accordance with IRS Publication 1075.

f) Contractor shall ensure information systems processing return information are compliant with Section 3544(a)(1)(A)(ii) of the Federal Information Security Management Act of 2002 (FISMA).

3.24.5. Ownership of Confidential Information

3.24.5.1. The Contractor expressly agrees and acknowledges that Confidential Information provided to and/or transferred by the State or to which the Contractor has access to for the performance of this Agreement is the sole property of the State and shall not be disclosed, used, misused, provided, or accessed by any other individuals, entities, or parties without the express written consent of the State. Further, the Contractor expressly agrees to forthwith return to the State all Confidential Information and/or databases upon the State's written request or upon cancellation or termination of this Agreement.

3.24.5.2. Confidential Information will remain the exclusive property of the State unless as otherwise provided for in any agreement and/or the Agreement between the State and Contractor; upon completion of the project and/or services, or whenever requested by the State, Contractor will promptly destroy or return to the State, in a form acceptable to the State, any and all Confidential Information and all copies thereof, including summaries, reports or notes based thereon, unless otherwise expressly authorized by the State in writing.

3.24.6. Compliance with Applicable Laws, Regulations, Policies, and Standards (CMS Checklist I.J.2.02)

3.24.6.1. The Contractor agrees to abide by, and require Representatives to abide by, all applicable, current and as amended federal and state laws, regulations, policies, guidance and standards governing privacy and the confidentiality of information to which it may have access to under this Agreement, including to but not limited to the Business Associate requirements of HIPAA (www.hhs.gov/ocr/hipaa) and 45 C.F.R. § 155.260. In addition, the Contractor agrees to comply with the state confidentiality policy recognizing a person's basic right to privacy and confidentiality of personal information.

3.24.6.2. The Contractor and its Representatives shall adhere to all applicable state and federal statutes and regulations relating to confidential health care and substance Abuse treatment including but not limited to:

a) 42 C.F.R. Part 2, regarding the confidentiality of substance use disorder patient records;
b) Rhode Island Mental Health Law, R.I. General Laws Chapter 40.1-5-26;
c) Confidentiality of Health Care Communications and Information Act, R.I. General Laws Chapter 5- 37.3-1 et. seq.;
d) Identity Theft Protection Act of 2015, R.I. General Laws Chapter 11-49.3; and
e) HIPAA and its implementing regulations.

3.24.6.3. The Contractor acknowledges that failure to comply with the provisions of this Section will result in remedies, including the termination of this Agreement.

3.24.6.4. In connection with all PII that Contractor receives or has access to under this Agreement, the Contractor and its Representatives shall comply with Minimum Acceptable Risk Standards for Exchanges ("MARS-E"), Version 2.0 dated November 15, 2015 which includes the following suite of documents:

a) Volume I: Harmonized Security and Privacy Framework;
b) Volume II: Minimum Acceptable Risk Standards for Exchanges;
c) Volume III: Catalog of Minimum Acceptable Risk Security and Privacy Controls for Exchanges; and
d) Volume IV: ACA Administering Entity System Security Plan.

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

3.24.7. Breach/Incident Reporting

Upon notice of a suspected or confirmed Incident or Breach, the State 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 Incident to determine the scope and duration of the third-party audit. If the Parties cannot agree on either the need for or the scope of such audit, then the matter shall be escalated to senior officials of each organization for resolution. The Contractor shall pay the costs of all such audits. Depending on the nature and scope of the Incident, remedies may include:

3.24.7.1. Providing information to individuals on obtaining credit reports and notification to applicable credit card companies.

3.24.7.2. Notification to the local office of the Secret Service and affected users and other applicable Parties.

3.24.7.3. Utilization of a call center.

3.24.7.4. Offering credit monitoring services on a selected basis.

3.24.8. Other

3.24.8.1. The Contractor agrees that no findings, listing, or information derived from information obtained through performance of this Agreement may be released or publicly disclosed in any form for any purpose if such findings, listing, or information contains any combination of data elements that might allow an individual to determine a beneficiary's identification without first obtaining written authorization from the EOHHS Managed Care Director. Examples of such data elements include, but are not limited to geographic indicators, age, sex, diagnosis, procedure, date of birth, or admission/discharge date(s). The Contractor agrees further that the State will be the sole judge as to whether any finding, listing, information, or any combination of data extracted or derived from the State's files identify or would, with reasonable effort, permit one to identify an individual, or to deduce the identifying of an individual to a reasonable degree of certainty.

3.24.8.2. The Contractor agrees that the conditions set forth herein apply to any materials presented or submitted review or publication that contain individual identifying elements in the information obtained, as stated above, unless such information is presented in the aggregate.

3.24.8.3. Under no circumstance will the Contractor publicly disclose or present or submit any materials for review or publication that contains an individual's social security number, in part or in whole.

3.24.8.4. The Contractor is hereby notified that all initial data received from EOHHS is considered confidential by the State.

3.24.8.5. Contractor shall inform the State of any change in its administrative, technical, or operational environment that would impact compliance with the terms of this Agreement, including but not limited to compliance with 45 C.F.R. § 155.260.

3.24.8.6. The Contractor shall monitor, periodically assess, and update its security controls and related system risks to ensure the continued effectiveness of those controls in accordance with 45 C.F.R. § 155.260(a)(5).

3.24.8.7. The Contractor shall not be required under the provisions of this Article to keep confidential any Confidential Information or information, which is or becomes legitimately publicly available or is rightfully obtained from third Parties under no obligation of confidentiality.

3.24.8.8. Contractor shall establish and maintain, throughout the term of this Agreement, policies and procedures to ensure the safekeeping of Confidential Information

and prevent unauthorized access to or use of such Confidential Information in compliance with ISO 27001 and ISO 27002 (or any replacement standard relating to information security), applicable regulatory requirements, and consistent with industry standards. In addition to its other obligations set forth in this Agreement, whenever Contractor possesses, stores, processes or has access to the State's Confidential Information, Contractor shall comply with those information security policies and procedures reasonably required by the State from time to time.

3.24.8.9. Nothing herein will limit the State's ability to seek injunctive relief or any and all damages resulting from the Contractor's negligent or intentional disclosure of Confidential Information.

3.24. Security and Confidentiality- Document History Log	
Contract Cross-References	
Governing Requirements and Authority	• 42 C.F.R. §§ 438.6(f)(1), 438.100(d), 438.208(b)(6), 438.224 • 42 C.F.R. Part 2 • 45 C.F.R. §§ 75.2, 155.260 • 45 C.F.R. Part 160, and Part 164 • OMB Memorandum M-17-12, "Preparing for and Responding to a Breach of Personally Identifiable Information" (January 3, 2017) • OMB Memorandum M-06-19, "Reporting Incidents Involving Personally Identifiable Information and Incorporating the Cost for Security in Agency Information Technology Investments" (July 12, 2006) • 26 U.S.C. § 6103(b)(2) • IRS Publication 1075 • FISMA Section 3544(a)(1)(A)(ii) • 26 C.F.R. § 301.6103(p)(4)-1 • 26 U.S.C. §§ 7213, 7213A, and 7431 • MARS-E, Version 2.0 (November 15, 2015) • 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.* • Identity Theft Protection Act of 2015, R.I. General Laws Chapter 11-49.3
CMS Checklist Sections	• I.G.2, Care Coordination, Section I.G.2.12 • I.J.2, Compliance with State and Federal Laws, Section I.J.2.02
Revision Date and Description	

3.25. General Reporting Requirements

3.25.1. Instructions (CMS Checklist I.I.2.13)

3.25.1.1. The Contractor and its Subcontractors shall comply with all reporting requirements described in this Agreement, including the Managed Care Manual.

3.25.1.2. Unless otherwise directed by EOHHS, reporting requirements relating to Members, or services provided to Members, include all eligibility groups described in Section 3.2, "Eligibility, Enrollment, and Disenrollment."

3.25.1.3. EOHHS will provide technical assistance regarding reporting requirements as needed.

3.25.1.4. Managed Care Manual Chapter 11, "Reporting Calendar and Templates," includes reporting requirements, templates, timeframes, and submission requirements. Unless otherwise indicated in the Reporting Calendar, reports are generally due within the following timeframes:

Report/Deliverable	Due Date
Daily Reports	Within two Business Days
Weekly Reports	Wednesday of the following week
Bi-Weekly Reports	5th and 20th Day of the month
Monthly Reports	Last Business Day of the following month
Quarterly Reports	Last Business Day of the month following the end of the quarter
Semi-Annual Reports	January 31 and July 31
Annual Reports	As specified by EOHHS
Ad Hoc/On Demand	As specified by EOHHS

3.25.1.5. As part of its QM/QI program, the Contractor shall review all reports and data submitted to EOHHS, including reports generated by Subcontractors. If the Contractor identifies instances or patterns of noncompliance with reporting requirements, it shall notify EOHHS of the errors, omissions, or deficiencies, and describe the corrective actions the Contractor is taking to resolve such issues.

3.25.1.6. EOHHS may require revisions to reports, including corrections to address errors, omissions, or deficiencies. EOHHS reserves the right to impose

contractual remedies, including liquidated damages, if the Contractor fails to comply with reporting requirements.

3.25.1.7. At its discretion, EOHHS may change the content, format, or frequency of reports, or require additional or ad hoc reports. The Contractor will have 30 Days to implement changes to reporting templates, unless otherwise indicated in EOHHS' notice of revision.

3.25.1.8. At EOHHS' request, the Contractor shall provide any other data, documentation, or information relating to its performance under this Agreement.

3.25. General Reporting Requirements- Document History Log	
Contract Cross-References	• Section 3.2, Covered Populations, Enrollment, and Disenrollment • Managed Care Manual Chapter 11, Reporting Calendar and Templates
Governing Requirement and Authority	
CMS Checklist Items	I.I.2, Requirements, Procedures, and Reporting, Section I.I.2.13
Revision Date and Description	

3.26. Claims Processing and Management Information Systems (MIS)

The obligations outlined in this Section will survive the termination of the Agreement.

3.26.1. General Requirements (CMS Checklist I.K.06, I.K.08)

3.26.1.1. The Contractor shall have a claims processing system and management information system (MIS) that collects, analyzes, integrates, and reports data. The system shall be sufficient to meet all Provider payment and reporting requirements described in this Agreement.

3.26.1.2. The Contractor shall ensure that all data received from Provider is screened for completeness, logic, and consistency.

3.26.1.3. The Contractor shall make all collected data available to EOHHS, and to CMS and upon request.

3.26.1.4. The Contractor shall ensure all data collected from providers is collected in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies used for EOHHS Medicaid quality improvement and Care Coordination efforts.

3.26.1.5. EOHHS will own the exclusive rights to all data produced or collected by the Contractor's claims processing and MIS system.

3.26.1.6. The Contractor shall ensure all Subcontractors performing claims or MIS system functions or related activities comply with the requirements in this Section.

3.26.2. Key Business Processes (CMS Checklist I.I.2.01, I.K.01-.03)

3.26.2.1. The Contractor's MIS shall include key business processing functions and/or features, which shall apply across all subsystems.

3.26.2.2. Key business functions shall include:

3.26.2.3. Collecting, analyzing, integrating, and reporting data, including data pertaining to utilization, claims, Grievances and Appeals, and disenrollment for reasons other than loss of Medicaid eligibility.

3.26.2.4. Operating claims processing and retrieval systems that are able to collect data elements necessary to enable mechanized claims processing and informed retrieval systems, as required by Section 6504(a) of the ACA and 42 C.F.R. § 438.242(b)(1). Electronic transmission of claims data shall be consistent with the Transformed Medicaid Statistical Information System (T-MSIS), including detailed individual Member Encounter Data and other information necessary for program integrity, program oversight and administration.

3.26.2.5. Processing electronic data transmission or media to add, delete or modify membership records with accurate begin and end dates.

3.26.2.6. Capturing and reporting Member data by race, ethnicity, language, and other demographic characteristics as specified by EOHHS.

3.26.2.7. Tracking Covered Services received by Members through the system, and accurately and fully maintaining those Covered Services as HIPAA-compliant encounter transactions.

3.26.2.8. Transmitting or transferring Encounter Data transactions on electronic media in the HIPAA format to EOHHS or its agent.

3.26.2.9. Maintaining a history of changes and adjustments and audit trails for current and retroactive data.

3.26.2.10. Maintaining procedures and processes for accumulating, archiving, and restoring data in the event of a system or subsystem failure.

3.26.2.11. Employing industry-standard medical billing taxonomies (procedure codes, diagnosis codes, NDC) to describe services delivered and encounter transactions produced.

3.26.2.12. Supporting the coordination of benefits and recoveries from responsible third-parties.

3.26.2.13. Producing standard EOBs for Providers.

3.26.2.14. Supporting mechanized claims processing and paying financial transactions to Subcontractors, Network Providers, and Out-of-Network Providers in compliance with Governing Requirements.

3.26.2.15. Ensuring all financial transactions are auditable according to GAAP guidelines.

3.26.2.16. Relating and extracting data elements to produce reports required by CMS or EOHHS.

3.26.2.17. Ensuring written process and procedures manuals document and describe all manual and automated system procedures and processes for the MIS.

3.26.2.18. Maintaining and cross-referencing all Member-related information with the most current Medicaid Provider number.

3.26.3. Provider Preventable Conditions (CMS Checklist I.F.7.01-02)

3.26.3.1. The Contractor shall require all Providers to report Provider Preventable Conditions associated with claims for payment or Member treatments for which payment would otherwise be made.

3.26.3.2. See Article 2, “Definitions” for a description of Provider Preventable Conditions, including the criteria for and Health Care Acquired Conditions and Other Provider Preventable Conditions.

3.26.4. HIPAA Compliance

3.26.4.1. The Contractor’s MIS system shall comply with operational and information system requirements of HIPAA, including data specification and reporting requirements; issuing applicable certificates of creditable coverage when coverage is terminated; and reporting requested data to EOHHS or its designee.

3.26.4.2. All transactions and code sets exchange with EOHHS or its designee shall comply with the appropriate standard formats specified under HIPAA.

3.26.5. National Correct Coding Initiatives (NCCI)

The Contractor shall comply with the requirements of Section 6507 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), regarding "Mandatory State Use of National Correct Coding Initiatives," including all applicable rules, regulations, and methodologies, as amended or modified, in accordance with EOHHS policy.

3.26.6. Claims Processing

3.26.6.1. The Contractor shall administer an effective, accurate, and efficient claims payment process that complies with this Agreement and Governing Requirements.

3.26.6.2. The Contractor shall process all claims in accordance with the benefit limits and exclusions set forth in the Rhode Island Medicaid State Plan and the terms of this Agreement.

3.26.6.3. The Contractor cannot directly or indirectly charge or hold a Member or Provider for claims adjudication or transaction fees.

3.26.7. Timely Payment (CMS Checklist I.D.6.01)

The Contractor shall pay all claims timely in accordance with the following standards:

3.26.7.1. Clean Claims shall be paid within 30 Days of receipt.

3.26.7.2. Timely payment is judged by the date that the Contractor receives the claim as indicated by its date stamped on the claim. The date of payment is the date of the check or other form of payment.

3.26.7.3. The Contractor is subject to contractual remedies, including liquidated damages, if it fails to meet the following performance standards:

a) 90% of all Clean Claims shall be paid within 30 Days of the date of receipt.
b) 99% of all Clean Claims shall be paid within 90 Days of the date of receipt.

3.26.8. Date of Receipt and Payment (CMS Checklist I.D.6.02)

The Contractor shall ensure that the date of receipt is the date the Contractor receives the claim, as indicated by its date stamp on the claim; and that the date of payment is the date of the check or other form of payment.

3.26.9. Timely Filing

The Contractor shall establish a written policy regarding timely filing of Subcontractor and Provider claims for payment. The timeframe for timely filing a claim shall not be greater than 90 Days from the date of service.

3.26.10. Denial of Payment

The Contractor may deny a claim submitted by a Provider for failure to file in a timely manner in accordance with the Contractor's written policy.

3.26.11. Payment Withholds

The Contractor shall withhold all or part of payment for any claim submitted by a Provider:

3.26.11.1. Debarred, suspended, or otherwise excluded from the Medicare, Medicaid, or CHIP programs for Fraud, Waste, or Abuse.

3.26.11.2. On payment hold under the authority of EOHHS or its authorized agents.

3.26.11.3. With debts, settlements, or pending payments due to EOHHS, or the state or federal government.

3.26.12. Penalties

The Contractor is subject to contractual remedies, including liquidated damages and interest, if the Contractor does not process and adjudicate claims in accordance with the procedures and the timeframes listed in this Agreement.

3.26.13. Electronic Data Interchange (EDI)

The Contractor shall offer its Providers and Subcontractors the option of submitting and receiving claims information through an electronic data interchange (EDI) that allows for automated processing and adjudication of claims. EDI processing shall be offered as an alternative to the filing of paper claims. Electronic claims shall use HIPAA-compliant electronic formats.

3.26.14. Electronic Funds Transfer (EFT)

The Contractor shall make an electronic funds transfer payment process for direct deposit available to Network Providers.

3.26.15. Provider Portal

The Contractor shall provide a Provider portal, at no cost to Providers, that supports functionality to reduce administrative burden on Network Providers. To the greatest extent possible, the Provider portal functionality should support both online and batch processing as applicable to the information being exchanged. To facilitate the exchange of clinical data and other relevant documentation, the Provider Portal shall provide a secure exchange of information between the Provider and Contractor, including, as applicable, a Subcontractor.

3.26.16. Audits

The Contractor shall conduct periodic audits of Provider claims in accordance with its Compliance Plan described in Section 3.22.2.

3.26.17. Claims System Changes

The Contractor shall notify EOHHS of major claim system changes in writing no later than 180 Days prior to implementation. The Contractor shall provide an implementation plan and schedule of proposed changes. EOHHS reserves the right to require a desk or onsite Readiness Review of the changes.

3.26.18. Policies Affecting Claims Adjudication

The Contractor shall make any policies affecting claims adjudication and claims coding and processing guidelines available to Providers for the applicable Provider type. Providers shall receive 90 Days' notice prior to the Contractor's implementation of changes to these claims policies and guidelines.

3.26.19. Inappropriate Payment Denials or Recoupments

3.26.19.1. If the Contractor has a pattern, as determined by EOHHS, of inappropriately denying, delaying, or recouping Provider payments for services, the Contractor may be subject to contractual remedies, including:

a) Suspension of new enrollments;
b) Monetary penalties equal to 150% of the value of the claims; inappropriately denied, delayed, or recouped;
c) Termination of this Agreement; and
d) Disqualification from future contract awards.

3.26.19.2. This Section applies not only to situations where EOHHS has ordered payment after a provider's claims payment appeal but also to situations where no appeal has been made (i.e., EOHHS is knowledgeable about the documented abuse from other sources).

3.26.20. Encounter Data Reporting (CMS Checklist I.I.2.01, I.K.04, I.K.07-.08, I.K.09-.12)

3.26.20.1. In accordance with 42 C.F.R. § 438.242(c), the Contractor shall submit complete, accurate, and timely Encounter Data for all services for which the Contractor has incurred any financial liability, whether directly or through Subcontracts or other arrangement.

3.26.20.2. The Contractor shall:

a) Collect and maintain sufficient Member Encounter Data to identify:
- Any items or services provided to Members and the identity of the Provider who furnished them;
- The allowed amount and paid amount;
- Member and Provider characteristics; and
- Any other data as specified by EOHHS or CMS based on program administration, oversight and program integrity needs or that EOHHS is required to report to CMS under 42 C.F.R. § 438.818.

b) Collect data from Providers in standardized formats to the extent feasible and appropriate.
c) Submit encounter data in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format, as appropriate.
d) Collect and submit all Subcontractor Encounter Data.
e) Comply with the procedures and requirements for data reporting, submission, and accuracy in the EOHHS guidance document "Rhode Island Medicaid Managed Care Encounter Data Quality, Thresholds and Penalties for Non-Compliance" (the "EOHHS Encounter Data Guidance") in Managed Care Manual Chapter 4, "Claims and Management Information Systems."
f) Make all collected data available to EOHHS and upon request, to CMS.

3.26.20.3. EOHHS reserves the right to make changes to the EOHHS Encounter Data Guidance at any time, and the Contractor shall implement those changes within the time specified by EOHHS.

3.26.21. Timeliness and Frequency Requirements (CMS Checklist I.K.09-.12)

3.26.21.1. The Contractor shall submit all specified Encounter Data at an agreed upon cadence with EOHHS.

3.26.21.2. Encounter data shall be submitted within 45 Days of the claim's paid date.

3.26.22. OMB Standards for Collecting and Reporting Demographic Data

3.26.22.1. In accordance with 42 U.S.C. § 300kk, the Contractor must be able to collect and report data on race, ethnicity, sex, primary language, and disability status.

3.26.22.2. The Contractor shall develop procedures to collect this information from Members or their legally Authorized Representatives.

3.26.22.3. The Contractor shall comply with the Office of Management and Budget (OMB) standards for data collection for race and ethnicity.

3.26.23. Accuracy (CMS Checklist I.K.05., I.K.06)

3.26.23.1. The Contractor shall ensure that the Encounter Data received from Subcontractors and Providers is accurate and complete by:

a) Verifying the accuracy and timeliness of reports date, including data from Network Providers the Contractor is compensating on the basis of capitation or APM payments.
b) Screening for completeness, logic, and consistency.
c) Attesting to the accuracy of each submission to the State.

3.26.23.2. The Contractor shall comply with standards for Encounter Data completeness, accuracy and timeliness in the EOHHS Encounter Data Guidance.

3.26.23.3. Contractor is responsible for reconciling Financial Data Cost Report cost allocations and the File Submission Report in accordance with the standards and requirements set forth in the EOHHS Encounter Data Guidance.

3.26.23.4. The Contractor shall cooperate and assist EOHHS to validate that the Contractor's Encounter Data is a complete and accurate representation of the services provided to Members under this Agreement by producing records, including samples of medical records and claims data upon request.

3.26.23.5. The Contractor is solely responsible for ensuring that its Subcontractors are in compliance with EOHHS' data submission and reporting requirements as described in this Agreement and the EOHHS Encounter Data Guidance.

3.26.24. All Payer Claims Database

3.26.24.1. The Rhode Island All Payer Claims Database (RI-APCD), is a repository of healthcare insurance payment information for people living in Rhode Island. The data will come from the major health insurance companies doing business

in Rhode Island, including fully insured and self-funded commercial plans, Medicare, and Medicaid. The development of the RI-APCD is a collaborative effort amongst the Rhode Island Department of Health, the Office of the Health Insurance Commissioner, the Health Benefits Exchanges, and the Executive Office of Health and Human Services.

3.26.24.2. Pursuant to RI General Laws § 23-17.17-10, the Contractor shall submit timely data exchange files to the RI-APCD according to the schedule established by the RI-APCD.

3.26.25. Penalties for Non-Compliance

3.26.25.1. At the discretion of EOHHS, the Contractor may be subject to penalties as set forth in the "Rhode Island Medicaid Managed Care Encounter Data Quality Measurement, Thresholds and Penalties for Non-Compliance" document.

3.26.25.2. For non-compliance with the standards for encounter data completeness, accuracy and timeliness that are incorporated by reference into this contract at Section 3.26.20, penalties shall be imposed in accordance with the procedures set forth in the EOHHS Encounter Data Guidance.

3.26.25.3. Failure of a Health Care Provider or Subcontractor to provide the Contractor with necessary Encounter Data will not excuse the Contractor's noncompliance with the encounter data requirements.

3.26.26. Financial Sanctions

EOHHS will request the Contractor submit a Corrective Action Plan when areas of noncompliance are identified. EOHHS may assess financial sanctions as provided in EOHHS Encounter Data Guidance based on the identification of instances of non-compliance.

3.26.27. Encounter Data Meetings

The Contractor shall participate in regular meetings with the State concerning Encounter Data reporting and submission and shall submit reports to the State as requested.

3.26.28. RIte Share Reporting

If the Contractor has an active non-Medicaid product, the Contractor shall provide claims-based data to EOHHS for any RIte Share Member enrolled and identified by EOHHS; provided however, that nothing in this Section nor in any other provision of this Agreement will be interpreted to require the Contractor to participate in RIte Share.

3.26. Claims Processing and Management Information Systems (MIS)- Document History Log	
Contract Cross-References	• Section 3.22, Program Integrity, Fraud, Waste, and Abuse • Managed Care Manual Chapter 4, "Claims and Management Information Systems"
Governing Requirement and Authority	• SSA §§ 1902(a)(37)(A) and 1932(f) • Health Insurance Portability and Accountability Act (HIPAA) of 1966, P.L. 104-191 • Patient Protection and Affordable Care Act of 2010 (PL 111-148) • 42 C.F.R. 434.6(a)(12) • 42 C.F.R. §§ 438.2, 438.3(g), 438.242(a)-(c) • 42 C.F.R. §§ 447.26(d), 447.45(d), 447.46
CMS Checklist Items	• I.D.6, Timely Payment, Sections I.D 6.01-.02 • I.F.7, Provider Preventable Conditions, Section I.F.7.01-.02 • I.I.2, Compliance with State and Federal Laws, Sections I.I.2.01, I.I 2.04, I.I 2.07-.12 stop • I.K, Health Information Systems and Enrollee Data, Sections I.K.01-.12
Revision Date and Description	

3.27. Financial Requirements

3.27.1. Third-Party Liability (CMS Checklist I.J.4.01)

3.27.1.1. Rhode Island Medicaid will be the payor of last resort for all Covered Services, unless otherwise required by federal laws or regulations.

3.27.1.2. Third-Party Liability ("TPL") refers to the legal obligation of any third-party entity or health insurance program, including health insurers, self-insured plans, group health plans (as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by law, contract, or agreement, responsible for payment of a claim for a Member's health care item or service.

3.27.1.3. Under Section 1902(a)(25) of the Social Security Act, EOHHS and the Contractor are required to take all reasonable measures to identify legally liable third parties and treat verified TPL as a resource of the Medicaid recipient.

3.27.1.4. The Contractor agrees to take primary responsibility for identifying, collecting, and reporting TPL coverage and collection information to EOHHS on a weekly basis. As TPL information is a component of Capitation Rate development, the Contractor shall maintain records regarding TPL collections and shall report these collections to EOHHS in the timeframe and format determined by EOHHS, in accordance with Section 3.27.9, "Financial Data Reporting."

3.27.1.5. The projected amount of third-party recovery that the Contractor is expected to recover may be factored into the rate setting process.

3.27.1.6. The Contractor shall designate one contact person for TPL matters.

3.27.1.7. The Contractor shall develop and maintain a TPL Policy. In accordance with Attachment F-1, Section 3.27.1, "Third Party Liability," the Contractor shall submit the TPL Policy for EOHHS review and approval within 90 Days of the execution of this Agreement. The Contractor shall submit the TLP annually thereafter and upon EOHHS' request. In the event of modification of the TPL Policy, the Contractor shall submit TPL Policy amendments to EOHHS for review and approval at least 90 Days before the proposed effective date.

3.27.1.8. When the Contractor is aware of other insurance coverage prior to paying for a Covered Service for a Member, it should avoid payment by rejecting a provider's claim and direct the provider to submit the claim to the appropriate third party. The Contractor shall follow exceptions to cost avoidance as outlined in 42 C.F.R. § 433.139.

3.27.1.9. The Contractor shall collect and retain all TPL collections. The Contractor shall document cost recovery and cost adjustment through the encounter data reporting process, including denials. All claims subject to "pay and chase" shall be reported to EOHHS on a monthly basis in accordance with Section 3.27.9, "Financial Data Reporting," and shall include current recovery efforts.

3.27.1.10. The Contractor shall obtain recovery of payment from a liable third party and not from the provider unless the provider received payment from both the Contractor and the liable third party.

3.27.1.11. The Contractor will have 365 Days from the original paid date to recover funds from the third-party entity. If funds have not been recovered by that date, EOHHS has the sole and exclusive right to pursue, collect and retain those funds.

3.27.1.12. The Contractor shall cooperate with EOHHS in the implementation of RI General Laws 40-6-9.1 by participating in the matching of data available to EOHHS and to the Contractor through an electronic file match. The matching of such data is critical to the integrity of the Medicaid program and the use of public funds. Requests made of the Contractor by EOHHS will be made at such intervals as deemed necessary by EOHHS to participate in the data matching. The Contractor shall respond with the requested data within five Business Days.

3.27.1.13. EOHHS will review the effectiveness of the Contractor's TPL recovery programs annually and may revoke TPL activities from the Contractor if the recovery programs do not meet the effectiveness criteria defined by EOHHS in Managed Care Manual Chapter 5, "Financial Requirements."

3.27.2. Reinsurance (CMS Checklist I.D.1.03)

3.27.2.1. The Contractor shall obtain reinsurance coverage from a source other than EOHHS. Proof of such reinsurance is a condition of contract award. The Contractor shall purchase reinsurance to protect against the financial risk of high-cost individuals and shall submit to EOHHS a complete copy of the reinsurance agreement. The Contractor shall submit new policies and insurance certificates, renewals, or amendments to EOHHS for review and approval at least 90 Days before becoming effective. The submitted copy shall include the following specifications and parameters:

a) Name of reinsurance carrier.
b) Services covered under reinsurance contract.
c) Specific stop loss threshold (deductible/retained liability).
d) Aggregate stop loss threshold (if applicable).
e) Coinsurance after stop loss threshold (if applicable).
f) Reinsurance maximum (if applicable).
g) Experience refund provisions (if applicable).
h) Coverage period.
i) Reinsurance premium amounts and structure.

3.27.2.2. The Contractor shall maintain the following set of minimum specifications and parameters for specific stop loss reinsurance unless otherwise approved by EOHHS:

a) The deductible shall be no more than $500,000.
b) The coinsurance after the deductible is no more than 20%.

c) The reinsurance maximum shall be at least $2,000,000.

d) At a minimum, the reinsurance contract shall cover inpatient services.

3.27.2.3. For purposes of this Section, "coinsurance" means the percentage the Contractor shall pay for covered losses after the Contractor's deductible has been paid. Coinsurance payments will not exceed the maximum reinsurance set forth in this Agreement.

3.27.2.4. EOHHS reserves the right to require changes to a reinsurance arrangement.

3.27.2.5. The Contractor shall maintain the reinsurance arrangement and submit any proposed changes to EOHHS for review and approval. EOHHS may require additional protections and documentation at any time.

3.27.2.6. EOHHS reserves the right to revisit reinsurance requirements annually and to modify the reinsurance specification and parameters required if a change is deemed warranted by EOHHS. The Contractor may not change the thresholds from those in the Contractor's approved insurance certificates without the prior written consent of EOHHS.

3.27.2.7. Reinsurance agreements will transfer risk from the Contractor to the reinsurer. The Contractor may request alternative reinsurance arrangements; however, EOHHS will maintain the sole discretion to determine if other forms of reinsurance are acceptable. EOHHS also may require other forms of security in addition to reinsurance. These other security tools may include parent company guarantees, letters of credit, or performance bonds. In determining whether the request will be approved, EOHHS may consider any or all of the following:

a) Whether the Contractor has sufficient reserves available to pay unexpected claims.

b) The Contractor's history in complying with financial indicators as specified in this Agreement.

c) The number of Members covered by the Contractor.

d) How long the Contractor has provided coverage for Medicaid Members (separately for Rhode Island and other contracts).

e) Financial metrics, such as risk-based capital ratios, from financial statements submitted to EOHHS.

f) Review of historical and projected claims distributions relative to the current and proposed reinsurance parameters.

3.27.3. Financial Benchmarks

3.27.3.1. The success of the Rhode Island Medicaid Managed Care program is contingent on the financial stability of participating Health Plans. As part of its oversight activities, the State has established financial viability criteria, or benchmarks, to be used in measuring and tracking the fiscal status of Health Plans.

3.27.3.2. In accordance with Section 3.27.9, "Financial Data Reporting," the Contractor shall provide documentation on a regular basis that it is financially solvent and

has the capital, financial resources, and management capability to operate under this risk-based contract and comply with the terms outlined in this Agreement.

3.27.3.3. The Contractor shall demonstrate to EOHHS that it is able to meet the solvency requirements set forth through the Rhode Island Office of the Health Insurance Commissioner (OHIC). EOHHS will not grant exceptions to minimum OHIC standards.

3.27.3.4. The Contractor shall provide all the information necessary for calculating financial benchmark levels. EOHHS may impose contractual remedies, including corrective action plans and liquidated damages, if the Contractor fails to meet financial benchmarks.

3.27.4. Financial Disclosures

3.27.4.1. Upon EOHHS' request, the Contractor shall disclose all financial terms and arrangements for payment of any kind that apply between the Contractor or the Subcontractor and any provider of a Medicaid service, except where federal or state law restricts disclosing the terms and arrangements. EOHHS acknowledges such information may be considered confidential and proprietary and thus will be held confidential by EOHHS to the extent allowed under Rhode Island law.

3.27.4.2. If applicable, the Contractor and Subcontractor shall narrowly designate portions of any agreement as proprietary information that should not be otherwise disclosed, except to EOHHS and its designees. Portions of any agreement designated as proprietary information will be limited to the portions that consist of unique business or pricing structures that a competitor may or would likely use to gain an unfair market advantage over the Contractor or Subcontractor. Proprietary designations in every agreement shall be limited consistent with the foregoing. Every portion of an agreement that is not designated as proprietary will be deemed to be a public record.

3.27.5. Limits on Payments to Associated Providers and Subcontractors

3.27.5.1. For any provider or Subcontractor associated with the Contractor, the Contractor shall not pay more for services rendered by the associated entity than it pays for similar services rendered by providers and Subcontractors not associated with the Contractor. For purposes of this Section, "associated with" means providers or Subcontractors that have an indirect ownership interest or ownership or control interest in the Contractor, an affiliate of the Contractor, or the Contractor's management company. The term "associated with" also includes providers or Subcontractors that the Contractor, an Affiliate of the Contractor, or the Contractor's management company has an indirect ownership interest or ownership or control interest in. The standards and criteria for determining indirect ownership interest, an ownership interest or a control interest are set out at 42 C.F.R. Part 455, Subpart B.

3.27.5.2. Any payments made by the Contractor that exceed the limitations set forth in this Section are considered non-allowable payments and shall be excluded from medical expenses and administrative expenses reported in the MLR report. This

restriction does not apply to Value-Added Service or cost-effective alternatives to Covered Services, which may be considered medical expenses.

3.27.5.3. In accordance with financial reporting requirements described below, the Contractor shall submit information on payments to related providers and Subcontractors. This information shall include claims and administrative expenses paid to the provider or Subcontractor.

3.27.6. Restriction on Payments to Related Entities

3.27.6.1. With the exception of payment of a claim, the Contractor shall not pay money or transfer any assets for any reason to a Related Entity without prior approval from EOHHS, if any of the following criteria apply:

3.27.6.2. The Contractor's risk-based capital (RBC) ratio was below the requirement in Section 3.27.3 as of December 31 of the most recent year for which the due date for filing the annual financial report has passed.

3.27.6.3. Subsequent adjustments are made to the Contractor's financial statement as the result of an audit, or are otherwise modified, such that after the transaction took place, a final determination is made that the Contractor was not in compliance with the RBC standards in Section 3.27.3. In this event, EOHHS may require repayment of amounts involved in the transaction.

3.27.6.4. EOHHS may elect to waive the requirements of this Section.

3.27.7. Related Entity Affiliations

3.27.7.1. The Contractor may not include a Related Entity hospital, FQHC, or other provider in its Network unless the Related Entity and all provider sites and clinics owned or controlled by the Related Entity are included in the network of another Health Plan contracted with EOHHS.

3.27.7.2. EOHHS may waive this requirement if it determines sufficient number of Health Plans are unwilling to contract with the provider at reasonable terms.

3.27.7.3. By way of example, this prohibition applies when the Related Entity arrangement is carried out through one or more unrelated parties.

3.27.8. Disclosure of Changes in Circumstances

3.27.8.1. The Contractor shall notify EOHHS and OHIC of any change in circumstances that may have a material adverse effect upon financial or operational conditions of the Contractor or a Related Entity. The Contractor shall provide the notice within ten Business Days of an event triggering the change in circumstance. By way of example, notice is required for the following events related to the Contractor or its parent company, or any Related Entity of either:

a) Suspension, debarment, or exclusion by any state or the federal government.
b) Suspension, debarment. or exclusion of a director, officer, partner, or person with beneficial ownership of more than 5% of the Contractor's equity.
c) Notice of a state or federal government's intent to suspend, debar, or exclude. In addition the Contractor, Contractor's parent, and any Related

Entity of either, this requirement applies to notices relating to any individuals with employment, consulting, or other arrangements that are material and significant.

d) Any new or previously undisclosed lawsuits or investigations by any federal or state agency that may have a material impact upon the Contractor's financial condition or ability to perform under this Agreement.

3.27.9. Financial Data Reporting (CMS Checklist I.I.2.02-.05)

3.27.9.1. The Contractor shall comply with all reporting requirements set forth in this Section, as well as the detailed requirements set forth in Managed Care Manual Chapter 5, "Financial Requirements." The Contractor shall submit all reports and required data completely and accurately within the specified timeframes established in Managed Care Manual Chapter 10, "Reporting Calendar and Templates." Such compliance includes submitting the following reports:

a) National Association of Insurance Commissioners (NAIC) Financial Statements, including Risk Based Capital Reports;
b) The Contractor's Audited Financial Statements;
c) The Contractor shall submit audited financial reports specific to the Managed Care Program on an annual basis. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.
d) The Contractor's Report to Owners, Shareholders, Members, and Others;
e) Company's General Liability and Directors' and Officer's Insurance Coverages;
f) Claims Reinsurance Coverage and attachment points;
g) Where applicable, evidence that the parent company provides 100% of subsidiary's financial backing;
h) Minimum Loss Ratio (MLR) Statement using the MLR template provided by EOHHS;
i) Financial Data Cost Reports;
j) Identification of Third-Party Liability;
k) Third-Party Liability collections, cost recoveries, and cost adjustments;
l) Accountable Entity Shared Savings Financial Performance Report;
m) Accountable Entity Total Cost of Care Historical Base Data Reports;
n) Accountable Entity Total Cost of Care Quarterly Performance Year Reports; and
o) Any other additional reports required due to special circumstances, studies, analyses, audits, and significant changes in the Contractor's financial position or performance.

The Contractor agrees to comply in a timely and complete manner with all financial reporting requirements associated with the Accountable Entity Initiative as described in Section 3.15.

3.27.10. Medical Loss Ratio Reporting (CMS Checklist I.D.4.01. I.D.4.14, I.D.4.30, I.I.2.03, I.L.5.10)

3.27.10.1. The Contractor shall submit annual consolidated Medical Loss Ratio (MLR) reports in accordance with Managed Care Manual Chapter 5, "Financial Requirements."

3.27.10.2. The Contractor shall comply with the MLR reporting standards described in 42 C.F.R. § 438.8 and any EOHHS directives required to satisfy the MLR requirements outlined in 42 C.F.R. § 438.74. EOHHS directives may include additional state-specific criteria or adjustments to the MLR calculation methodology or reporting instructions.

3.27.10.3. The Contractor shall submit MLR Reports by the earlier of the EOHHS deadline or within 12 months of the end of the reporting year. EOHHS may also require interim reporting on a more frequent basis.

3.27.10.4. The MLR report shall include the following items:

a) Total incurred claims;
b) Expenditures on quality improving activities;
c) Expenditures related to activities compliant with program integrity requirements;
d) Non-claims costs;
e) Premium revenue;
f) Taxes;
g) Licensing fees;
h) Regulatory fees;
i) Methodology for allocation of expenditures;
j) Any credibility adjustment applied;
k) The calculated MLR;
l) Any remittance owed to the state, if applicable;
m) A comparison of the information reported with the audited financial report;
n) A description of the aggregation method used to calculate total incurred claims; and
o) The number of Member months.

3.27.10.5. Following submission of each MLR Report, EOHHS will provide either an acceptance or a request for additional information or reconciliation. The Contractor shall submit a good faith response in the timeframe specified in the EOHHS request. Failure to respond to these requests or to make required corrections within the timeline requested may result in contractual remedies, including corrective action or liquidated damages. EOHHS has the authority to determine when the MLR Report is final for purposes of submission to CMS and the calculation of any remittance payments. In the event the Contractor's response takes longer to be submitted than the timeframe specified by EOHHS, EOHHS may, at its discretion, move forward to a final settlement of the

Contractor's MLR reports without regard to any additional data the Contractor provides.

3.27.10.6. The Contractor is responsible for complete and accurate MLR reporting as specified in 42 C.F.R. § 438.8 and should rely on their own consultants and advisors to ensure compliance with these requirements. The acceptance of an MLR Report as final by EOHHS does not constitute a waiver of this requirement.

3.27.11. Minimum Medical Loss Ratio Remittance (CMS Checklist I.D.4.02, I.D.4.14)

3.27.11.1. EOHHS requires an MLR remittance, as outlined in 42 C.F.R. § 438.8(j), for Contractors with an MLR as calculated in the MLR Report accepted by EOHHS of less than 86%. The MLR used for purposes of calculating a remittance will be calculated in aggregate across all eligibility groups in the Medicaid Managed Care Program.

3.27.11.2. If the calculated MLR is less than 86%, the Contractor shall remit the difference between the minimum MLR of 86% and the calculated MLR multiplied by the revenue paid to the Contractor during the contract year.

3.27.11.3. Fifty percent of the calculated total remittance, up to a maximum of 2% of the revenue paid to the Contractor during the contract year, will be expended for community reinvestment purposes as defined in Attachment F-1, Article 1, Definitions, EOHHS reserves the right to approve or reject the Contractor's community reinvestment plan, which shall be submitted within 60 Days after EOHHS accepts the submitted MLR. The community reinvestment shall be paid within 365 Days after EOHHS's approval of the plan. As community reinvestment expenditures are a component of the MLR remittance, they will not qualify as expenses reported in the numerator of the MLR calculation in subsequent MLR reporting periods.

3.27.11.4. The remaining remittance amount (total remittance less community reinvestment expenditures) shall be returned to EOHHS. The Contractor shall pay the remittance to EOHHS within 60 Days after EOHHS accepts the submitted MLR.

3.27.12. Calculating the Medical Loss Ratio (CMS Checklist I.D.4.03-.34)

3.27.12.1. The MLR calculation for the Contractor is the ratio of the numerator (as defined in accordance with 42 C.F.R. § 438.8(e)) to the denominator (as defined in accordance with 42 C.F.R. § 438.8(f)).

3.27.12.2. Each Contractor expense shall be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense shall be prorated between types of expenses.

a) Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, shall be reported on pro rata basis.

b) The Contractor's expense allocation shall be based on a generally accepted accounting method that is expected to yield the most accurate results.

c) Shared expenses, including expenses under the terms of a management contract, shall be apportioned pro rata to the contract incurring the expense.

d) Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, shall be borne solely by the reporting entity and are not to be apportioned to the other entities.

3.27.12.3. The Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible.

a) The credibility adjustment is added to the reported MLR calculation before calculating any remittances, if required by the state.

b) The Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

c) If the Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

3.27.12.4. The Contractor shall aggregate data for all Medicaid eligibility groups covered under this Agreement unless otherwise indicated by EOHHS.

3.27.12.5. The Contractor shall require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 Days of the end of the MLR reporting year or within 30 Days of being requested by EOHHS or the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

3.27.12.6. If EOHHS makes a retroactive change to the Capitation Payments for a MLR reporting year where the MLR report has already been submitted to EOHHS, the Contractor shall:

a) Recalculate the MLR for all MLR reporting years affected by the change; and

b) Submit a new MLR report meeting the applicable requirements.

3.27.12.7. The Contractor shall attest to the accuracy of the MLR calculation in accordance with the MLR standards when submitting the required MLR reports.

3.27.13. SOBRA Reporting

SOBRA related expenses are to be reported using the format specified in Managed Care Manual, Chapter 4, "Claims and MIS Requirements."

3.27.14. State Directed Payments

3.27.14.1. The Contractor shall fully participate in and faithfully execute all directed payment programs established by EOHHS, and as approved by CMS.

3.27.14.2. EOHHS will establish criteria for each directed payment program, including the timeframe for the directed payment; providers who will participate in the directed payment; and the mechanism for the calculation and delivery of the amounts to be paid to the selected Providers.

3.27.14.3. The Contractor shall collect and provide EOHHS such information as is required to support all directed payment programs.

3.27.14.4. Directed payment programs shall be established in accordance with all applicable CMS requirements, including 42 C.F..R § 438.6(c).

3.27.14.5. EOHHS may require the Contractor to adopt a minimum fee schedule for Network Providers, provide a uniform dollar or percentage increase for Network Providers, or adopt a maximum fee schedule so long as the Contractor retains ability to reasonably manage risk.

3.27.14.6. Per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), states no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State Plan approved rates, as defined in 42 C.F.R. § 438.6(a).

3.27.14.7. EOHHS will require the Contractor to implement following state directed payments:

Directed Payment	State Directed Payment Requirement[1]	Effective Date
Hospital Inpatient and Outpatient Rates	__% increase over prior year rates	7/1/2023
Nursing Home Rates	__% increase over prior year rates	10/1/2023
PCMH PMPM	$__ PMPM for each member attributed to providers that meet the OHIC definition of PCMH.	7/1/2023
PCMH Quality Incentive	$__ PMPM incentive for each member attributed to providers that meet quality targets on clinical target measures.	7/1/2023
Level 4 Detoxification	$__ per diem	7/1/2023

3.27.15. Nonpayment (CMS Checklist I.F.9.05-.06)

3.27.15.1. The Contractor shall not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):

a) With any prohibited funds under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.

b) With any funds expended for roads, bridges, stadiums, or any other item or service not covered under the Rhode Island Medicaid State Plan.

3.27.16. Reporting Transactions (CMS Checklist I.I.4.01)

The Contractor shall report to EOHHS and, upon request, to the Secretary of DHHS, the Inspector General of DHHS, and the Comptroller General a description of transactions between

[1] EOHHS will add requirements to the final negotiated contract.

the Contractor and a party in interest (as defined under 1318(b) of the Social Security Act) including the following transactions:

a) Any sale or exchange, or leasing of any property between the MCP and such a party;

b) Any furnishing for consideration of goods, services (including management services), or facilities between the Contractor and a party of interest, but not including salaries paid to employees for services provided in the normal course of employment; and

c) Any lending of money or other extension of credit between the Contractor and the party.

3.27.17. Reserving

The Contractor shall establish an actuarially sound process for estimating and tracking incurred but not reported claims (IBNRs). The Contractor also shall reserve funds by major categories of service (e.g., hospital inpatient; hospital outpatient) to cover both IBNRs and reported but unpaid claims. As part of its reserving methodology, the Contractor shall conduct "look backs" at least annually to assess its reserving methodology and make adjustments as necessary.

3.27.18. Disproportionate Share Payments to Hospitals

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

3.27. Financial Requirements- Document History Log	
Contract Cross-References	• Section 3.15, Accountable Entities • Managed Care Manual Chapter 4, "Claims and MIS Requirements" • Managed Care Manual Chapter 5, "Financial Requirements" • Managed Care Manual Chapter 11, "Reporting Calendar and Templates"
Governing Requirement and Authority	• Section 1902(a)(25) of the Social Security Act • Section 607(1) of the Employee Retirement Income Security Act of 1974 • 42 C.F.R. § 433.139 • 42 C.F.R. § 438.6 • 42 C.F.R. § 438.74 • 42 C.F.R. § 438.8 • 42 C.F.R. Part 455, Subpart B • RI General Laws 40-6-9.1
CMS Checklist Items	• I.D.1. General, Section I.D.1.03 • I.D.4. Medical Loss Ratio (MLR), Sections I.D.4.01-.34 • I.F.9, Nonpayment, I.F.9.05-.06 • I.I.2. Requirements, Procedures and Reporting, Sections I.I.2.01-.05 • I.J.4. Third Party Liability (TPL) Activities, Section I.J.4.01 • I.L.5. Data Collection, Section I.L.5.10
Revision Date and Description	

3.28. Alternative Payment Methodologies

3.28.1. Purpose

EOHHS seeks to significantly reduce the use of fee-for-service (FFS) payment to Managed Care Program Providers and to replace them with qualified APMs that incentivize better quality and more efficient delivery of Health Care Services.

3.28.2. Qualified APMs

3.28.2.1. A qualified APM is a payment arrangement between the Contractor and AEs or other Network Providers that are within Categories 2 through 4 of the Health Care Payment Learning and Action Network (HCP-LAN, or LAN) APM Framework. Payment arrangements in Category 2A are not considered qualified APMs.

3.28.2.2. For AEs, the Contractor's APM strategy shall conform to the "EOHHS Medicaid Managed Care: Alternative Payment Methodology Requirements," located in Managed Care Manual Chapter 8, "Care Program and Accountable Entities."

3.28.2.3. For Network Providers, the Contractor's APM strategies shall include qualified APMs that conform to the EOHHS requirements. These APM arrangements shall be categorized into the following payment model classifications as defined by the LAN-APM framework:

a) Category 2 Fee for Service-Link to Quality and Value
b) Category 3 APM Built on Fee-For Service Architecture
c) Category 4 Population Based Payment

3.28.3. Requirement

3.28.3.1. The Contractor shall meet EOHHS APMs targets for both AEs and Network Providers and demonstrate progressive movement toward HCP-LAN Category 4 population-based payment methodologies.

3.28.3.2. The Contractor shall participate in primary care capitation policy, planning, and design processes led by OHIC and EOHHS and leveraging the technical expertise of contractors, including but not limited to Bailit Health and CTC-RI. Participation shall include attendance at relevant meetings, providing requested data, financial analysis, design preferences, and any other such effort to support the development of both financial and clinical models to enable implementation of primary care capitation. The Contractor shall also stimulate practice revenues under the designed model to test the efficacy of the model per guidance from EOHHS.

3.28.4. EOHHS APM Targets

The Contractor shall meet the following EOHHS defined AE APM target and non-AE APM targets:

3.28.4.1. AE APM Target: Beginning with the Contract Period 1 (July 1, 2023 – June 30, 2024), at least 60% of the Contractor's payments to AEs shall be made for

Members attributed to an AE participating in a Total Cost of Care (TCOC) arrangement. EOHHS will continue to monitor the AE market through the course of the Contract Period and adjust this target annually.

3.28.4.2. Non-AE APM Target: Contractor shall meet separate targets related to qualified APMs with Network Providers. AE TCOC arrangements are excluded from all calculations related to these targets; however, other qualified APMs with AE Providers can be included, along with qualified APMs with non-AE Providers. Below are the targets for each year, which gradually increase the proportion of payments made under qualified APMs:

a) In Contract Period 1 (July 1, 2023 – June 30, 2024), the Contractor shall complete the APM Reporting Template, as described in Managed Care Manual Chapter 8, "Care Programs and Accountable Entities" to meet the non-AE APM Target.

b) For Contract Periods 2 through 5, the Contractor's total payments to Network Providers through qualified APMs shall meet the following minimum standards:

LAN Category	Contract Period 2	Contract Period 3	Contract Period 4	Contract Period 5
Category 2B-C	At least **12%** of the medical portion of capitation shall be made to providers participating in Category 2B-C, 3, or 4 contracts	At least **17%** of the medical portion of capitation shall be made to providers participating in Category 2B-C, 3, or 4 contracts	At least **22%** of the medical portion of capitation shall be made to providers participating in Category 2B-C, 3, or 4 contracts	At least **25%** of the medical portion of capitation shall be made to providers participating in Category 2B-C, 3, or 4 contracts
Category 3	At least **7%** of the medical portion of capitation shall be made pursuant to Category 3 or 4 contracts.	At least **10%** of the medical portion of capitation shall be made pursuant to Category 3 or 4 contracts.	At least **13%** of the medical portion of capitation shall be made pursuant to Category 3 or 4 contracts.	At least **15%** of the medical portion of capitation shall be made pursuant to Category 3 or 4 contracts.
Category 4	At least **2%** of the medical portion of capitation shall be made pursuant to Category 4 contracts.	At least **3%** of the medical portion of capitation shall be made pursuant to Category 4 contracts.	At least **4%** of the medical portion of capitation shall be made pursuant to Category 4 contracts.	At least **5%** of the medical portion of capitation shall be made pursuant to Category 4 contracts.

3.28.5. Changes to Targets

EOHHS reserves the right to review and modify the APM targets described above with advance notice to the Contractor.

3.28.6. APM Strategy and Implementation Plan

The Contractor shall develop an APM Strategy and Implementation Plan that outlines how it intends to achieve EOHHS' defined targets and describes the APM methodologies it intends to adopt. The APM Strategy shall conform to the "EOHHS Medicaid Managed Care: Alternative Payment Methodology Requirements" in the Managed Care Manual. The APM Strategy and Implementation Plan shall be submitted to EOHHS for review and approval during Readiness Review, annually thereafter and upon modification.

3.28.7. APM Reporting

The Contractor shall complete EOHHS' APM Reporting Template in accordance with the Managed Care Manual Chapter 11, "Reporting Calendar and Templates."

3.28.8. Withhold

3.28.8.1. Except as provided below, for each Contract Period, EOHHS will:

a) Withhold 0.25% from the Contractor's capitation payments pending demonstration the Contractor has met 100% of the APM targets for AEs.

b) Withhold 0.25% from the Contractor's capitation payment pending demonstration the Contractor has met 100% of the APM targets for non-AEs.

3.28.8.2. The withholds described above do not apply for the first two Contract Periods for a Health Plan who is a new entrant to Rhode Island's Medicaid Managed Care Program.

3.28. Alternative Payment Methodologies- Document History Log	
Contract Cross-References	• Managed Care Manual Chapter 8, Care Program and Accountable Entities • Managed Care Manual Chapter 11, Reporting Calendar and Templates
Governing Requirement and Authority	
CMS Checklist Items	
Revision Date and Description	

4. Turnover Phase Requirements

4.1. Introduction

This section includes the Scope of Work for the Turnover Phase of the Agreement. During this phase, the Contractor shall provide all turnover assistance EOHHS determines necessary to close out the Agreement and transition the work to another vendor or the state.

4.1.1. Turnover Events

4.1.1.1. The Contractor is required to complete Turnover Phase activities in the following circumstances:

a) Expiration or termination of all or part of the Agreement.
b) The Contractor's merger with or acquisition by another entity.

4.1.1.2. During the Turnover Phase, the Contractor shall continue to perform its responsibilities under the Agreement, including rendering all contracted services, until EOHHS determines the Contractor has completed all Turnover Phase requirements.

4.1.1.3. Contractor shall provide all reasonably necessary assistance to EOHHS in transitioning Members out of the Contractor's Health Plan. Such assistance shall include:

a) Forwarding medical and other records.
b) Facilitating and scheduling Medically Necessary appointments for care and services.
c) Identifying Members with special health care needs, including those who are chronically ill, high risk, hospitalized, or pregnant.

4.1.1.4. The Contractor shall maintain sufficient key personnel and support staff based in Rhode Island to support all required Agreement functions. The Contractor's transition team shall assist with Member transitions to new Health Plans and share all documentation required by EOHHS, such as active Prior Authorizations, current assessments and care plans, and other necessary information to support continuity of care, particularly for Members with special health care needs.

4.1.2. Turnover Plan

4.1.2.1. No later than six months after the Effective Date of the Agreement, the Contractor shall provide a comprehensive Turnover Plan for EOHHS approval. The Contractor shall provide the Turnover Plan and annual updates to the plan in accordance with Managed Care Manual Chapter 11, "Reporting Calendar and Templates."

4.1.2.2. The Turnover Plan shall include the Contractor's proposed:

a) Schedule, activities, and resources associated with Turnover Phase tasks.
b) Process for turning over records and information maintained by the Contractor and its Subcontractors to either EOHHS or a third party designated by EOHHS.

c) Approach completing the data transfer activities described in Section 4.1.3, below.
d) Quality assurance process for monitoring Turnover Phase activities.
e) Approach to training EOHHS or a subsequent Health Plan's staff on the operation of the Contractor's business practices.
f) Third-party software used by the Contractor and its Subcontractors to perform contractual duties, including how the software is used and the terms of the license agreement, so that EOHHS can determine if the software is needed to transition operations.

4.1.2.3. The Contractor shall update the Turnover Plan within one month of notifying EOHHS of a merger or acquisition impacting the Agreement, or at EOHHS's request prior to the expiration or termination of the Agreement.

4.1.2.4. EOHHS may require the Contractor to submit additional information or make modifications to the Turnover Plan.

4.1.3. Data Transfer

4.1.3.1. The Contractor shall transfer all data, records, documentation, and information (collectively "information") necessary to transition operations to EOHHS or a subsequent Health Plan, including:

a) Data and reference tables.
b) Data entry software.
c) License agreements for third-party software and modifications.
d) Documentation relating to software and interfaces.
e) Functional business process flows.
f) Operational information, including correspondence, documentation of ongoing or outstanding issues, operations support documentation, and operational information regarding Subcontractors.
g) Member and Covered Service information.
h) Any other EOHHS determines necessary for EOHHS or a subsequent Health Plan to assume operational activities successfully.

4.1.3.2. For purposes of this section, "documentation" includes all operations, technical, and user manuals used in conjunction with the software. The Contractor shall produce all documentation EOHHS determines is needed to view and extract application data in a proper format.

4.1.3.3. The Contractor shall provide, in a HIPAA-compliant format, all information needed to map information from the Contractor's systems to the replacement systems, including a comprehensive data dictionary.

4.1.3.4. The Contractor shall provide all information at no additional cost to EOHHS.

4.1.3.5. If EOHHS determines information provided by the Contractor or its Subcontractors is not accurate, complete, or HIPAA compliant, it reserves the

right to hire an independent contractor, at the Contractor's expense, to assist in obtaining and transferring information.

4.1.4. Post-Turnover Services

4.1.4.1. The Contractor shall provide EOHHS a Turnover Results Report no later than 30 Days after completing Turnover Phase activities. The report shall document that all activities outlined in the Turnover Plan are complete. Turnover shall not be considered complete until EOHHS approves this plan.

4.1.4.2. During the transition to a new Health Plan, for the last month of the Contract, EOHHS will withhold up to 75% of the final Capitation Payments until EOHHS approves the Turnover Results Report and determines the Contractor has successfully completed all required Turnover Phase activities.

4.1.4.3. If the Contractor fails to provide information necessary for EOHHS or a subsequent Health Plan to assume operational activities, the Contractor is responsible for all costs incurred by EOHHS and its agents (including travel and attorney's fees and costs) to carry out inspection, audit, review, analysis, reproduction, and transfer functions at the locations where information is kept. EOHHS may subtract such costs from the withheld Capitation Payments or invoice the Contractor. Contractor shall pay an invoice no later than ten Days after receipt.

4. Turnover Requirements- Document History Log	
Contract Cross-References	Managed Care Manual Chapter 11, Reporting Calendar and Templates
Governing Requirements and Authority	
CMS Checklist Items	
Revision Date and Description	

ATTACHMENT F-2

EOHHS General Terms and Conditions

Table of Contents

Introduction

1.1. Purpose

This Agreement sets forth the terms and conditions for the Contractor's participation in the Rhode Island Medicaid Managed Care Program. Under the terms of this Agreement, the Contractor shall provide comprehensive health care services through a managed care delivery system.

1.2. Inducements

In making the award of this Agreement through RFP XXXXX, EOHHS relied on Contractor's assurances and attestations of the following:

1.2.1. Contractor is an HMO that is either licensed by the Rhode Island Department of Business Regulation or shall receive HMO licensure or approval to conduct business in Rhode Island no later than 60 Days after execution of this Agreement.

1.2.2. Contractor and its Subcontractors have the skills, qualifications, expertise, financial resources, and experience necessary to provide the services and deliverables described in the EOHHS Request for Proposals (RFP), the Contractor's Proposal, and this Agreement in an efficient, cost- effective manner, with a high degree of quality and responsiveness, and has performed similar services for other public or private entities.

1.2.3. Contractor has thoroughly reviewed, analyzed, and understood the RFP, and has timely raised all questions or objections to the RFP.

1.2.4. Contractor is knowledgeable of the EOHHS managed care program and its operating environment.

1.2.5. Contractor had the opportunity to review and understand the State's stated objectives and needs in entering this Agreement and, based on such review and understanding, has the capability to perform in accordance with the Agreement terms.

1.2.6. Contractor has reviewed and understands the risks associated with the EOHHS managed care program described in the RFP, including the risk of non-appropriation of funds.

1.3. Construction of the Agreement (CMS Checklist I.C.8.10-.41)

1.3.1. Introductory articles in the Agreement are intended to be a general introduction and not to expand the scope of the Parties' obligations under the Agreement or to alter the plain meaning of the terms and conditions.

1.3.2. References in the Agreement to the "State" mean the State of Rhode Island unless otherwise specifically indicated and shall be interpreted, as appropriate, to mean or include EOHHS and other agencies of the State of Rhode Island that may participate in the administration of the Medicaid managed care program, provided, however, that no provision shall be interpreted to include any entity other than EOHHS as the contracting agency.

1.3.3. Termination or expiration of this Agreement for any reason shall not release either Party from any liabilities or obligations set forth in this Agreement that:

1.3.3.1. The Parties have expressly agreed that such liabilities or obligations shall survive termination or expiration; or

1.3.3.2. Arose before the effective date of termination and remain to be performed, or by their nature would be intended to apply after termination or expiration.

1.3.4. Global drafting conventions:

1.3.4.1. The terms "include," "includes," and "including" are terms of inclusion, and are deemed to be followed by the words "without limitation."

1.3.4.2. Any references to "sections," "appendices," "exhibits," "attachments," or "addenda" are deemed to be references to sections, appendices, exhibits, attachments, or addenda to this Agreement.

1.3.4.3. Any references to laws, rules, regulations, and manuals in this Agreement are deemed references to these documents as amended, modified, or supplemented from time to time during the Agreement term.

1.3.5. All definitions in the Section 1 of Attachment F-1 are the state-developed or state-adopted definition for the terms therein. The Contractor shall use the state-developed or state-approved definition in their execution of this Agreement.

1.4. Signatures and Authority (CMS Checklist I.A.1.01)

1.4.1. The Agreement shall be signed and dated by all Parties.

1.4.2. EOHHS is authorized to enter this Agreement under R.I. Gen. Laws § 42-7.2-1 *et. seq.*

1.4.3. Contractor is authorized to enter this Agreement pursuant to the authorization of its governing board or controlling owner or officer.

1.4.4. The person or persons executing this Agreement on behalf of the Parties warrant and guarantee are duly authorized to execute this Agreement and to legally bind the Parties to its terms.

2. General Provisions

1. Introduction – Document History Log	
Contract Cross-References	
Governing Requirements and Authority	R.I. Gen. Laws § 42-7.2-1 *et. seq.*
CMS Checklist Items	• I.A., Contract Completeness, Section I.A.1.01 • I.C.8, General Information Requirements, Sections I.C.8.10-.41
Revision Date and Description	

2.1. Agreement Composition and Order of Precedence

2.1.1. In addition to the documents identified in Section 13.4 of the General Conditions of Purchase, "Entire Agreement," the EOHHS Managed Care Manual is incorporated by reference into this Agreement. The EOHHS Managed Care Manual is published on the agency's website.

2.1.2. The terms of the General Conditions of Purchase and Addendum A through F shall apply to this Agreement. In the event of a conflict between the items stated in 220-RICR-30-00-13.4(B)(3) (State Procurement Regulations, General Conditions of Purchase and the GC Addendums), the following order of precedence shall apply (highest to lowest):

2.1.2.1. GC Addendum F, Attachments F-1 through F-6;

2.1.2.2. The General Conditions of Purchase;

2.1.2.3. GC Addenda A, B, and D; and

2.1.2.4. GC Addendum F, Attachment F-7, Contractor's Proposal, unless the proposal includes services or performance levels that exceed the requirements in the documents described above. In such cases, the Contractor's Proposal shall take precedence.

2.1.3. In the event of a conflict or contradiction between GC Addendum F, "EOHHS Special Requirements," Attachments F-1 through F-7, the EOHHS Managed Care Manual, the EOHHS RFQ, and the Contractor's proposal, the following order of precedence shall apply (highest to lowest):

2.1.3.1. GC Addendum F, Attachments F-1 thorough F-5, and all amendments thereto.

2.1.3.2. EOHHS Managed Care Manual, and all amendments thereto.

2.1.3.3. Attachment F-6, EOHHS RFQ.

2.1.3.4. Attachment F-7, Contractor's Proposal, unless the proposal includes services or performance levels that exceed the requirements in the other Agreement attachments. In such cases, the Contractor's Proposal shall take precedence.

2.2. Counterparts

This Agreement may be executed simultaneously in counterparts, each of which shall be deemed an original, and together shall constitute one and the same instrument.

2.3. Subsequent Conditions

The Contractor shall comply with all requirements of this Agreement and the State will have no obligation to enroll any recipients into the Contractor's comprehensive health care plan until such requirements have been met.

2.4. Term of the Agreement

This Agreement will begin on the date of execution by both Parties (the "Effective Date") and conclude on June 30, 2028 (the "Expiration Date"). The Parties may extend or renew the Agreement for up to three additional one-year periods, through June 30, 2031. All Agreement extensions beyond the Expiration Date shall be subject to good faith negotiations between the Parties.

2.5. Federal Approval (CMS Checklist I.A.1.02-.03, I.A.1.06, and I.A.1.08-.12)

2.5.1. The Capitation Rates and all terms conditions of this Agreement, and all amendments thereto, are subject to final approval from CMS pursuant to 42 C.F.R. § 438.6.

2.5.2. This Agreement is subject to CMS approval and concurrence of award. The Contractor understands and agrees that EOHHS will submit the Agreement and all attachments thereto to CMS for review and approval. EOHHS will also submit all documents incorporated by reference as requested by CMS and needed to demonstrate compliance with federal regulations and the CMS contract review tool.

2.5.3. The Agreement terms comply with all applicable federal authorities approved by CMS, including the State's approved 1115 waiver agreement.

2.5.4. Delivery system and provider payment initiatives under 42 C.F.R. § 438.6(c) must receive CMS approval before implementation and comply with the requirements of this regulation.

2.5.5. If CMS does not approve the Agreement or initiatives under 42 C.F.R. § 438.6(c), they shall be considered null and void.

2.6. Notices

2.6.1. Any notice, approval, or consent permitted or required under this Agreement shall be in writing and sent by email to and/or by postage prepaid, certified mail or registered mail, return receipt requested, or by reputable overnight delivery service to the other party at the address set forth below, or such other address as either party may direct by notice given to the other as provided, and shall be deemed to be given when sent.

2.6.2. Notices shall be addressed as follows:

2.6.2.1. In case of notice to the Contractor: Chief Executive Officer

2.6.2.2. In case of notice to EOHHS: EOHHS Administrator, 3 West Road, Virks Building, Cranston, RI 02920

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

2.7. Notification of Legal and Other Proceedings and Related Events

The Contractor shall notify the EOHHS Managed Care Director of all proceedings, reports, documents, actions, and events specified in Managed Care Manual Chapter 11, "Reporting Calendar and Templates."

2.8. Publicity

Any publicity relating to the managed care program or services provided herein, including notices, information pamphlets, press releases, research, reports, signs, and similar public notices prepared by or for the Contractor shall identify the State of Rhode Island. All such publicity shall comply with Managed Care Manual Chapter 3, "Marketing Policies and Procedures" and receive prior written approval from EOHHS.

2.9. Assignment

2.9.1. In accordance with Section 13.25(B) of the General Conditions of Purchase, "Assignment," Contractor shall not sell, transfer, assign, or otherwise dispose of all or any portion of its rights under or interests in the Agreement without prior written consent

of the State Purchasing Agent. The Contractor's written request for assignment shall be accompanied by written acceptance by the assignee. Except where otherwise agreed in writing by the State, assignment shall not release the Contractor from its obligations under the Agreement.

2.9.2. EOHHS may in one or more transactions assign, pledge, or transfer the Agreement to another State agency.

2.9.3. An assignee shall assume all assigned interests in and responsibilities under the Agreement and any documents executed with respect to the Agreement.

2.10. Other Agreements

2.10.1. Nothing contained in this Agreement shall prevent the Contractor from operating other comprehensive health care plans or providing health care services to persons other than those covered hereunder; provided, however, the Contractor shall provide the EOHHS Managed Care Director with a complete list of such plans and services, including rates, upon request.

2.10.2. Nothing in this Agreement shall prevent EOHHS from contracting with other comprehensive health care plans in the same enrollment area.

2.10.3. EOHHS will not disclose any proprietary information received pursuant to this section except as required by law.

2.11. Award of Related Agreements

2.11.1. The State may undertake other agreements for work related to this Agreement, including agreements with other comprehensive health care plans to provide Medicaid managed care services and agreements with management firms to assist in administration of this Agreement.

2.11.2. The Contractor shall fully cooperate with other contractors as directed by the State and require all Subcontractors to comply with this requirement.

2.12. Renegotiation and Procurement Rights

2.12.1. EOHHS may at any time notify the Contractor that it has elected to renegotiate certain terms of the Agreement. Upon the Contractor's receipt of such notice, the Contractor and EOHHS will enter good faith negotiations and may amend the Agreement in accordance with Article 4, "Amendments and Modifications."

2.12.2. Notwithstanding anything in the Agreement to the contrary, EOHHS may issue a request for proposals at any time for all or part of the Scope of Work included in this Agreement, or for services or deliverables similar or comparable to those provided under this Agreement. If EOHHS elects to procure the Scope of Work or any portion thereof from another vendor, EOHHS may subsequently exercise any of its termination rights set forth in Article 10, "Termination of the Agreement."

2.13. RFP or Agreement Errors or Omissions

The Contractor shall perform in a commercially reasonable manner and shall not take advantage of any errors or omissions in the RFQ or the resulting Agreement and shall promptly notify the EOHHS Managed Care Director of any such errors or omissions discovered.

2. General Provisions – Document History Log	

Contract Cross-References	• Rhode Island General Conditions of Purchase, Sections 13.4 and 13.25(B)
	• Attachments F-1 through F-7
	• Managed Care Manual
	  ○ Chapter 3, Marketing Policies and Procedures
	  ○ Chapter 11, Reporting Calendar and Templates
	• Attachment F-2, General Terms and Conditions
	  ○ Article 4, Amendments and Modifications
	  ○ Article 10, Termination of the Agreement

Governing Requirements and Authority	42 C.F.R. § 438.6
CMS Checklist Items	I.A, Contract Completeness, Sections I.A.1.02-.03, 1.06, .08-.12
Revision Date and Description	

3. Governing Laws and Regulations

3.1. State Purchasing Laws

The State's Purchasing Law (Chapter 37-2 of the Rhode Island General Laws) and Rhode Island Department of Administration, Division of Purchases, State Procurements Regulations (https://rules.sos.ri.gov/organizations/subchapter/220-30-00), and General Conditions of Purchase apply as the governing terms and conditions of this Agreement, which can be obtained at https://rules.sos.ri.gov/regulations/part/220-30-00-13. In addition, the provisions of federal laws, regulations and procedures governing the implementation of federal funds apply to this Agreement.

3.2. Nondiscrimination in Employment and Services (CMS Checklist I.B.1.04, I.J.2.01-.02)

3.2.1. In accordance with Attachment F-1, Section 3.1.13, "Employment Practices," and Attachment F-2, Section 3.3, "Compliance with Governing Requirements," the Contractor shall comply with, and cause its Subcontractors to comply with, all applicable state and federal laws relating to fair employment practices.

3.2.2. As required by 42 C.F.R. § 438.100(a)(2), the Contractor shall also comply with any applicable federal and state laws pertaining to enrollee rights and ensure that its employees, Subcontractors, and Network Providers observe and protect those rights.

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

3.3. Compliance with Governing Requirements (CMS Checklist I.J.2.01)

3.3.1. In accordance with Section 13.24 of the General Conditions of Purchase, "Compliance with Law," the Contractor, its Subcontractors, and other Representatives shall comply, to the satisfaction of EOHHS, with all provisions set forth in this Agreement, all provisions of state and federal laws, rules, regulations, codes, federal waivers, and policies, and any court orders that govern the performance of the Scope of Work (collectively "Governing Requirements") including all applicable provisions of the following:

3.3.1.1. Titles XIX of the Social Security Act.

3.3.1.2. Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et. seq.).

3.3.1.3. The Age Discrimination Act of 1975 (42 U.S.C. § 6101 et. seq.).

3.3.1.4. The Rehabilitation Act of 1973 (Pub. L. 93-112).

3.3.1.5. Title IX of the Education Amendments of 1972 (regarding education programs and activities) (20 U.S.C. § 1681 et. seq.).

3.3.1.6. Section 1557 of the Patient Protection and Affordable Care Act (ACA) (42 U.S.C. § 18116).

3.3.1.7. 42 C.F.R. § 438.3(f)(1) and 438.100(d).

3.3.1.8. 42 C.F.R. Parts 417, 438, and 455.

3.3.1.9. 45 C.F.R. Part 92.

3.3.1.10. 48 C.F.R. Part 31.

3.3.1.11. 2 C.F.R. Part 200.

3.3.1.12. The Patient Protection and Affordable Care Act ("PPACA;" Pub. L. 111-148).

3.3.1.13. The Health Care and Education Reconciliation Act of 2010 ("HCERA;" Pub. L. 111-152).

3.3.1.14. Clinical Laboratory Improvement Amendments of 1988 (Pub. L. 100-578, 42 C.F.R. Part 493) (for purposes of the Agreement, the Contractor shall require its Providers to agree that the Contractor and EOHHS are "authorized persons").

3.3.1.15. The Immigration and Nationality Act (8 U.S.C §§ 1101 et seq.) and all subsequent immigration laws and amendments.

3.3.1.16. Laws regarding the use of Electronic Visit Verification, including section 12006 of the Cures Act (Public Law 114-255).

3.3.1.17. Laws regarding medication synchronization, including R.I. Gen. Laws § 27-18-50.1, R.I. Gen. Laws § 27-19-26.1, R.I. Gen Laws § 27-20-23.1, and R.I. Gen. Laws § 27-41-38.1.

3.3.1.18. Laws regarding off label uses for prescription drugs, including R.I. Gen. Laws §§ 27-55-1 and 27-55-2.

3.3.1.19. R.I Gen. Laws § 27-18.9-8, regarding procedural requirements for external appeals.

3.3.1.20. R.I. Gen. Laws § 27-18-84, regarding continuous coverage for contraception.

3.3.2. The Parties acknowledge that Governing Requirements affecting the performance of this Agreement may be added, judicially interpreted, or amended by competent authority. Contractor acknowledges that the EOHHS managed care program will be subject to continuous change during the term of the Agreement and, except as provided in Article 4, "Amendments and Modifications," Contractor shall provide for adequate resources, at no additional charge to EOHHS, to reasonably accommodate such changes.

3.3.3. The Parties further acknowledge Contractor was selected, in part, because of its expertise, experience, and knowledge concerning the Governing Requirements. In keeping with EOHHS' reliance on this knowledge and expertise, Contractor is responsible for identifying the impact of changes in Governing Requirements that affect the performance of the Scope of Work. Contractor shall timely notify EOHHS of such changes and shall work with EOHHS to identify the impact of such changes.

3.3.3.1. Contractor is responsible for compliance with changes in Governing Requirements that occur during the Agreement term. If there are any conflicts between rules promulgated by CMS and this Agreement, the federal rules take precedence over the Agreement and the Contractor shall comply with the federal rules unless CMS has waived applicability of the provision to Rhode Island Medicaid via a waiver.

3.3.3.2. Contractor is responsible for any fines, penalties, or disallowances imposed on the State or Contractor arising from noncompliance with the Governing Requirements by the Contractor or its Representatives.

3.3.3.3. Contractor is responsible for ensuring all Subcontractors and Representatives who provide Services under the Agreement is properly licensed, certified, and/or has proper permits to perform any activity related to the Services.

3.3.3.4. Contractor warrants that the Services and Deliverables shall comply with all Governing Requirements. Contractor shall indemnify EOHHS from and against any losses, liability, claims, damages, penalties, costs, fees, or expenses arising from or in connection with Contractor's failure to comply with or violation of any such Governing Requirement.

3. Governing Laws and Regulations – Document History Log	
Contract Cross-References	• Attachment F-1, Scope of Work, Section 3.1.13, Employment Practices
Governing Requirements and Authority	• R. I. Gen. Laws, Chapter 37-2 • Titles XIX of the Social Security Act • Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et. seq*.) • The Age Discrimination Act of 1975 (42 U.S.C. § 6101 *et. seq*.) • The Rehabilitation Act of 1973 (Pub. L. 93-112) • Title IX of the Education Amendments of 1972 (regarding education programs and activities) (20 U.S.C. § 1681 *et. seq.)* • Section 1557 of the Patient Protection and Affordable Care Act (ACA) (42 U.S.C. § 18116). • 42 C.F.R. § 438.3(f)(1) and 438.100(d) • 42 C.F.R. Parts 417, 438, and 455 • 45 C.F.R. Part 92 • 48 C.F.R. Part 31 • 2 C.F.R. Part 200 • The Patient Protection and Affordable Care Act ("PPACA;" Pub. L. 111-148) • The Health Care and Education Reconciliation Act of 2010 ("HCERA;" Pub. L. 111-152) • Clinical Laboratory Improvement Amendments of 1988 (Pub. L. 100-578, 42 C.F.R. Part 493) (for purposes of the Agreement, the Contractor shall require its Providers to agree that the Contractor and EOHHS are "authorized persons") • The Immigration and Nationality Act (8 U.S.C §§ 1101 et seq.) and all subsequent immigration laws and amendments • Section 12006 of the Cures Act (Public Law 114-255) • R.I. Gen. Laws § 27-18-50.1 • R.I. Gen. Laws § 27-19-26.1 • R.I. Gen Laws § 27-20-23.1 • R.I. Gen. Laws § 27-41-38.1 • R.I. Gen. Laws §§ 27-55-1 and 27-55-2 • R.I Gen. Laws § 27-18.9-8 • R.I. Gen. Laws § 27-18-84 • 42 C.F.R. §§ 438.3 and 438.100
CMS Checklist Items	• I.B.1, No Discriminations, Section I.B.1.04 • I.J.2, Compliance with State and Federal Laws, Sections I.J.2.01-.02
Revision Date and Description	

4. Amendments and Modifications

4.1. Mutual Agreement

The Parties may mutually agree to amend this Agreement at any time.

Except as provided in Section 4.7, "Modification to the Managed Care Manual," amendments shall be in writing and signed by individuals authorized to bind the Parties.

4.2. Changes in Law or Agreement

If either Party's ability to fulfill its obligations under this Agreement is altered by changes in Governing Requirements, the Parties will enter into good faith negotiations to equitably adjust the terms and conditions of the Agreement.

4.3. Additional Populations or Services

EOHHS reserves the right to amend the Agreement to include new populations, services, or programs, including the RIte Smiles and Rhode Island Medicare-Medicaid Plan (MMP) programs.

4.4. Changes to Capitation Payments

EOHHS and Contractor will use amendments to reduce or increase Capitation Payments. Annual adjustments in Capitation Payments will be actuarially sound, as required by 42 C.F.R. § 438.6(c).

4.5. Modification as a Remedy

This Agreement may be modified under the terms of Article 9, "Performance Standards, Remedies, and Disputes."

4.6. Amendment Process

4.6.1. If EOHHS seeks to amend the Agreement, it will provide a written notice to the Contractor identifying the proposed the modifications to the Scope or Work, pricing terms, or other terms and conditions.

4.6.2. If the Contractor objects to the proposed modifications, it shall provide a written response within the timeframe specified in the notice, but no later than ten Business Days of receipt. Following receipt of the Contractor's objections, the Parties will enter negotiations to arrive at a mutually agreeable amendment, including mediation. If EOHHS determines the Parties will not be able to reach agreement, it will provide written notice to the Contractor of its intent terminate all or part the Agreement.

4.6.3. The Contractor agrees to provide a signed amendment no later 30 Days after receiving the final amendment from EOHHS. EOHHS may impose contractual remedies, as described in Article 9, "Performance Standards, Remedies, and Disputes" if the Contractor fails to return a signed amendment within 30 Days of receipt.

4.7. Modifications to the Managed Care Manual

4.7.1. The Managed Care Manual, and all modifications thereto made during the term of the Agreement, are incorporated by reference into this Agreement.

4.7.2. EOHHS will provide Contractor at least ten Business Days advance written notice before implementing a material and substantive change to the Managed Care Manual. EOHHS will provide Contractor a reasonable amount of time to comment on such changes,

generally at least five Business Days. EOHHS is not required to provide advance written notice of changes that are not material substantive in nature, such as corrections of clerical errors.

4.7.3. The Parties will work in good faith to resolve disagreements concerning modifications to the Managed Care Manual. If the Parties are unable to resolve such issues, either Party may terminate the agreement in accordance with Article 9, "Performance Standards, Remedies, and Disputes."

4.7.4. Modifications to the Managed Care Manual will be effective on the date specified in EOHHS' notice.

4.8. Required Compliance with Amendment or Modification Procedures

No different or additional services, work, or products shall be authorized or performed except as authorized by this Article. Contractor shall not be entitled to payment for any services, work or products that are not authorized by a properly executed amendment in writing.

4.9. Waivers

4.9.1. Except as provided below, no waiver of any term, covenant, or condition of this Agreement shall be valid unless executed in compliance with this Article. Waiver of any breach of this Agreement shall not be deemed a waiver of any prior or subsequent breach.

4.9.2. The EOHHS Managed Care Director is authorized to waive one or more of the tailored remedies described in Article 9 for minor breaches of this Agreement. Such waiver must be in writing and signed by the Managed Care Director and filed with the Division of Purchases.

4.10. Division or Purchases Modification Procedure

All modifications to the Agreement are subject to 220-RICR-30-00-13.4(C)(1)(c).

4. Amendments and Modifications – Document History Log	
Contract Cross-References	• Attachment F-1, Article 9, Performance Standards, Remedies, and Disputes
Governing Requirements and Authority	• 42 C.F.R. § 438.6 • 220-RICR-30-00-13.4(C)(1)(c)
CMS Checklist Items	
Revision Date and Description	

5. Terms and Conditions of Payment

5.1. Capitation Payments (CMS Checklist I.D.1.02)

5.1.1. EOHHS will make Capitation Payments in the manner described herein.

5.1.2. The Capitation Payments made pursuant to this Agreement may only be made by EOHHS and retained by the Contractor for Medicaid-eligible Members. Adjustments to Capitation Payments due to Member reconciliations will be made in the month following their discovery.

5.1.3. All payments will be subject to the availability of funds.

5.2. Rate Setting Methodology (CMS Checklist I.D.01.01)

5.2.1. Attachment F-4, "Capitation Rates and Fiscal Assurances," includes the rate setting methodology used to develop actuarially sound Capitation Rates.

5.3. Risk Adjustments

5.3.1. EOHHS will risk-adjust Capitated Payments. As described in Attachment F-4, "Capitation Rates and Fiscal Assurances," EOHHS will analyze the risk profile of Members enrolled with each Health Plan using a risk adjustment model selected by EOHHS.

5.3.2. EOHHS will assign each Member a risk category based on their age, sex, classified disease conditions, or other criteria as established by EOHHS. This information and the relative cost associated with each risk category reflects the anticipated utilization of Covered Services relative to the overall population.

5.4. Payments to and from Plans (CMS Checklist I.D.1.01)

5.4.1. The Contractor will receive a Capitation Payment covering all In-plan Benefits, as described in Attachment F-1, Section 3.3, "Covered Benefits, Service Requirements, and Limits," and Attachment F-3.1, "Schedule of In-Plan Benefits."

5.4.2. EOHHS will make Capitation Payments in the amount specified in Attachment F-4, "Capitation Rates and Fiscal Assurances" for the Rating Period covered thein. Reimbursement will be subject to all conditions specified in this Agreement.

5.4.3. Attachment F-4 describes the rate-setting process used to establish the Capitation Rates. EOHHS reserves the right to adjust rates during the Rate Period based on actuarial analysis. Adjustments will be made by written amendment to the Agreement, as specified in Article 4, "Amendments and Modifications."

5.4.4. The Capitation Rates and all amendments thereto are subject to CMS review and approval.

5.4.5. EOHHS will make Capitation Payments on a monthly basis via electronic funds transfer in the following manner:

5.4.5.1. For RIte Care and Children with Special Health Care Needs Members, on or before the fifth Business Day of every month, the Contractor will receive Capitation Payments for individuals projected to be enrolled or assigned to the Health Plan for the present month, as of a date on or about the 25th Day of the

preceding month. These payments will reimburse the Contractor for services rendered to these individuals during the present month.

5.4.5.2. Along with the amount identified in the above paragraph, adjustment will be made for Members for whom an enrollment or disenrollment transaction was made after the 25th Day of the next previous month but before the close of the month in question. The adjustment will be based on a daily rate equal to l/30th of the month rate for each age/sex Rate Cell (rounded to l/10th of a cent, e.g., $3.873). A remittance advice will accompany all payments identifying every Member, their Medicaid ID number, the number of Days paid and total payment and/or adjustments.

5.4.5.3. For Members whose enrollment lapses for any portion of a month in which a Capitation Payment was made, due to loss of eligibility, death, or other circumstance, EOHHS will adjust its next monthly Capitation Payment to recoup the portion of the Capitation Payment to which it is due to a refund.

5.4.5.4. For Rhody Health Partners Members, on or before the last Day of every month, the Contractor will receive a roster of individuals projected to be enrolled in or assigned to the Contractor for the following month. For these Member, on or before the fifth Day of every month, the Contractor will receive capitation payments for individuals projected to be enrolled or assigned to the Contractor for that month, based on the roster provided at the end of the preceding month. These payments will reimburse the Contractor for services rendered to these individuals during that month. For RIte Care Members who are pregnant and whose pregnancy results in a live birth or still birth (still birth defined as spontaneous fetal death at greater than or equal to 20 weeks gestation), EOHHS will make a supplemental (SOBRA) payment for delivery as part of its monthly capitation payment on the basis of a valid claim by the Contractor. EOHHS will not pay a SOBRA payment for miscarriages (defined as spontaneous fetal death less than 20 weeks), nor will EOHHS make a SOBRA payment for a pregnancy resulting in induced termination regardless of gestational age.

5.4.5.5. For Members with a cost-sharing requirement to the Contractor, the amount of the Capitation Payment will be reduced by the portion of the premium or copayment that is the responsibility of the Member.

5.4.6. The Contractor agrees to accept enrollment information and Capitation Payments in the manner described above and shall have written policies and procedures for receiving and processing Capitation Payments.

5.4.7. For RIte Care Members on or before the fifth Business Day of every month, the Contractor will receive Capitation Payments for individuals projected to be enrolled or assigned to the Contractor for that month, based on the roster provided at the end of the preceding month. These payments will reimburse the Contractor for services rendered to these individuals during that month.

5.5. Incentive and Withhold Arrangements (CMS Checklist I.D.2.01-.06 and I.D.3.01-.06)

5.5.1. Attachment F-1, Section 3.17, “Quality Assurance” describes the EOHHS quality incentive program for Health Plans. In accordance with 42 C.F.R. § 438.6(b)(2), the

quality incentive program and corresponding withhold arrangement will comply with the following requirements:

5.5.1.1. All incentive and withhold arrangements will be for a fixed period of time, which will generally coincide with a Rating Period.

5.5.1.2. Performance will be measured during the Rating Period under the Agreement for which the incentive arrangement is applied.

5.5.1.3. Incentive and withhold arrangements will not renew automatically, will be made available to all Health Plans under the same terms of performance, and will not be conditioned on Health Plans entering into or adhering to intergovernmental transfer agreements.

5.5.1.4. Incentive and withhold arrangements will align with the state's quality strategy, and the activities, targets, performance measures, and quality-based outcomes included in the arrangements will support the quality strategy.

5.5.2. If the Contractor is eligible for incentive payments under the quality incentive program, such payments will not exceed 105% of the approved Capitation Payments.

5.6. Risk Sharing (CMS Checklist I.D.1.03)

5.6.1. This Agreement does not include risk corridors, stop-loss limits, or other risk sharing mechanisms, with the exception of:

5.6.1.1. Attachment F-4, "Capitation Rates and Fiscal Assurances," regarding "COVID-19 Vaccination non-risk payment."

5.6.1.2. Attachment F-1, Section 3.27.12, "Calculating the Medical Loss Ratio."

5.6.1.3. Attachment F-1, Section 3.27.2 "Reinsurance."

5.7. Payments to Subcontractors and Providers

EOHHS shall bear no liability (other than liability for making payments required by this Agreement) for paying the valid claims of Contractor's suppliers or Representatives, including Subcontractors and Providers.

5.8. Liability for Payment (CMS Checklist I.J.7.01-.04)

5.8.1. In accordance with Section 1932(b)(6) of the Social Security Act and 42 C.F.R. §§ 438.3, 438.106, and 438.230, the Contractor and its Representatives shall not hold Members liable for:

5.8.1.1. The Contractor's debts, in the event of the Contractor's insolvency.

5.8.1.2. Covered Services provided to the Member, for which the EOHHS does not pay the Contractor, or for which the EOHHS or the Contractor does not pay the individual or the health care provider that furnishes the services under a contractual, referral, or other arrangement.

5.8.1.3. Payments for Covered Services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the Member would owe if the Contractor provided the services directly.

5.8.2. Should any part of the scope of work under this Agreement relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor shall do no work on that part after the effective date of the loss of program authority. EOHHS will adjust Capitation Rates to remove costs that are specific to any program or activity that is no longer authorized by law. If Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If EOHHS paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Agreement the work was to be performed after the date the legal authority ended, the payment for that work should be returned to EOHHS. However, if Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and EOHHS included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

5.9. Payments for Health System Transformation Project Incentives and Other Initiatives (CMS Checklist I.D.1.04)

5.9.1. EOHHS will make Health System Transformation Project (HSTP) related payments to the Contractor as described in the "HSTP and the Medicaid Infrastructure Incentive Program" document. All payments will be subject to the availability of funds.

5.9.2. All delivery system and payment initiatives, as described in 42 C.F.R. § 438.6(c) will be approved by CMS prior to implementation and shall comply with the terms of such approval.

5.10. Payments for Institutions for Mental Diseases (CMS Checklist I.D.1.05)

5.10.1. In accordance with 42 C.F.R. § 438.6(e), EOHHS will only make Capitation Payments for Members ages 21-64 receiving inpatient psychiatric treatment in an Institution for Mental Diseases (IMD), as defined in 42 C.F.R. § 435.1010, when the length of stay in the IMD is for a short term stay of no more than 15 Days during the period of the monthly Capitation Payment.

5.10.2. For Members ages 21-64 receiving inpatient opioid use disorder or other substance use disorder services in an IMD, EOHHS will only make Capitation Payments for services provided in accordance with the requirements of the Rhode Island Comprehensive Demonstration 1115 waiver and Attachment F-3.1, "Schedule of In-Plan Benefits."

5.11. Payments for Federal Qualified Health Centers and Rural health Centers (CMS Checklist I.F.10.01)

5.11.1. The Contractor shall reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) either on a capitated basis considering adverse selection factors or on a cost related basis.

5.11.2. In accordance with Section 1903(m)(2)(A)(ix) of the Social Security Act, the Contractor shall reimburse FQHCs/RHCs at a rate not less than that paid for comparable services provided by non-FQHC/RHC based providers.

5.11.3. The Contractor shall ensure the total revenue it provides to each FQHC/RHC is equal to the number of eligible encounters as outlined in EOHHS' "Principles of Reimbursement for Federally Qualified Health Centers" multiplied by that FQHCs/RHCs rate for the fiscal year, as shared by EOHHS. This funding is provided for in the Capitation Rates paid to the Contractor.

5.12. Payments to Indian Health Care Providers (CMS Checklist I.D.5.01-.03)

The Contractor shall ensure that payments to Indian Health Care Providers (ICHPs) comply with the requirements of 42 C.F.R. § 438.14(b), as described in Attachment F-1, Section 3.14.25, "Networks Related to Native Americans."

5. Terms and Conditions of Payment – Document History Log	

Contract Cross-References	• Attachment F-1, Scope of Work
	  ○ Section 3.3, Covered Benefits, Service Requirements, and Limits
	  ○ Section 3.17, Quality Assurance
	  ○ Section 3.27.2, Reinsurance
	  ○ Section 3.27.12, Calculating the Medical Loss Ratio
	• Attachment F-2, Article 4, Amendments and Modifications
	• Attachment F-3.1, Schedule of In-Plan Benefits
	• Attachment F-4, Capitation Rates and Fiscal Assurances

Governing Requirements and Authority	• Sections 1903(m)(2)(A)(ix) and 1932(b)(6) of the Social Security Act • 42 C.F.R. § 435.1010 • 42 C.F.R. §§ 438.3, 438.6, 438.14, 438.106, 438.230, and 438.340
CMS Checklist Items	• I.D.1, General, Sections I.D.1.02-.05 • I.D.2, Incentive Arrangements, Sections I.D.2.01-06 • I.D.3, Withhold Arrangements, Sections I.D.3.01-.06 • I.D.5, Payment for Indian Health Care Providers, Sections I.D.5.01-.03 • I.F.10, FQHC Payments, Section I.F.10.01 • I.J.7, Insolvency, Sections I.J.7.01-.04
Revision Date and Description	

6. Assurances, Certifications, Guarantees, and Warranties

6.1. Ability to Perform

The Contractor warrants it has the financial resources to fund the capital expenditures required under the Agreement without advances by EOHHS or assignment of any payments by EOHHS to a financing source.

6.2. Proposal Certifications

Contractor acknowledges its continuing obligation to comply with the requirements of its Proposal certifications and shall immediately notify EOHHS of any changes in circumstances affecting the certifications.

6.3. Certification of Truthfulness

The Contractor certifies the information provided in its Proposal and this Agreement is true, correct, and complete to the best of the Contractor's knowledge and belief. EOHHS may terminate the Agreement at any time in accordance with Article 10, "Termination of the Agreement," if an investigation discloses a material misrepresentation or falsification by the Contractor.

6.4. Certification of Legality

The Contractor represents, to the best of its knowledge, that it has complied with and is complying with all Governing Requirements relating to its property and the conduct of operations; and, to the best of its knowledge, there are no existing or threated violations of any Governing Requirements.

6.5. Certification of Licensure and Accreditation (CMS Checklist I.J.7.06)

6.5.1. The Contractor has obtained and shall maintain all licenses, certifications, permits, and authorizations necessary to perform its obligations under this Agreement and is in good standing with all regulatory agencies.

6.5.2. The Contractor certifies that it is licensed by the Rhode Island Department of Business Regulation ("DBR") as an:

6.5.2.1. HMO under Chapter 27-41 of the Rhode Island General Laws (the "HMO Act");

6.5.2.2. Nonprofit hospital service corporation under Chapter 27-19 of the Rhode Island General Laws;

6.5.2.3. Nonprofit medical service corporation under Chapter 27-20 of the Rhode Island General Laws; or

6.5.2.4. Another licensed health insurance entity that meets the following requirements:

a) Is accredited by the National Committee for Quality Assurance ("NCQA") as a Medicaid managed care organization or, if the Contractor is a newly entering plan, is NCQA accredited as Medicaid managed care organization in another state and will achieve full accreditation for Rhode Island Medicaid within 12 months of the execution of this Agreement.

b) Is certified by a nationally known health utilization management organization.

c) Meets the requirements under 27-18.9-8, "External Appeal Procedural Requirements" of the Benefit Determination and Utilization Review Act.

6.5.3. The Contractor certifies it meets all state requirements for licensure and operation of the applicable entity described above under Rhode Island law and DBR regulations. If the Contractor loses State approval or qualification during the term of the Agreement, it shall report such loss to EOHHS within one Business Day. Such loss may be grounds for termination of the Agreement.

6.5.4. Ensuring access to high quality and cost-effective services to all Rhode Islanders is paramount; therefore, the Contractor shall obtain NCQA distinction in Multicultural Health Care within 24 months of execution of this Agreement.

6.5.5. Achievement of provisional accreditation status shall require a corrective action plan within 30 Days of receipt of the Final Report from the NCQA and may result in termination of the Agreement.

6.5.6. Failure to obtain NCQA accreditation and Multicultural Health Care distinction within 24 months of execution of the Agreement may result in suspension of enrollment or termination of this Agreement.

6.5.7. The Contractor agrees to notify EOHHS within 30 Days of any complaint, investigation, disciplinary action, or other compliance review initiated or issued to the Contractor by a federal or state government agency or other regulatory body. The Contractor also agrees to forward to EOHHS a copy of any correspondence sent by the Contractor to the Rhode Island Department of Business Regulation that pertains to the Contractor's licensure or its contract status with any institution or provider group.

6.5.8. The Contractor agrees to provide EOHHS or its designees any information requested pertaining to its licensure, accreditation, and distinction including communications with DBR or NCQA. Such information shall include communication with NCQA and Healthcare Effectiveness Data and Information System (HEDIS)® and Consumer Assessment of Healthcare Providers & Systems (CAHPS)® data, transmittals, and reports.

6.5.9. The Contractor shall authorize any private independent accrediting entity to provide EOHHS with a copy of the Contractor's most recent accreditation review including the expiration date of the accreditation, accreditation status, survey type and level, as applicable, and any recommended actions or improvements, corrective action plans, and summaries of findings.

6.6. Conflict of Interest

6.6.1. The Contractor is aware that: (1) no official or employee of the State of Rhode Island or the federal government who exercises any functions or responsibilities in the review or approval of this Agreement will voluntarily acquire any personal interest, direct or indirect, in the Agreement or proposed Agreement; and (2) all State employees will be subject to the provisions of Chapter 36-14 of the General Laws of Rhode Island.

6.6.2. The Contractor warrants that it presently has no pecuniary interest and shall not acquire any such interest, direct or indirect, without first disclosing to the State in writing and then subsequently obtaining approval, in writing, from the State, that would conflict in

any manner or degree with the performance of services required under this Agreement. The Contractor further covenants that no person having any such interest shall be employed by the Contractor for the performance of any work associated with this Agreement.

6.6.3. The Contractor shall establish safeguards to prohibit employees, agents, and Subcontractors from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain. The Contractor shall operate with complete independence and objectivity without actual, potential, or apparent conflict of interest with respect to the activities conducted under this Agreement.

6.7. Organizational Conflict of Interest

6.7.1. An organizational conflict of interest is a set of facts or circumstances, a relationship, or other situation under which a Health Plan or a Subcontractor has past, present, or currently planned personal or financial activities or interests that either directly or indirectly:

6.7.1.1. Impairs or diminishes the Health Plan's or Representative's ability to render impartial or objective assistance or advice to EOHHS; or

6.7.1.2. Provides the Health Plan or Representative an unfair competitive advantage in future EOHHS procurements (excluding the award of this Agreement).

6.7.2. Except as otherwise disclosed and approved by EOHHS before the Effective Date of the Agreement, the Contractor warrants that, as of the Effective Date and to the best of its knowledge and belief, there are no relevant facts or circumstances that could give rise to an organizational conflict of interest affecting this Agreement. The Contractor affirms that it has neither given, nor intends to give, at any time hereafter, any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant or any employee or representative of same, at any time during the procurement process or in connection with the procurement process except as allowed under relevant state and federal law.

6.7.3. If after the Effective Date the Contractor discovers or is made aware of an organizational conflict of interest, the Contractor shall immediately and fully disclose such interest in writing to EOHHS. In addition, the Contractor shall promptly disclose any relationship that might be perceived or represented as a conflict after its discovery as a potential conflict. Disclosures shall include a description of the actions the Contractor has taken or proposes to take to avoid or mitigate such conflicts. EOHHS reserves the right to make a final determination regarding the existence of conflicts of interest, and the Contractor agrees to abide by EOHHS's decision.

6.7.4. If EOHHS determines an organizational conflict of interest exists, it may, at its discretion, terminate the Agreement pursuant to Article 10, "Termination of the Agreement."

6.7.5. The Contractor shall include provisions in its Subcontracts that impose obligations on Subcontractors that are consistent with the obligations imposed on Contractor pursuant to this Section.

6.8. Anti-kickback Provision

The Contractor certifies it shall comply with the Anti-Kickback Act of 1986 (41 U.S.C. §§ 51-58) and Federal Acquisition Regulation § 52.203-7, to the extent applicable.

6.9. Reporting of Political Contributions

6.9.1. The Contractor shall comply with R.I. Gen. Laws § 17-25.10.1, regarding reporting campaign contributions and expenditures, and shall provide EOHHS copies of any form filed with the Secretary of State regarding political contributions.

6.9.2. The Contractor shall update such forms as future political contributions subject to this reporting requirement are made. Failure to complete or update the form accurately, completely, and in conformance with its terms, or to file it with the Secretary of State within 60 Days of receipt, shall amount to a violation of the Agreement and may render the Contractor ineligible for further State contracts.

6. Assurances, Certifications, Guarantees, and Warranties – Document History Log	
Contract Cross-References	
Governing Requirements and Authority	• Anti-Kickback Act of 1986 (41 U.S.C. §§ 51-58) • Federal Acquisition Regulation § 52.203-7 • 42 C.F.R. § 438.6 • Rhode Island General Laws, Chapters 27-19, 27-20, 27-41, and Section 27-18.9-8 • Rhode Island General Laws, Chapter 36-14 • Rhode Island General Laws, Section 17-25.10.1
CMS Checklist Items	I.J.7, Insolvency, Section I.J.7.06
Revision Date and Description	

7. Intellectual Property

7.1. Ownership of Intellectual Property

7.1.1. All data, technical information, encounter data, information systems, materials gathered, originated, developed, prepared, modified, used, or obtained by the Contractor in performance of the Agreement, including, all hardware, software computer programs, data files, application programs, intellectual property, source code, documentation, and manuals, regardless of state of completion shall be deemed to be owned and remain owned by the State ("State Property").

7.1.2. However, each Party will retain all rights in any preexisting software, ideas, concepts, know-how, development tools, techniques or any other proprietary material or information that it owned or developed prior to the date of this Agreement or acquired or developed after the date of this Agreement without reference to or use of the intellectual property of the other Party.

7.1.3. All software that is licensed by a party from a third-party vendor will be and remain the property of such vendor.

7.2. Patent or Copyright Infringement

7.2.1. The Contractor represents that, to the best of its knowledge, none of the software to be used, developed, or provided pursuant to this Agreement violates or infringes upon any patent, copyright, or any other right of a third party.

7.2.2. If any claim or suit is brought against the State for the infringement of such patents or copyrights arising from the Contractor's use of any equipment, materials, software and products, or information prepared by or on behalf of the Contractor or developed in connection with the Contractor's performance of this Agreement, then the Contractor shall, at its expense, indemnify and defend the State against such claim or suit. The Contractor shall satisfy any final award for such infringement, through a judgment involving such a claim, suit or by settlement, with the Contractor's right of approval.

7. Intellectual Property – Document History Log	
Contract Cross-References	
Governing Requirements and Authority	
CMS Checklist Items	
Revision Date and Description	

8. Liability

The Contractor shall indemnify the State in accordance with Section 13.21 of the General Conditions of Purchase. Additionally:

8.1. Limitation of EOHHS' Liability

8.1.1. EOHHS will not be liable for any incidental, indirect, special, or consequential, exemplary, or punitive damages under contract, tort (including negligence), or other legal theory for the intentional acts or negligence of the Contractor. This will apply regardless of the cause of action and even if EOHHS has been advised of the possibility of such damages.

8.1.2. EOHHS' liability to the Contractor under this Contract will not exceed the per member per month total for one calendar month, including amendment or change order costs agreed to by the Parties or otherwise adjudicated.

8.1.3. The Contractor's remedies are governed by the provisions in Article 9, "Performance Standards, Remedies, and Disputes."

8. Liability – Document History Log	
Contract Cross-References	• Rhode Island General Conditions of Purchase, Section 13.22, Vendor Obligations • Attachment F-2, Article 9, Performance Standards, Remedies, and Disputes
Governing Requirements and Authority	
CMS Checklist Items	
Revision Date and Description	

9. Performance Standards, Remedies, and Disputes

9.1. Understanding and Expectations

9.1.1. The remedies described in this Section are directed to Contractor's timely and responsive performance of the Agreement's requirements, and the creation of a flexible and responsive relationship between the Parties.

9.1.2. The Contractor is expected to meet or exceed all performance requirements. EOHHS may conduct performance reviews at any time, and impose the remedies described in this Section if the Contractor's does not meet performance standards or other contractual requirements.

9.2. Corrective Action Plans

9.2.1. EOHHS may develop a Corrective Action Plan (CAP) to address a material breach of this Agreement. The Contractor shall accept and implement such CAP within the timeframes specified by EOHHS in the written notice of the CAP.

9.2.2. Alternatively, without waiving any of its other rights under this Agreement, EOHHS may require the Contractor to develop a Corrective Action Plan (CAP) to address a material breach of this Agreement.

9.2.3. Following notification of the original violation giving rise to the CAP, the Contractor shall immediately cease the noncompliant behavior and take actions to mitigate the harm caused by the violation.

9.2.4. A CAP developed by the Contractor shall, at a minimum, identify the following:

9.2.4.1. The finding resulting in a request for corrective action by EOHHS.

9.2.4.2. A description of how the Contractor will remediate the finding.

9.2.4.3. The timeline for implementing and completing the corrective action(s).

9.2.4.4. The names of the person responsible for leading all corrective action activities.

9.2.5. The Contractor shall submit the CAP no later than 10 Days after the date of EOHHS' written notice requesting a CAP. EOHHS may shorten or extend this deadline depending on the nature of the violation.

9.2.6. The Contractor's CAP must be approval by the EOHHS Managed Care Director.

9.2.6.1. The EOHHS Managed Care Director can accept the plan as submitted, accept the plan with specified modifications, or reject it.

9.2.6.2. If the EOHHS Managed Care Director requests modifications or rejects the CAP, the Contractor shall revise or submit a new CAP within ten Days, or another time specified in EOHHS' written notice. The revised or new CAP shall address all identified issues in the EOHHS notice.

9.2.7. The Contractor shall complete all corrective actions contained in the CAP within the time period determined and approved by the EOHHS Managed Care Director.

9.2.8. The Contractor shall provide updates to EOHHS on the remediation of all findings resulting in a request for corrective action at the interval requested by EOHHS.

9.2.9. EOHHS' acceptance of a CAP will not excuse the Contractor's prior substandard performance, relieve the Contractor of its duty to comply with performance standards or requirements, prohibit EOHHS from imposing other tailored remedies as it deems appropriate, and/or waive any other rights under this Agreement.

9.3. Tailored Remedies

9.3.1. EOHHS may pursue one or more of the following tailored remedies for each instance of noncompliance and will determine remedies on a case-by-case basis.

9.3.2. EOHHS' pursuit or non-pursuit of a tailored remedy does not constitute a waiver of any other remedy EOHHS may have in law or equity.

9.3.3. EOHHS will notify the Contractor of breaches that, in EOHHS' determination, do not result in a material deficiency. No later than five Business Days after receipt of such notice, the Contractor shall provide the EOHHS Managed Care Director a written response explaining the reasons for the deficiency, the Contractor's plan to cure the deficiency, and the date by which the deficiency will be cured. EOHHS may regard a repeated commission of or failure to cure of a non-material deficiency as a material breach and pursue additional remedies as described herein.

9.3.4. In addition to CAPs described in Section 9.2, "Corrective Action Plans," EOHHS may impose one or more of the following remedies for a material breach of this Agreement:

9.3.4.1. Conduct accelerated monitoring of the Contractor, including more frequent or extensive monitoring.

9.3.4.2. Require additional reporting.

9.3.4.3. Decline to renew or extend the Agreement.

9.3.4.4. Impose intermediate sanctions in accordance with Section 9.4.

9.3.4.5. Suspend new enrollment of Members in accordance with Section 9.4.1.4.

9.3.4.6. Require forfeiture of all of part of the Contractor's performance bond.

9.3.4.7. Terminate the Agreement in accordance with Article 10, "Termination of the Agreement."

9.3.5. Except for accelerated monitoring and additional reporting, EOHHS will provide the Contractor written notice 30 Days prior to imposing one or more of the tailored remedies described in this Section. The notice will include the basis for the remedy and any available appeal rights.

9.4. Intermediate Sanctions (CMS Checklist I.J.5.01-.20, I.L.2.02-.04)

9.4.1. In accordance with 42 C.F.R. §§ 438.700 and 438.702, EOHHS may impose the following types of intermediate sanctions for violations of this Agreement, including violations of Sections 1903(m), 1932, 1905(t) of the Social Security Act or 42 C.F.R. Part 438:

9.4.1.1. Civil monetary penalties as described in Section 9.7.

9.4.1.2. Appoint mandatory temporary management under the circumstances described in 42 C.F.R. § 438.706.

9.4.1.3. Notify Members of the Contractor's breach and allow Members to disenroll from the Contractor's Health Plan without cause if the Contractor repeatedly fails to meet the Agreement's requirements.

9.4.1.4. Suspend all new enrollment, including default enrollment, as described in Section 9.6.1 after the date the CMS or EOHHS notifies the Contractor of a determination of a violation of any requirement under Sections 1903(m) or 1932 of the Social Security Act.

9.4.1.5. Suspend payment for Members enrolled after the effective date of the sanction and until CMS or EOHHS is satisfied that the reason for the sanction no longer exists and is not likely to recur.

9.4.2. EOHHS retains the authority to impose additional sanctions under State statutes or regulations that address areas of noncompliance specified in 42 C.F.R. § 438.700, and any additional areas of noncompliance.

9.5. Notice to External Agencies

9.5.1. EOHHS will provide written notice to CMS in accordance with 42 C.F.R. § 438.724 no later than 30 Days after EOHHS imposes or lifts an intermediate sanction for any violation described in 42 C.F.R. § 438.700.

9.5.2. EOHHS will provide notice as required by law to any other state or federal agency for violations of the terms, conditions, or requirements of this Agreement or for any other violation of applicable laws or regulations by the Contractor.

9.5.3. EOHHS shall notify the Division of Purchases in writing of any action taken under this section, which may be considered in any future State procurement involving the Contractor.

9.6. Suspension of New Enrollment (CMS Checklist I.J.5.20)

9.6.1. EOHHS may suspend the new enrollment in the Contractor's Health Plan based on a material breach of this Agreement. The suspension period will be for a reasonable length of time specified by EOHHS, depending on the severity and circumstances of the breach.

9.6.2. EOHHS also may notify enrolled Members of the Contractor's suspension and allow these Members to disenroll from the Contractor's health plan without cause.

9.7. Civil Monetary Penalties (CMS Checklist I.J.5.01-.07 and I.L.2.01)

EOHHS may impose civil monetary penalties for the following activities, subject to the limits described below:

9.7.1. Failing to substantially provide Medically Necessary Covered Services to Member that the Contractor is required to provide under the terms of this Agreement (up to $25,000 per incident).

9.7.2. Charging premiums or charges exceeding those permitted in the Rhode Island Medicaid program. (Should Rhode Island Medicaid implement cost sharing requirements, EOHHS may impose up to $25,000 or double the amount of the excess charge, whichever is greater.)

9.7.3. Discriminating among Members based on their health status or need for health services (up to $15,000 per individual not enrolled due to a discriminatory act, subject to a maximum of $100,000 for each determination of discrimination).

9.7.4. Misrepresenting or falsifying information furnished to a Member, potential member, healthcare provider, EOHHS or other state agency or designee (up to $25,000 per instance).

9.7.5. Distributing Marketing Materials not approved by EOHHS or that contain false or misleading information, either directly or indirectly through a Representative (up to $25,000 per distribution).

9.8. Publication of Remedial Actions, Intermediate Sanctions, and Liquidated Damages

9.8.1. EOHHS will publish on its website on a quarterly basis a list of Contractors that were subject to remedial actions, intermediate sanctions, or liquidated damages during the prior quarter, the type of actions imposed on the Contractor, and the basis for the actions taken by EOHHS.

9.8.2. EOHHS will not publish, as final, any actions that are under dispute with the Contractor or any remedial actions, intermediate sanctions, or liquidated damages that have been waived or lifted by EOHHS.

9.9. Damages

9.9.1. EOHHS will be entitled to actual and consequential damages resulting from the Contractor's failure to comply with any of the terms of the Agreement.

9.9.2. In some cases, the actual damage to EOHHS or State of Rhode Island due to Contractor's failure to comply with the performance standards is difficult or impossible to determine with precise accuracy. In such cases, EOHHS will assess liquidated damages in accordance with Attachment F-5, "Liquidated Damages Matrix."

9.9.3. EOHHS, in its sole discretion, may waive, modify, or lift the imposition of any action taken against a Contractor, for good cause as determined by EOHHS, which includes the right of EOHHS to suspend the imposition of a remedial action, liquidated damages, or an intermediate sanction while the Contractor works to resolve and correct the underlying issue that resulted in the action taken by EOHHS.

9.10. Deduction from Payment

9.10.1. EOHHS may deduct civil monetary penalties, damages (actual, consequential, or liquidated), or other amounts owed to EOHHS from any amount payable to the Contractor pursuant to this Agreement.

9.10.2. The EOHHS Managed Care Director or his or her designee will provide advance written notice to the Contractor before EOHHS deducts such sums from amounts payable to the Contractor.

9.11. Payments Denied by CMS

9.11.1. EOHHS may recommend that CMS impose a denial of payment for new Members pursuant to 42 C.F.R. § 438.730. If the EOHHS' determination becomes CMS' determination, EOHHS will:

9.11.1.1. Provide the Contractor with written notice of the basis of the proposed sanction.

9.11.1.2. Allow the Contractor 10 Days from the date it received the notice to provide evidence contesting the basis for the sanction.

9.11.1.3. Conduct a reconsideration, if requested by the Contractor.

9.11.1.4. Provide the Contractor a written decision setting forth the basis for the reconsideration decision.

9.11.2. If the Contractor does not seek reconsideration, the denial of payment will be effective 15 Days after the date the Contractor is notified.

9.12. Enforcement Costs

In the event of any litigation, appeal, or other legal action to enforce any provision of the Contract, the Contractor agrees to pay all reasonable expenses of such action if EOHHS is the prevailing Party.

9.13. Disputes

9.13.1. Prior to the institution of arbitration or litigation concerning any dispute arising under this Agreement, the Purchasing Agent is authorized to resolve any disputes in accordance with 220-RICR-30-00-1.5, with further appeal to the Chief Purchasing Officer in accordance with 220-RICR-30-00-1.6.

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

9.13.3. Any fraudulent activity may result in criminal prosecution.

9. Performance Standards, Remedies, and Disputes – Document History Log	
Contract Cross-References	• Rhode Island General Conditions of Purchase, Section 13.31, Governing Law, Forum • Attachment F-5, Liquidated Damages Matrix
Governing Requirements and Authority	• Social Security Act, Sections 1903(m), 1905(t), and 1932(e) • 42 C.F.R. Part 438 and §§ 438.700, 438.702, 438.704, 438.706, 438.724, 438.726, and 438.730 • 220-RICR-30-00-1.5 • 220-RICR-30-00-1.6
CMS Checklist Items	• I.J.5, Sanctions, Sections I.J.5.01-.20 • I.L.2, Contract Standards and Terminations, Sections I.J.2.01-.04
Revision Date and Description	

10. Termination of the Agreement

As set forth in 220-RICR-30-00-13.20(D) and the General Conditions of Purchase, the State Purchasing Agent may terminate the Agreement, in whole or in part, for convenience at any time when the State Purchasing Agent determines in writing that the termination is in the State's best interest. EOHHS will provide reasonable advance written notice of the termination, as it deems appropriate under the circumstances. The termination will be effective on the date specified in the notice of termination.

10.1. Termination by Mutual Agreement

The Contract may be terminated by mutual written agreement of the Parties.

10.2. Availability of Funds

The Agreement may be terminated in whole or in part in accordance with 220-RICR-30-00-13.20(C) of the General Conditions of Purchase.

10.3. Termination by EOHHS for Cause (CMS Checklist I.J.6.01)

EOHHS and/or the State Purchasing Agent may terminate the Contract, in whole or in part, in accordance with 220-RICR-30-00-13.20(A). Additionally, EOHHS and/or the State Purchasing Agent may terminate upon the following conditions and subject to the pre-termination process described in Section 10.4:

10.3.1. EOHHS and/or the State Purchasing Agent may terminate the Agreement if the Contractor makes an assignment for the benefit of its creditors; admits in writing its inability to pay its debts generally as they become due; or consents to the appointment of a receiver, trustee, or liquidator of the Contractor's business or any part of its property.

10.3.2. EOHHS and/or the State Purchasing Agent may terminate the Agreement if a court of competent jurisdiction finds the Contractor failed to adhere to any Governing Requirements of any public authority having jurisdiction, and EOHHS determines such violation prevents or substantially impairs the Contractor's performance of its duties under the Agreement.

10.3.3. EOHHS and/or the State Purchasing Agent may terminate the Agreement if the Contractor breaches confidentiality laws with respect to this Agreement.

10.3.4. EOHHS and/or the State Purchasing Agent may terminate the Agreement if, after providing notice and an opportunity to correct, it determines the Contractor failed to supply personnel or resources and such failure results in the Contractor's inability to fulfill its duties under the Agreement.

10.3.5. EOHHS and/or the State Purchasing Agent may terminate the Agreement if a judicial or quasi-judicial authority determines the Contractor, its employees, agents, or representatives violated Rhode Island laws or regulations governing gifts to officers or employees of EOHHS or the State (see R. I. Gen. Laws §§ 36-14-5, 36-14.1-2, and Rhode Island Ethics Commission Regulation 36-14-5009).

10.3.6. EOHHS may terminate the Contract if a court or governmental body issues a judgement for the payment of money in excess of $500,000 that is not covered by insurance, and the Contractor does not: discharge the judgment, procure a stay of execution from the

judgement within 30 Days of entry, or perfect an appeal and cause a stay of execution of the judgment during the appeal, providing the financial reserves required by generally accepted accounting principles. Furthermore, if a writ or warrant of attachment or any similar process is issued by any court against all or any material portion of the property of Contractor, and it is not released or bonded within 30 Days after its entry, EOHHS may terminate the Agreement.

10.3.7. EOHHS may terminate the Agreement if it determines, at its sole discretion, that the Contractor has committed a material breach by failing to carry out or abide by substantive terms of this Agreement or meet the applicable requirements of federal laws or regulations, including sections 1932, 1903(m), or 1905(t) of the Social Security Act.

10.3.8. EOHHS may terminate the Agreement or require replacement of a Subcontractor if the Contractor or Subcontractor is convicted of a criminal offense in a state or federal court.

10.3.9. EOHHS may terminate the Agreement if the Contractor violates Attachment F-1, Section 3.1.14, "Employment of State Personnel."

10.3.10. EOHHS may terminate the Agreement if an audit or investigation discloses any material misrepresentation or falsification by the Contractor.

10.4. Pre-termination Process (CMS Checklist I.L.2.04-.10)

10.4.1. The following process will apply when EOHHS terminates the Agreement for any reason set forth in Section 10.3, "Termination by EOHHS for Cause."

10.4.2. In accordance with 42 C.F.R. § 438.710 and the State's Administrative Procedures Act, R.I. Gen. Laws § 42-35-1 *et. seq*., before terminating the Agreement, EOHHS will provide the Contractor with a pre-termination hearing. EOHHS will provide the Contractor reasonable advance written pre-termination notice, which will include the following information:

10.4.2.1. The reason for the termination;

10.4.2.2. The proposed effective date of the termination; and

10.4.2.3. The time and place of the pre-termination hearing.

10.4.3. After the pre-termination hearing, the State Medicaid Director will provide the Contractor with a written notice of EOHHS' final decision affirming or reversing the proposed Agreement termination and the effective date of termination, if applicable.

10.4.4. If the decision to terminate is affirmed, EOHHS will notify Members of the termination in accordance with Section 10.11, "Notification to Members."

10.5. Termination by Contractor

Contractor may terminate the Agreement upon the following conditions, subject to the notice requirements described in Section 10.6, "Contractor's Notice of Intent to Terminate."

10.5.1. Contractor may terminate the Agreement if EOHHS fails to pay undisputed charges when due under the Agreement. It is not cause for termination if EOHHS retains premiums, recoupments, sanctions, or penalties that are allowed under the Agreement and result from the Contractor's breach, failure to perform, or default. Termination does not release EOHHS from the obligation to pay undisputed charges for services provided before the

termination date. If EOHHS pays all undisputed amounts within 30 Days after receiving the Contractor's notice of intent to terminate, the Contractor cannot proceed with termination under this Article.

10.5.2. Except as provided below, regarding changes to the Managed Care Manual, the Contractor may terminate the Contract if EOHHS proposes an amendment or extension to this Agreement that is unacceptable to the Contractor, including a modification of the Capitation Rates.

10.5.3. If EOHHS proposes a substantive change to the Managed Care Manual that materially impacts the Contractor's financial obligations or ability to fulfill its obligations under the Agreement, the Contractor may terminate the Agreement.

10.6. Contractor's Notice of Intent to Terminate

If the Contractor intends to terminate the Agreement pursuant to this Article or allow the Agreement to expire, it shall give EOHHS advance written notice at least one year prior to the proposed termination or expiration. The termination date will be calculated as the last Day of the month following the one-year notice period.

The Parties can negotiate an earlier termination date by mutual written agreement.

10.7. Extension of Extension of Termination Date

The Parties may extend the effective date of termination one or more times by mutual written agreement.

10.8. Procedures on Termination

10.8.1. Upon expiration of this Agreement or receipt of a Notice of Termination, the Contractor shall:

10.8.2. Stop work under this Agreement on the expiration date or the date specified in the Notice of Termination.

10.8.3. With the approval of the State, settle all outstanding liabilities and claims arising out orders and subcontracts.

10.8.4. If applicable, complete work as has not been terminated by any Notice of Termination.

10.8.5. Provide all reasonably necessary assistance to EOHHS in transitioning Members out of the Health Plan. Such assistance shall include, but not be limited to, the forwarding of medical and other records; facilitating and scheduling Medically Necessary appointments for care and services; and identifying chronically ill, high risk, hospitalized and pregnant Members in their last four weeks of pregnancy. The transition of all data shall be delivered at no cost and in a format determined by EOHHS.

10.8.6. Provide monthly reports with the following information until the earlier of six months from the termination or expiration or instructed otherwise. Reports are due on the fifteenth working Day of each month for the prior month:

10.8.6.1. Claims aging reports identifying providers/creditors and IBNR amounts;

10.8.6.2. A summary of cash disbursements; and

10.8.6.3. Copies of all bank statements received by the Contractor in the preceding month.

10.8.6.4.

10.9. Refunds of Advance Payments

The Contractor shall return within 30 Days of receipt any funds advanced for coverage of Members for periods after the date of termination or expiration.

10.10. Liability for Medical Claims

The Contractor shall be liable for all medical claims incurred up to the date of termination or expiration of the Agreement. For Members hospitalized as of the date of termination, the Contractor's liability shall extend through the end of the impatient stay

10.11. Notification of Members (CMS Checklist I.L.2.11-.13)

10.11.1. Prior to expiration or termination of this Agreement, EOHHS will notify all impacted Members of:

10.11.1.1. The date of termination.

10.11.1.2. Their right to disenroll immediately without cause.

10.11.1.3. The process by which Members will continue to receive Covered Services.

10.12. Responsibilities upon Termination and/or Default of Agreement

10.12.1. Upon termination or default in accordance with 220-RICR-30-00-13.20 and the delivery to the Contractor of the final decision to terminate in accordance with Section 10.3, "Pre-termination Process," the Contractor shall:

10.12.1.1. Stop work under this Agreement on the date and to the extent specified in the notice of termination.

10.12.1.2. Take such action as may be necessary, or as the EOHHS Managed Care Director may reasonably direct, for the protection and preservation of the property related to this Agreement that is in the possession of the Contractor and in which the State has or may acquire an interest.

10.12.1.3. Terminate all orders to the extent that they relate to the performance of work terminated by the notice of termination.

10.12.1.4. Subject to the provisions of this paragraph, assign to the State all of the rights, title, and interest of the Contractor under the orders so terminated, in which case EOHHS shall have the right, at its discretion, to settle or pay any or all claims arising out of the termination of such orders, however, notwithstanding this provision, the Contractor shall not be obligated to assign any such rights, title or interest in the absence of payment therefore by the State.

10.12.1.5. With the approval or ratification of the State, initiate settlement of all outstanding liabilities and all claims, arising out of such termination of orders, the cost of which would be reimbursable in whole or in part, in accordance with the provisions of this Agreement. Final approval by EOHHS shall not be unreasonably withheld.

10.12.1.6. Subject to the provisions of this paragraph, transfer title, or if the Contractor does not have title, then transfer their rights to the State (to the extent that title has not already been transferred) and deliver in the manner, at reasonable times,

and to the extent reasonably directed by the State all files, processing systems, data manuals, or other documentation, in any form, that relate to the work completed or in progress prior to the notice of termination.

10.12.1.7. If instructed, complete the performance of such part of the work as shall not have been terminated by the notice of termination. The Contractor shall proceed immediately with the performance of the above obligations notwithstanding any delay in determining or adjusting the amount of any item of reimbursable price under this clause.

10.12.2. Upon termination, Contractor agrees to an orderly transition in accordance with 220-RICR-30-00-13.30 and Addendum F-1, Scope of Work, Article 4, "Turnover Phase Requirements."

10.13. Contractor Responsibility for Termination Costs

If EOHHS terminates the Agreement for any reason set forth in Section 10.3, "Termination by EOHHS for Cause," the Contractor shall be responsible to EOHHS for all reasonable costs incurred by EOHHS and the State of Rhode Island to replace the Contractor. These costs include, but are not limited to, the costs of procuring a substitute vendor and the cost of any claim or litigation reasonably attributable to Contractor's breach or failure to perform any service in accordance with the terms of the Contract.

10. Termination of the Agreement – Document History Log	

Contract Cross-References	• Rhode Island General Conditions of Purchase, Section 13.20
	• Addendum F-1, Scope of Work
	  ○ Attachment F-1, Section 3.1.14, Employment of State Personnel
	  ○ Section 4, Turnover Requirements

Governing Requirements and Authority	• Social Security Act, Sections 1903(m), 1905(t), and 1932 • 42 C.F.R. §§ 438.10, 438.708, 438.710, 438.722 • 220-RICR-30-00-13.20 • 220-RICR-30-00-13.30 • R.I. Gen. Laws §§ 36-14-5, 36-14.1-2, and 42-35-1 *et. seq*., • R.I. Ethics Commission Regulation 36-14-5009
CMS Checklist Items	• I.J.6, Termination, Section I.J.6.01 • I.L.2, Contract Sanctions and Terminations, Sections I.L.2.04-.13
Revision Date and Description	

ATTACHMENT F-3.1

Schedule of In-Plan Benefits

Schedule of In-Plan Benefits

Service	Benefit Detail		Reference Coverage Document
Inpatient Hospital Care	As Medically Necessary	The Contractor will be responsible for inpatient admissions or authorizations, even after the Member has been disenrolled from the Contractor's Health Plan and enrolled in another Health Plan or re- enrolled into Medicaid fee- for-service, until the management of the Member's care is formally transferred to the care of another Health Plan, another program option, or fee-for-service Medicaid.	Provider Manual: Inpatient
Outpatient Hospital Services	As Medically Necessary	Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting.	Provider Manual: Outpatient
Therapies	As Medically Necessary	Includes physical therapy, occupational therapy, speech therapy, hearing therapy, respiratory therapy and other related therapies. All therapy services must be prescribed by a physician and Speech Therapy performed by a licensed therapist. Therapy services must be Services directly related to an active plan of care designed by the prescribing physician and of such a level of complexity and sophistication that the judgment, knowledge and skills of a qualified therapist are required. All therapies must be medically necessary under accepted standards of medical practice to the treatment of the patient's condition.	Provider Manual: Physical, Occupational, and Speech Therapy
Physician Services	As Medically Necessary	Includes primary care, specialty care, obstetric and newborn care.	Provider Manual: Physician Services
Provider Services	As Medically Necessary	Includes primary care, specialty care, obstetric and newborn care.	Provider Manual: Provider Services
Family Planning Services	As Medically Necessary	Enrolled female members have freedom of choice of providers for family planning services.	N/A
Prescription Drugs	Covered if Referred by a Health Plan Physician or Provider	Generic substitution only unless provided for otherwise as described in the *Managed Care Pharmacy Benefit Plan Protocols*.	Provider Manual: Pharmacy
Non-Prescription Drugs	Covered if Referred by a Health Plan Physician or 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.	
Laboratory	Covered if	Includes urine drug screens	Provider Manual:

Services	Referred by a Health Plan Physician or Provider		Clinical Laboratory
Radiology Services	Covered if Referred by a Health Plan Physician or Provider	N/A	Provider Manual: Radiology Services
Diagnostic Services	Covered if Referred by a Health Plan Physician or Provider	N/A	Provider Manual: Diagnostic Services
Home Health Services	Covered if Referred by a Health Plan Physician or Provider	Includes 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 use at home. Home Health Services do not include respite care, relief care or day care.	Provider Manual: Home Health Services
Ambulance Services	Covered if Referred by a Health Plan Physician or Provider	The Medicaid Program covers emergency and non-emergency emergency transportation of patients who cannot sit, stand or walk. Only ground transportation is covered. Wheelchair or air transportation is not a covered service. The type of trip (emergency/non-emergency) must be consistent with the diagnosis of the patient transported (e.g., a trip billed as emergency transport would not be covered if the patient had a non-emergency diagnosis)	Provider Manual: Ambulance
Nursing Home Care and Skilled Nursing Facility Care	Covered if Referred by a Health Plan Physician or Provider	All skilled and custodial care covered. For Rhody Health Partners/Expansion members, the Contractor payments are limited to 30 consecutive Days. The Contractor is responsible for notifying the State to begin dis-enrollment process.	Provider Manual: Nursing Home Care and Skilled Nursing Facility Care
School-Based Clinic Services	As Medically Necessary	Covered for RIte Care members as Medically Necessary at all designate sites.	Provider Manual: Local Education Agency
Services of Other Practitioners	Covered if Referred by a Health Plan Physician or Provider	Includes practitioners certified and licensed by the State of Rhode Island including nurse practitioners, physicians' assistants, social workers, licensed dietitians, psychologists and licensed nurse midwives	Provider Manual: Other Practitioners
Podiatry Services	Covered if Referred by a Health Plan	The Medicaid Program covers routine foot care, such as debridement of nails and treatment for ingrown toenails.	Provider Manual: Podiatry

	Physician or Provider		
Optometry Services	As Medically Necessary	*For children under 21*: Covered as medically necessary with no other limits. *For adults 21 and older:* 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. 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.	Provider Manual: Vision
Hospice Services	Covered if Referred by a Health Plan Physician or Provider	Available to individuals who are certified as terminally ill.	Provider Manual: Hospice
Durable Medical Equipment	Covered if Referred by a Health Plan Physician or Provider	A guide to covered DME Items can be found in the provider manual.	Provider Manual: Durable Medical Equipment
Tobacco Cessation Services	Covered if Referred by a Health Plan Physician or Provider	Covers over-the-counter and prescription cessation products, as well as counseling. Prior Authorization may be required.	Tobacco Cessation Benefits
Interpreter Services	Covered if Referred by a Health Plan Physician or Provider	Reimbursement for Interpreter Services for Medicaid fee for service recipients is available for services provided during a one on one, face to face medically necessary office visit. Provider types eligible to seek reimbursement include physicians, podiatrists, optometrists, nurse practitioners, outpatient hospital clinics, and behavioral health providers.	Provider Manual: Interpreter Services
Transplant Services	Covered if Referred by a Health Plan Physician or Provider	N/A	N/A
HIV/AIDS Non-Medical Targeted Case Management for People	Covered if Referred by a Health Plan Physician or Provider	N/A	Provider Manual: HIV/AIDS Providers

Living with HIV/AIDS and those at High Risk for acquiring Risk for Acquiring HIV			
AIDS Medical Case Management	Covered if Referred by a Health Plan Physician or Provider	It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to- face, phone contact, and any other form of communication	Provider Manual: AIDS / HIV Case Management
Rehabilitation Services	Covered if Referred by a Health Plan Physician or Provider	N/A	Provider Manual: Rehabilitation Services
Complementary Alternative Medicine Services	Covered if Referred by a Health Plan Physician or Provider	Treatment from a chiropractor, acupuncturist, and massage therapist for the treatment of chronic pain	N/A
Community Health Worker Services	Covered if Referred by a Health Plan Physician or Provider	CHW services will be available to Medicaid 17 eligible individuals who have one or more chronic 18 health (including behavior health) conditions, who 19 are at risk for a chronic health condition, and 20 who face barriers meeting their health or 21 health-related social needs.	Community Health Workers Services
Doula Services	As Medically Necessary	Covered when medically necessary. ***Special Note:*** EOHHS must obtain approval from CMS on the proposed SPA during this contract amendment period. Until EOHHS receives such SPA approval, Contractor should not pay for any Doula services, except if offered as a value-add program. Upon SPA approval, EOHHS will communicate to Contractors the retroactive effective date of the SPA and Contractor must pay Doula services that were provided from the SPA effective date onward.	Draft State Plan Pages: Doula
Home Care Services	Covered if Referred by a Health Plan Physician or Provider	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	Provider Manual: Home Care

Treatment for Gender Dysphoria	Covered if Referred by a Health Plan Physician or Provider	Gender Nonconformity - extent to which a person's gender identity, role or expression differs from cultural norms prescribed for people of a particular sex and Gender Dysphoria - discomfort or distress that is caused by a discrepancy between the person's identity and that person's sex at birth. Covered services for members age 18 and older: 1. Behavioral Health 2. Hormonal therapy 3. Laboratory testing required to monitor hormonal therapy 4. Surgical procedures included in list below. Covered services for members age 17 or younger: 1. Behavioral Health 2. Pharmacological and hormonal therapy to delay physical changes of puberty to masculinize or feminize. *REQUIRES PRIOR AUTHORIZATION.* 3. Non-reversible hormonal therapy. *REQUIRES PRIOR AUTHORIZATION.*	Provider Manual: Gender Dysphoria PDF Version of Coverage Guidelines
Early Intervention	Covered if Referred by a Health Plan Physician or Provider	Covered for RIte Care members as included within the Individual Family Service Plan (IFSP), consistent with the 2005 Article 22 of the General Laws of Rhode Island	Provider Manual: Early Intervention

Health Homes for Children	Covered if Referred by a Health Plan Physician or Provider	Cedar services are established as EPSDT- based Medicaid services which are eligible for reimbursement by the State for all Medicaid eligible children under the age of 21, including children enrolled in RIte Care or RIte Share.
		
		Eligibility Criteria:
		• Suspected of having a severe mental illness, or severe emotional disturbance
		• Suspected of having two or more chronic conditions as listed below:
		  • Mental Health Condition
		  • Asthma
		  • Diabetes
		  • Developmental Disabilities
		  • Down Syndrome
		  • Mental Retardation
		• Seizure Disorders
		
		• Has one chronic condition listed above and is at risk of developing a second.
			Provider Manual: CEDARR Services

Institutes for Mental Disease Exclusion for Substance Use	Covered if Referred by a Health Plan Physician or	Management to members upon discharge and coordinate and/or arrange for in-plan medically necessary services. The Contractor will ensure that members discharged from an IMD after 15 Days receive appropriate clinical treatment in a non-IMD facility for as many Days as medically necessary. Additionally, the Contractor will recognize cases in which member are subject to a court ordered length of stay longer than 15 Days. The Contractor will ensure that the length of stay for	Provider Manual: IMD

Disorder treatment up to 30 Days	Provider	members is in compliance with the court order. While EOHHS requires that Contractor comply with all State and Federal regulations, Contractor should exercise its judgement with regard to clinical decisions.	
Adult Day Health	Covered if Referred by a Health Plan Physician or Provider	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.	Provider Manual: Adult Day Health
Children's Evaluations	Covered if Referred by a Health Plan Physician or Provider	Covered as needed, child sexual abuse evaluations (victim and perpetrator); parent child evaluations; fire setter evaluations; PANDA clinic evaluations; and other evaluations deemed medically necessary.	N/A
Nutrition Services	Covered if Referred by a Health Plan Physician or Provider	Covered as delivered by a registered or licensed dietitian for certain medical conditions as defined in Medicaid Managed Care Manual	Managed Care Manual Chapter 2
Extended Family Planning Services	As Medically Necessary	N/A	Managed Care Manual Chapter 2
Behavioral Health (Outpatient& Inpatient)	Covered if Referred by a Health Plan Physician or Provider	Includes residential substance use treatment for youth. Covered services include a full continuum of Mental Health and Substance Use Disorder treatment, including but not limited to, community- based narcotic treatment, methadone, and community detox. **Includes both Adults and Children.**	See Medicaid Managed Care Manual Chapter 2.X Services Provider Manual: BH Services
Preventive Services	Covered if Referred by a Health Plan Physician or Provider	Preventive services are services provided to individuals who require minimal assistance with ADL's/IADL's. Individuals are Medicaid Eligible but do not need to meet LTC eligibility requirements. Individuals must meet the preventive level of care. Includes homemaker services, minor environmental modifications, physical therapy evaluation and services, and personal care services.	Provider Manual: Preventive Services
Personal Care Services	Covered if Referred by a Health Plan Physician or Provider	Personal Care Services provide direct support in the home or community to an individual in performing activities of daily living (ADL) tasks (e.g., bathing, dressing, eating, grooming, mobility, toileting, and transferring) that he/she is functionally unable to complete independently due to disability. Personal care services may be provided by: • A Certified Nursing Assistant which is employed under a state licensed home care/ home health agency and meets such standards of education and training as are established by the State for the provision of these activities. • A Personal Care Attendant via Employer Authority under the Self Direction option.	Provider Manual: Personal Care

EPSDT Services	As Medically Necessary	Provided to all children, pregnant women, unborn children, and young adults up to age 21. See Section 3.7.1.	Provider Manual: EPSDT Services
Emergency Room Services and Emergency Transportation Services	Covered if Referred by a Health Plan Physician or Provider	Covered both in-and out-of-State, for Emergency Services	Provider Manual: Emergency Room Transportation
Court-Ordered Mental Health and Substance Use Services – Criminal Court	Covered if Referred by a Health Plan Physician or Provider	Covered for all members. Treatment must be provided in totality, as directed by the Court or other State official or body (i.e., a Probation Officer, The Rhode Island State Parole Board). If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. The following are examples of Criminal Court Ordered Benefits that must be provided in totality as an in-plan benefit: ***Bail Ordered:*** Treatment is prescribed as a condition of bail/bond by the court. ***Condition of Parole:*** Treatment is prescribed as a condition of parole by the Parole Board. ***Condition of Probation***: Treatment is prescribed as a condition of probation ***Recommendation by a Probation State Official:*** Treatment is recommended by a State official (Probation Officer, Clinical social worker, etc.). ***Condition of Medical Parole:*** Person is released to treatment as a condition of their parole, by the Parole Board.	Provider Manual: BH and SUD Services Managed Care Manual Chapter 2
Court-Ordered Mental Health and Substance Use Treatment – Civil Court	Covered if Referred by a Health Plan Physician or Provider	All Civil Mental Health Court Ordered Treatment must be provided in totality as an in-plan benefit. All regulations in the State of Rhode Island and Providence Plantations, Title 40.1, Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 40.1- 5, Mental Health Law, Section 40.1-5.5 must be followed. If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. Note the following are facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than 7 calendar Days, will be dis-enrolled from the Health Plan at the end of the month, and be re- assigned into Medicaid FFS. Civil Court Ordered Treatment can be from the result of: a) Voluntary Admission b) Emergency Certification	Provider Manual: BH and SUD Services Managed Care Manual Chapter 2

		c) Civil Court Certification Court-ordered treatment that is not an in-plan benefit or to a non-network provider, is not the responsibility of the Contractor. Court ordered treatment is exempt from the 14-Day prior authorization requirement for residential treatment.	
Court Ordered Treatment for Children	Covered if Referred by a Health Plan Physician or Provider	All Court Ordered Treatment must be provided in totality as an in-plan benefit including treatments which are ordered by the court to be provided by a non-network provider. If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires.	Provider Manual: BH and SUD Services Managed Care Manual Chapter 2
Dental Services *(Limited Benefit. – See Out-of-Plan Benefits)*	Covered if Referred by a Health Plan Physician or Provider	***Inpatient:*** The Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an inpatient setting. ***Outpatient:*** The Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an outpatient hospital setting. ***Oral Surgery:*** Treatment covered as medically necessary.	Provider Manual: Dental Managed Care Manual Chapter 2

ATTACHMENT F-3.2

Schedule of Out-of-Plan Benefits

Schedule of Out-of-Plan Benefits

SERVICE	SERVICE DETAILS
Dental Services	**Covered Benefits for Adults up to age 22:** • **Preventive Services:** Two cleanings and two oral exams per calendar year. • **Diagnostic & Radiology Services:** Bitewing and full series X-rays, biopsies of oral tissue, all medically necessary diagnostic evaluations and radiographic/diagnostic images. • **Endodontic Services** Complete root canal therapy for anterior teeth, intraoperative radiographs, limited other reinforcements, and limited other medically necessary endodontic services. • **Restorative Services** Limited restorative services, including amalgams, resins, and other medically necessary restorative services. • **Periodontal Services** Gingival curettage, gingivectomy, when medically necessary, and limited other periodontal procedures. • **Prosthodontic Services** Relines and adjustments, partial or full dentures, and limited other medically necessary prosthodontic procedures. • **Emergency and Palliative Services** Medically necessary emergency dental services, all palliative services, including routine and surgical extractions, incisions and drainage of abscesses. • **Oral Surgery:** Covered when medically necessary. **Not Covered for Adults up to age 22:** • General Anesthesia Services • Orthodontic Services • Missed Appointments **Covered Benefits for Children Under age 21[2]:** • **Preventive Services:** o **Routine Dental Exams:** Every six months o **Cleanings:** Every six months o **Fluoride Varnish**: Every six months o **Sealants:** Covered only for permanent molars; one treatment per tooth every five years.

[2] Treatment for children born after May 1, 2000 is managed through the RIteSmiles program.

	• **Diagnostic & Radiographs[3] Services:**
	  ○ **Intraoral/complete series:** Every four years;
	  ○ **Bitewing:** Once every calendar year;
	  ○ **Panoramic Film:** Every four years;
	• **Restorative Services**
	  ○ **Fillings:** As needed
	  ○ **Crowns:** As medically necessary
	  ○ **Dentures, partial or complete**: As medically necessary
	• **Other Services**
	  ○ **Space Maintainers:** As needed;
	  ○ Removable space maintainers will not be replaced. Medicaid will only pay once for recementation of any space maintainer.
	  ○ **Oral Surgery:** Extractions (removing a tooth) or other mouth surgery; as medically necessary.
	  ○ **Emergency Dental Care Services:** As medically necessary
	• **Other Services, *Requires Prior Authorization***
	  ○ **Orthodontics**: As medically necessary to correct a handicapping malocclusion
	  ○ **Other Dental Services:** As medically necessary

Non-Emergency Medical Transportation (NEMT)	NEMT means an entity that provides only NEMT services to Members under contract with the State, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates. NEMT is defined at 42 CFR §457.1206. The Contractor will coordinate and collaborate with the EOHHS-selected transportation broker to assist members in NEMT services.
Long-Term Care – Home and Community-Based Services (LTCS-HCBS)	The Contractor is required to assist Medicaid-only (not enrolled in Medicare) members accessing necessary LTCS-HCBS services covered by Fee-For-Service Medicaid (including services provided through consumer/self-directed and agency/Provider delivery models).
Residential services for MR/DD clients that are paid by the State's BHDDH	The Contractor is required to assist members accessing necessary developmental disabilities services that are provided by BHDDH as out-of-plan services as specified in Managed

[3] Regarding radiographs, Medicaid believes it is the dentist's responsibility to follow the ALARA Principle (As Low as Reasonably Achievable) to minimize the patient's radiation exposure and follows the recommendations developed by the American Dental Association and the Food and Drug Administration. For new patient adults or adolescents, recommendation is for individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized oral disease or a history of extensive dental treatment. Medicaid will not reimburse for both a full mouth series and panoramic radiographic in the same year.

	Care Manual, Chapter 2.
Special Education services as defined in the child's Individual Education Plan (IEP) for children with special health needs or developmental delays	The Contractor will not be financially liable for speech, hearing, and language therapy services or other Medicaid-covered services specified in Special Education Individual Education Plans (IEPs) and provided to special education students. However, the Contractor must create and implement written policies and procedures for promptly transferring medical and developmental data and for coordinating ongoing care with special education services. Included within these policies and procedures will be provisions for the Contractor participation in IEP development and monitoring, if so requested.
Lead Program home assessment and non-medical case management provided by Department of Health or Lead Centers for lead poisoned children	The Contractor will create and implement written policies and procedures to provide lead screening, education, and any Medically Necessary lead reduction therapies and agrees to work cooperatively with the Department of Health Lead Program or the Lead Centers to coordinate delivery of these services with those provided through the Contractor.
Department of Children, Youth and Families/Department of Health/Rhode Island Executive Office of Health and Human Services Special Program	The Contractor is encouraged to make referrals to these special programs as appropriate.
Adolescent Self-Sufficiency Collaborative (ASSC).	The Contractor is required to make appropriate referrals to the ASSC network of social service and community health agencies providing services to pregnant and parenting teens aged less than 20 in Rhode Island. Referrals could be for services such as Family Independence Program cash assistance, RIte Care Medical Assistance, Food Stamps, WIC, educational requirements and services, employment and training opportunities, childcare assistance, etc.
Centers of Excellence Programs	Centers of Excellence are considered out of plan benefits. Notwithstanding the foregoing, a Contractor will treat a Center of Excellence as an in-plan benefit when it is certified by certified by BHDDH to be providers under the Governor's Opioid Overdose Prevention and Intervention Task Force.

ATTACHMENT F-3.3

Schedule of Non-Covered Benefits

Schedule of Non-Covered Benefits

- Any service (medication, device, procedure, or equipment) that is not medically necessary.
- Experimental/investigational medications, devices, procedures, or equipment.
- Abortion, except to preserve the life of the woman, or in cases of rape or incest.
- Private rooms in hospitals, except when medically necessary.
- Cosmetic medications, devices, procedures, or equipment.
- Medications for sexual or erectile dysfunction, pursuant to Public Law No. 109-91, § 104.
- Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, related office visits (medical or clinic), drugs, laboratory services, radiological and diagnostic services, and surgical procedures.
- Any services or items furnished for which the provider does not normally charge.
- Services or items furnished for any condition or accidental injury arising out of and in the course of employment for which any benefits are available under the provisions of any workers' compensation law, temporary disability benefits law, occupational disease law, or similar legislation, whether or not the Medicaid beneficiary claims or receives benefits there under, and whether or not any recovery is obtained from a third-party for resulting damages.
- Services or items furnished for any sickness or injury occurring while the covered person is on active duty in the military.
- Payments to outside the United States and territories pursuant to § 6505 of the Affordable Care Act which amends section 1902(a) of the Social Security Act.
- All claims arising directly from services provided by or in institutions owned or operated by the federal government such as Veterans Administration hospitals.

ATTACHMENT F-3.4

Schedule of In Lieu of Services

SCHEDULE OF IN LIEU OF SERVICES (ILOS)

SERVICES APPROVED BY EOHHS AS IN-LIEU OF SERVICES:
• Chiropractic Services • Acupuncture • Massage Therapy • Yoga • Meditation classes

• Medication management services which include:
  ○ Ensuring compliance with medication regime
  ○ Prepacking medication boxes
  ○ Creating reference guide describing medications and dosages

• Nutritional Programs which include:
  ○ Weight reduction programs for obesity
  ○ Therapeutic counseling
  ○ Group support programs

• Meals on Wheels - Meal delivery for persons who are in danger of malnutrition and/or have limited mobility or access to transportation.
• Home care hours greater than six hours per Day to prevent increases in level of care or institutionalization
• Medically appropriate smart phone applications
• Therapeutic Light Boxes

ATTACHMENT F-4

Capitation Rates and Fiscal Assurances (Will be Added to Final Executed Contract)

Capitation Rates and Fiscal Assurances

(Placeholder Document to be Finalized at Execution)

ATTACHMENT F-5

Liquidated Damages Matrix

Liquidated Damages Matrix

Liquidated Damages		
Contract Reference	**Description**	**Damages**
Attachment F-2, General Terms and Conditions		
6.6	Failure to comply with conflict-of-interest requirements described in Attachment F-2 GTC, Article 6. Assurances, Certifications, Guarantees, and Warranties §6.6 Conflict of Interest.	**$10,000** per occurrence.
6.6, 3.22	Failure to timely provide conflict of interest or criminal conviction disclosures as required by Attachment F-2 GTC, Article 6. Assurances, Certifications, Guarantees, and Warranties §6.6 Conflict of Interest and §3.22.19 Required Disclosures.	**$1,000** per Day.
6.5	Failure to obtain and/or maintain NCQA accreditation within the timeframes specified in Attachment F-2 GTC, Article 6. Assurances, Certifications, Guarantees, and Warranties §6.5 Certification of Licensure and Accreditation.	**$100,000** per month for every month beyond the month NCQA accreditation must be obtained.
9.2, 3.23	Failure to provide a corrective action plan in a timely manner or failure to receive EOHHS approval for a submitted corrective action plan in accordance with Attachment F-2 GTC, Article 9, §9.2 Corrective Action Plans; 3.23.4. Audits of Services and Deliverables.	**$500** per Day for each Day the corrective action plan is not submitted and approved by EOHHS.
9.2, 3.23	Failure to comply with a corrective action plan as required by EOHHS in accordance with Attachment F-2 GTC, Article 9, §9.2 Corrective Action Plans; 3.23.4. Audits of Services and Deliverables.	**$1,500** per Day for each Day the Contractor fails to comply with an approved corrective action plan.
Article 2, Readiness Review Phase		
2.2.1.3	Failure to correct all Readiness Review deficiencies within required timeframes.	**$500** per Day.

2.2.2.2	Failure to provide pre-onsite materials as requested.	**$500** per deliverable.
2.2.3.2	Failure to meet plan Readiness Review Schedule as set by EOHHS.	**$5,000** per Day.
Article 3, Operational Requirements		
3.1 Contract Administration and Management		
3.1.9.3	Failure to obtain EOHHS approval for Subcontractors.	**$15,000** per occurrence.
3.2 Covered Populations, Enrollment, Disenrollment		
3.2.1	Failure to comply with Member enrollment and disenrollment processing timeframes as described in Section 3.2.	**$1,000** per occurrence per Member.
3.2.1.4(c)	Acts to discriminate among members on the basis of their health status or need for health care services.	**$15,000** for each Member EOHHS determines was either not enrolled or disenrolled due to a discriminatory practice.
3.3 Covered Benefits, Service Requirements, and Limitations		
3.3.2	Failure to provide any Medically Necessary Covered Services, or approved In-Lieu of Services, as outlined by this Agreement.	**$25,000** per incidence.
3.4 Behavioral Health		
3.4.1.8	Failure to report on or meet performance targets regarding behavioral health quality metrics and outcomes.	**$10,000** per missed quality target.
3.4.14	Failure to report on or complete plan activities describing Behavioral Health Innovation Plan activities and outcomes.	**$2,000** per Day.
3.5 Pharmacy		
3.5.11	Failure to timely update pharmacy reimbursement schedules.	**$2,500** per Day per occurrence.
3.5.14	Failure to implement and maintain a Pharmacy Lock-In Program.	**$2,000** per Day for each Day EOHHS determines the contractor is not in compliance.
3.7 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)		

3.7.8.1	Failure to achieve annual performance standards for EPSDT and lead screening services.	**$15,000** per deficient metric.
3.13 Care Program and Coordination of Care		
3.13.2	Failure to develop a Care Plan for a Member that includes all required elements as described in the Section 3.13.	**$500** per deficient/missing plan.
3.13.2	Failure to make at least three documented attempts to conduct a Health Risk Assessment for 100% of the Contractor's Members pursuant to 3.13.2.	**$20,000** per month that the Contractor's performance is less than 100%.
3.13.2	Failure to successfully conduct a Health Risk Assessment for at least 40% of the Contractor's Members pursuant to 3.13.2.	**$20,000** per month that the Contractor's performance is less than 40% of the membership.
3.13.2; 3.13.2.2.	Failure to timely develop and furnish to EOHHS the Care Program Plan as described in Section 3.13.2 "Care Program Plan Requirements", Subsection 3.13.2.2.	**$250** per Day.
3.13.2.4	Failure to delegate specified duties to Accountable Entities as required for Care Management functions pursuant to Section 3.13, Section 3.15.	**$10,000** for each instance EOHHS finds the Contractor failed to delegate required duties and functions.
3.14 Provider Networks and Requirements, Access to Care		
3.14	Failure to timely provide notice to EOHHS of capacity to serve the Contractor's expected enrollment as described in Section 3.14.	**$2,500** per Day.
3.14.11	Failure to report notice of Provider termination from participation in the Contractor's Provider network (includes terminations initiated by the Provider or by the Contractor) to EOHHS or to the affected Members within the timeframes required by Section 3.14.	**$100** per Day per Member for failure to timely notify the affected Member.
3.14.32	Failure to provide Covered Services within the timely access, distance, and appointment availability standard (excludes Department approved exceptions to the network adequacy standards).	**$2,500** per month for failure to meet a time or distance standard or appointment availability standard.

3.14.42	Failure to allow a Member to obtain a second medical opinion at no expense and regardless of whether the provider is a network Provider as specified in Section 3.14.	**$5,000** per occurrence.
3.15 Accountable Entities		
3.15.1.6	Failure to provide required data to Accountable Entities as required pursuant to Section 3.15.	**$500** for each Member EOHHS finds the Contractor failed to provide required data to the Accountable Entity.
3.15.2	Failure to properly monitor and oversee Accountable Entities on an ongoing basis to assess performance, deficiencies, or areas for improvement.	**$25,000** for each instance EOHHS finds the Contractor failed to properly monitor or oversee the Accountable Entities.
3.16 Utilization Management		
3.16.	Failure to comply with Member notice requirements for denials, reductions, terminations, or suspensions of services as described in Section 3.16.	**$1,000** per occurrence.
3.16	Failure to confer a timely response to a service authorization request in accordance with 42 C.F.R. § 438.210(d) as specified in Section 3.16.	**$5,000** per standard authorization request OR **$7,500** per expedited authorization request.
3.16.2.2	Failure to follow Department required Clinical Coverage Policies as specified in 3.16.2.2 (c).	**$2,500** per occurrence.
3.16.9	Imposing arbitrary utilization guidelines, prior authorization restrictions, or other quantitative coverage limits on a Member as prohibited under the Agreement or not in accordance with an approved Utilization Management Program Plan policy and protocols as described in Section 3.16.9.	**$5,000** per occurrence per Member.
3.17 Quality Assurance		
3.17	Failure to submit quality measures including audited HEDIS and CAHPS results within the timeframes specified in Section 3.17.	**$5,000** per Day.
3.17	Failure to timely submit appropriate PIPs to EOHHS as described in Section 3.17.6.	**$1,000** per Day.
3.17	Failure to timely submit QAPI to EOHHS as described in Section 3.17.9.	**$1,000** per Day.

3.17.10.1	Failure to take corrective action regarding the reporting of accurate, complete and timely performance measures to EOHHS.	**$2,500** per occurrence.
3.18 Marketing Requirements		
3.18.4.5	Failure to ensure Provider compliance with Marketing guidelines.	**$10,000** per incident.
3.18.5	Distribution of Marketing Materials that have not been approved by EOHHS or that contain false or misleading information, either directly or indirectly through any Representative.	**$25,000** per distribution or reported incident.
3.18.5	Misrepresents or falsifies information that it furnishes to a Member, potential Member, or health care Provider.	**$25,000** for each instance of misrepresentation.
3.18.5	Engaging in prohibited marketing activities or discriminatory practices or failure to market in an entire Region as described in 3.18.5.	**$25,000** per occurrence of prohibited activity.
3.18.6, 3.19.2	Failure to obtain approval of any agreements or materials requiring review and approval by EOHHS prior to distribution as specified in the Contract.	**$500** per Day the unapproved agreement or materials are in use.
3.19 Member Materials		
3.19.4, 3.19.5	Failure to comply with timeframes for providing Member Welcome Packets, handbooks, identification cards, and Provider Directories as described in 3.19.	**$250** per occurrence, per Member.
3.19.7	Failure to update online and printed Provider Directory as required by Section 3.19.	**$1,000** per monthly occurrence.
3.19.7	Failure to provide a Member a printed, braille, or oral Provider Directory within 30 Days of request as required by Section 3.19.	**$2,500** per occurrence.
3.19.7	Failure to maintain accurate Provider Directory information as required by Section 3.19.	**$100** per confirmed incident.
3.20 Member Services		

3.20.2.9	Contractor's Helpline 100% of operating hours must be properly equipped to accept calls including, without limitation, calls from members with limited English proficiency and calls from members who are deaf, hearing impaired or have other special needs as described in 3.20.2.9.	**$1,000** for each instance EOHHS finds the Contractor failed to meet a metric in a given month.
3.20.3.1(a)	Answer at least 95% of incoming Member information telephone calls within 30 seconds as described in 3.20.3.(a) "Call Center Performance Standards".	**$500** for each instance EOHHS finds the Contractor failed to meet a metric in a given month.
3.20.3.1(b)	Daily average Hold Time must be two minutes or less during regular business hours. A Member is considered on hold when they are waiting for a call center representative after navigating the interactive voice response (IVR) system and when a customer service representative places the Member on hold as described in 3.20.3.(b).	**$500** for each instance EOHHS finds the Contractor failed to meet a metric in a given month.
3.20.3.1(c)	Maintain a call abandonment rate of less than 5% as described in 3.20.3.1 (c).	**$1,000** for each instance EOHHS finds the Contractor failed to meet a metric in a given month.
3.20.3.3	Failure to provide notification within the 30-minute timeframe of service outage or operational failure of the Call Center.	**$1,500** for each instance EOHHS finds the Contractor failed to notify EOHHS within timeframe.
3.21 Grievances and Appeals		
3.21	Failure to attend mediations and hearings as scheduled	**$2,500** for each mediation or hearing that the Contractor fails to attend as required.
3.21	Failure to comply with all orders and final decisions relating to claim disputes, Grievances, Appeals and/or State Fair Hearing as issued or as directed by EOHHS.	**$5,000** per occurrence.
3.21.3.4.	Failure to report to EOHHS a denial of an Expedited Appeal request and the reasoning for the denial within 24 hours of the issuance of the Notice to the Member.	**$1,000** per Day.

3.21.5, 3.21.6	Failure to provide continuation or restoration of services where Member was receiving the service as required by Department rules or regulations, applicable Rhode Island or federal regulations and law, and all court orders governing Appeal procedures as they become effective as described in Section 3.21.	**$500** per Day for each Day the Contractor fails to provide continuation or restoration as required by EOHHS.
3.21.8.3	Failure to meet the following performance standards: a) 98% of Grievances resolved within 90 Days of receipt. b) 98% of Appeals resolved within 30 Days of receipt.	**$2,500** for each instance EOHHS finds the Contractor failed to meet a metric in a given month
3.22 Program Integrity, Fraud, Waste, and Abuse		
3.22.2	Failure to timely submit on an annual basis the Compliance Program pursuant to 42 CFR 438.608 and Section 3.22.	**$1,000** per Day.
3.22.3.1	Failure to establish and maintain a Special Investigative Unit as described in Section 3.22.	**$5,000** per Day that EOHHS determines the Contractor is not in compliance
3.22.12	Failure to timely submit a Fraud Prevention Plan or the Fraud Prevention Report that includes all required components as described in Section 3.22.	**$2,000** per Day.
3.22.13.4	Contractor does not suspend payments to the Provider, or the Contractor does not correctly report the amount of the payments held.	**$10,000** per occurrence.
3.22.15	Failure to timely report, or report all required information, for any credible allegation or confirmed instance of fraud or abuse relating to the Contractor's own conduct, a Provider, or a Member as described in Section 3.22.15 "Reporting Requirements."	**$2,000** per Day.
3.22.19	Failure to require and ensure compliance with ownership and disclosure requirements as required by §3.22.19 Required Disclosures.	**$2,500** per Provider disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a Provider that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 C.F.R. part 455, subpart B.

3.22.20	Failure to cooperate fully with EOHHS and/or any other Rhode Island or federal agency during an investigation of Fraud or Abuse, complaint, or Grievance as described in Section 3.22.20 "Cooperation."	**$2,500** per incident for failure to fully cooperate during an investigation.
3.24 Security and Confidentiality		
3.24; 3.24.4; 3.24.6 DOA GC Addendum F. Par. 10.	Failure by the Contractor or its Subcontractor to ensure that all data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable, and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of EOHHS Member's PHI as described in Section 3.24, "Security and Confidentiality", 3.24.4 "Privacy and Security Safeguards and Obligations" and 3.24.6, "Compliance with Applicable Laws, Regulations, Policies, and Standards", DOA GC Addendum F. Par. 10.	**$500** per Member per occurrence
3.24.6.3	Failure to comply with Applicable Laws, Regulations, Policies, and Standards	**$10,000** per occurrence.
3.24.7, DOA GC Addendum F. Par. 10.	Failure by the Contractor to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of Breach or notification of provisional Breach as described in Section 3.24.7, "Breach/Incident Reporting" and DOA GC Addendum F. Par.10.	**$500** per Member per occurrence, not to exceed $10,000,000.
3.24; 3.24.4; 3.24.6, 3.24.8 DOA GC Addendum F. Par. 10.	Failure by the Contractor to execute the appropriate agreements to effectuate transfer and exchange of Member PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, Business Associate Agreement or qualified	**$500** per Member per occurrence.

	protective order prior to the use or disclosure of PHI to a third party pursuant to the Contract as described in Sections 3.24.4. "Privacy and Security Safeguards and Obligations" and 3.24.6. "Compliance with Applicable Laws, Regulations, Policies, and Standards", 3.24.8. "Other", DOA GC Addendum F. Par. 10.	
3.24.8.1	Failure to abide by the State's confidentiality policy or the required signed Business Associate Agreement ("BAA").	**$20,000** per occurrence.
3.25 General Reporting Requirements		
3.25	Failure to timely submit complete and accurate reports and statements to EOHHS pursuant to the Managed Care Reporting Calendar as described in 3.25, "General Reporting Requirements".	**$2,000** per Day.
3.25.1.6	Failure to comply with reporting requirements.	**$500** per incident per report.
3.26 Claims and MIS Management		
3.26.7	Timeliness: Contractor fails to make timely payments to Providers pursuant to Section 3.26.	**$1,000** per Day.
3.26.7.3	Failure to meet the following performance standards: a) 90% of all Clean Claims must be paid within 30 Days of the date of receipt. b) 99% of all Clean Claims must be paid within 90 Days of the date of receipt.	**$15,000** per payment deficiency.
3.26.12	Failure to process and adjudicate Clean Claims in accordance with the procedures and the timeframes listed in this Agreement.	**$500** per incident.
3.26.19.1. (b)	Contractor demonstrates a pattern of inappropriately denying, delaying, or recouping Provider payments for services as determined by EOHHS	Monetary penalties equal to 150% of the value of the claims; inappropriately denied, delayed, or recouped;
Encounter Data Requirements		

3.26.25	Failure to comply with standards for encounter data completeness, accuracy and timeliness as described in "Rhode Island Medicaid Managed Care Encounter Data Quality Measurement, Thresholds and Penalties for Non-Compliance" and noted below.	See individual damages per incidence of noncompliance below
Timeliness		
	Timely File Submission Failure of the MCO to submit at least one file for each file type in the agreed upon cadence with EOHHS.	**$1,000** per Day late fee.
	Timely Submission Failure to submit and have encounters accepted into the MMIS within 45 Days of the claim payment date.	**$15,000** per month where the timeliness submission rate is greater than 2%.
Accuracy		
	Acceptance Rate Failure to maintain a rejection rate for encounter claim submission that is less than or equal to 2%.	**$5,000** for each month the encounter rejection rate is above 2%.
	Diagnosis Code Accuracy Failure to be able to attest that the diagnosis code distribution matches the diagnosis codes on the paid claims associated with the accepted encounter data for each state fiscal year and file type combination.	**$100,000** for each quarter the attestation is not completed.
	Data Accuracy for Business Use Failure to submit accurate encounter data resulting in interruptions to EOHHS business operations.	**$100,000** per occurrence.
Completeness		
	Completeness Variance Failure of the MCO to reach 98% threshold for encounter completeness.	**$100,000** for each quarter the encounter completeness ratio is below 98%.
	Completeness Attestation Failure of the MCO attest the FSR is an accurate and complete representation of the claim payment financial liability and encounter submission activity of the MCO.	**$10,000** for each quarter the attestation is not submitted with the FSR submission, or within the timeframe specified by EOHHS.

	Completeness Consistency Failure of the MCO to report total incurred cost within the 0.1% threshold in the FSR and FDCR submissions.	**$100,000** per quarter the FSR and FDCR are not reconciled within 0.1%.
3.27 Financial Requirements		
3.27.1	Failure to timely submit Third-Party Liability identification and collections as described in 3.27.	**$2,000** per Day.
3.27.1	Failure to timely submit a Third-Party Liability Policy as described in 3.27	**$2,000** per Day.
3.27.1	Failure to submit a Third-Party Liability Policy that fulfills the requirements as described in 3.27.	**$2,000** per Day.
3.27.9.1	Failure to timely submit the Recoveries and Collections from the report(s) described in Section 3.27.	**$250** per Day.
3.27.10.5	Failure to respond to requests for additional MLR Report information or reconciliation, or failure to make required corrections within the timeframe requested.	**$250** per Day.
Article 4, Turnover Phase Requirements		
4.1.1.3	Failure to comply with Transition of Care requirements pursuant to Attachment F-1 SOW, Article 4 Turnover Phase Requirements, §4.1 Introduction, 4.1.1.3 and the Medicaid Manual, Chapter 2, "Medicaid Services."	**$250** per Day per Member.
Directives and Deliverables		
	Failure to respond to or comply with any formal written requests for information or a directive made by EOHHS within the timeframe provided by EOHHS.	**$500** per Day that EOHHS determines the Contractor is not in compliance.
	Failure to establish or participate on any committee as required under the Contract, by EOHHS, or pursuant to Rhode Island or federal law or regulation.	**$1,000** per occurrence per committee that EOHHS determines the Contractor is not in compliance.

ATTACHMENT F-6

Request for Qualification – On file with the Division of Purchases)

Request for Qualification

(Placeholder Document, insert link to DOA website)

ATTACHMENT F-7

Contractor's Proposal -- On file with the Division of Purchases

Contractor's Proposal

On file with the Division of Purchases

APPENDIX C: Draft Medicaid Managed Care Manual

https://eohhs.ri.gov/providers-partners/medicaid-managed-care/medicaid-managed-care-manual

APPENDIX D: Managed Care Organization Request for Qualification: Financial Bidders Packet

https://eohhs.ri.gov/providers-partners/medicaid-managed-care/addendum-d-managed-care-organization-request-qualification

APPENDIX E: 2022 Medicaid Managed Care Procurement Library

https://eohhs.ri.gov/providers-partners/medicaid-managed-care/2022-medicaid-managed-care-procurement-library

Contract Terms and Conditions

Table of Contents

Terms and Conditions

BID STANDARD TERMS AND CONDITIONS

TERMS AND CONDITIONS FOR THIS BID

INSURANCE REQUIREMENTS (ADDITIONAL)

ANNUAL RENEWAL INSURANCE CERTIFICATES FOR WORKERS' COMPENSATION, PUBLIC LIABILITY, PROPERTY DAMAGE INSURANCE, AUTO INSURANCE, PROFESSIONAL LIABILITY INSURANCE (AKA ERRORS & OMISSIONS), BUILDER'S RISK INSURANCE, SCHOOL BUSING AUTO LIABILITY, ENVIRONMENTAL IMPAIRMENT (AKA POLLUTION CONTROL), VESSEL OPERATION (MARINE OR AIRCRAFT) PROTECTION & INDEMNITY, ETC., MUST BE SUBMITTED TO THE SPECIFIC AGENCY IDENTIFIED IN THE "SHIP TO" SECTION OF THE PURCHASE ORDER. CERTIFICATES ARE ANNUALLY DUE PRIOR TO THE BEGINNING OF ANY CONTRACT PERIOD BEYOND THE INITIAL TWELVE-MONTH PERIOD OF A CONTRACT. FAILURE TO PROVIDE ANNUAL INSURANCE CERTIFICATION MAY BE GROUNDS FOR CANCELLATION.

PURCHASE AGREEMENT BID

BIDDING (a) A single price shall be quoted for each item against which a proposal is submitted. This price will be the maximum in effect during the agreement period. Any price decline at the manufacturer's level shall be reflected in a reduction of the agreement price to the State. (b) Quantities, if any, are estimated only. The agreement shall cover the actual quantities ordering during the period. Deliveries will be billed at the single, firm, awarded unit price quoted regardless of the quantities ordered. (c) Bid price is net F.O.B. destination and shall include inside delivery at no extra cost. (d) Bids for single items and/or a small percentage of total items listed, may, at the State's sole option, be rejected as being non-responsive to the intent of this request. ORDERING (a) The User Agency(s) will submit individual orders for the various items and various quantities as may be required during the agreement period. (b) Exception - Regardless of any agreement resulting from this bid, the State reserves the right to solicit prices separately for any extra large requirements for delivery to specific destinations.

Mailing Address for Bid Proposals issued by the State of Rhode Island, Division of Purchases:

All Bid Proposals must be submitted to the following address:

State of Rhode Island

Department of Administration

Division of Purchases, 2nd Floor

One Capitol Hill

Providence, RI 02908

EQUAL OPPORTUNITY COMPLIANCE

THIS PURCHASE ORDER IS AWARDED SUBJECT TO EQUAL OPPORTUNITY COMPLIANCE.

BLANKET PAYMENT

DELIVERY OF GOODS OR SERVICES AS REQUESTED BY AGENCY. PAYMENTS WILL BE AUTHORIZED UPON SUBMISSION OF PROPERLY RENDERED INVOICES NO MORE THAN MONTHLY TO THE RECEIVING AGENCY. ANY UNUSED BALANCE AT END OF BLANKET PERIOD IS AUTOMATICALLY CANCELLED.

PAYMENT FULL IN ADVANCE

PAYABLE IN FULL IN ADVANCE. SUBMIT INVOICE TO RECEIVING AGENCY.

PURCHASE AGREEMENT AWARD

THIS IS A NOTICE OF AWARD, NOT AN ORDER. Any quantity reference in the agreement or in the bid preceding it are estimates only and do not represent a commitment on the part of the state to any level of billing activity, other than for quantities or volumes specifically released during the term. No action is to be taken except as specifically authorized, as described herein under AUTHORIZATION AND RELEASE. ENTIRE AGREEMENT - This NOTICE OF AWARD, with all attachments, and any release(s) against it shall be subject to: (1) the specifications, terms and conditions set forth in the Request/Bid Number cited herein, (2) the General Terms and Conditions of Contracts for the State of Rhode Island and (3) all provisions of, and the Rules and Regulations promulgated pursuant to, Title 37, Chapter 2 of the General Laws of the State of Rhode Island. This NOTICE shall constitute the entire agreement between the State of Rhode Island and the Vendor. No assignment of rights or responsibility will be permitted except with the express written permission of the State Purchasing Agent or his designee. CANCELLATION, TERMINATION and EXTENSION - This Price Agreement shall automatically terminate as of the date(s) described under CONTRACT PERIOD unless this Price Agreement is altered by formal amendment by the State Purchasing Agent or his designee upon mutual agreement between the State and the Vendor.

RIVIP INFO - BID SUBMISSION REQUIREMENTS

It is the vendor's responsibility to check and download anyand all addenda from the RIVIP. Thisoffer may not be considered unless a signed RIVIP generated BidderCertification Cover Form is attached and the Unit Price column is completed.The signed Certification Cover Form should be attached to the front of theoffer. Each bid proposal must be submitted in a separate sealed envelope withthe bidder's name and address and the specific "Solicitation Number,""Solicitation Title," and the "Bid Proposal Submission Deadline" marked in theupper left-hand corner of the envelope.

The bid proposal must be delivered (via mail, messengerservice, or personal delivery) to the Division of Purchases and date-stampedreceipted by the date and time specified for the bid proposal submissiondeadline. Bidders should mail bid proposals sufficiently in advance of the bidproposal submission deadline to ensure timely delivery to the Division ofPurchases or, when delivering a bid proposal in person or by messenger, shouldallow additional time for parking and clearance through security checkpoints.Bid proposals must be addressed to:

Rhode Island Department of Administration

Division of Purchases, 2nd Floor

One Capitol Hill, Providence, RI 02908-5855

Bid proposals that are not received by the Division ofPurchases by the bid proposal submission deadline for whatever reason will bedeemed late and will not be considered. The submission time will be determinedby the time clock in the Division of Purchases. Postmarks will not be considered proof of timely submission.

Bid proposals in electronic format are not accepted at thistime.

At the bid proposal submission deadline, bid proposals willbe opened and read aloud in public.

DIVESTITURE OF INVESTMENTS IN IRAN REQUIREMENT:
No vendor engaged in investment activities in Iran as described in R.I. Gen. Laws §37-2.5-2(b) may submit a bid proposal to, or renew a contract with, the Division of Purchases. Each vendor submitting a bid proposal or entering into a renewal of a contract is required to certify that the vendor does not appear on the list maintained by the General Treasurer pursuant to R.I. Gen. Laws §37-2.5-3.