Contract

BETWEEN

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

IN PARTNERSHIP WITH

The State of Rhode Island and Providence Plantations

Executive Office of Health and Human Services

AND

Neighborhood Health Plan of Rhode Island

EXECUTED:

January 1, 2018

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This Contract, made on January 1, 2018, is between the United States Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services (CMS), The State of Rhode Island and Providence Plantations, acting by and through the Executive Office of Health and Human Services (RI EOHHS), and Neighborhood Health Plan of Rhode Island (Contractor). Contractor's principal place of business is 910 Douglas Pike, Smithfield, RI 02917.

WHEREAS, CMS is an agency of the United States, Department of Health and Human Services, responsible for the administration of the Medicare, Medicaid, and State Children's Health Insurance Programs under Title XI, Title XVIII, Title XIX, and Title XXI of the Social Security Act;

WHEREAS, Section 1115A of the Social Security Act provides CMS the authority to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals under such titles, including allowing states to test and evaluate fully integrating care for dual eligible individuals in the State;

WHEREAS, RI EOHHS is an agency responsible for operating a program of medical assistance under 42 U.S.C. § 1396 et seq., and the RI 1115a Demonstration Waiver, designed to pay for medical, behavioral health, and Long Term Services and Supports (LTSS) for eligible beneficiaries (Enrollee, or Enrollees);

WHEREAS, Contractor is in the business of arranging medical services, and CMS and RI EOHHS desire to purchase such services from Contractor;

WHEREAS, Contractor agrees to furnish these services in accordance with the terms and conditions of this Contract and in compliance with all federal and State laws and regulations;

WHEREAS, the goal of the Phase II of the Integrated Care Initiative (ICI) is to improve the health, well-being, and health care of Medicare-Medicaid beneficiaries in Rhode Island and to reduce overall health care costs by redesigning the care delivery system.

WHEREAS, through an integrated financing mechanism, Contractor agrees to provide an integrated service delivery model that promotes the use of alternative payment models, eliminates fragmentation in care delivery, improves coordination of services, promotes community-based care over institutional care, and provides access to high quality, cost-effective person-centered services and supports.

WHEREAS, the essential elements of the ICI Phase II care delivery model include: a comprehensive continuum of high-quality services that are easily accessible, effectively coordinated, delivered in the least restrictive setting, and funded through a single capitated financing structure in a Medicare-Medicaid managed care organization; the transition to value-based over volume-based purchasing, through specified contracting targets for the Medicare-Medicaid managed care organization; integration of medical, behavioral health, LTSS, and social services; and an interdisciplinary care management model that effectively leverages existing care

management and care coordination services available to Enrollees and is integrated with the care and services delivered by Enrollee's providers;

WHEREAS, this Contract replaces in its entirety, the Contract entered into by CMS, RI EOHHS, and Neighborhood Health Plan of Rhode Island (the Contractor) executed and amended August 3, 2016,

NOW, THEREFORE, in consideration of the mutual promises set forth in this Contract, the Parties agree as follows:

Section 1. Definition of Terms

1.1. Advance Directive - An individual's written directive or instruction, such as a power of attorney for health care or a living will, for the provision of that individual's health care if the individual is unable to make his or her health care wishes known.

1.2. Adverse Action - (i) The denial or limited authorization of a service authorization request, including the type or level of service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the failure to provide services in a timely manner; or denial in whole or in part of a payment for an item or covered service for Enrollee; determination that a requested service is not a covered benefit (does not include requests for items or services that are paid fee-for-service outside the Contractor); (iv) the failure by the Contractor to render a decision within the required timeframes; or (v) solely with respect to a Medicare-Medicaid Plan that is the only serving a rural area, the denial of Enrollee's request to obtain services outside of the Service Area.

1.3. Adverse Benefit Determination - (i) 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 Service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; (iv) the failure to provide services in a timely manner, as defined by the State; (v) the failure of the Contractor to act within the required timeframes for the standard resolution of Grievances and Appeals; (vi) for a resident of a rural area with only one Medicare-Medicaid Plan, the denial of an Enrollee's request to obtain services outside of the Service Area; or (vii) the denial of an Enrollee's request to dispute a financial liability.

1.4. Affordability Standards - Established and adopted by the Rhode Island Office of the Health Insurance Commissioner, standards that work to transition health care payments towards value-based payment methodologies and encourages the model of care delivery to transition to one that emphasizes care coordination and increased quality of care.

1.5. Alternative Format – Provision of information in a format that takes into consideration the special needs of those who, for example, are visually impaired or have limited reading proficiency. Examples of Alternative Formats shall include, but not be limited to, Braille, large font, audio tape, video tape, and Enroll information read aloud to Enrollee.

1.6. Alternative Payment Methods – Methods of payment that are not solely based on fee-for-service reimbursements, and may include, but shall not be limited to, bundled payments, global payments, and shared savings arrangements. Alternative Payment Methods may include fee-for-service payments, which are settled or reconciled with a bundled or global payment.

1.7. Appeal — Enrollee's request for review of an Adverse Action or Adverse Benefit Determination to the Enrollee's coverage in accordance with Section 2.11 of the Contract.

1.8. Behavioral Health and Substance Abuse Treatment Services - Inpatient, outpatient and community mental health and rehabilitative services that are covered by the Demonstration.

1.9. Behavioral Health Inpatient Services – Services provided in a hospital setting to include inpatient medical/surgical/mental health/treatment of substance use disorders.

1.10. Behavioral Health Outpatient Services – Services that are provided in the home or community setting and to who are able to return home after care without an overnight stay in a hospital or other inpatient facility.

1.11. Capitated Financial Alignment Model — A model under the Medicare-Medicaid Financial Alignment Initiative where a State, CMS, and a health plan enter into a three-way Contract, and the health plan receives a prospective blended payment to provide comprehensive, coordinated care. Phase II of the ICI uses the Capitated Financial Alignment Model.

1.12. Capitation Payment – A payment CMS and RI EOHHS make periodically to the Contractor on behalf of each Enrollee under a contract for the provision of services within this Demonstration, regardless of whether the Enrollee receives services during the period covered by the payment.

1.13. Capitation Rate — The sum of the monthly Capitation Payments for the Demonstration Year (reflecting coverage of Medicare Parts A & B services, Medicare Part D services, and Medicaid services, pursuant to Appendix A of this Contract) including: 1) the application of risk adjustment methodologies as described in Section 4.2.4 and 2) any payment adjustments as a result of the reconciliation described in Section 4.6. Total Capitation Rate revenue will be calculated as if the Contractor had received the full quality withhold payment.

1.14. Care Coordinator - An individual who is responsible for managing all activities performed by the Interdisciplinary Care Team (ICT) for Enrollees who are not receiving long-term services and supports (LTSS) and are otherwise not identified as being at high-risk.

1.15. Care Management – A set of individualized, person-centered, goal-oriented, culturally relevant services to assure that an Enrollee receives needed services in a supportive, effective, efficient, timely and cost-effective manner. Care Management emphasizes prevention, continuity, and coordination, that support linkages across the full continuum of Medicare and Medicaid Covered Services based on individual Enrollee strength-based needs and preferences.

1.16. Carved-Out Service(s) - The subset of Medicaid and Medicare Covered Services, described in Appendix A, for which the Contractor will not be responsible under this Contract. Contractor agrees to coordinate and refer to these services as necessary.

1.17. Centers for Medicare & Medicaid Services (CMS) — The federal agency under HHS responsible for administering the Medicare and Medicaid programs.

1.18. Claim - An itemized statement of services rendered by Health Care Professionals (such as hospitals, physicians, dentists, etc.), billed electronically or on the CMS-1500, UB-04, or UB-92.

1.19. Community Health Team (CHT) Locally-based care coordination teams comprised of multidisciplinary staff from such fields of nursing, behavioral health, pharmacy, and social work that manage patients' complex illnesses across providers, settings, and systems of care. CHTs emphasize in-person contact with patients and integration with PCPs and community resources.

1.20. Community Transition Plan – A comprehensive plan that is created for Enrollees who have been identified as able to safely transition from a nursing facility to a community setting.

1.21. Community-Based Supportive Living Program - The Medicaid community-based LTSS program established by R. I. Gen. Laws § 40-8.13 for Medicaid and dually-eligible Medicaid and Medicare beneficiaries who choose to receive services through a long-term care managed care arrangement as defined therein. Under CSLP, certified assisted living residences and supportive care residences must have the capacity and authority to furnish personalized Medicaid services to meet the Enrollee's LTSS needs in a manner that promotes self-reliance, dignity and independence. In Rhode Island, assisted living residences and supportive care residences are licensed at various levels that reflect their capacity to provide different kinds of Medicaid services, depending on a beneficiary's level of care needs.

1.22. Compliance Officer – Contractor staff who must meet the requirements at 42 C.F.R. § 422.503(b)(4)(vi)(B).

1.23. Comprehensive Functional Needs Assessment (CFNA) – A multidimensional, interdisciplinary process to determine actionable risk factors and Enrollees' strength-based needs and preferences based on their medical, psychological, and functional capabilities. The CFNA is the basis of Enrollee-specific coordinated and integrated ICPs.

1.24. Consumer Assessment of Healthcare Providers and Systems (CAHPS) - Enrollee survey tool developed and maintained by the Agency for Healthcare Research and Quality to support and promote the assessment of consumers' experiences with health care.

1.25. Contract – The participation agreement that CMS and RI EOHHS have with the Contractor, for the terms and conditions pursuant to which a Contractor may participate in this Demonstration.

1.26. Contract Management Team — A group of CMS and RI EOHHS representatives responsible for overseeing the contract management functions outlined in Section 3.1.1 of the Contract.

1.27. Contract Operational Start Date — The first date on which any Enrollment into the Contractor's Medicare-Medicaid Plan (MMP) is effective.

1.28. Contractor — An entity approved by CMS and RI EOHHS that enters into a Contract with CMS and RI EOHHS in accordance with and to meet the purposes specified in this Contract. For purposes of this Contract, Contractor is Neighborhood Health Plan of Rhode Island.

1.29. Cost Sharing – Co-payments paid by the Enrollee in order to receive medical services.

1.30. Covered Services — The set of services to be offered by the Contractor.

1.31. Cultural Competence – Understanding those values, beliefs, and needs that are associated with an individual's age, gender identity, sexual orientation, and/or racial, ethnic, or religious backgrounds. Cultural Competence also includes a set of competencies which are required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities.

1.32. Days – Calendar days unless otherwise specified.

1.33. Demonstration – Phase II of the Rhode Island Integrated Care Initiative, implemented through the Financial Alignment Initiative, a CMS initiative that partners with states, health plans, and coordinated care entities to integrate service delivery and financing for Medicare-Medicaid enrollees. CMS' Financial Alignment Initiative uses two models to integrate service delivery and financing: 1) a capitated model, under which a State, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care; and 2) a managed fee-for-service model, under which a State and CMS enter into an agreement by which the State would be eligible to benefit from a portion of savings from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid. In Rhode Island, the Financial Alignment Initiative is using the Capitated Financial Alignment Model. See also Capitated Financial Alignment Model.

1.34. Department – Rhode Island Executive Office of Health and Human Services (RI EOHHS).

1.35. Direct Messaging – Secure, standards-based electronic messaging used for sending authenticated, encrypted health information directly to known trusted recipients over the internet.

1.36. Discharge Opportunity Assessment – A comprehensive assessment, administered in-person by a clinical professional, of an Enrollee's desire and ability to be safely discharged from a nursing facility into a community setting.

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

1.38. Electronic Visit Verification (EVV) – An in-home visit scheduling, tracking and billing system that uses telephone-based technology and GPS tracking to capture time and service information about home and community-based service visits. EVV is intended to employ controls within the delivery of home and community-based services to ensure quality of care, program efficiency, and quality assurance for various in-home and community-based care services.

1.39. Eligible Beneficiary — An individual who is eligible to enroll in the Demonstration but has not yet done so. This includes individuals who are enrolled in Medicare Part A and B and are receiving full Medicaid benefits, have no other comprehensive private or public health coverage, and who meet all other Demonstration eligibility criteria.

1.40. Emergency Dental Condition – Dental conditions requiring immediate treatment to control hemorrhage, relieve acute pain, and eliminate acute infection, pulpal death, or loss of teeth.

1.41. Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn child.

1.42. Emergency Services – Inpatient and outpatient services covered under this Contract that are furnished by a Health Care Professional qualified to furnish such services and that are needed to evaluate or stabilize an Enrollee's Emergency Medical Condition.

1.43. Encounter Data - The record of an Enrollee receiving any item(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated, or any other risk basis payment methodology submitted to CMS and RI EOHHS. This record must incorporate HIPAA security, privacy, and transaction standards and be submitted in the ASC X12N 837 format or any successor format.

1.44. Enrollee — Any Eligible Beneficiary who is actually enrolled in the Contractor's Medicare-Medicaid Plan.

1.45. Enrollee Medical Record – Documentation containing medical history, including information relevant to maintaining and promoting each Enrollee's general health and well-being, as well as any clinical information concerning illnesses and chronic medical conditions.

1.46. Enrollee Ombudsman – An independent, conflict-free entity, planned with support from a grant from CMS, under RI EOHHS that will assist Enrollees in accessing their care, understanding and exercising their rights and responsibilities, and appealing adverse decisions made by the Contractor. The Enrollee Ombudsman will be accessible to all Enrollees by telephone and, where appropriate, in-person, including support from community-based organizations. The Enrollee Ombudsman will provide advice, information, referral and assistance in accessing benefits and assistance in navigating the Contractor, providers, or RI EOHHS. The Enrollee Ombudsman may participate in the Contractor's Enrollee advisory committee activities.

1.47. Enrollee Services – Materials, processes, infrastructure (e.g., call center), and functions offered by the Contractor to provide information and support to Enrollees and Eligible Beneficiaries and respond to inquiries and concerns raised by Enrollees and Eligible Beneficiaries about the MMP, including, but not limited to, benefits, policies, processes and/or Enrollee rights.

1.48. Enrollment – The processes by which an Eligible Beneficiary is enrolled into the Contractor's MMP.

1.49. Enrollment Counselor – An independent entity contracted with RI EOHHS, which is responsible for processing all Enrollment and disenrollment transactions. The Enrollment Counselor will provide unbiased education to Enrollees on the Contractor and other potential Enrollment choices, and ensure ongoing customer service related to outreach, education, and support for individuals eligible for the Demonstration. The Enrollment Counselor will incorporate the option of PACE Enrollment into its scripts and protocols.

1.50. Environmental Modifications – Physical adaptations to the home of the Enrollee or the Enrollee's Family as required by the Enrollee's LTSS Care Plan, that are necessary to ensure the health, welfare, and safety of the Enrollee or that enable the Enrollee to attain, maintain, or retain capability for independence or self-care in the home and to avoid institutionalization, and are not covered or available under any other funding source.

1.51. Expedited Appeal –The accelerated process by which the Contractor must respond to an Appeal by an Enrollee if a denial of care decision by the Contractor may jeopardize life, health, or ability to attain, maintain, or regain maximum function, as determined by the Contractor.

1.52. External Appeal – An Appeal, subsequent to the Contractor's Appeal decision, to the State Fair Hearing process for Medicaid-based Adverse Benefit Determinations or the Medicare process for Medicare-based Adverse Actions.

1.53. External Quality Review Organization (EQRO) – An independent entity that contracts with the State and evaluates the access, timeliness, and quality of care delivered by managed care organizations to their Enrollees.

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

1.55. Federally-Qualified Health Center (FQHC) — An entity that has been determined by CMS to satisfy the criteria set forth in 42 U.S.C. § 1396d(1)(2)(B).

1.56. First Tier, Downstream and Related Entity — An individual or entity that enters into a written arrangement with the Contractor, acceptable to CMS, to provide administrative or health care services of the Contractor under this Contract.

1.57. Fiscal Employer Agent – An organization operating under Section 3504 of the IRS Code and IRS Revenue Procedure 70-6 and Notice 2003-70 which has a separate Federal Employer Identification Number used for the sole purpose of filing federal employment tax forms and payments on behalf of Enrollees who are receiving consumer directed services.

1.58. Flesch Score - Score which measures the readability of documents, as set forth in Rudolf Flesch, The Art of Readable Writing (1949, as revised 1974).

1.59. Flexible Benefits – Benefits the Contractor may choose to offer outside of the required Covered Services.

1.60. Grievance - Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or an Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the Contractor's or Health Care Professional's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. Possible subjects for Grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Primary Care Provider (PCP) or employee of the Contractor, or failure to respect the Enrollee's rights, as provided in Appendix B of this Contract.

1.61. Health Care Professional – A physician or other provider of health care services under this Demonstration, including but not limited to: a podiatrist, optometrist, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy assistant.

1.62. Health Effectiveness Data and Information Set (HEDIS) — Tool developed and maintained by the National Committee for Quality Assurance that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality.

1.63. Health Home - A comprehensive system of care coordination for Enrollees with chronic conditions. Health Homes integrate and coordinate all primary, acute, behavioral health and LTSS to treat the "whole-person" across the lifespan.

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

1.65. Health Outcomes Survey (HOS) — Enrollee survey used by CMS to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health.

1.66. Health Plan Management System (HPMS) — A system that supports contract management for Medicare health plans and prescription drug plans and supports data and information exchanges between CMS and health plans. Current and prospective Medicare health plans submit applications, information about Provider Networks, plan benefit packages, formularies, and other information via HPMS.

1.67. Homemaker Services – Services that consist of the performance of general household tasks (such as: meal preparation and routine household care) provided by a qualified homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

1.68. Home Care Services – Those services provided under a home care plan 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 provider, physical therapy, occupational therapy, respiratory therapy, and speech therapy. 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 Homemaker 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.

1.69. Home Stabilization Services – Evidence-based, time-limited tenancy support services that promotes independence and ensures that an individual is able to meet the obligations of their tenancy. These services include: early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations; education and training on the role, rights, and responsibilities of the landlord and tenant; coaching on developing and maintaining key relationships with landlords/property managers with the goal of fostering successful tenancy; assistance in resolving disputes with landlords/neighbors to reduce the risk of eviction or other adverse action; advocacy and linkage with community resources to prevent eviction when housing is, or may be, jeopardized; assistance with the housing recertification process; coordinating with the tenant to review, update, and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers; and continued training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

1.70. Initial Health Screen (IHS) – A telephonic IHS is conducted to identify and prioritize all Demonstration Enrollees not receiving long-term services, to identify Enrollees who are "at risk" and may benefit from Care Management services. The IHS explores the Enrollee's condition and need for Care Management.

1.71. Incurred But Not Reported (IBNR) – Liability for services rendered for which Claims have not been received.

1.72. Indian Enrollee – An Enrollee who is an Indian (as defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12.) This includes an enrollee is a member of a Federally recognized tribe; resides in an urban center and meets one or more of four criteria including: is 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; is an Eskimo or Aleut or other Alaska Native; is considered by the Secretary of the Interior to be an Indian for any purpose; or is determined to be an Indian under regulations issued by the Secretary; is considered by the Secretary of the Interior to be an Indian for any purpose; or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian Health Services, including as a California Indian, Eskimo, Aleut, or other Alaska Native

1.73. Indian Health Care Providers – A health care program operated by the Indian Health Services or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) as those terms are defined in the Indian Health Care Improvement Act (25 U.S.C. 1603).

1.74. Intensive Care Management (ICM) – Intensive Care Management services are available to Enrollees eligible for LTSS, and to individuals who are not eligible for LTSS and are designated as being at high-risk based on a CFNA performed by the Contractor. ICM services consist of (1) care coordination and management performed by a Lead Care Manager, (2) an ICP, (3) an ICT, (4) coordination of Medicare and Medicaid services, and monitoring of ICPs, (5) management of care transitions, and (6) analyzing ICM effectiveness and appropriateness, and Enrollee outcomes.

1.75. Interdisciplinary Care Plan (ICP) – The ICP is a written plan developed for all Enrollees. For enrollees eligible for LTSS or otherwise determined to be at high risk, the ICP is developed in collaboration with the Enrollee; the Enrollee's Family, guardian or other caregivers; PCP; and/or other ICT or other providers involved with the Enrollee and with the Enrollee's consent, that delineates the activities to be undertaken to address key issues of risk for the Enrollee across the full care continuum. For Enrollees receiving LTSS, the ICP must include the LTSS Care Plan.

1.76. Interdisciplinary Care Team (ICT) – A team of professionals and para-professionals that collaborate, in person and/or through other means, with Enrollees to develop and implement an ICP that meets Enrollees' medical, behavioral, LTSS, and social needs. The ICT will be developed by the Contractor (and under the direction of the Lead Care Manager for Enrollees eligible for LTSS or determined to be at high risk).

1.77. Lead Care Manager (LCM) – An appropriately qualified professional who is the Contractor's designated accountable point of contact for each Enrollee's ICM services, for Enrollees eligible for LTSS or Enrollees not eligible for LTSS and determined to be at high risk based on the results of a CFNA performed by the Contractor. The LCM is the primary individual responsible for implementing all responsibilities associated with the delivery of ICM services.

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

1.79. Long Term Services and Supports (LTSS) - A range of medical, social, or rehabilitation services a person needs over months or years in order to improve or maintain function or health, which are provided in the community or in a long-term care facility such as a nursing facility.

1.80. LTSS Care Plan – A written plan that addresses the LTSS needs of individuals who meet Medicaid LTSS eligibility criteria. The LTSS Care Plan includes, but is not limited to, the individual's LTSS goals and recommendations, LTSS services and care to be provided, LTSS clinical and non-clinical supports and services, a risk mitigation plan, and a 24/7 emergency back-up plan. For Enrollees, the LTSS Care Plan is part of the ICP.

1.81. Marketing, Outreach, and Enrollee Communications — Any materials designed to communicate plan benefits, policies, processes and/or rights to Enrollees or Eligible Beneficiaries that are consistent with the definition of marketing materials at 42 C.F.R. § 422.2260. This includes pre-Enrollment and post-Enrollment communications.

1.82. Medicaid - The program of medical assistance benefits under Title XIX of the Social Security Act, Title 44 of the SC Code of Laws, applicable laws and regulations and various demonstrations and waivers thereof.

1.83. Medicaid Management Information System (MMIS) - The medical assistance and payment information system of the Rhode Island Executive Office of Health and Human Services.

1.84. Medicaid-only Beneficiaries – Individuals who are entitled to full Medicaid benefits but are not eligible for Medicare.

1.85. Medicaid Waiver – Generally, a waiver of existing law authorized under Section 1115(a), 1115A, or 1915 of the Social Security Act. A Section 1115(a) waiver is also referred to as a demonstration.

1.86. Medically Necessary Services – Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise Medically Necessary under 42 U.S.C. § 1395y. In accordance with Medicaid law and regulations, and per Rhode Island Medicaid, the term "Medical Necessity," "Medically Necessary," or "Medically Necessary Service" means medical, surgical, or other services required for the prevention, diagnosis, cure, or treatment of a health-related condition including such services necessary to prevent a detrimental change in either medical or mental health status. Medically Necessary Services must be provided in the most cost effective and appropriate setting and shall not be provided solely for the convenience of the Enrollee or service provider.

1.87. Medicare – Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis. Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, DME, and laboratory services and Supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.

1.88. Medicare Advantage - The Medicare managed care options that are authorized under Title XVIII as specified at Part C and 42 C.F.R. § 422.

1.89. Medicare Waiver - Generally, a waiver of existing law authorized under Section 1115A of the Social Security Act.

1.90. Medicare-Medicaid Beneficiaries - For the purposes of this Demonstration, individuals who are entitled to Medicare Part A and enrolled in Medicare Parts B and D and receive full Medicaid benefits under the Rhode Island Medicaid State Plan.

1.91. Medicare-Medicaid Coordination Office (MMCO) – Formally, the Federal Coordinated Health Care Office, established by Section 2602 of the Affordable Care Act.

1.92. Medicare-Medicaid Plan (MMP) – A health plan under contract with CMS and the State to provide fully integrated Medicare and Medicaid benefits under the Demonstration. The MMP integrates the provision of Primary Care, acute care, behavioral health care, and LTSS and supports through Care Management strategies focused on the person's needs.

1.93. Mid-Level Practitioners – Mid-Level Practitioners include physician assistants, certified nurse practitioners, and certified nurse midwives. These individuals are subject to the laws and regulations of Rhode Island and may not exceed the authority of these regulations.

1.94. Minimum Data Set (MDS) – Part of the federally mandated process for assessing individuals receiving care in certified skilled nursing facilities in order to record their overall health status regardless of payer source. The process provides a comprehensive assessment of individuals' current health conditions, treatments, abilities, and plans for discharge. The MDS is administered to all residents upon admission, quarterly, yearly, and whenever there is a significant change in an individual's condition. Section Q is the part of the MDS designed to explore meaningful opportunities for nursing facility residents to return to community settings.

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

1.96. Money Follows the Person (MFP) – Demonstration designed to create a system of LTSS that better enable individuals to transition from certain long-term care institutions into the community. Individuals enrolled in MFP will be included in the Demonstration. In Rhode Island, MFP is called Rhode to Home.

1.97. Non-Participating Physician – A physician licensed to practice that has not contracted with or is not employed by the Contractor to participate in the network of Health Care Professionals under this Contract.

1.98. Nursing Home Transition Program (NHTP) – An RI EOHHS-run program designed to help an individual transition from a nursing facility to the community.

1.99. Opt-Out – A process by which an Enrollee can choose to be excluded from passive enrollment in the Demonstration.

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

1.101. Participating Physician – A physician licensed to practice in Rhode Island who has contracted with or is employed by the Contractor to furnish services covered in this Contract.

1.102. Party – Either the State of Rhode Island, CMS, or the Contractor in its capacity as a contracting Party to this Contract.

1.103. Passive Enrollment – An Enrollment process through which an eligible individual is enrolled by RI EOHHS (or its vendor) into the Contractor, following a minimum sixty (60) day advance notification from the enrollment effective date that includes the plan selection and the opportunity to cancel the passive enrollment into the Demonstration prior to the effective date. The individual may Opt-Out of passive enrollment in the Demonstration at any time.

1.104. Patient Centered Medical Home (PCMH) – A 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. PCMHs are certified by National Committee for Quality Insurance (NCQA) and RI EOHHS requires the inclusion of PCMH as PCPs in this procurement.

1.105. Peer Navigator – An individual who provides services to meet the needs of Enrollees who require assistance and peer mentoring to facilitate access to community services. Typically a trained para-professional who is responsible for helping Enrollees navigate the delivery system across their local communities.

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

1.107. Personally Identifiable Information (PII) – Any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, 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 2 CFR § 200.79 and as defined in OMB Memorandum M-06-19, "Reporting Incidents Involving Personally Identifiable Information and Incorporating the Cost for Security in Agency Information Technology Investments"). 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, 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 2 CFR § 200.82 Protected Personally Identifiable Information).

1.108. Phase I – Phase I of the Rhode Island Integrated Care Initiative includes the provision of all Medicaid-covered benefits to Medicaid-only Beneficiaries who receive LTSS, and to all full benefit Medicare-Medicaid Beneficiaries, except for those individuals who are specifically excluded from the ICI. Some services for individuals with intellectual and developmental disabilities is provided via the FFS system and is not covered by the capitation rate. The contract in Phase I is between RI EOHHS and the participating RHO plan.

1.109. Phase II – Phase II of the Rhode Island Integrated Care Initiative includes the integrated provision of both Medicare and Medicaid benefits to Medicare-Medicaid Beneficiaries eligible for full Medicare and Medicaid benefits. Phase II will require the Contractor to provide both Medicare and Medicaid benefits to Enrollees, with the exception of certain developmental disability and other services that will be provided to Enrollees via the FFS system and will not be covered by the capitation rate. CMS and RI EOHHS may seek to bring these services into the Demonstration in the future. The conduct of Phase II shall be governed through a three-way contract between CMS, RI EOHHS, and the Contractor. The Contractor shall receive prospective, capitated payments to provide comprehensive, coordinated care to Rhode Island Medicare-Medicaid Beneficiaries.

1.110. Post-stabilization Care Services - Covered Services, related to an emergency medical condition that are provided after an Enrollee is stabilized in order to maintain the stabilized condition or are provided to improve or resolve the Enrollee's condition and/or under the circumstances described in 42 C.F.R. § 438.114(e).

1.111. Pre-Admission Screening Resource Referral (PASRR) - The process to: (i) evaluate the functional, nursing, and social supports of Enrollees referred for long-term services and supports; (ii) assist Enrollee in determining needed services; (iii) evaluate whether community services are available to meet the Enrollees' needs; and (iv) refer Enrollee to the appropriate provider for Medicaid-funded facility or home- and community-based care in accordance with Rhode Island Medicaid Code of Administrative Rules (MCAR) Section 0378.05.

1.112. Prevalent Languages – Those non-English languages that meet the more stringent of either Medicare's five (5) percent threshold for translation as specified in 42 CFR § 422.2264(e), or the RI EOHHS prevalent language requirement of fifty (50) enrollees who speak a single language other than English as a primary language.

1.113. Primary Care – Services that are: New and established patient office or other outpatient evaluation and management (E/M) visits; initial, subsequent, discharge, and other nursing facility E/M services; new and established patient domiciliary, rest home (for example, boarding home), or custodial care E/M services; domiciliary, rest home (for example, assisted living facility), or home care plan oversight services; or new and established patient home E/M visits.

1.114. Primary Care Provider (PCP) – A Health Care Professional selected by or assigned to the Enrollee to provide and coordinate the Enrollee's health care needs and to initiate and monitor referrals for specialized services when required. The PCP shall be a physician, physician assistant, or certified nurse practitioner in one of the following specialties: family medicine, general practice, gynecology, internal medicine, or geriatrics. PCPs shall meet the credentialing criteria established by the Contractor and approved by RI EOHHS. On a case-by-case basis, a PCP may also be a specialist who has an ongoing clinical relationship with an Enrollee, serves as the principal coordinating provider for the Enrollee's special health care needs, and plays a critical role in managing that Enrollee's care on a regular basis.

1.115. Privacy – Requirements established in the Health Insurance Portability and Accountability Act of 1996, and implementing Medicaid regulations, including 42 C.F.R. §§ 431.300 through 431.307, as well as relevant Rhode Island privacy laws.

1.116. Private Duty Nursing – Private Duty nursing services means nursing services for beneficiaries 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. Private Duty Nursing services are provided by a registered nurse or a licensed practical nurse under the direction of the beneficiary's physician. Services may be provided to the beneficiary in his or her own home, a hospital or a skilled nursing facility.

1.117. Program Manager – Employed by the Contractor and responsible for managing and coordinating the resources allocated for the Demonstration.

1.118. Program of All-inclusive Care for the Elderly (PACE) – A capitated benefit authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing for frail elderly individuals who meet nursing facility level of care requirements. The PACE program in Rhode Island is a three-way partnership between the Federal government, the State of Rhode Island, and the PACE organization of Rhode Island (PORI).

1.119. Provider Network – A network of health care and social support providers, including but not limited to PCPs, nurses, nurse practitioners, physician assistants, care managers, specialty providers, behavioral health/substance abuse providers, community and institutional long-term care providers, pharmacy providers, and acute providers employed by or under subcontract with the Contractor.

1.120. Provider Preventable Condition – *Health care-acquired condition* means a condition occurring in a hospital setting, identified as HAC in the State Plan as described in Section 1886(d)(4)(D)(ii) and (iv) of the Social Security Act; other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients. *Other provider-preventable condition* means a condition occurring in any health care setting that meets the following criteria: (1) is identified in the State plan (2) has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines, (3) has a negative consequence for the beneficiary, (4) is auditable, and (5) includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

1.121. Quality Improvement Organization (QIO) – As set forth in Section 1152 of the Social Security Act and 42 C.F.R. Part 476, an organization under contract with CMS to perform utilization and quality control peer review in the Medicare program or an organization designated as QIO-like by CMS. The QIO or QIO-like entity provides quality assurance and utilization review.

1.122. Readiness Review - Prior to entering into a three-way Contract with the State and CMS, the Contractor selected to participate in the Demonstration will undergo a Readiness Review. The Readiness Review will evaluate the Contractor's ability to comply with the Demonstration requirements, including but not limited to: the ability to quickly and accurately process Claims and Enrollment information, accept and transition new Enrollees, and provide adequate access to all Medicare- and Medicaid-covered Medically Necessary Services. CMS and the State will use the results to inform their decision of whether the Contractor is ready to participate in the Demonstration. At a minimum, the Readiness Review will include a desk review and a site visit to the Contractor's headquarters.

1.123. Rhode Island All-Payer Claims Database (RI-APCD) - A repository of healthcare insurance payment information for people living in Rhode Island, which has been developed through a collaborative effort of the Rhode Island DOH, the Office of the Health Insurance Commissioner, the Health Benefits Exchange, and RI EOHHS. The data in the RI-APCD is reported by the major health insurance companies doing business in Rhode Island, including fully-insured and self-funded commercial plans, Medicare and Medicaid.

1.124. Rhode Island Executive Office of Health and Human Services (RI EOHHS) – The agency responsible for administering the Medicaid program in the State of Rhode Island, and responsible for implementation and oversight of the Demonstration with CMS.

1.125. Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) – The Department responsible for assuring access to quality services and supports for Rhode Islanders with intellectual and developmental disabilities, mental health and substance abuse issues, and chronic long-term medical and psychiatric conditions; and for advancing the State's mission to address and erase the stigma attached to these disabilities as well as planning for the development of new services and prevention activities.

1.126. Rhode Island Integrated Care Initiative (ICI) – The ICI integrates the provision of Primary Care, acute care, behavioral health care, and LTSS for Medicaid-only Beneficiaries and Medicare-Medicaid beneficiaries through Care Management strategies focused on the person's needs. Phase I of the ICI includes the provision of Medicaid-covered benefits to Medicaid-only adults eligible for LTSS, and to all full-benefit Medicare-Medicaid beneficiaries except for those individuals who are specifically excluded from the ICI or choose to Opt-Out, through the Rhody Health Options (RHO) program. Under Phase II of the ICI, Medicaid-only Beneficiaries and Medicare-Medicaid beneficiaries enrolled in a RHO plan will continue to receive Medicaid services from that plan. Medicare-Medicaid beneficiaries who enroll in the Demonstration will newly receive Medicare benefits from an RHO plan serving as an MMP. As under Phase I, certain developmental disability services, as well as a limited number of other services, will continue to be funded and managed under the FFS system. CMS and RI EOHHS may seek to include these services in the ICI (including the Demonstration) at a later point in time.

1.127. Rhode Island Personal Choice Program – Provides a home and community-based personal care program where individuals who are eligible for LTSS have the opportunity to exercise choice and control (i.e., hire, fire, supervise, manage) individuals who provide their personal care, and to exercise choice and control over a specified amount of funds in a participant-directed budget.

1.128. Rhody Health Options (RHO) – The comprehensive Medicaid managed care delivery system implemented under Phase I of the ICI for Medicaid-only Beneficiaries eligible for LTSS and Medicare beneficiaries who are entitled to full Medicaid benefits.

1.129. Rhode to Home – Program administered through the federal Money Follows the Person Demonstration Grant that allows Medicaid-eligible enrollees who are residing in a nursing facility for at least ninety (90) consecutive days to receive transition coordination services for transitioning from institutions to the community of their choice. This program is an effort to address the need to rebalance the long-term care system. RI EOHHS utilizes the State's existing Nursing Home Transition Program to implement requirements set forth under ICI.

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

1.131. Self-Directed Services – Services that empower public program participants and their families by expanding their degree of choice and control over LTSS they need to live at home. Self-direction transfers much, but not all, of the decision-making and managerial authority over LTSS to participants and/or their designated representatives.

1.132. Self-Direction – The ability of an Enrollee to direct his/her own services through a consumer-directed personal assistance option.

1.133. Service Area - The specific geographic area of Rhode Island designated in the CMS HPMS, and as referenced in Appendix H, for which the Contractor agrees to provide Covered Services to all Enrollees who select or are passively enrolled with the Contractor under this Demonstration. The Service Area for the Demonstration is statewide.

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

1.135. Stabilized - As defined in 42 C.F.R. § 489.24(b), 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 (including discharge) of the individual from a hospital or, in the case of a pregnant woman who is having contractions, that the woman has delivered the child and the placenta. The attending emergency physician, or the medical provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently Stabilized for transfer or discharge.

1.136. State – The State of Rhode Island acting by and through the RI EOHHS, or its designee.

1.137. State Fair Hearing – The RI EOHHS State hearing process available to an Enrollee once they have exhausted the Contractor's internal Appeals process.

1.138. Supplies – Health care-related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, and are required to address an individual medical disability, illness, or injury. Supplies do not need to be incidental to other Covered Services.

1.139. Telemedicine – Method, other than home monitoring, of delivering live health care services utilizing technologies for diagnosis, treatment, education, counseling and care management when the Enrollee and Health Care Professional are not located at the same service site and do not have access to in-person interactions.

1.140. Total Adjusted Expenditures – The Contractor's actual amount incurred for expenditures for Covered Services and non-service expenditures, including both administrative and care management costs.

1.141. Total Adjusted Capitation Rate Revenue - Sum of the monthly capitation payments for the applicable Demonstration Year (reflecting coverage of Medicare Parts A/B services and Medicaid services, pursuant to Appendix A of this contract).

1.142. Urgent Care – Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include Primary Care services or services provided to treat an Emergency Medical Condition.

1.143. Utilization Management – The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria.

1.144. Wellness Assessment – An assessment that is conducted for Enrollees residing in nursing facilities who do not want and/or are not able to transition safely to a community setting. This assessment can be conducted via phone or in person with a nursing facility resident, Family member, or nursing facility clinical staff member, as appropriate.

1.145. Wellness Plan – A long-term care plan, informed by the Wellness Assessment, developed to help Enrollees residing in nursing facilities stay healthy in the nursing facility setting. The Wellness Plan will coordinate with all other clinical plans of care at the nursing facility, and will supplement where necessary.

Section 2. Contractor Responsibilities

2.1. Compliance

2.1.1. Contractor Requirements for State Operations

2.1.1.1. Through this Capitated Financial Alignment Model initiative, CMS and RI EOHHS will work in partnership to offer Eligible Beneficiaries the option of enrolling into Contractor's MMP, which consists of a comprehensive network of Health Care Professionals and social service providers. The Contractor will deliver and coordinate all components of Medicare and Medicaid Covered Services for Enrollees.

2.1.1.2. Licensure and Certification

2.1.1.2.1. Contractor certifies that it is licensed in Rhode Island as an Health Maintenance Organization (HMO) under the provisions of Rhode Island General Laws R.I. Gen. Laws §27-41-1 et. seq., "the Health Maintenance Organization Act." If Contractor is not a licensed HMO in Rhode Island, Contractor certifies that it is either a nonprofit hospital service corporation that is licensed by the RI Department of Business Regulation (RI DBR) under R.I. Gen. Laws §27-19-1 et. seq., a nonprofit medical service corporation that is licensed by RI DBR under R.I. Gen. Laws §27-20-1 et. seq., or another health insurance entity licensed by RI DBR, and that it meets the following requirements:

2.1.1.2.1.1. Is certified by the Rhode Island Department of Health (RI DOH) as a Health Plan under the Rules and Regulations for the Certification of Health Plans (R23-17.13-CHP); and

2.1.1.2.1.2. Meets the requirements of R23-17.13-CHP §§ 3.4, 5.2, 6.1.4, and 6.4.7; and

2.1.1.2.1.3. Meets the requirements under the RI DOH Rules and Regulations for the Utilization Review of Health Care Services (R23-17.12).

2.1.1.2.2. Contractor agrees to provide to RI EOHHS, or its designees, any information requested pertaining to its licensure or certification.

2.1.1.2.3. Contractor agrees to provide a copy to RI EOHHS of any correspondence to RI DBR and/or RI DOH concerning its license, Contract status with any institution or provider group and/or certification. Contractor agrees to provide RI EOHHS a copy of any complaints, decisions, orders or notices from RI DBR, RI DOH or any other regulatory or oversight entities (e.g., Rhode Island Department of Attorney General) within thirty (30) days of Contractor's receipt of any complaints, decisions, orders or notices.

2.1.1.3. Accreditation

2.1.1.3.1. The Contractor is accredited by the NCQA as a Medicaid managed care organization.

2.1.1.3.2. The Contractor must submit to RI EOHHS a PDF copy of its current NCQA accreditation certificate for a Medicaid managed care organization and must maintain such accreditation for the duration of this Contract.

2.1.1.3.3. The Contractor must report to RI EOHHS any deficiencies noted by the NCQA for the Contractor's Medicare and/or Medicaid product lines within thirty (30) calendar Days of being notified of the deficiencies, or on the earliest date permitted by NCQA, whichever is earliest.

2.1.1.3.4. Achievement of provisional accreditation status shall require a corrective action plan within thirty (30) calendar days of receipt of the final report from the NCQA and may result in termination of CMS' and RI EOHHS's Contract with the Contractor in accordance with the termination provisions of the Contract as outlined in Section 5.5 herein.

2.1.1.3.5. Contractor agrees to forward to RI EOHHS any complaints received from NCQA within thirty (30) days of Contractor's receipt of a complaint.

2.1.1.3.6. Contractor agrees to provide to the RI EOHHS, or its designees, any information requested pertaining to its accreditation including communication to and from the NCQA. Such information shall include any communications pertaining to Contractor's accreditation by NCQA as well as actual HEDIS® and CAHPS® data, transmittals, and reports.

2.1.1.4. Mergers and Acquisition

2.1.1.4.1. In addition to the requirements at 42 C.F.R. § 422 Subpart L, the Contractor must adhere to the NCQA notification requirements regarding mergers and acquisitions and must notify RI EOHHS and CMS of any action by NCQA that is prompted by a merger or acquisition (including, but not limited to change in accreditation status, loss of accreditation, etc.).

2.1.1.5. Ownership and Controlling Interest

2.1.1.5.1. In accordance with 42 C.F.R. § 455.104, the Contractor must submit completed forms documenting full and complete disclosure of the Contractor's ownership and controlling interests formatted in conformance with requirements established by RI EOHHS and CMS. Disclosures will be due at any of the following times:

2.1.1.5.1.1. Upon execution of the Contract with RI EOHHS and CMS;

2.1.1.5.1.2. Upon renewal or extension of the Contract; or

2.1.1.5.1.3. Within thirty-five (35) days after any change in ownership of the Contractor.

2.1.2. Compliance with Contract Provisions and Applicable Laws

2.1.2.1. The Contractor shall comply with all sections of this Contract, including the Readiness Review, to the satisfaction of CMS and RI EOHHS.

2.1.2.2. The Contractor shall comply with all applicable provisions of federal and State laws, regulations, guidance, waivers, Demonstration terms and conditions, including the implementation of a compliance plan.

The Contractor must comply with the Medicare Advantage requirements in Part C of Title XVIII, and 42 C.F.R. Part 422 and Part 423, except to the extent that variances from these requirements are provided in the MOU signed by CMS and RI EOHHS for this initiative.

2.1.2.3. The Contractor shall comply with all applicable administrative bulletins issued by CMS and RI EOHHS.

2.1.2.4. The Contractor shall comply with other laws:

2.1.2.4.1. No obligation imposed herein on the Contractor shall relieve the Contractor of any other obligation imposed by law or regulation, including, but not limited to the federal Balanced Budget Act of 1997 (Public Law 105-33), and regulations promulgated by RI EOHHS or CMS.

2.1.2.4.2. RI EOHHS and CMS shall report to the appropriate agency any information it receives that indicates a violation of a law or regulation.

2.1.2.4.2.1. RI EOHHS or CMS will inform the Contractor of any such report unless the appropriate agency to which RI EOHHS or CMS has reported requests that RI EOHHS or CMS not inform the Contractor.

2.1.3. Compliance Program

2.1.3.1. General Requirements

2.1.3.1.1. In accordance with 42 C.F.R.§§422.503(b)(4)(vi) and 423.504(b)(4)(vi), the Contractor shall implement an effective compliance program which must include measures to prevent, detect and correct Part C or D program noncompliance as well as fraud, waste and abuse (FWA). An electronic copy of the Contractor's written compliance plan, including all relevant operating policies, procedures, workflows, and relevant chart of organization must be submitted to RI EOHHS for review and approval on an annual basis. The Contractor's compliance plan must address the following requirements:

2.1.3.1.1.1. Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and State standards;

2.1.3.1.1.2. Designation of a Compliance Officer and a compliance committee that are accountable to senior management;

2.1.3.1.1.3. Effective training and education for the Compliance Officer, the Contractor's employees, chief executive or other senior administrator, managers and governing body members, and the Contractor's First Tier, Downstream, and Related Entities;

2.1.3.1.1.4. Effective lines of communication between the Compliance Officer and the Contractor's employees;

2.1.3.1.1.5. Enforcement of standards through well publicized disciplinary guidelines;

2.1.3.1.1.6. Description of how potential compliance issues are investigated and resolved by the Contractor including a provision for prompt response to detected offenses and for development of corrective action initiatives.

2.1.3.1.1.7. Policy of non-intimidation and non-retaliation for good faith participation in the compliance program including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials;

2.1.3.1.1.8. Establishment and implementation of an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the first tier entities' compliance and the overall effectiveness of the compliance program.

2.1.3.1.1.9. Education for Contractor's employees, members, providers, and vendors to include detection and investigation and procedures to guard against FWA as well as reporting Adverse Benefit Determinations taken for fraud, integrity, and quality;

2.1.3.1.1.10. Obligation to suspend payments to Health Care Professionals.

2.1.3.1.1.11. Fraud detection and investigation and procedures to guard against fraud and abuse; and

2.1.3.1.1.12. Disclosures;

2.1.3.1.1.12.1. Disclosure of ownership and control of Contractor in accordance with 42 C.F.R.§ 455.104;

2.1.3.1.1.12.2. Disclosure of business transactions in accordance with 42 C.F.R. § 455.105;

2.1.3.1.1.12.3. Prohibitions on certain relationships as required by 42 C.F.R. § 438.610;

2.1.3.1.1.12.4. Disclosure of information in writing to RI EOHHS and CMS within ten (10) business Days on persons convicted of health care crimes in accordance with 42 C.F.R.§ 455.106; and

2.1.3.1.1.12.5. Report to RI EOHHS and CMS in writing within ten (10) business Days disclosures made by Health Care Professionals to the Contractor in accordance with 42 C.F.R.§§ 1002.3 and 1001.1001;

2.1.3.2. Investigating Fraud, Waste and Abuse

2.1.3.2.1. The explanation of member benefits procedures shall delineate how the Contractor will respond to subsequent feedback from Enrollees, including any interactions with recipients who report that goods or services which had been billed by a Health Care Professional or vendor were not received. These procedures should address how such information from Enrollees will be communicated to the Contractor's fraud and abuse investigations unit.

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

2.1.3.2.2.1. Claims data mining to identify aberrant billing patterns;

2.1.3.2.2.2. Feedback from Enrollees upon EOB transmittal process;

2.1.3.2.2.3. Calls received on the Contractor's toll-free number for reporting possible fraud and abuse;

2.1.3.2.2.4. Peer profiling and provider credentialing functions;

2.1.3.2.2.5. Analyses of Utilization Management reports and prior authorization requests;

2.1.3.2.2.6. Monthly reviews of the CMS list of excluded individuals and entities; and

2.1.3.2.2.7. Queries from State or federal agencies

2.1.3.3. Reporting of Fraud, Waste or Abuse

2.1.3.3.1. In the event that the Contractor determines that there is a credible allegation of fraud and/or abuse by the Health Care Professional, the Contractor will notify RI EOHHS Office of Program Integrity (OPI) and CMS within five (5) business days of the Contractor's conclusion of its initial investigation. OPI will investigate and refer on to the Attorney General (RI AG) if warranted. In addition, the Contractor shall also submit quarterly reports to CMS, RI EOHHS, and to the Medicaid Fraud Control Unit documenting the Contractor's open and closed cases.

2.1.3.3.2. For cases that are not determined to be a credible allegation of fraud but are cases of abuse and waste, a referral using the RI EOHHS approved referral form, should be completed and forwarded to OPI and to CMS.

2.1.3.4. The Contractor shall comply with all aspects of the joint Readiness Review.

2.2. Management and Readiness Review Requirements

2.2.1. Contract Readiness Review Requirements

2.2.1.1. CMS and RI EOHHS, or their designee, will conduct a Readiness Review of the Contractor, which must be completed successfully, as determined by CMS and RI EOHHS, prior to the Contract Operational Start Date.

2.2.1.2. CMS and RI EOHHS Readiness Review Responsibilities

2.2.1.2.1. CMS and RI EOHHS or its designee will conduct a Readiness Review of the Contractor that will include, at a minimum, one on-site review. This review shall be conducted prior to marketing to and Enrollment of Eligible Beneficiaries into the Contractor. CMS and RI EOHHS or its designee will conduct the Readiness Review to verify the Contractor's assurances that the Contractor is ready and able to meet its obligations under the Contract.

2.2.1.3. The scope of the Readiness Review will include, but is not limited to, a review of the following elements:

2.2.1.3.1. Network provider composition and access, in accordance with Section 2.7;

2.2.1.3.2. Staffing, including key personnel and functions directly impacting Enrollees (e.g., adequacy of Enrollee Services staffing, in accordance with Section 2.9);

2.2.1.3.3. Capabilities of First Tier, Downstream and Related Entities, in accordance with Appendix C;

2.2.1.3.4. Care Management capabilities, in accordance with Section 2.5 and Section 2.6;

2.2.1.3.5. Content of Health Care Professional Contracts, including any provider performance incentives, in accordance with Section 2.13 and Section 5.1.7;

2.2.1.3.6. Enrollee Services capability (materials, processes and infrastructure, e.g., call center capabilities), in accordance with Section 2.9;

2.2.1.3.7. Comprehensiveness of quality management/quality improvement and Utilization Management strategies, in accordance with Section 2.12.6;

2.2.1.3.8. Internal Grievance and Appeal policies and procedures, in accordance with Section 2.10 and Section 2.11;

2.2.1.3.9. Fraud and abuse and program integrity policies and procedures, in accordance with Section 2.1.3.2;

2.2.1.3.10. Financial solvency, in accordance with Section 2.14; and

2.2.1.3.11. Information systems, including Claims payment system performance, interfacing and reporting capabilities and validity testing of encounter data, in accordance with Section 2.16, including IT testing and security assurances.

2.2.1.4. No individual shall be enrolled into the Contractor's MMP unless and until CMS and RI EOHHS determine that the Contractor is ready and

able to perform its obligations under the Contract as demonstrated during the Readiness Review.

2.2.1.5. CMS and RI EOHHS or their designee will identify to the Contractor all areas where the Contractor is not ready and able to meet its obligations under the Contract and provide an opportunity for the Contractor to correct such areas to remedy all deficiencies prior to the Contract Operational Start Date.

2.2.1.6. CMS or RI EOHHS may, at its discretion, postpone the Contract Operational Start Date for the Contractor that fails to satisfy all Readiness Review requirements. If, for any reason, the Contractor does not fully satisfy CMS or RI EOHHS that it is ready and able to perform its obligations under the Contract prior to the Contract Operational Start Date, and CMS or RI EOHHS do not agree to postpone the Contract Operational Start Date, or extend the date for full compliance with the applicable Contract requirement, then CMS or RI EOHHS may terminate the Contract pursuant to Section 5.5 of this Contract.

2.2.1.7. Readiness Review Responsibilities

2.2.1.7.1. The Contractor must demonstrate to CMS' and RI EOHHS' satisfaction that the Contractor is ready and able to meet all Contract requirements identified in the Readiness Review prior to the Contract Operational Start Date, and prior to the Contractor engaging in marketing of its MMP;

2.2.1.7.2. The Contractor must provide CMS and RI EOHHS, or their designee, with corrections requested by the Readiness Review.

2.2.2. Contract Management

2.2.2.1. The Contractor shall employ a qualified individual to serve as the Program Manager of its MMP. The Program Manager may be the same as the Compliance Officer as required by 42 C.F.R. § 422.503; if the Contractor assigns separate individuals to the Compliance Officer and Program Manager roles, these individuals should work together to ensure continuity of Contractor operations. The Program Manager shall be located in an operations/business office within the State of Rhode Island. The Program Manager shall be dedicated to the Contractor's program and be authorized and empowered to represent the Contractor in all matters pertaining to the Contractor's program,

such as rate negotiations for the program, Claims payment, and Health Care Professional relations/contracting. The Program Manager shall be able to make decisions about the program and policy issues. The Program Manager shall act as liaison between the Contractor, CMS, and RI EOHHS and has responsibilities that include but, are not limited to, the following:

2.2.2.1.1. Ensure the Contractor's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;

2.2.2.1.2. Oversee all activities by the Contractor and its First Tier, Downstream and Related Entities, including but not limited to coordinating with the Contractor's quality management director, medical director, and behavioral health clinician;

2.2.2.1.3. Ensure that Enrollees receive written notice of any significant change in the manner in which services are rendered to Enrollees at least thirty (30) days before the intended effective date of the change, such as a retail pharmacy chain leaving the Provider Network;

2.2.2.1.4. Receive and respond to all inquiries and requests made by CMS and RI EOHHS in time frames and formats specified by CMS and RI EOHHS;

2.2.2.1.5. Meet with representatives of CMS or RI EOHHS, or both, on a periodic or as-needed basis to resolve issues within specified timeframes;

2.2.2.1.6. Ensure the availability to CMS and RI EOHHS, upon their request, of the members of the Contractor's staff who have appropriate expertise in administration, operations, finance, management information systems, Claims processing and payment, clinical service provision, quality management, Enrollee Services, Utilization Management, Provider Network management, and benefit coordination;

2.2.2.1.7. Represent the Contractor at the RI EOHHS and CMS meetings;

2.2.2.1.8. Coordinate requests and activities among the Contractor, all First Tier, Downstream, and Related Entities, CMS, and RI EOHHS;

2.2.2.1.9. Make best efforts to promptly resolve any issues related to the Contract identified either by the Contractor, CMS, or RI EOHHS; and

2.2.2.1.10. Meet with CMS and RI EOHHS at the time and place requested by CMS and the RI EOHHS if either CMS or RI EOHHS, or both, determine that the Contractor is not in compliance with the requirements of the Contract.

2.2.2.2. The Contractor shall perform in accordance with applicable State statutory and policy requirements as well as Federal statutory and policy requirements (as defined in 2 C.F.R. § 200.300). More specifically, the Contractor's obligations and duties herein, where applicable, shall include performance measurement(s) 2 C.F.R. § 200.301, monitoring and reporting program performance 2 C.F.R. § 200.328, and performance must be in accordance with requirements for pass-through entities 2 C.F.R. § 200.331.

2.2.3. Organizational Structure

2.2.3.1. The Contractor shall establish and maintain the interdepartmental structures and processes to support the operation and management of its Demonstration line of business in a manner that fosters integration of physical health, behavioral health, and community-based and facility-based LTSS service provisions. The provision of all services shall be based on prevailing clinical knowledge and the study of data on the efficacy of treatment, when such data is available. The Contractor shall describe the interdepartmental structures and processes to support the operation and management of its Demonstration line of business.

2.2.3.2. On an annual basis, and on an ad hoc basis when changes occur or as directed by RI EOHHS and CMS, the Contractor shall submit to the Contract Management Team (CMT) an overall organizational chart that includes senior and mid-level managers.

2.2.3.3. For all employees, by functional area, the Contractor shall establish and maintain policies and procedures for managing staff retention and employee turnover. Such policies and procedures shall be provided to the CMT upon request.

2.2.3.4. If any Demonstration-specific services and activities are provided by a First Tier, Downstream or Related Entity, the Contractor shall submit the organizational chart of the First Tier, Downstream or Related Entity which clearly demonstrates the relationship with the First Tier, Downstream or Related Entity and the Contractor's oversight of the First Tier, Downstream or Related Entity.

2.2.3.5. The Contractor shall notify the CMT monthly whenever positions held by key personnel become vacant and shall notify the CMT when the position is filled and by whom.

2.2.3.5.1. Key personnel positions, or their equivalents, include, but are not limited to:

2.2.3.5.1.1. The Program Manager and/or the Compliance Officer with oversight of the program,

2.2.3.5.1.2. Chief executive officer,

2.2.3.5.1.3. Chief financial officer,

2.2.3.5.1.4. Chief operating officer,

2.2.3.5.1.5. Chief medical officer/medical director,

2.2.3.5.1.6. Chief information officer,

2.2.3.5.1.7. Pharmacy director,

2.2.3.5.1.8. Quality assurance manager/coordinator,

2.2.3.5.1.9. Utilization manager/coordinator,

2.2.3.5.1.10. Care coordination/Care Management/disease management program manager,

2.2.3.5.1.11. Behavioral health director,

2.2.3.5.1.12. Director of LTSS,

2.2.3.5.1.13. Enrollee Services director,

2.2.3.5.1.14. Provider services director,

2.2.3.5.1.15. Marketing, outreach and community liaison director(s),

2.2.3.5.1.16. ADA compliance director,

2.2.3.5.1.17. Claims director,

2.2.3.5.1.18. Management information system (MIS) director, and

2.2.3.5.1.19. Other key contacts, as deemed by the Contractor.

2.2.3.6. If RI EOHHS or CMS is concerned that any of the key personnel are not performing the responsibilities, including but not limited to, those provided for in the person's position under Section 2.2.3.5, RI EOHHS and CMS shall inform the Contractor of this concern. The Contractor shall investigate said concerns promptly, take any actions the Contractor reasonably determines necessary to ensure full compliance with the terms of this Contract, and notify RI EOHHS and CMS of such actions. If the Contractor's actions fail to ensure full compliance with the terms of this Contract, as determined by RI EOHHS and CMS, the Corrective Action Provisions in Section 5.3.13 may be invoked by RI EOHHS and CMS.

2.3. Eligibility and Enrollment Responsibilities

2.3.1. Eligibility Determinations

2.3.1.1. CMS and RI EOHHS shall have sole responsibility for determining the eligibility of an eligible beneficiary for Medicare- and Medicaid-funded services. CMS and RI EOHHS shall have sole responsibility for determining enrollment in the Contractor's MMP.

2.3.2. General Enrollment

2.3.2.1. RI EOHHS will begin opt-in Enrollment prior to the initiation of Passive Enrollment. Once opt-in Enrollment begins, Eligible Beneficiaries may choose to enroll into the Contractor's MMP at any time during the demonstration. Eligible Beneficiaries who do not select the Contractor's MMP and who do not Opt-Out of the Demonstration may be assigned to the Contractor's MMP during Passive Enrollment.

2.3.2.2. The first effective opt-in Enrollment date is scheduled for no earlier than May 1, 2016.

2.3.2.3. All Enrollment effective dates are prospective. Enrollee-elected Enrollments are effective the first day of the month following an Eligible Beneficiary's request to enroll, so long as the request is received by the 10th of the month. Enrollment requests received after the 10th of the month will be effectuated the first day of the second month following the request.

2.3.2.4. Enrollment and disenrollment transactions will be processed through the Enrollment Counselor, consistent with the Enrollment effective date requirements outlined in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance. RI EOHHS (or its vendor) will submit Enrollment transactions to the CMS Medicare Advantage Prescription Drug (MARx) Enrollment system directly or via a third-party CMS designates to receive such transactions. CMS will also submit a file to RI EOHHS identifying individuals who have elected to disenroll from the Contractor, Opt-Out of Passive Enrollment, or have enrolled in, or have selected another type of, available Medicare coverage. RI EOHHS will share Enrollment, disenrollment, and Opt-Out transactions with the Contractor.

2.3.2.5. Uniform Enrollment / disenrollment and Opt-Out Letters and Forms will be made available to stakeholders by both CMS and RI EOHHS.

2.3.2.6. All disenrollment requests will be effective the first day of the month following an Enrollee's request to disenroll from the Demonstration.

2.3.2.7. The Contractor will be required to accept opt-in Enrollments for Eligible Beneficiaries no earlier than sixty (60) calendar Days prior to the first effective Enrollment date, and begin providing coverage for opt-in Enrollees no earlier than May 1, 2016.

2.3.2.8. RI EOHHS and CMS must agree in writing to any changes to the Enrollment effective dates.

2.3.2.9. No Enrollments will be accepted within six (6) months of the end of the Demonstration.

2.3.3. Passive Enrollment

2.3.3.1. Passive Enrollment is effective no sooner than sixty (60) calendar days after beneficiary notification of the right to select the Contractor's MMP.

2.3.3.2. RI EOHHS will utilize a phased approach to Passive Enrollment, which will enable CMS and RI EOHHS to assess the Contractor's

ability to serve a subset of Enrollees before receiving a larger volume of beneficiaries who are passively enrolled.

2.3.3.2.1. Wave 1: The tentative effective Enrollment date for the first wave of Passive Enrollment is no earlier than July 1, 2016, or at least two months after the first opt-in effective Enrollment date.

2.3.3.2.2. Wave 2: The tentative effective Enrollment date for the second wave of Passive Enrollment is no earlier than August 1, 2016, or at least three months after the first opt-in effective Enrollment date.

2.3.3.2.3. Wave 3: The tentative effective Enrollment date for the third wave of Passive Enrollment is no earlier than September 1, 2016, or at least four months after the first opt-in effective Enrollment date.

2.3.3.2.4. Wave 4: The tentative effective Enrollment date for the fourth wave of Passive Enrollment is no earlier than October 1, 2016, or at least five months after the first opt-in effective Enrollment date.

2.3.3.2.5. Wave 5: The tentative effective Enrollment date for the fifth wave of Passive Enrollment is November 1, 2016, or no earlier than six months after the first opt-in effective Enrollment date.

2.3.3.2.6. Wave 6: The tentative effective Enrollment date for the sixth wave of Passive Enrollment is December 1, 2016, or no earlier than seven months after the first opt-in effective Enrollment date.

2.3.3.3. RI EOHHS may passively enroll into the demonstration only the Contractor's existing Enrollees, Medicaid fee-for-service beneficiaries, or other eligible beneficiaries who are not enrolled in a Medicare Advantage plan or otherwise ineligible for passive enrollment. All other eligible beneficiaries who are not passively enrolled into the Demonstration will be provided the option to opt-in.

2.3.3.4. CMS and RI EOHHS may stop Passive Enrollment to Contractor's MMP if the Contractor does not meet reporting requirements necessary to maintain Passive Enrollment as set forth by CMS and RI EOHHS.

2.3.3.5. Enrollees who otherwise are included in Medicare reassignment effective January 1 of a given year either from their current Medicare Prescription Drug Plan (PDP) or terminating Medicare Advantage Prescription Drug Plan (MA-PD) to another PDP, will not be eligible for Passive Enrollment that same year. For example: those reassigned to a new PDP effective January 1, 2016, will be eligible for Passive Enrollment into the Contractor's MMP effective no earlier than January 1, 2017.

2.3.3.6. Passive Enrollment activity will be coordinated with CMS activities such as annual reassignment and daily auto-assignment for individuals with the Part D Low Income Subsidy.

2.3.4. Customer Service

2.3.4.1. RI EOHHS will provide customer service, including mechanisms to counsel Enrollees notified of Passive Enrollment and to receive and communicate Enrollee choice of Opt-Out to CMS on a daily basis via transactions to CMS' MARx system. Medicare resources, including 1-800-MEDICARE, will remain resources for Medicare Enrollees; calls related to Demonstration Enrollment will be referred to the Enrollment Counselor for customer service and Enrollment support.

2.3.5. Enrollment Transactions

2.3.5.1. Enrollments and disenrollments will be processed through RI EOHHS or its authorized agent. RI EOHHS or its vendor will submit Passive Enrollment transactions sixty (60) days in advance of the effective date to the CMS MARx Enrollment system directly or via a third party designated by CMS to receive such transactions. RI EOHHS or its authorized agent will receive reply notification on the next daily transaction reply report, confirming or disapproving the Eligible Beneficiary's Medicare eligibility for Passive Enrollment. The Contractor will then receive Enrollment transactions from RI EOHHS or its authorized agent. The Contractor will only process Enrollment transactions using the RI EOHHS 834 Enrollment file, upon request from RI EOHHS, or with a specified file provided by RI EOHHS for this purpose. The Contractor will also use the CMS-designated third party to submit additional Enrollment-related information to MARx and to receive files from CMS.

2.3.5.2. The Contractor must have a mechanism for receiving timely information about all Enrollments in the Contractor's MMP, including the effective Enrollment date, from CMS and RI EOHHS systems.

2.3.5.3. The Contractor shall accept for Enrollment all Eligible Beneficiaries, as described in Section 2.3. The Contractor shall accept for Enrollment all Eligible Beneficiaries identified by RI EOHHS at any time without regard to income status, physical or mental condition, age, gender, sexual orientation, gender identity, religion, creed, race, color, physical or mental disability, national origin, ancestry, pre-existing conditions, expected health status, or need for health care services.

2.3.5.4. Upon instruction by RI EOHHS, its authorized agent shall not provide new Enrollments within six (6) months (or less) of the end date of the Demonstration.

2.3.5.5. RI EOHHS and CMS will monitor Enrollments and Passive Enrollment auto-assignments to the Contractor's MMP and may make adjustments to the volume and spacing of Passive Enrollment periods based on the capacity of the Contractor to accept projected Passive Enrollments. Adjustments to the volume of Passive Enrollment based on the capacity of the Contractor will be subject to any capacity determinations, including but not limited to, those documented in the CMS and RI EOHHS final Readiness Review report and ongoing monitoring by CMS and RI EOHHS.

2.3.6. Disenrollment

2.3.6.1. Voluntary Disenrollment

2.3.6.1.1. The Contractor shall have a mechanism for receiving timely information from CMS and RI EOHHS or its vendor about all disenrollments from the Contractor, including the effective date of disenrollment. All disenrollment-related transactions will be performed by RI EOHHS.

2.3.6.1.2. Enrollees may elect to voluntarily disenroll from the Contractor's MMP or the Demonstration at any time. Enrollees who disenroll will have the choice to enroll in or remain in Rhody Health Options, or any other Medicaid program that may be available to Medicare-Medicaid Beneficiaries for Medicaid services only. For Medicare benefits, individuals who Opt-Out of the Demonstration will have the choice to enroll in a MA-PD plan, or receive FFS Medicare and enroll in a PDP. Medicare-Medicaid Beneficiaries eligible for the Demonstration may also be eligible to enroll in PACE, if they choose not to enroll in the Demonstration. Outreach and Enrollment notices for the Demonstration will inform Medicare-Medicaid Beneficiaries of all Enrollment options.

2.3.6.1.3. Disenrollment requests received by RI EOHHS or its designee, or by CMS or its Contractor, either orally or in writing, by the last calendar day of the month will be effective on the first calendar day of the following month.

2.3.6.1.4. The Contractor may not request disenrollment on behalf of an Enrollee.

2.3.6.1.5. The Contractor shall be responsible for ceasing the provision of Covered Services to an Enrollee upon the effective date of disenrollment.

2.3.6.1.6. The Contractor shall not interfere with the Enrollee's right to disenroll through threat, intimidation, pressure, or otherwise.

2.3.6.2. Discretionary Involuntary Disenrollments

2.3.6.2.1. 42 C.F.R. § 422.74 and Sections 40.3 and 40.4 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance provide instructions to the Contractor on discretionary involuntary disenrollment. This Contract and other guidance provide procedural and substantive requirements the Contractor, RI EOHHS, and CMS must follow prior to involuntarily disenrolling an Enrollee. If all of the procedural requirements are met, RI EOHHS and CMS will decide whether to approve or deny each request for involuntary disenrollment based on an assessment of whether the particular facts associated with each request satisfy the substantive evidentiary requirements.

2.3.6.2.2. Bases for Discretionary Involuntary Disenrollment:

2.3.6.2.2.1. Disruptive conduct: When the Enrollee engages in conduct or behavior that seriously impairs the Contractor's ability to furnish Covered Services to either this Enrollee or other Enrollees and provided the Contractor made and documented reasonable efforts to resolve the problems presented by the Enrollee.

2.3.6.2.3. Procedural requirements:

2.3.6.2.3.1. The Contractor's request must be in writing and include all of the supporting documentation outlined in the evidentiary requirements.

2.3.6.2.3.2. The process requires three (3) written notices from the Contractor. The Contractor must include in the request submitted to RI EOHHS and CMS evidence that the first two (2) have already been sent to the Enrollee. The notices are:

2.3.6.2.3.2.1.	Advance notice to inform the Enrollee that the consequences of continued disruptive behavior will be disenrollment. The advance notice must include a clear and thorough explanation of the disruptive conduct and its impact on the Contractor's ability to provide services, examples of the types of reasonable accommodations the Contractor has already offered the Grievance procedures, and an explanation of the availability of other accommodations. If the disruptive behavior ceases after the Enrollee receives notice and then later resumes, the Contractor must begin the process again. This includes sending another advance notice.
2.3.6.2.3.2.2.	Notice of intent to request RI EOHHS and CMS' permission to disenroll the Enrollee; and
2.3.6.2.3.2.3.	A planned action notice advising that CMS and RI EOHHS have approved the Contractor's request. This notice is not a procedural prerequisite for approval and should not be sent under any circumstances prior to the receipt of express written approval and a disenrollment transaction from CMS and RI EOHHS.

2.3.6.2.3.3. The Contractor must provide information about the Enrollee, including age, diagnosis, mental status, functional status, a description of his or her social support systems, and any other relevant information;

2.3.6.2.3.4. The submission must include statements from Health Care Professionals describing their experiences with the Enrollee (or refusal in writing, to provide such statements); and

2.3.6.2.3.5. Any information provided by the Enrollee. The Enrollee can provide any information he/she wishes.

2.3.6.2.3.6. If the Contractor is requesting the ability to decline future Enrollment requests from this individual, the plan must include this request explicitly in the submission to RI EOHHS and CMS.

2.3.6.2.3.7. Prior to approval, the complete request must be reviewed by RI EOHHS and CMS, including representatives from the Center for Medicare, and must include staff with appropriate clinical or medical expertise.

2.3.6.2.4. Evidentiary standards: At a minimum, the supporting documentation must demonstrate the following to the satisfaction of both RI EOHHS and CMS staff with appropriate clinical or medical expertise:

2.3.6.2.4.1. The Enrollee is presently engaging in a pattern of disruptive conduct that is seriously impairing the Contractor's ability to furnish Covered Services to the Enrollee and/or other Enrollees.

2.3.6.2.4.2. The Contractor took reasonable efforts to address the disruptive conduct including at a minimum:

2.3.6.2.4.2.1. A documented effort to understand and address the Enrollee's underlying interests and needs reflected in his/her disruptive conduct and provide reasonable accommodations as defined by the Americans with Disabilities Act, including those for individuals with mental and/or cognitive conditions. An accommodation is reasonable if it is efficacious in providing equal access to services and proportional to costs. RI EOHHS and CMS will determine whether the reasonable accommodations offered are sufficient.

2.3.6.2.4.2.2. A documented provision of information to the individual of his or her right to use the Contractor's Grievance procedures.

2.3.6.2.4.3. The Contractor provided the Enrollee with a reasonable opportunity to cure his/her disruptive conduct.

2.3.6.2.4.4. The Contractor must provide evidence that the Enrollee's behavior is not related to the use, or lack of use, of medical services.

2.3.6.2.4.5. The Contractor may also provide evidence of other extenuating circumstances that demonstrate the Enrollee's disruptive conduct.

2.3.6.2.5. Limitations: The Contractor shall not seek to terminate Enrollment because of any of the following:

2.3.6.2.5.1. The Enrollee's uncooperative or disruptive behavior resulting from such Enrollee's special needs unless treating Health Care Professionals explicitly document their belief that there are no reasonable accommodations the Contractor could provide that would address the disruptive conduct.

2.3.6.2.5.2. The Enrollee exercises the option to make treatment decisions with which the Contractor or any Health Care Professionals associated with the Contractor disagree, including the option of declining treatment and/or diagnostic testing.

2.3.6.2.5.3. An adverse change in an Enrollee's health status or because of the Enrollee's utilization of Covered Services.

2.3.6.2.5.4. The Enrollee's mental capacity is, has, or may become diminished.

2.3.6.2.6. Fraud or abuse: When the Enrollee provides fraudulent information on an Enrollment form or the Enrollee willfully misuses or permits another person to misuse the Enrollee's ID card:

2.3.6.2.6.1. The Contractor may submit a request that an Enrollee be involuntarily disenrolled if an Enrollee knowingly provides, on the election form, fraudulent information that materially affects the individual's eligibility to enroll in the Contractor's MMP; or if the Enrollee intentionally permits others to use his or her Enrollment card to obtain services under the Contractor's MMP.

2.3.6.2.6.2. Prior to submission of the request noted immediately above, the Contractor must have and provide to the CMT credible evidence substantiating the allegation that the Enrollee knowingly provided fraudulent information or intentionally permitted others to use his or her card.

2.3.6.2.6.3. The Contractor must immediately notify the CMT so that the Enrollment broker and the HHS Office of the Inspector General may initiate an investigation of the alleged fraud and/or abuse.

2.3.6.2.6.4. The Contractor must provide notice to the Enrollee prior to submission of the request outlining the intent to request disenrollment with an explanation of the basis of the Contractor's decision and information on the Enrollee's access to Grievance procedures and a State Fair Hearing.

2.3.6.2.7. Necessary consent or release: When the Enrollee knowingly fails to complete and submit any necessary consent or release allowing the Contractor and/or Health Care Professionals to access necessary health care and service information for the purpose of compliance with the care delivery system requirements in Section 2.5 and Section 2.6 of this Contract and pursuant to Rhode Island law:

2.3.6.2.7.1. The Contractor must provide notice to the Enrollee prior to submission of the request outlining the intent to request disenrollment with an explanation of the basis of the Contractor's decision and information on the Enrollee's access to Grievance procedures and a State Fair Hearing.

2.3.6.3. Required Involuntary Disenrollments

2.3.6.3.1. RI EOHHS and CMS shall terminate an Enrollee's coverage upon the occurrence of any of the conditions enumerated in Section 40.2 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, State-specific Enrollment and Disenrollment Guidance, or upon the occurrence of any of the conditions described in this Section 2.3.6.3. Except for the CMT's role in reviewing documentation related to an Enrollee's alleged material misrepresentation of information regarding third-party reimbursement coverage, as described in this section, the CMT shall not be responsible for processing disenrollments under this section. Further, nothing in this section alters the obligations of the Parties for administering disenrollment transactions described elsewhere in this Contract.

2.3.6.3.2. The Contractor shall notify RI EOHHS of any individual who is no longer eligible to remain enrolled in the Demonstration per CMS Enrollment guidance, in order for RI EOHHS to disenroll the Enrollee.

2.3.6.3.3. The Contractor shall notify RI EOHHS within five (5) Days of the date when the Contractor becomes aware that an Enrollee has any other health care insurance coverage with the Contractor or any other insurance carrier in accordance with Section 5.1.13.2.

2.3.6.3.4. The Enrollment of any Enrollee under this Contract shall be terminated if the Enrollee becomes ineligible for Enrollment due to a change in eligibility status. When an Enrollee's Enrollment is terminated for eligibility, the termination shall take effect at 11:59 p.m. on the last day of the month in which the eligibility is lost or person determined to be out of the Service Area. Reasons for termination include, but are not limited to:

2.3.6.3.4.1. Upon the Enrollee's death. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month in which the Enrollee dies. Termination may be retroactive to this date.

2.3.6.3.4.2. When an Enrollee remains out of the Service Area or for whom residence in the Service Area cannot be confirmed for more than six (6) consecutive months.

2.3.6.3.4.2.1. When an Enrollee no longer resides in the Service Area, except for an Enrollee living in the Service Area who is admitted to a Nursing facility outside the Service Area and placement is not based on the family or social situation of the Enrollee. If an Enrollee is to be disenrolled at the request of the Contractor under the provisions of this section, the Contractor must first provide documentation satisfactory to RI EOHHS and CMS that the Enrollee no longer resides in the Service Area. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month prior to the month in which RI EOHHS and CMS determine that the Enrollee no longer resides in the Service Area.

2.3.6.3.4.3. When CMS or RI EOHHS is made aware that an Enrollee is incarcerated in a county jail, Rhode Island Department of Corrections facility, or Federal penal institution. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month during which the Enrollee was incarcerated.

2.3.6.3.4.4. When an Enrollee is residing at Tavares, Eleanor Slater, or an out-of-state hospital.

2.3.6.3.5. The termination or expiration of this Contract terminates coverage for all Enrollees with the Contractor. Termination will take effect at 11:59 p.m. on the last day of the month in which this Contract terminates or expires, unless otherwise agreed to, in writing, by the Parties.

2.3.6.3.6. The Enrollment of any Enrollee under this Contract shall be terminated when the CMT approves a request based on information sent from any Party showing that an Enrollee has materially misrepresented information regarding third-party reimbursement coverage according to Section 40.2.6 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance.

2.3.6.4. Contractor Coverage of Services Following Disenrollment

2.3.6.4.1. An Enrollee whose Enrollment is terminated for any reason, other than incarceration, at any time during the month is entitled to receive Covered Services, at the Contractor's expense, through the end of that month.

2.3.6.4.2. In no event will an Enrollee be entitled to receive services and benefits under this Contract after the last day of the month in which their Enrollment is terminated, except:

2.3.6.4.2.1. When the Enrollee is hospitalized at termination of Enrollment and continued payment is required in accord with the Section 2.8 of this contract;

2.3.6.4.2.2. For the provision of information and assistance to transition the Enrollee's care with another provider; or

2.3.6.4.2.3. As necessary to satisfy the results of an Appeal or hearing.

2.3.6.4.3. Regardless of the procedures followed or the reason for termination, if a disenrollment request is granted, or the Enrollee's Enrollment is terminated by RI EOHHS for one of the reasons described in this Contract, the effective date of the disenrollment will be no later than 11:59 p.m. on the last day of the month following the month the request was made.

2.3.6.4.4. The Contractor shall transfer Enrollee Medical Record information promptly to RI EOHHS, or its designee, as appropriate upon disenrollment of the Enrollee from the Demonstration.

2.3.6.5. The Contractor shall complete a safe discharge process for disenrollments under this section, in accordance with guidance from RI EOHHS.

2.4. Covered Services

2.4.1. General

2.4.1.1. The Contractor must authorize, arrange, integrate, and coordinate the provision of all Covered Services for its Enrollees. (See Covered Services in Appendix A.) Covered Services must be available to all Enrollees, as authorized by the Contractor and as determined Medically Necessary pursuant to Section 2.8.3. Covered Services will be managed and coordinated by the Contractor and through the ICT (see Section 2.5.4), as needed.

2.4.1.2. The Contractor will have discretion to use the Capitated Payment to offer Flexible Benefits, as specified in the Enrollee's ICP, as appropriate to address the Enrollee's needs. The Contractor may provide certain LTSS services in a limited fashion to Enrollees who do not currently meet the eligibility criteria for LTSS, in order to prevent admission, re-admission or reduce lengths of stay in an institution. These services are outlined in Appendix A.

2.4.1.3. Under the Demonstration, skilled nursing level of care may be provided in a long-term care facility and/or skilled nursing facility without a preceding acute care inpatient stay for Enrollees, when the provision of this level of care is clinically appropriate and can avert the need for an inpatient stay. As a condition for payment the Contractor must ensure that the nursing facility has met all federal and State Pre-Admission Screen and Resident Review (PASSR) requirements for all individuals seeking admission or readmission to a nursing facility,

subsequent to the provisions in 42 C.F.R. §§ 483.100-138 and MCAR Section 0378.05.

2.4.1.4. Contractor shall provide three hundred and sixty-five (365) days of nursing facility care as medically and/or functionally necessary for the Enrollee, inclusive of skilled care, custodial care or any other level of nursing facility care including but not limited to emergency placement, hospice and respite care.

2.4.1.5. The Contractor must provide the full range of Covered Services. If either Medicare or Rhode Island Medicaid provides more expansive services than the other program does for a particular condition, type of illness, or diagnosis, the Contractor must provide the most expansive set of services required by either program. The Contractor may not limit or deny services to Enrollees based on Medicare or Rhode Island Medicaid providing a more limited range of services than the other program.

2.4.1.6. Covered Services must be delivered in a way that preserves all protections to the Enrollee provided by Medicare and Rhode Island Medicaid.

2.4.1.7. The Contractor is responsible for implementing a gender dysphoria treatment policy. The Contractor may submit an internal policy for gender dysphoria treatment for RI EOHHS review and approval. If RI EOHHS does not approve a policy for Contractor, Contractor must implement the gender dysphoria policy provided by RI EOHHS.

2.4.1.8. LTSS, as described in Appendix A, are only available to Enrollees who meet certain RI EOHHS eligibility criteria. RI EOHHS has sole authority for determining eligibility for LTSS and will communicate eligibility to the Contractor.

2.4.1.9. An Enrollee is entitled to a second opinion from a qualified Health Care Professional within the Provider Network or, if approved by the Contractor, to a second opinion by a non-participating Health Care Professional outside the Provider Network, at no cost to the Enrollee.

2.4.1.10. Telemedicine

2.4.1.10.1. The Contractor must implement a Telemedicine pilot program and submit an internal policy and procedure for Telemedicine services for RI EOHHS review and approval. The Contractor may use Telemedicine as a cost-saving mechanism for certain high-cost Enrollees. As with in-person encounters, the patient-clinician relationship is established when the Health Care Professional agrees to undertake diagnosis and treatment and the Enrollee agrees to be cared for using Telemedicine. Telemedicine is not intended to replace all in-person encounters relevant to an Enrollee.

2.4.1.11. Electronic Visit Verification (EVV)

2.4.1.11.1. No earlier than September 1, 2017 the Contractor must implement EVV for home and community-based services, as specified by RI EOHHS.

2.4.1.11.2. At a minimum, the Contractor's EVV program must meet the following requirements:

2.4.1.11.2.1. The Contractor must contract with RI EOHHS' designated EVV vendor.

2.4.1.11.2.2. The Contractor must require its Provider Network to use EVV to capture time, service, and claim information for home and community-based services, as specified by RI EOHHS, including for Enrollees receiving self-directed services. Required time and service information to be captured using EVV includes, but is not necessarily limited to:

2.4.1.11.2.2.1. Service date;

2.4.1.11.2.2.2. Provider identifier;

2.4.1.11.2.2.3. Recipient identifier;

2.4.1.11.2.2.4. Direct care provider;

2.4.1.11.2.2.5. Visit verification method (e.g., landline telephone, mobile telephone, verification device in the home);

2.4.1.11.2.2.6. GPS coordinates (for mobile telephone verification only);

2.4.1.11.2.2.7. Telephone number from which the call originates;

2.4.1.11.2.2.8. Visit start time;

2.4.1.11.2.2.9. Visit end time; and

2.4.1.11.2.2.10. Tasks.

2.4.1.11.2.3. The Contractor must establish data feeds with RI EOHHS' designated EVV vendor to send enrollment, prior authorization, and provider data to the EVV vendor and to receive time, service, and claim information for home and community-based services, as specified by EOHHS. The Contractor must pay all applicable fees to the EVV vendor, as specified by RI EOHHS.

2.4.1.12. The Contractor may have a list of preapproved medical equipment, Supplies, and appliances for administrative ease, but not as an absolute limit on coverage. The Contractor must provide and make available to Enrollees and Health Care Professionals a reasonable and meaningful procedure to request medical equipment, Supplies, or appliances not on the list based on medical necessity.

2.4.2. Excluded Services

2.4.2.1. The Carved-Out Services, as described in Appendix A, will be carved out from this Contract and will be provided to Enrollees via fee-for-service Medicaid. The Contractor is required to refer to Carved-Out Services as needed. For Enrollees receiving Carved-Out Services, the Contractor will ensure that Covered Services and Carved-Out Services are coordinated, while avoiding any duplication of Covered Services. The Contractor will include in contracts with PCP, behavioral health,

LTSS, and other relevant Health Care Professionals the requirement to coordinate Covered Services with Carved-Out Services.

2.4.2.2. Election of Medicare Hospice Benefit – As in Medicare Advantage, if, after Enrollment, an Enrollee elects to receive the Medicare hospice benefit, the Enrollee will remain in the Contractor's MMP, but will obtain the hospice service through the Medicare FFS benefit and the Contractor would no longer receive Medicare Parts A & B component of the capitated payment for that Enrollee. Medicare hospice services and all other Original Medicare Parts A & B services would be paid for under Medicare FFS. The Contractor and providers of hospice services would be required to coordinate these services with the rest of the Enrollee's care, including with Medicaid and Part D benefits and any additional Flexible Benefits and supplemental benefits offered by the Contractor. The Contractor will continue to receive a Medicare Part D capitated payment, for which no changes would occur. Medicaid services and payments for hospice Enrollees must comply with the Section 1115(a) demonstration requirements.

2.4.2.3. Supplemental Benefits – RI EOHHS and CMS may consider adding certain supplemental benefits to the required Demonstration benefit package in Demonstration Years 2 and 3. These services may include the following:

2.4.2.3.1. Integrated pain management program;

2.4.2.3.2. Screening, Brief Intervention and Referral to Treatment (SBIRT); and

2.4.2.3.3. Non-medical transportation.

2.4.2.4. Covered Services may be added at any time based on a required legislative change.

2.4.2.5. The non-Covered Services or benefits, as described in Appendix A, are not Covered Services or benefits.

2.5. Care Delivery Model

2.5.1. The Contractor shall abide by the care delivery model described within this Contract and is not required to submit a model of care to CMS or RI EOHHS unless otherwise requested.

2.5.2. Person-centered System of Care

2.5.2.1. The Contractor shall implement a person-centered system of care that governs the care provided to Enrollees and meets the following requirements:

2.5.2.1.1. Focuses on the individual, his or her strengths, and his or her network of Family and community supports;

2.5.2.1.2. Respects and responds to individual needs, goals and values;

2.5.2.1.3. Allows the Enrollee maximum choice and control over the supports he or she needs to live as independently as possible;

2.5.2.1.4. Works in full partnership with Enrollees and Health Care Professionals to guarantee that each person's values, experiences, and knowledge drive the creation of an individual plan as well as the delivery of services;

2.5.2.1.5. Is built on the principle that Enrollees have rights and responsibilities, know their circumstances and needs first-hand, and should be invested in the care they receive;

2.5.2.1.6. Establishes a foundation for independence, self-reliance, self-management, and successful intervention outcomes;

2.5.2.1.7. Crafts interventions that recognize and address the needs, deficits, and supports of each Enrollee based on the unique set of strengths, resources, and motivations that he or she brings;

2.5.2.1.8. Meaningfully involves the Enrollee and/or his or her designee in all phases of the Care Management process including in the assessment of needs, development of a care plan, identification of ICT members (if applicable), delivery of care and support services, and evaluation of the effectiveness and impact of care including the need for continued care or supports;

2.5.2.1.9. Provides the Enrollee with the primary decision-making role in identifying his or her needs, preferences and strengths, and a shared decision making role in determining the services and supports that are most effective and helpful;

2.5.2.1.10. Leverages existing community resources and engages the Enrollee's informal support system to address Enrollee needs;

2.5.2.1.11. Provides direct high-touch, often face-to-face contact throughout the Care Management process between Care Managers/providers and the Enrollee;

2.5.2.1.12. Facilitates a partnership among the Enrollee, his/her Family, Health Care Professionals, and treatment team coordinators;

2.5.2.1.13. Provides the Enrollee the right to designate someone (e.g., a Family member, friend, caregiver) to serve as his or her representative for a range of purposes or time periods. If a representative is needed at a point in time when an individual is too impaired to make a choice, the representative should be someone who has a history of close involvement with the person;

2.5.2.1.14. Ensures that care planning meetings are held at a time and place that is convenient and accessible to the Enrollee; and

2.5.2.1.15. Provides the Enrollee with information, including Olmstead rights (for individuals who are eligible for LTSS) and advanced directives, to make informed decisions about service options.

2.5.3. Health Care Promotion and Wellness Activities

2.5.3.1. The Contractor shall provide a broad range of health care promotion and wellness information and programs for Enrollees, their Families, and caregivers. The focus and content of this information and programs shall be appropriate to the population such as: (1) self-management of chronic disease management, (2) smoking cessation, (3) nutrition, (4) exercise, (5) prevention and treatment of substance abuse, and (6) other intervention and health care promotion and wellness activities. The Contractor shall establish its own programs as

well as link Enrollees with existing community-based programs to improve the health, safety and quality of life of Enrollees.

2.5.4. Care Management

2.5.4.1. The Contractor will offer Care Management services to all Enrollees as needed, and will develop, maintain, and monitor a care plan for all Enrollees to support health and wellness, ensure effective linkages and coordination between the PCP and other Health Care Professionals and providers and services, and to coordinate the full range of medical and behavioral health services, preventive services, medications, LTSS, social supports, Telemedicine services and enhanced benefits as needed, both within and outside the Contractor. Care Management services include ICM for community-based LTSS Enrollees and non-LTSS high-risk Enrollees. Care Management services also include care coordination services for individuals with more limited Care Management needs and transition coordination for Enrollees in nursing facilities who have an opportunity for discharge to the community. All Care Management services will be person-centered and will be delivered to Enrollees according to their strength-based needs and preferences. Enrollees will be encouraged to participate in decision making with respect to their care.

2.5.4.2. The Contractor shall have effective systems, policies, procedures and practices in place to identify Enrollees in need of Care Management services, including an early warning system and procedures that foster proactive identification of high-risk Enrollees and to further identify Enrollees' emerging needs. A determination of which Enrollees are at high risk will be made by the Contractor as a result of either its predictive modeling results or a CFNA, as described in Section 2.6.2. Enrollees who are determined to be at high-risk and eligible for ICM may include, but not be limited to, individuals with complex medical conditions and/or social support needs that may lead to: the need for high-cost services; deterioration in health status; or institutionalization.

2.5.4.3. The Contractor shall have effective systems, policies, procedures, and practices in place to identify Enrollees in need of Home Stabilization Services. The Contractor is required to refer these Enrollees to the RI EOHHS designee for Home Stabilization Services and will be required to coordinate with the out-of-plan Home Stabilization Service providers as part of the Enrollee's ICP and other care plans (e.g., LTSS Care Plan). The Contractor will be required to report on this at an interval defined by RI EOHHS.

2.5.4.4. Care Coordinators should ensure that Enrollees receive aftercare follow-up when transitioning from a higher level of care. Care Management services will assist Enrollees to obtain needed medical, behavioral health, prescription and non-prescription drugs, community-based or facility-based LTSS, social, educational, psychosocial, financial and other services in support of the ICP or general Enrollee goals, irrespective of whether the needed services are covered under the Capitation Payment to the Contractor under this Demonstration. Care Management services are planned and provided based on opportunities to deliver quality-based outcomes such as: improved/maintained functional status, improved/maintained clinical status, enhanced quality of life, Enrollee satisfaction, adherence to the ICP, improved Enrollee safety, cost savings, wellness, and Enrollee autonomy. Care Management services include supports available to all Enrollees, at the level needed to effectively support each Enrollee.

2.5.4.5. The Contractor shall develop and implement cost effective Care Management strategies that improve or maintain the level of quality by using payment incentives among other tools. The Contractor's payment, measurement and incentive strategies shall include strategies that decrease avoidable hospitalizations and emergency room utilization, and reduce nursing facility admissions and lengths of stay, with a focus on high utilizers and promotion of community-based care or the least restrictive setting possible.

2.5.4.6. For LTSS, the Contractor shall implement a conflict free Care Management system that complies with the following characteristics:

2.5.4.6.1. There is separation of eligibility determination from direct services provision. Eligibility for services is established separately from the provision of services, so assessors do not feel pressure to make Enrollees eligible to increase business for their organization. Eligibility is determined by an entity or organization that has no fiscal relationship to the Enrollee;

2.5.4.6.2. Funding levels for the Enrollee will be established using a tool reviewed and approved by RI EOHHS.

2.5.4.6.3. A plan of supports and services will be developed based on the Enrollee's assessed needs.

2.5.4.6.4. Individuals performing LTSS evaluations and assessments and developing LTSS Care Plans cannot be related by blood or marriage to the Enrollee or any of the Enrollee's paid caregivers, financially responsible for the Enrollee, or empowered to make financial or health-related decisions on behalf of the Enrollee.

2.5.4.6.5. In circumstances in which one entity is responsible for providing Care Management and service delivery, appropriate safeguards and firewalls must be in place to mitigate risk of potential conflict.

2.5.4.6.6. The requirement to provide conflict free Care Management is not intended to hinder or prohibit accountable care, value-based, or other alternative payment strategies.

2.5.5. Interdisciplinary Care Team (ICT)

2.5.5.1. The Contractor shall ensure assembly of an ICT for each community-based Enrollee based on the Enrollee's person-centered needs.

2.5.5.2. The ICT shall include the Enrollee, the LCM or Care Coordinator (as applicable), and the PCP. With the Enrollee's consent, the ICT may also include but is not limited to: the Enrollee's Family, guardian, and/or other caregiver; physicians; physician assistants; LTSS providers; nurses; specialists; pharmacists; behavioral health specialists; social workers; and peer supports appropriate for the Enrollee's medical diagnoses and health condition, co-morbidities, and community support needs. The Contractor will utilize the ICT to:

2.5.5.2.1. Serve as a communication hub to coordinate services across the full continuum of care, including but not limited to primary care, specialty care, behavioral health, LTSS, and other services, and including both Covered and Carved-Out Services;

2.5.5.2.2. Support transitions from hospital or nursing facility to community, under the direction of the LCM or Care Coordinator, as applicable;

2.5.5.2.3. Collaborate across all physical, behavioral, and social support disciplines with attention to coordinated provision of Enrollee education and self-management support; behavior change techniques and motivational interviewing practices when delivering services to Enrollees; medication management; coordination of community-based services and supports; referrals, as desired by the Enrollee and as appropriate, to end-of-life services and supports; and changes in the Enrollee's condition when additional multidisciplinary planning is necessary and potentially beneficial;

2.5.5.2.4. Promote the delivery of Care Management services in an integrated fashion at the practice level; and

2.5.5.2.5. Promote the use of performance data at the individual and the population-based level to promote incentives to improve care delivery.

2.5.5.3. For community-based Enrollees who are eligible for LTSS or otherwise determined to be high-risk, the LCM shall oversee development of the ICT.

2.5.5.4. For community-based Enrollees not eligible for LTSS and not otherwise determined to be high-risk, the Care Coordinator shall oversee development of the ICT.

2.5.6. Coordination of Care

2.5.6.1. General

2.5.6.1.1. The Contractor shall ensure coordination of care of all Covered Services under this Contract, as well as Carved-Out Services per Section 2.5.5.4.1. Coordination of care includes identification and follow-up of high-risk Enrollees, ensuring coordination of services and appropriate referral and follow-up. In particular, Contractor shall ensure coordination between medical services, behavioral health services, LTSS and other needs required by the Enrollees.

2.5.6.2. Coordination with Medicaid Health Homes

2.5.6.2.1. Enrollees may be eligible to receive Health Home services if they meet RI EOHHS-specified criteria and an approved Health Home operates in the Demonstration Service Area. Enrollees who receive Care Management from a Health Home will have their needs coordinated by the Health Home for the condition(s) qualifying those Enrollees for Health Home services. The Contractor's LCM will be required to coordinate with the Health Home for both Health Home and Contractor services. The Health Home care manager will be a member of the ICT, and any Health Home care plan will be integrated into the ICP developed by the Contractor.

2.5.6.2.2. The Contractor and Health Homes will ensure there are no gaps or duplication in services provided to Enrollees.

2.5.6.3. Community Health Teams

2.5.6.3.1. Contractor is required to coordinate, participate, and collaborate with RI EOHHS in the enhancement and improvement of Community Health Teams. Contractor is required to provide updates and reports on this program as requested by RI EOHHS.

2.5.6.4. Coordinating Carved-Out Services with Federal, State and Community Agencies

2.5.6.4.1. The federal government, the State and community agencies support various special service programs targeted to persons who may be enrolled in the Contractor's MMP. The Contractor is not obligated to provide or pay for any Carved-out Services for Enrollees. However, the Contractor shall develop policies and procedures to require coordination of Covered Services with Carved-out Services. Examples of services with which it must coordinate are described below, but this list is not exhaustive. Although such services are not Covered Services, the Contractor must promote and coordinate such services to avoid service fragmentation. In addition, these services are significant for the promotion of health and to assure optimal outcomes of the clinical services.

2.5.6.4.1.1. For individuals with intellectual and developmental disabilities who have a diagnostic and premium rate category status that is confirmed by RI EOHHS and who are enrolled in the Contractor's MMP, RI EOHHS will continue to assume responsibility for providing the required community support program services and will be financially responsible for the associated costs for those Carved-Out Services described in Appendix A of this Agreement. The Contractor will be required to ensure coordination of Carved-Out and Covered Services for individuals with intellectual and developmental disabilities. RI EOHHS has sole authority for making determinations regarding the status for individuals with intellectual and developmental disabilities for Enrollment in the community support program.

2.5.6.4.1.2. Services of the Rhode Island Division of Elderly Affairs

2.5.1.1.1.1.1. The Contractor shall assist Enrollees to access necessary services provided by the RI Division of Elderly Affairs (DEA). These services include but are not limited to: Rhode Island's Aging and Disability Resource Center, known as THE POINT; Congregate Nutrition and Home-Delivered Meals programs; the DEA Protective Services Unit; the Enrollee Ombudsman; and the Long-Term Care Ombudsman.

2.5.6.4.1.3. Services of the Rhode Island Department of Human Services (DHS)

2.5.1.1.1.1.2. The Contractor shall assist Enrollees with accessing necessary services provided by DHS. These services include but are not limited to, services of the Office of Rehabilitation Services, and the Supplemental Nutrition Assistance Program (SNAP).

2.5.6.5. Services of the Rhode Island Department of Health

2.5.6.5.1. The Contractor shall assist Enrollees to access necessary services provided by the RI Department of Health (DOH). These services include but are not limited to the Disability and Health Program, the Chronic Conditions Workforce Initiative, and the Chronic Disease Self-Management Programs.

2.5.6.6. Housing

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

2.5.6.7. CurrentCare

2.5.6.7.1. CurrentCare, Rhode Island's statewide Health Information Exchange, is a secure electronic health network that stores and shares patients' health information with participating providers. CurrentCare keeps providers informed about their clients' health care and allows them to more easily and effectively coordinate their care. The Contractor shall provide information and education to Enrollees on the benefits of enrolling in CurrentCare. Contractor must include language in all Health Care Professional contracts to encourage Health Care Professional enrollment as a user of CurrentCare, including hospital alerts. Contractor must cooperate with the State-designated regional health information organization in engaging Health Care Professional participation in Direct Messaging services to improve care coordination.

2.5.6.8. Non-Emergency Transportation

2.5.6.8.1. The Contractor shall assist Enrollees to access non-emergency transportation. The Contractor shall coordinate and collaborate with the RI EOHHS-selected transportation broker, including but not limited to supplying provider directories to the broker on a quarterly basis, and shall comply with all RI EOHHS-established referral policies.

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

2.5.6.9.1. Contractor is required to participate both financially and operationally in CTC-RI, according to the requirements for participation as set forth by RI EOHHS and consistent with parameters established by the CTC-RI executive committee. This participation shall include, but not be limited to, provision of high utilizer reports to participating practice sites, Health Care Professional per member per month (PMPM) payments, CTC-RI administrative payments, and referrals to community health teams.

2.5.6.10. Changing Levels of Care or Care Settings

2.5.6.10.1. Success of this program depends on the ability of the Contractor to manage the transition of Enrollees when they move across care settings, such as:

2.5.6.10.1.1. Hospital to nursing facility;

2.5.6.10.1.2. Hospital to home/community;

2.5.6.10.1.3. Nursing facility to hospital;

2.5.6.10.1.4. Nursing facility to community;

2.5.6.10.1.5. Community to nursing facility; and

2.5.6.10.1.6. Community to hospital.

2.5.6.10.2. The Contractor must adopt or modify existing transition models or develop its own transition model to ensure effective transitions and continuity of care when Enrollees move between levels of care. A key in transition management is to have effective strategies that prevent Enrollees from moving to a higher level of care, when it is avoidable.

2.5.6.10.3. The Contractor shall have transitional Care Management and support during transitions across care settings twenty-four (24) hours a day, seven (7) days a week.

2.5.6.10.3.1. The transitional Care Management program must provide onsite visits with the LCM and/or Care Coordinator upon discharge from hospitals, nursing facilities, or other institutional settings.

2.5.6.10.3.2. LCMs and/or Care Coordinators will assist with the development of discharge plans.

2.5.6.10.4. The Contractor shall have policies, procedures and practices for transitioning Enrollees between levels of care settings that are approved by RI EOHHS.

2.5.7. Routine Care Coordination for Low- and Moderate-risk Enrollees in the Community

2.5.7.1. Upon initial Enrollment, Enrollees who reside in the community, are not eligible for LTSS, and have not otherwise been determined to be high-risk will receive a telephonic IHS to risk stratify them into a low-, moderate-, or high-risk category. Those who stratify as high-risk will then receive an in-person CFNA, described in Section 2.6.2.4. Care Management for individuals at low- and moderate-risk will include, but is not limited to:

2.5.7.1.1. Routine support from Enrollee Services within the Contractor. The Enrollee can contact Enrollee Services as needed to obtain telephonic support (e.g. referrals to community-based services, identification of specialists, assistance arranging services). Enrollee Services will facilitate contact with Care Management services as requested or needed by the Enrollee;

2.5.7.1.2. Health and wellness information will be shared with the ICT as appropriate, including the Enrollee, a caregiver if desired by the Enrollee, the PCP, and any other relevant providers as determined by the PCP or the Enrollee;

2.5.7.1.3. Peer Navigator services to the extent that the Contractor's Care Management staff determines such supports to be necessary and beneficial. Low-risk Enrollees will be eligible to receive Peer Navigator services, based on need, as periodic support to identify additional needs and to follow through on referrals and community-based services;

2.5.7.1.4. Targeted support from Contractor Care Management or Enrollee Services staff, to be designated by the Contractor at the time the Enrollee is identified as being in need of support;

2.5.7.1.5. A CFNA, in the event that the Enrollee experiences a change in health status or social supports, as described in Section 2.6.2.4. The provision of a CFNA may be triggered by: predictive modeling data; a self- or other referral regarding the Enrollee's needs; or contact with Contractor staff that indicates the potential for increased risk such that the Enrollee may qualify for ICM services;

2.5.7.1.6. Home safety checks, as indicated by an IHS or CFNA; and

2.5.7.1.7. In-home services, as needed.

2.5.8. Intensive Care Management (ICM) for High-risk Enrollees in the Community

2.5.8.1. As part of RI EOHHS' high utilizer initiative, the Contractor will share high utilizer information with Health Care Professionals in a secure and easily accessible manner. The Contractor will work with Health Care Professionals to design thoughtful data sharing arrangements that are more impactful than the use of the provider portals. The Contractor will also bolster contracts with Health Care Professionals to include standards for using high utilizer data information and assisting Enrollees with hospital discharge. The Contractor is required to coordinate Care Management of high utilizers with PCPs, including PCMH practices, and other Health Care Professionals.

2.5.8.2. ICM will be available to community-based Enrollees who are eligible for LTSS or determined to be high-risk via the IHS or other sources. ICM will include a set of high-touch, person-centered Care Management activities requiring direct interaction with the Enrollee and ICT; data collection, analysis, interpretation, and communication of data to the ICT; and monitoring and quality assurance of ICM activities. Specific ICM services will include, but are not limited to:

2.5.8.2.1. Person-centered Care Management and coordination from an LCM with physical and/or behavioral health expertise, as described in Section 2.6.4, based on the Enrollees' strength-based preferences and needs;

2.5.8.2.2. Creation of a comprehensive ICP, as described in Section 2.6.5. The ICP will be shared with and updated by the ICT, and will include ongoing monitoring and revisions to the ICP to continuously improve the health and well-being of the Enrollee until such time that ICM services are not needed;

2.5.8.2.3. Coordination of a range of home and community-based services as needed, including but not limited to Peer Navigator services, to the extent that Contractor Care Management staff determines such supports to be necessary and beneficial;

2.5.8.2.4. For Enrollees with intellectual and developmental disabilities (I/DD) who are receiving Carved-Out Services excluded from the Capitation Rates, coordination of those Carved-Out Services as part of the ICP;

2.5.8.2.5. Home safety checks as determined by the CFNA; and

2.5.8.2.6. Payment incentives by the Contractor to support ICM goals and objectives.

2.5.9. LCM and Care Coordinator Qualifications

2.5.9.1. LCMs and Care Coordinators must have the experience, qualifications and training appropriate to the needs of the Enrollee. The Contractor must establish policies for appropriate assignment of LCMs and Care Coordinators.

2.5.9.2. LCMs and Care Coordinators must have knowledge of physical health, aging and loss, appropriate support services in the community, frequently used medications and their potential negative side-effects, depression, challenging behaviors, Alzheimer's disease and other disease-related dementias, behavioral health, and issues related to accessing and using DME as appropriate.

2.5.9.3. LCMs who are assigned to Enrollees with higher risk levels must have a clinical background and may also have community-based experience working with the elderly, persons with disabilities, including intellectual and developmental disabilities, and person-centered planning approaches.

2.5.9.4. Care Coordinators who are assigned to Enrollees with lower risk levels may have non-clinical backgrounds.

2.5.10. LCM and Care Coordinator Training

2.5.10.1. LCMs and Care Coordinators must have knowledge, experience, qualifications and training appropriate to the needs of the Enrollee. The Contractor must establish policies for appropriate training of LCMs and Care Coordinators.

2.5.11. LCM and Care Coordinator Assignments and Change Requests

2.5.11.1. The Contractor shall assign to every community-based Enrollee an LCM or a Care Coordinator with the appropriate experience and qualifications based on the Enrollee's assigned risk level and individual needs (e.g., communication, cognitive, or other barriers).

2.5.11.2. The Contractor must have a process to ensure that an Enrollee and/or his/her caregiver are able to request a change in his or her LCM or Care Coordinator at any time. In the event that the Enrollee wishes to select a different LCM or Care Coordinator, the Contractor shall assist the Enrollee with the requested change.

2.5.11.3. LCMs and Care Coordinators shall maintain contact with Enrollees as frequently as appropriate.

2.5.12. LCM and Care Coordinator Caseloads

2.5.12.1. The Contractor must ensure that LCM and Care Coordinator caseloads are reasonable to provide appropriate care coordination and Care Management.

2.5.13. Care Management Tools

2.5.13.1. The Contractor shall maintain effective systems, policies, procedures and practices that govern Care Management processes.

2.5.13.2. The Contractor shall have integrated electronic information systems that maximize interoperability in order to provide LCMs and Care Coordinators with access to all essential data related to the Enrollee, including but not limited to:

2.5.13.2.1. Enrollee's clinical history;

2.5.13.2.2. Enrollee diagnosis;

2.5.13.2.3. Enrollee sentinel events;

2.5.13.2.4. Urgent/on-going care need;

2.5.13.2.5. Other data sources (pharmacy, utilization);

2.5.13.2.6. Data mining tools (predictive modeling, risk scores) to: (1) place an Enrollee into his/her appropriate Care Management model (for that particular date in time); (2) implement his/her ICP; (3) monitor ICP for effectiveness and appropriateness; and (4) modify the ICP to accurately reflect any change in the Enrollee's circumstances.

2.6. Enrollee Stratification, Assessments, and Plans of Care

2.6.1. General

2.6.1.1. The Contractor will ensure the conduct of Enrollee stratification, assessments, and plans of care, as described in this section. Where available and appropriate, the Contractor will leverage Claims data, assessments completed by home health agencies and other Health Care Professionals, RHO assessments completed by the Contractor, and other existing data sources to stratify Enrollees and complete assessments. Use of other data sources to complete assessments should be restricted to information collected in the prior six (6) month period, or less if there is an indication that the information should be updated. Further, the Contractor will leverage existing community and facility-based resources to deliver Care Management, case management, and care coordination services to Enrollees, where appropriate and where the Contractor can ensure that the services are conflict-free.

2.6.2. Enrollee Stratification

2.6.2.1. The assessment process consists of two main components for community-based LTSS and non-LTSS Enrollees: IHSs for Enrollees who are not eligible for LTSS, and CFNA for community-based Enrollees who are eligible for LTSS or who are otherwise determined to be high-risk (as described in Section 2.6.2.4). Both types of assessment are informed by and will result in risk profiling.

2.6.2.2. The assessment process consists of two main components for facility-based LTSS Enrollees: Discharge Opportunity Assessments for Enrollees who may have the desire and/or opportunity to return to the community and Wellness Assessments for Enrollees who do not desire to return to the community.

2.6.2.3. Initial Health Screen (IHS)

2.6.2.3.1. The Contractor will develop an IHS, which RI EOHHS will review and approve. During the first six (6) months of the Demonstration, the Contractor will ensure the administration of a telephonic or in person IHS within one hundred-eighty (180) calendar Days of effective Enrollment to all community-based Enrollees who are not eligible for LTSS and not otherwise determined to be high-risk. An IHS performed by telephone must be conducted by a live person, unless otherwise approved by the CMT in advance. After the first six (6) months of the Demonstration, Contractor must ensure the administration of the IHS within forty-five (45) calendar Days of effective Enrollment in the Demonstration for non-LTSS Enrollees not otherwise determined to be high-risk. The Contractor will re-administer the IHS for an Enrollee based on the Enrollee's condition or needs, including as indicated by predictive modeling or provider- or self-referral. For Enrollees not receiving LTSS and for whom there has been no change in condition, the Contractor will readminister the IHS annually. If the Enrollee, Enrollee's caregiver or Health Care Professional requests an IHS, it must be completed within fifteen (15) calendar Days of the request. If predictive modeling or other data sources indicate a need to re-administer the IHS, it must be completed within forty-five (45) calendar Days of identification of need to re-administer the IHS.

2.6.2.3.1.1. Previous RHO: For Enrollees who were enrolled in the Contractor's RHO plan immediately prior to the Demonstration and had an IHS completed within the one hundred eighty (180) calendar days prior to Enrollment in the Demonstration, the IHS will be re-administered according to the applicable timeframe for that Enrollee, using the RHO IHS date as the starting point.

2.6.2.3.2. At a minimum, the IHS shall include:

2.6.2.3.2.1.	Complete demographic information including, but not limited to household information including mailing address, and phone number; the Enrollee's preferred language; age/date of birth; living arrangement (lives alone, lives with Family, etc.); and current residence status (community or facility-based);
2.6.2.3.2.2.	Strength-based needs and preferences;
2.6.2.3.2.3.	Self-reported health status;
2.6.2.3.2.4.	Access to and utilization of primary and specialty care;
2.6.2.3.2.5.	Emergency room utilization in the last six (6) months;
2.6.2.3.2.6.	History of medical and behavioral health hospitalizations in the last year;
2.6.2.3.2.7.	Presence of co-morbid chronic conditions;
2.6.2.3.2.8.	Current medications;
2.6.2.3.2.9.	Behavioral health screening;
2.6.2.3.2.10.	Social needs;
2.6.2.3.2.11.	Community and Family supports;
2.6.2.3.2.12.	Availability of an informal caregiver;
2.6.2.3.2.13.	Prior nursing facility admissions;
2.6.2.3.2.14.	Ability to perform ADLs and instrumental activities of daily living (IADLs); and
2.6.2.3.2.15.	Perceived risks (e.g. of falls).

2.6.2.3.3. The Contractor will stratify each Enrollee who receives the IHS as being low-, moderate-, or high-risk, using criteria approved by RI EOHHS. RI EOHHS may identify minimum required determinants of high-risk status that may include, but are not limited to, multiple emergency department visits, inpatient hospital behavioral health admissions and re-admissions, inpatient hospital medical admissions and re-admissions, loss of an informal caregiver, loss of housing, polypharmacy, and indication of an unstable chronic disease process. The Contractor should align the risk stratification criteria with other RI EOHHS initiatives, where appropriate.

2.6.2.3.4. IHS results for low- and moderate-risk Enrollees will be distributed to the PCP as appropriate.

2.6.2.4. Comprehensive Functional Needs Assessment (CFNA)

2.6.2.4.1. For Enrollees eligible for LTSS, and Enrollees not eligible for LTSS but determined to be at high-risk based on the IHS or other sources, the Contractor will ensure the completion of a CFNA within the timeframes described in this Section 2.6.2.4.

2.6.2.4.2. The Contractor shall develop and submit to RI EOHHS a CFNA tool and scoring methodology, subject to RI EOHHS review and approval, to identify high-risk Enrollees who require ICM services.

2.6.2.4.3. The Contractor shall ensure the completion of a CFNA for the following Enrollees, within the following timeframes:

2.6.2.4.3.1. Non-LTSS High-risk: Enrollees living in the community who are not eligible for LTSS and who are determined by the Contractor based on the IHS or via predictive modeling activities to be high-risk Enrollees will receive an in-person CFNA in their homes (with Enrollee consent). Throughout the Demonstration, the CFNA must be completed no later than fifteen (15) Days after IHS completion. Reassessments will be conducted by phone or in-person at least annually or sooner if required based on the Enrollee's condition or needs or the circumstances described in Section 2.6.2.4.8.

2.6.2.4.3.2. Community LTSS: Enrollees who are eligible for LTSS and who reside in the community will receive an in-person CFNA in their homes (with Enrollee consent).

2.6.2.4.3.2.1. During the first six (6) months of the Demonstration, for Enrollees eligible for community-based LTSS who were not enrolled in the Contractor's RHO plan immediately prior to the Demonstration, the CFNA will be completed no later than one hundred-eighty (180) calendar Days after the effective Enrollment date. After the first six months (6) of the Demonstration, the CFNA must be completed no later than fifteen (15) calendar Days after the effective Enrollment date, or sooner if required based on the Enrollee's condition, needs or circumstances. Reassessments will be conducted in-person, or by phone if needed or requested by the Enrollee, at least every ninety (90) calendar Days, or sooner if required based on the Enrollee's condition or needs or the circumstances described in Section 2.6.2.4.8.

2.6.2.4.3.2.2. Previous RHO: For community-based Enrollees eligible for LTSS who were enrolled in the Contractor's RHO plan immediately prior to the Demonstration, the previous assessment conducted by the RHO plan will be shared with the ICT within thirty (30) Days of Demonstration Enrollment. If the RHO assessment was completed within the one hundred eighty (180) calendar Days prior to Enrollment in the Demonstration, the Enrollee will be reassessed according to the applicable timeframe for that Enrollee, using the RHO assessment date as the starting point.

2.6.2.4.4. For all Enrollees described above in Sections 2.6.2.4.3.1 through 2.6.2.4.3.2.2, the Contractor will further be required to ensure an in-person re-assessment within fifteen (15) calendar Days of identifying a significant change in the Enrollee's condition or needs or the circumstances described in Section 2.6.2.4.8, with the exception of hospitalizations. Following a hospitalization, reassessments will be conducted within five (5) Days of discharge.

2.6.2.4.5. At a minimum, a CFNA for community-based LTSS and high-risk non-LTSS individuals must include, but not be limited to, an assessment of:

2.6.2.4.5.1. Enrollee strength-based preferences and needs for care delivery, housing, caregiver involvement and other key factors as they relate to care;

2.6.2.4.5.2. Self-reported health status;

2.6.2.4.5.3. Utilization history for emergency room services, inpatient services, community-based LTSS, and nursing facility services within the last eighteen (18) months;

2.6.2.4.5.4. Access to and utilization of primary and specialty care;

2.6.2.4.5.5. Medical and behavioral health history including all chronic conditions and history of exacerbations within the prior twelve (12) months;

2.6.2.4.5.6. Medications and medication management needs;

2.6.2.4.5.7. Mental health screening;

2.6.2.4.5.8. Cognitive functioning;

2.6.2.4.5.9. Alcohol, tobacco, and substance use;

2.6.2.4.5.10. Ability to perform ADLs and IADLs;

2.6.2.4.5.11. Fall risks, home safety evaluation, and Environmental Modifications needed;

2.6.2.4.5.12. Advance directives;

2.6.2.4.5.13. Cultural and linguistic preferences;

2.6.2.4.5.14. Evaluation of visual and hearing needs and preferences;

2.6.2.4.5.15. Caregiver resources and involvement;

2.6.2.4.5.16. Family, informal, and community support systems;

2.6.2.4.5.17. Nutritional status and availability of appropriate food based on the Enrollee's medical needs and preferences;

2.6.2.4.5.18. Social needs;

2.6.2.4.5.19. Housing, social service, legal needs;

2.6.2.4.5.20. Potential to avoid institutional care (e.g. housing status, availability of an informal caregiver);

2.6.2.4.5.21. Interest in vocational rehabilitation, employment/supported employment, or volunteer work; and

2.6.2.4.5.22. Barriers to meeting goals or complying with the ICP.

2.6.2.4.6. The Contractor shall notify PCPs of any new Enrollee who has not completed a CFNA re-assessment within the time period set forth above and whom the Contractor has been unable to contact. The Contractor shall encourage PCPs to conduct outreach to these Enrollees.

2.6.2.4.7. The CFNA, including reassessments, will be administered by a qualified individual.

2.6.2.4.8. CFNA Re-assessment: The Contractor will be required to ensure the completion of comprehensive re-assessments on an ongoing basis for Enrollees eligible for community-based LTSS and high-risk non-LTSS Enrollees using the timelines listed in Section 2.6.2.4.4. The comprehensive re-assessment will have the same content as the initial CFNA and must be fully updated at the time of re-assessment. The Contractor shall develop and submit to RI EOHHS a comprehensive re-assessment tool and scoring methodology, subject to RI EOHHS review and approval.

2.6.2.4.8.1. Changes in the Enrollee's condition or needs that may warrant a comprehensive re-assessment include, but may not be limited to: hospitalization; significant changes in medication; change in, or loss of, a caregiver; medical, psychosocial or behavioral health crisis; excessive emergency department utilization; other major changes in the Enrollee's psychosocial, medical, behavioral condition; or major changes in caregivers or housing.

2.6.2.4.8.2. The Contractor will ensure the incorporation of the results of the comprehensive re-assessment into the Enrollees' ICPs, and will distribute the revised ICPs to appropriate ICT members including, but not limited to, Enrollees and their caregivers.

2.6.2.5. Discharge Opportunity Assessment

2.6.2.5.1. Facility-based LTSS: Every six (6) months, the Contractor shall identify Enrollees who are nursing facility residents who may have the desire and/or opportunity to return to the community, based on methods including but not limited to self- or provider referral, MDS results, and predictive modeling. The Contractor shall ensure the development of a Discharge Opportunity Assessment for those individuals. The Discharge Opportunity Assessment shall be conducted within thirty (30) Days of Enrollee identification or referral.

2.6.2.5.2. The Discharge Opportunity Assessment may include, but not be limited to data regarding:

2.6.2.5.2.1. Whether the Enrollee wishes to return to a community-based residence;

2.6.2.5.2.2. The Enrollee's MDS score;

2.6.2.5.2.3. How long the Enrollee has been residing in the nursing facility;

2.6.2.5.2.4. Whether the Enrollee has a home in the community; and

2.6.2.5.2.5. Whether the Enrollee has an informal caregiver to assist at a community-based residence.

2.6.2.5.3. For Enrollees residing in nursing facilities who are found to have the desire and/or opportunity to return to the community, the Contractor shall ensure the development of a person-centered Community Transition Plan designed to support community reintegration. Such Enrollees will also be assigned a transition coordinator, as described in Appendix K. The transition coordinator will participate in discharge planning meetings, develop a Community Transition Plan, facilitate referrals to community providers, conduct a home safety evaluation, and follow the Enrollee upon discharge, including a face-to-face home visit within twenty-four (24) hours of the discharge.

2.6.2.5.4. The Community Transition Plan shall include, but is not limited to:

2.6.2.5.4.1. Identification of community supports;

2.6.2.5.4.2. Availability of housing;

2.6.2.5.4.3. Safety assessment of residence;

2.6.2.5.4.4. Identification of Environmental Modification needs; and

2.6.2.5.4.5. Identification of DME needs.

2.6.2.5.5. The Contractor will meet the requirements of the Nursing Home Transition Program (NHTP) and Rhode to Home (RTH), as described in Appendix K, for eligible Enrollees.

2.6.2.6. Wellness Assessment

2.6.2.6.1. For Enrollees in nursing facilities who do not desire to return to the community, the Contractor shall ensure the completion of a Wellness Assessment in the facility using MDS and other existing data to the greatest extent possible and appropriate. The Wellness Assessment shall be completed within one hundred-twenty (120) Days of Enrollment, and will inform development of a Wellness Plan (see Section 2.6.6). Reassessments will be conducted at least annually, or sooner based on the Enrollee's condition or needs or the circumstances described in Section 2.6.2.4.8. The Wellness Assessment will include, but is not limited to:

2.6.2.6.1.1. Enrollee strength-based preferences and needs for care delivery, housing, caregiver involvement, and other key factors as they relate to care;

2.6.2.6.1.2. Health status;

2.6.2.6.1.3. Access to and utilization of primary and specialty care;

2.6.2.6.1.4. Utilization history for inpatient services and other acute care needs within the last eighteen (18) months;

2.6.2.6.1.5. Medical and behavioral health history;

2.6.2.6.1.6. Mental health screening, including but not limited to depression;

2.6.2.6.1.7. Cognitive functioning;

2.6.2.6.1.8. Ability to perform ADLs and IADLs;

2.6.2.6.1.9. Fall risks;

2.6.2.6.1.10. Advance directives;

2.6.2.6.1.11. Cultural and linguistic preferences;

2.6.2.6.1.12. Evaluation of visual and hearing needs and preferences;

2.6.2.6.1.13. Nutritional status;

2.6.2.6.1.14. Stress management;

2.6.2.6.1.15. Physical activity;

2.6.2.6.1.16. Social needs;

2.6.2.6.1.17. Desire to return to the community, including Section Q of the MDS; and

2.6.2.6.1.18. Barriers to meeting goals or complying with the Wellness Plan.

2.6.2.7. The Contractor shall develop policies and procedures to assist Enrollees to understand and make informed decisions about service options, including information about Olmstead rights, consumer-directed services, services provided by DOH, the Department of Human Services and the Division of Elderly Affairs.

2.6.2.8. Contractor will ensure the leveraging of existing MDS data, RHO Care Management assessments, and other data sources when conducting an assessment of the needs of individuals who are eligible for LTSS and are residing in a nursing facility.

2.6.3. Requirements for Lead Care Managers (LCMs)

2.6.3.1. The Contractor will assign an LCM to each community-based LTSS and high-risk non-LTSS Enrollee. Such Enrollees will be eligible to receive ICM services.

2.6.3.2. For Enrollees with a primary medical condition(s), a licensed clinician with physical health expertise shall be designated as the LCM. For Enrollees with a primary mental illness or substance use disorder, a licensed clinician with behavioral health expertise shall be designated as the LCM. The Contractor will make physical health Care Management resources available to the primary behavioral health LCMs, and vice versa, to meet the comprehensive needs of Enrollees. The Contractor shall establish the role and responsibilities of each type of LCM.

2.6.3.3. The Contractor will maintain policies and procedures for assigning LCMs to manage the delivery of ICM services in a manner that ensures that Enrollees are served by the staff best qualified to meet

their needs. In the event that Enrollees wish to select different LCMs, the Contractor shall help them do so.

2.6.3.4. The Contractor is expected to leverage existing Care Management supports that may already be in place. These supports may include a nurse care manager in a Primary Care practice where the Enrollee receives Primary Care.

2.6.3.5. The LCM or Care Manager will:

2.6.3.5.1. Conduct the CFNA (to the extent that the Contractor has sufficient information to assign an LCM or Care Manager with appropriate expertise to an Enrollee prior to full CFNA results) and fully incorporate such results into the Enrollee's ICP. If the Contractor does not have sufficient information to assign an LCM or Care Manager to an Enrollee prior to the CFNA, a qualified LCM will perform the CFNA and another LCM or Care Manager with expertise more relevant to the Enrollee's needs may be assigned after the CFNA is completed;

2.6.3.5.2. Discuss the Enrollee's desired treatment results and outcomes;

2.6.3.5.3. Oversee creation of the ICT with appropriate participants, reflecting both Covered and Carved-Out Services, as appropriate;

2.6.3.5.4. Convene a telephonic or in-person meeting of the ICT, if appropriate and necessary, to discuss Enrollee needs and preferences;

2.6.3.5.5. Hold in-person or telephonic ICT meeting(s) on an as needed basis, including any time an Enrollee experiences a significant change in condition (e.g. hospitalization or loss of caregiver) and qualifies for ICM;

2.6.3.5.6. Use all relevant information from the CFNA, Enrollee and Family input, and other data to create and implement a comprehensive, multidisciplinary ICP;

2.6.3.5.7. Share the ICP with members of the ICT, including the Enrollee, the Enrollee's Family and/or caregiver (with Enrollee consent);

2.6.3.5.8. Coordinate Medicare and Medicaid service delivery among all Health Care Professionals associated with the Enrollee's care, including but not limited to providers of medical, LTSS, and behavioral health services and providers of Carved-Out Services, as described in Appendix A;

2.6.3.5.9. Manage care transitions;

2.6.3.5.10. Follow up with Health Care Professionals to obtain necessary test and treatment results, or other information about the Enrollee's health status;

2.6.3.5.11. Provide or link Enrollees to self-management and disease management education, with a focus on self-care;

2.6.3.5.12. Monitor, review and update the ICP periodically as needed, assessing progress toward achieving Enrollee-centered goals and outcomes, and making appropriate revisions in collaboration with the Enrollee and the Enrollee's Health Care Professionals as the Enrollee's condition and needs change;

2.6.3.5.13. Provide information and engage in discussion with Enrollees to help inform decisions about the use of medical resources, including the emergency room;

2.6.3.5.14. Make referrals for services and assist Health Care Professionals in obtaining the necessary authorization to provide services, including access to alternative therapies;

2.6.3.5.15. Receive training on interdisciplinary care coordination and key LCM responsibilities; and

2.6.3.5.16. Analyze ICM effectiveness and appropriateness and Enrollee outcomes.

2.6.4. Requirements for Care Coordinators and Care Management Staff for Low-and Moderate-Risk Non-LTSS Enrollees

2.6.4.1. The Contractor will make Care Coordinators and/or Care Management staff available to Enrollees who are not eligible for LTSS and are not otherwise designated as being high-risk.

2.6.4.2. Care Coordinators and/or other Care Management staff will:

2.6.4.2.1. Support Health Care Professionals to the greatest degree possible to incorporate Care Management activities at the practice level;

2.6.4.2.2. Coordinate care with and leverage resources available at the Enrollee's medical home, as appropriate;

2.6.4.2.3. Coordinate care with other members of the Enrollee's ICT, as appropriate;

2.6.4.2.4. Ensure the IHS is conducted and that data from the IHS, and other sources as appropriate, are conveyed to the PCP in order to deliver preventive services, if appropriate;

2.6.4.2.5. Be available to educate Enrollees on prevention, wellness, employment/vocational training, self-care, self-management, and disease management as needed and desired by the Enrollees;

2.6.4.2.6. Facilitate timely referrals to appropriate services, as needed;

2.6.4.2.7. Coordinate service delivery among providers associated with the Enrollee's care, including but not limited to providers of medical, LTSS, and behavioral health services as needed, and including both Covered and Carved-Out Services;

2.6.4.2.8. Make referrals for Covered and Carved-Out Services and assist Health Care Professionals in obtaining the necessary authorization to provide services, including access to alternative therapies as necessary and appropriate;

2.6.4.2.9. Provide Enrollee Services support to link Enrollees who do not receive LTSS to necessary Care Management resources within the Contractor;

2.6.4.2.10. Address changes in condition and arrange for a CFNA based on the terms in Section 2.6.2.4.4 of this Contract, when needed as a result of a change in the Enrollee's condition, and refer Enrollees for ICM services when appropriate;

2.6.4.2.11. Arrange home safety checks for the Enrollee, when indicated by the IHS;

2.6.4.2.12. Make available all relevant information to support the delivery of integrated care at the practice level;

2.6.4.2.13. Promote the sharing of data and information with providers through tools that include, but are not limited to, shared medical records, secure messaging, health information exchange and other techniques to support care integration; and

2.6.4.2.14. Provide other support as appropriate.

2.6.5. Interdisciplinary Care Plan (ICP)

2.6.5.1. Requirements for the ICP: The Contractor will ensure the development of an appropriate ICP for all Enrollees. The requirements in this Section 2.6.5 pertain to the ICP that the Contractor will develop for each community-based LTSS and high-risk non-LTSS Enrollee. For low- and moderate risk non-LTSS Enrollees, the Contractor will submit a proposed set of requirements, including minimum care plan contents and timeline for completion, to RI EOHHS and CMS for review and approval prior to the first ICI Demonstration effective enrollment date.

2.6.5.2. The ICP must be developed within fifteen (15) calendar Days of completion of the CFNA, or sooner, based on Enrollee needs. The ICP must be modified, if necessary, within five (5) Days after a hospitalization.

2.6.5.3. The Contractor will comprehensively document within the ICP the needs and interventions identified by the ICT and CFNA, including medical, behavioral health, LTSS, Health Home services, and other critical needs (e.g. legal or housing), and including services covered by the Contractor (i.e. included in the capitated rate) as well as Carved-Out Services. The ICP will include a written description of Enrollee-specific health care goals to be achieved and the amount, duration, and scope of the Covered Services to be provided to achieve such goals.

The ICP shall include all services covered under the Demonstration, as well as any non-Covered Services, with an emphasis on Care Management and informal supports necessary to support the Enrollee's health care goals and effectiveness of the Covered Services in a culturally and linguistically person-centered manner. ICP effectiveness is monitored through reassessment and ongoing ICT determination as to whether the health care goals are being met. At minimum, the ICP will include but not be limited to:

2.6.5.3.1. Short- and long-term goals and expected outcomes and measures including timelines for achievement of goals;

2.6.5.3.2. The LTSS Care Plan for Enrollees receiving LTSS;

2.6.5.3.3. Barriers to service delivery and strategies to address such barriers;

2.6.5.3.4. Measures taken to reduce risks without restricting the Enrollee's autonomy to undertake risks to achieve goals;

2.6.5.3.5. Medical, behavioral, and psychosocial support needs and ICM interventions, including but not limited to:

2.6.5.3.5.1. Integrated interventions that incorporate medical, behavioral health, LTSS, social service, and community living support needs;

2.6.5.3.5.2. Plans for known or anticipated care transitions;

2.6.5.3.5.3. Disease management/chronic condition management including, but not limited, to self-management and education;

2.6.5.3.5.4. Prevention and wellness goals and strategies;

2.6.5.3.5.5. Home safety needs, issues, and interventions;

2.6.5.3.5.6. Availability of informal support systems, including factors that put the Enrollee's informal supports at risk;

2.6.5.3.5.7. Specific person(s) and/or any provider agency responsible for delivering LTSS, including back-up plans to the extent possible;

2.6.5.3.5.8. Self-Directed Services and supports;

2.6.5.3.5.9. Advanced care planning, if desired by the Enrollee;

2.6.5.3.5.10. Other needed interventions (e.g. housing, legal, recreational);

2.6.5.3.5.11. Signatures (or other indications of consent, where applicable) of all people with responsibility for ICP implementation, including the Enrollee and the Enrollee's designee, if applicable and with the Enrollee's consent, and a timeline for Enrollee and/or LCM ICP review signifying ICP acceptance and an intention to follow the ICP; and

2.6.5.3.5.12. Emergency after-hours backup plan that ensures that an informal caregiver is available, if needed, from a contracted agency in person twenty-four (24) hours per day, seven (7) days per week. Such emergency situations include but are not limited to: significant change in Enrollee condition, unexpected caregiver absence, loss of safe housing, or natural disaster.

2.6.5.3.6. Distribute copies of the original ICP and ICP updates to the Enrollee, the Enrollee's Family or caregiver, and providers, as appropriate and with Enrollee consent.

2.6.5.3.7. Develop the ICP with an emphasis on leveraging existing caregivers and services and avoiding duplication with existing resources, including but not limited to sources of Care Management outside of the Contractor's MMP.

2.6.5.3.8. Write the ICP in a culturally and linguistically appropriate manner that enhances the Enrollee's health literacy while considering the Enrollee's overall capacity to learn and be self-directed. Goals must be documented in the first person.

2.6.5.3.9. Ensure that the ICP considers processes and strategies for resolving conflict or disagreement within the ICM and care coordination processes. The Contractor must maintain clear conflict of interest guidelines for all ICM participants, as well as a method for the Enrollee to request ICP revision.

2.6.6. Requirements for the Wellness Plan

2.6.6.1. The Contractor will ensure the development of an appropriate Wellness Plan for Enrollees receiving facility-based LTSS who do not desire to return to the community. Such Enrollees will also be assigned a Care Coordinator. The Wellness Plan must be developed within fifteen (15) calendar Days of completion of the Wellness Assessment, or sooner, based on Enrollee needs. The Wellness Plan must be modified, if necessary, within five (5) Days of a hospitalization. At minimum, the Wellness Plan will include but not be limited to:

2.6.6.1.1. Short- and long-term goals and expected outcomes and measures including timelines for achievement of goals and reference to any goals, outcomes, and measures listed in other clinical care plans the Enrollee may have outside of the Contractor;

2.6.6.1.2. Barriers to service delivery and strategies to address such barriers;

2.6.6.1.3. Measures taken to reduce risks without restricting the Enrollee's autonomy to undertake risks to achieve goals;

2.6.6.1.4. Medical, behavioral, and psychosocial support needs, including but not limited to:

2.6.6.1.4.1. Plans for known or anticipated care transitions;

2.6.6.1.4.2. Prevention and wellness goals and strategies;

2.6.6.1.4.3. Advanced care planning, if desired by the beneficiary;

2.6.6.1.4.4. Safety and crisis management planning; and

2.6.6.1.4.5. ADL and IADL needs, goals, and strategies.

2.6.7. Responsibilities for Peer Navigators

2.6.7.1. Responsibilities for Peer Navigators, with oversight by the LCM, as applicable, may include:

2.6.7.1.1. Participating in Peer Navigator training administered by the Contractor;

2.6.7.1.2. Assisting with making appointments for health care services;

2.6.7.1.3. Canceling scheduled appointments if necessary;

2.6.7.1.4. Assisting with transportation needs;

2.6.7.1.5. Following up with Enrollees and Health Care Professionals to assure that appointments are kept;

2.6.7.1.6. Rescheduling missed appointments;

2.6.7.1.7. Linking Enrollees to alternatives to facility-based medical care, including the emergency room, when appropriate and desired by the Enrollee;

2.6.7.1.8. Assisting Enrollees to access both formal and informal community-based support services such as child care, housing, employment, and social services;

2.6.7.1.9. Assisting Enrollees to deal with non-medical emergencies and crises;

2.6.7.1.10. Assisting Enrollees in meeting ICP goals, objectives, and activities;

2.6.7.1.11. Providing emotional support to Enrollees, when needed; and

2.6.7.1.12. Serving as a role model in guiding the Enrollee to practice responsible health behavior.

2.6.8. Requirements for Predictive Modeling

2.6.8.1. The Contractor shall utilize predictive modeling software to stratify Enrollees for whom Claims history exists into low-, moderate-, and high-risk categories. At a minimum, the Contractor will utilize predictive modeling software that uses Claims data and evidence-based algorithms to categorize Enrollees. Such software will further identify Enrollees at risk for poor health outcomes who may benefit from Care Management services.

2.6.8.2. The Contractor shall use predictive modeling data, to identify Enrollees' changing needs on an ongoing basis, where Claims history is available. The Contractor must stratify Enrollees' needs based on acuity as well as risk for hospitalization or nursing facility placement.

2.6.8.3. The Contractor shall include a thorough analysis of Claims data, encounter data, and/or data from other systems over a one-year period in predictive modeling activities, where a full year of Claims data exists for an Enrollee. Where one year of data does not exist, the Contractor will determine whether and how to conduct predictive modeling activities.

2.6.8.4. The Contractor shall at least monthly, conduct a data "sweep" and subsequent analysis of Claims data for new and existing Enrollees to identify Enrollees at risk of poor health outcomes who may benefit from Care Management services.

2.6.8.5. The Contractor shall review predictive modeling data and any other available information for each Enrollee not eligible for LTSS to determine if an in-person CFNA is needed and in what timeframe, as described in Section 2.6.2.

2.6.9. Requirements for Additional Data Analysis

2.6.9.1. In addition to predictive modeling activities, the Contractor will be required to analyze Enrollee risk and potential needs based upon all available information, including IHS and CFNA results, encounter data, hospital discharge summaries, Health Care Professional referrals and referrals of all types (including Enrollee self-referral), data collected through Utilization Management processes, and Enrollee and caregiver input.

2.6.9.2. The Contractor shall utilize all available data, including information gathered via the full range of applicable assessment activities, to identify and plan for each Enrollee's person-centered needs and to inform development of an appropriate ICP, where applicable.

2.6.9.3. The Contractor shall review referrals and any other available information for each Enrollee not eligible for LTSS to determine if an in-person CFNA is needed and in what timeframe, as described in Section 2.6.2.

2.6.10. Medicaid LTSS Eligibility Assessments, Reassessments, and Care Plans

2.6.10.1. All Enrollees who are identified as high-risk (as described in Section 2.6.2 Enrollee Stratification) or whose CFNAs indicate a need for LTSS will be referred by the Contractor to RI EOHHS for a Medicaid LTSS eligibility assessment and level of care determination.

2.6.11. RI EOHHS LTSS Care Plans

2.6.11.1. The Contractor is responsible for monitoring the LTSS Care Plan, as described in Section 3.4, on an ongoing basis and ensuring that the LTSS Care Plan meets the needs of the Enrollee. The Contractor may adjust the LTSS Care Plan to meet the Enrollee's LTSS care needs. Factors that might trigger a change to the LTSS Care Plan include, but are not limited to, changes in Enrollee acuity, health and functional status, living situation, and caregiver support.

2.6.11.2. The Contractor must coordinate with RI EOHHS for Enrollees receiving LTSS or residing in a nursing facility in accordance with guidance from RI EOHHS.

2.6.11.3. The Contractor must report to RI EOHHS on a monthly basis on changes to LTSS Care Plans, including the total number and percent of LTSS Care Plans with service level increases and decreases.

2.6.12. Self-Directed Services

2.6.12.1. Rhode Island Personal Choice Program Requirements

2.6.12.1.1. The Contractor will support community-based LTSS Enrollees to self-direct their own care through participation in the Personal Choice program.

2.6.12.1.2. The Enrollee must be informed of the option to self-direct his or her own services at each Comprehensive Functional Needs (CFNA) Assessment, Comprehensive Reassessment, and when the ICP is updated.

2.6.12.1.3. Explanations of the Self-Direction option must:

2.6.12.1.3.1. Make clear that Self-Direction of services is voluntary and that Enrollees can choose the extent to which they would like to self-direct their services;

2.6.12.1.3.2. Provide the options to select self-directed supports or services; and

2.6.12.1.3.3. Provide an overview of the supports and resources available to assist Enrollees to participate to the extent desired in Self-Direction.

2.6.12.1.4. The Contractor shall contract with Medicaid self-directed First Tier, Downstream, and Related Entities for the first twelve (12) months of the Demonstration to support self-directed Enrollees. (These First Tier, Downstream, and Related Entities conduct on-line assessments, background checks on care givers as well as serve as fiscal intermediaries and advisors to Enrollees.)

2.6.12.1.5. The Contractor is responsible for overseeing and approving self-directed care plans and personal budgets. The Contractor shall indicate in the ICP how the Contractor provides the oversight and approval of self-directed services.

2.6.12.1.6. After the first twelve (12) month period, the Contractor shall be required to subcontract with organizations to perform fiscal intermediary responsibilities for Enrollees who use self-directed supports and services. The Contractor has the option to enable the fiscal intermediary First Tier, Downstream, or Related Entity to perform Care Management functions and to conduct the re-assessments.

2.6.12.1.7. The Contractor shall have policies and procedures to ensure that the Enrollee's self-directed program is maintained and shall be part of the Contractor's ICP discussed in Sections 2.6.5 of this Contract.

2.6.13. Continuity of Care

2.6.13.1. Service Transitions

2.6.13.1.1. For all items and services other than nursing facility services and non-Part D prescription drugs, the Contractor must allow Enrollees to maintain current Health Care Professionals and service levels at the time of Enrollment for at least six (6) months after Enrollment, or until an IHS (for Enrollees determined to be low or moderate risk) or CFNA and ICP have been completed by the Contractor, whichever is later, unless the Enrollee refuses to complete the CFNA or ICP. If the Enrollee refuses to complete the CFNA or ICP, the Contractor must allow Enrollees to maintain current Health Care Professionals and service levels at the time of Enrollment for at least six (6) months after Enrollment. Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 C.F.R. § 438.404 which clearly articulates the Enrollee's right to file an Appeal (either expedited, if warranted, or standard), the right to have authorized service continue pending the Appeal, and the right to a fair hearing if the Contractor renders an adverse determination (either in whole or in part) on the Appeal.

2.6.13.1.2. The Contractor is required to maintain current LTSS service authorization levels for all LTSS services (including personal care, waiver nursing, home care, respite care, community living, adult day health, social work, counseling, and independent living assistance) during six (6) month transition period, unless a significant change has occurred and is documented during the CFNA and/or CFNA Reassessment.

2.6.13.1.3. Enrollees who are permanent residents of nursing facilities or assisted living facilities may remain in that nursing facility or assisted living facility, regardless of whether that nursing facility or assisted living facility is in the Contractor's Provider Network.

2.6.13.2. Drug Transitions

2.6.13.2.1. During the first 90 days of coverage, the Contractor will provide:

2.6.13.2.1.1. An appropriate transition process when an Enrollee requests a refill of a non-formulary drug (including a drug that is on the Contractor's formulary but requires prior authorization or step therapy under the Contractor's Utilization Management rules) that otherwise meets the definition of a Part D drug. The transition process shall be consistent with requirements at 42 C.F.R. § 423.120(b)(3), and the Contractor shall provide a temporary supply of drugs, consistent with the requirements at 42 C.F.R. § 423.120(b)(3)(iii).

2.6.13.2.1.2. A ninety (90) Day supply of drugs when an Enrollee requests a refill of a non-Part D drug that is covered by Medicaid.

2.6.13.2.2. Except as provided in Appendix A, all prior approvals for non-Part D drugs, therapies, or other services existing in Medicare or Medicaid at the time of Enrollment will be honored for 60 days after Enrollment and will not be terminated at the end of 60 days without advance notice to the Enrollee and transition to other services, if needed.

2.6.13.3. Health Care Professional Transitions

2.6.13.3.1. During the six (6) month transition period, the Contractor will approve an Enrollee request to access to a Health Care Professional seen by the Enrollee within the previous six (6) months prior to transition, even if the Health Care Professional is not in the Contractor's Provider Network, so long as the Health Care Professional is licensed and qualified to provide the requested service.

2.6.13.3.2. During the transition period, the Contractor will advise Enrollees and Health Care Professionals if and when they have received care that would not otherwise be covered in-network.

2.6.13.3.3. On an ongoing basis, and as appropriate, the Contractor must provide information on becoming in-network Health Care Professionals to providers who provide services to Enrollees during the transition period and are not part of the Contractor's Provider Network.

2.6.13.3.4. Out-of-network PCPs and specialists providing an ongoing course of treatment must be offered single case agreements to continue to care for the Enrollee beyond the six (6) month transition period if the out-of network PCP and/ or specialist chooses not to participate in the Contractor's Provider Network. If an out-of-network provider does not enter in to the single case agreement, the Contractor may treat the provider as out-of-network for purposes of the ongoing course of treatment.

2.6.13.3.4.1. For nursing facility services that are part of the traditional Medicaid benefit package, the Contractor will be required to pay non-contracting Health Care Professionals a rate similar to the Medicaid FFS rate.

2.6.13.3.4.2. If an Enrollee is receiving any item or service that would not otherwise be covered by the Contractor at an in-network level after the continuity of care period, the Contractor must notify the Enrollee prior to the end of the continuity of care period, according to the requirements at 42 C.F.R. § 438.208 and 42 C.F.R. § 422.568.

2.6.13.3.4.3. The Enrollee shall be entitled to all Appeal rights, including the right to have covered benefits continue pending resolution of the Appeal, if applicable, as outlined in Section 2.11 of this Contract.

2.6.13.4. Transferring Service Plans and Liabilities

2.6.13.4.1. The Contractor must be able to accept and honor established service plans provided on paper or electronically transferred from fee-for-service or prior plans when the Enrollee transitions with service plans in place; and

2.6.13.4.2. The Contractor must be able to ensure timely transfer of ICPs to other Contractors, other plans, and/or RI EOHHS, as appropriate, when an Enrollee is disenrolling from the Contractor's MMP.

2.6.13.4.3. If an Enrollee is receiving medical care or treatment as an inpatient in an acute care hospital at the time coverage under this Contract is terminated, the Contractor shall arrange for the continuity of care or treatment for the current episode of illness until such medical care or treatment has been fully transferred to a treating Health Care Professional who has agreed to assume responsibility for such medical care or treatment for the remainder of that hospital episode and subsequent follow-up care. The Contractor must maintain documentation of such transfer of responsibility of medical care or treatment. For hospital stays that would otherwise be reimbursed under Medicare or the Rhode Island State Medicaid Program on a per diem basis, the Contractor shall be liable for payment for any medical care or treatment provided to an Enrollee until the effective date of disenrollment. For hospital stays that would otherwise be reimbursed under Medicare or the Rhode Island State Medicaid Program on a diagnosis-related group basis, the Contractor shall be liable for payment for any inpatient medical care or treatment provided to an Enrollee where the discharge date is after the effective date of disenrollment.

2.6.13.5. Transitions Prior to the End of the Six (6) Month Transition Period

2.6.13.5.1. The Contractor may choose to transition an Enrollee to a participating physician earlier than six (6) months only if all the following criteria are met:

2.6.13.5.1.1. The Enrollee is assigned to a PCP that is capable of serving his/her needs appropriately;

2.6.13.5.1.2. The Contractor has completed an IHS and/or a CFNA for the Enrollee;

2.6.13.5.1.3. The Contractor consulted with the new PCP and determined that the PCP is accessible, competent, and can appropriately meet the Enrollee's needs;

2.6.13.5.1.4. A transition plan is in place (to be updated and agreed to with the new PCP, as necessary); and

2.6.13.5.1.5. The Enrollee agrees to the transition and the transition plan prior to the expiration of the six (6) month transition period.

2.6.13.5.2. The Contractor may choose to transition an Enrollee to a network specialist or LTSS provider earlier than six (6) months only if all the following criteria are met:

2.6.13.5.2.1. An IHS and/or a CFNA, if necessary, is complete;

2.6.13.5.2.2. A transition plan is in place (to be updated and agreed to with the new Health Care Professional, as necessary); and

2.6.13.5.2.3. The Enrollee agrees to the transition and the transition plan prior to the expiration of the six (6) month transition period.

2.7. Provider Network

2.7.1. Network Adequacy

2.7.1.1. The Contractor must maintain a Provider Network sufficient to provide all Enrollees with access to the full range of Covered Services, including the appropriate range of preventive, Primary Care, and specialty services, behavioral health services, other specialty services, and all other services required in 42 C.F.R. §§422.112, 423.120, and 438.206, and under this Contract (see Covered Services in Appendix A), taking into consideration:

2.7.1.1.1. The anticipated number of Enrollees;

2.7.1.1.2. The expected utilization of services, in light of the characteristics and health care needs of the Contractor's Enrollees;

2.7.1.1.3. The number and types (in terms of training, experience, and specialization) of providers required to furnish the Covered Services;

2.7.1.1.4. The number of network Health Care Professionals who are not accepting new patients;

2.7.1.1.5. The geographic location of Health Care Professionals and Enrollees, distance, travel time, the means of transportation ordinarily used by Enrollees, and whether the location provides physical access for Enrollees with disabilities;

2.7.1.1.6. The communication needs of Enrollees; and

2.7.1.1.7. The cultural and ethnic diversity and demographic characteristics of Enrollees.

2.7.1.2. The Contractor must demonstrate annually that its Provider Network meets the following standards:

2.7.1.2.1. For Medicare medical Health Care Professionals and facilities, time, distance and minimum number standards updated annually on the CMS website (CMS MMCO FAI Information and Guidance for Plans); and

2.7.1.2.2. For Medicare pharmacy providers, time, distance and minimum number as required in Appendix D, Article II, Section I and 42 C.F.R. § 423.120.

2.7.1.2.3. For Health Care Professionals of overlap services that may be subject to either Medicaid or Medicare network requirements, the stricter of any applicable standards will apply.

2.7.1.3. The Contractor must demonstrate quarterly that its Provider Network meet the following standards:

2.7.1.3.1. For services in which Medicaid is the traditional primary payor, including behavioral health and substance abuse services, the Contractor must establish a Provider Network that meets the existing requirements of the Medicaid Managed Care program, as dictated by the Medicaid Managed Care Contract, and Policy and Procedures Guide, available on the RI EOHHS website.

2.7.1.3.2. For behavioral health providers, the Contractor must contract with providers whose office is located within 20 minutes or less driving distance from the Enrollee's home, unless the Contractor has an RI EOHHS-approved alternative time standard.

2.7.1.3.3. The Contractor agrees to provide RI EOHHS with

2.7.1.3.3.1. A list of all its participating Health Care Professionals for services in which Medicaid is the traditional primary payor, including behavioral health and substance abuse services. This list must include information on the language capability of the Health Care Professional, Health Care Professional addresses and telephone numbers, and ADA compliance.

2.7.1.3.3.2. A list of PCPs who have adequate capacity to accept Enrollees.

2.7.1.4. The Contractor's network must also meet the following access to care requirements:

2.7.1.4.1. In correlation with the LTSS transition, the Contractor must extend contracts to every willing LTSS provider that accepts the Contractor's contract provisions and meets all applicable licensing, credentialing and other requirements by Medicaid.

2.7.1.5. Primary Care

2.7.1.5.1. Contractor agrees to have written policies and procedures for assigning every Enrollee to a PCP, who has not chosen one at the time of Enrollment. The policies and procedures must address how the Contractor will offer Enrollees who are long-stay nursing facility residents the option to select a community PCP.

2.7.1.5.2. PCP responsibilities include at a minimum:

2.7.1.5.2.1. Provide overall clinical direction and serve as the central point for the integration and coordination of care;

2.7.1.5.2.2. Make referrals for specialty care and other Medically Necessary Services, including both Covered and Carved-Out Services;

2.7.1.5.2.3. Maintain a current medical record for the Enrollee; and

2.7.1.5.2.4. Serve as the general care manager and refer Enrollees for specialized Care Management services, where appropriate.

2.7.1.5.3. The Contractor agrees to retain responsibility for monitoring PCP actions to ensure they comply with Contractor, Medicare, and RI Medicaid managed care program policies.

2.7.1.5.4. On a case-by-case basis, a PCP may be a specialist who has an ongoing clinical relationship with an Enrollee, serves as the principal coordinating provider for the Enrollee's special health care needs, and plays a critical role in managing that Enrollee's care on a regular basis.

2.7.1.5.5. The Contractor shall include NCQA certified PCMH in its Provider Network that serve as PCPs. A PCMH will not count towards meeting Primary Care provider access standards to the extent the PCMH does not include one of the Health Care Professionals that meets the PCP definition in 1.110.

2.7.1.5.5.1. Contractor shall auto-assign Enrollees to PCPs in a PCMH practice before auto assigning Enrollees to PCPs in a non-PCMH practice.

2.7.1.5.5.2. The Contractor will provide RI EOHHS with quarterly reports of the number and percent of total Enrollees assigned to a PCP in a PCMH practice either by auto-assignment or Enrollee choice.

2.7.1.5.5.3. The Contractor is responsible for creating an auto-assignment algorithm and submitting this algorithm to RI EOHHS for review and approval within ninety (90) days of the execution of this Contract. Once this logic is approved by RI EOHHS, the Contractor should operationalize the auto-assignment algorithm within sixty (60) days.

2.7.1.5.5.4. Contractor should consider the following when creating the algorithm:

2.7.1.5.5.4.1. The member panel size to ensure that Health Care Professionals have not exceeded their maximum panel size;

2.7.1.5.5.4.2. The Health Care Professional's ability to comply with RI EOHHS and CMS specified access standards, as well as the Health Care Professional's ability to accommodate persons with disabilities or other special health needs; and

2.7.1.5.5.4.3. In the event of a full panel or access issue, the algorithm for auto assignment must allow a Health Care Professional to be skipped until the situation is resolved.

2.7.1.5.5.5. The Contractor will be required to provide registries of Enrollees to each PCP where the Enrollees are assigned, no less frequently then quarterly or at an interval defined by RI EOHHS.

2.7.1.5.6. The Contractor shall have a network of PCPs who provide services in Enrollees' homes.

2.7.1.5.7. If the Contractor's Primary Care network includes institutions with accredited Primary Care residency training programs, it may use PCP teams, comprised of residents and a supervising faculty physician, to serve as a PCP. Contractor shall organize its PCP teams so as to ensure continuity of care to Enrollees and must identify a "lead physician" within the team for each Enrollee. The "lead physician" must be an attending physician and the physician who is accountable as the PCP. Teams shall be small in size and team members shall be assigned for sufficient duration to maintain patient continuity. At all times, the Enrollee maintains the right to determine if the PCP team may participate on his or her ICT.

2.7.1.5.8. If the Contractor's Primary Care network includes Federally Qualified Health Centers (FQHCs) or Rural Health Centers (RHCs), it may designate either type of site as a PCP. In both instances, the Contractor shall organize its PCP sites so as to ensure continuity of care to Enrollees and shall identify a "lead physician" within the site for each Enrollee and the physician who is accountable as the PCP. An FQHC or RHC will not count towards meeting primary care provider access standards to the extent the FQHC or RHC does not include one of the Health Care Professionals that meets the Primary Care provider definition in 2.7.1.5.

2.7.1.5.9. The Contractor agrees to assign no more than fifteen hundred (1,500) Enrollees to any single PCP in its Provider Network. For PCP teams and PCP sites, the Contractor agrees to assign no more than one thousand (1,000) Enrollees per single PCP within the team or site, e.g., a PCP team with three (3) PCPs may be assigned up to three thousand (3,000) Enrollees.

2.7.1.5.10. A Mid-Level Practitioner who serves as a PCP must have a collaborative relationship with a physician that agrees to: share responsibility for the care of assigned Enrollees; assume responsibility for the components of care that are beyond the scope of practice and/or expertise of the Mid-Level Practitioner; and collaborate with the Mid-Level Practitioner to ensure that Enrollees receive specialty care and other referrals as needed.

2.7.1.6. Specialty Care

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

2.7.1.6.2. The Contractor agrees to have written policies and procedures that permit Enrollees at a minimum to self-refer for one (1) annual and up to five (5) GYN/Family Planning visits annually and for sexually-transmitted (STD) services, without obtaining a referral from the PCP.

2.7.1.7. Behavioral Health Care

2.7.1.7.1. The Contractor agrees to include a mix of mental health providers in its network to ensure that a broad range of treatment options representing a continuum of care is available including mental health rehabilitation service needs. The mental health Provider Network shall at least include, but is not limited to, psychiatrists, clinical psychologists, psychiatric nurses, licensed clinical social workers, and providers licensed by the Departments of Children, Youth and Families (DCYF) and/or the Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH). The Contractor shall include licensed outpatient and residential substance abuse treatment programs and licensed substance abuse professionals in its substance abuse Provider Network. The network shall include providers experienced in serving low-income populations, persons with poly pharmacy, and persons with dual diagnosis in sufficient numbers to meet the needs of the population to be served in a timely manner.

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

2.7.1.7.3. The Contractor shall include Community Mental Health Centers (CMHCs) in its network.

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

2.7.1.7.5. The Contractor shall comply with the requirements of 42 C.F.R. § 438.214 regarding selection, retention and exclusion of behavioral health providers. The requirements related to the provision of behavioral health care is described in the following State documents: Integrated Health Homes Rhode Island SMI Program Description and Integrated Health Home (IHH) and Assertive Community Treatment (ACT) Program Provider Billing Manual; Opioid Treatment Program (OTP) Health Home Provider Manual; and OTP Health Home Billing Manual.

2.7.1.8. Long Term Services and Supports (LTSS)

2.7.1.8.1. The Contractor shall provide three hundred and sixty-five (365) days of nursing facility care as medically and/or functionally necessary for the Enrollee, in accordance with Section 2.4.

2.7.1.8.2. The Contractor shall demonstrate that sufficient capacity exists to provide timely access to quality institutional care (e.g., nursing facility) and home and community-based services and supports that meet the needs where the Enrollee population resides and is accessible to the Enrollee's primary caregiver.

2.7.1.8.3. The Contractor shall monitor the availability of long-term care providers and shall make the appropriate adjustments to maintain timely access to quality long-term care.

2.7.1.8.4. The Contractor must abide by RI EOHHS guidance for the Community-Based Supportive Living Program (CSLP). The Contractor is responsible for reporting on CSLP to RI EOHHS. The Contractor is also responsible for tracking savings to this program and preparing financial reporting to RI EOHHS.

2.7.1.8.5. The Contractor shall ensure that Medicaid home and community-based services are available twenty-four (24) hours a Day, seven (7) Days a week. The required services must be in place within five (5) Days of an Enrollee's need being determined.

2.7.1.8.6. Assisted Living Facilities, Adult Day Centers, and other community-based LTSS agencies shall be located within twenty (20) minutes driving time of the Enrollee's residence, unless the Enrollee selects a provider located more than twenty (20) minutes driving time of the residence.

2.7.1.8.7. The Contractor must include Adult Day Care providers in its Provider Network that:

2.7.1.8.7.1. Are licensed by the DOH as an Adult Day Care Program;

2.7.1.8.7.2. Agree to comply with all of the provisions in the DOH Regulations; and

2.7.1.8.7.3. Comply with RI EOHHS guidelines.

2.7.1.9. Family Planning

The Contractor cannot restrict the choice of the Health Care Professional from whom the Enrollee may receive Family planning services and Supplies. The Contractor must provide or arrange Family planning services as follows:

2.7.1.9.1. Ensure that all Enrollees are made aware that Family planning services are available to the Enrollee through any Family planning Health Care Professional and that Enrollees do not need authorization in order to receive such services.

2.7.1.9.2. Provide all Enrollees with sufficient information and assistance on the process and available Health Care Professionals for accessing Family planning services in and out of the Contractor's Provider Network.

2.7.1.9.3. Provide all Enrollees who seek Family planning services from the Contractor with services including, but not limited to, all methods of contraception, including sterilization, vasectomy, and emergency contraception: (1) Counseling regarding HIV, sexually transmitted diseases, and risk reduction practices; and (2) Options Counseling for pregnant Enrollees, including referrals for the following: prenatal care, foster care or adoption, or pregnancy termination.

2.7.1.9.4. Comply with the requirements of 42 C.F.R. § 441.202 and the covered abortion services requirements as outlined in Appendix A.

2.7.1.10. Essential Community Providers

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

2.7.1.11. Indian Health Care Providers

2.7.1.11.1. The Contractor shall demonstrate that it made reasonable efforts to contract with Indian Health Care Providers in the network to ensure timely access to services available under the contract for Indian Enrollees who are eligible to receive services from such providers.

2.7.1.11.2. The Contractor shall permit Indian Enrollees eligible to receive services from an Indian Health Care Provider the option to choose an Indian Health Care Provider as a PCP if the Contractor has an PCP in its network that has capacity to provide such services whether the Indian Health Care Provider is in or out of network..

2.7.1.11.3. The Contractor must permit an out-of-network Indian Health Care Provider to refer an Indian enrollee to a network provider without requiring an Indian Enrollee to obtain a referral from an in-network provider.The Contractor shall demonstrate that there are sufficient Indian Health Care Providers in the provider network to ensure timely access to Covered Services for Indian Enrollees who are eligible to receive services.

2.7.1.11.4. The Contractor shall pay both network and non-network Indian Health Care Providers who provide Covered Services to Indian Enrollee a negotiated rate which shall be no lower than the EOHHS fee for service rate for the same service or, in the absence of a negotiated rate, an amount not less than the amount that the Contractor would pay for the Covered Service provided by a non-Indian Health Care Provider.

2.7.1.11.5. The Contractor shall not reduce payment that is due under Medicaid to the Indian Health Care Provider through referral under CHS for furnishing an item or service to an Indian. The State must pay these providers the full Medicaid payment rate for furnishing the item or service.

2.7.1.11.6. The Contractor shall make prompt payment to Indian Health Care Providers in its network as required for payments to practitioners in individual or group practices under 42 C.F.R. §§ 447.45 and 447.46, and shall pay non-network Indian Health Care Providers, including those that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that the Contractor would pay to a network FQHC that is not an Indian Health Care Provider including any supplemental payment from EOHSS to make up the difference between the contract amount and what the Indian Health Care Provider would have received under Medicaid Fee For Service. When the amount the in-network Indian Health Care Provider receives from the Contractor is less than the amount the Indian Health Care Provider would receive under Medicaid Fee For Service, EOHHS must make a supplemental payment to the Indian Health Care Provider that the Indian Health Care Provider would receive under Medicaid Fee For Service or the applicable encounter rate.

2.7.1.11.7. The Contractor shall permit any Indian who is enrolled in a non-Indian Demonstration and eligible to receive services from a participating Indian Health Care Provider, to choose to receive Covered Services from that provider, and if that Indian Health Care Provider participates in the network as a PCP, to choose that Indian Health Care Provider as his or her PCP, as long as that provider has capacity to provide the services.

2.7.1.11.8. The Contractor shall not impose enrollment fees, premiums, or similar charges on Indians served regardless of payer. The Contractor must exempt from all cost sharing any Indian Enrollee who is currently receiving or has ever received an item or service furnished by an Indian Health Care Provider or through referral under contract health services.

2.7.1.12. The Contractor must notify CMS and RI EOHHS, through the CMT, of any significant Provider Network changes immediately, but no later than 5 (five) calendar Days after becoming aware of an issue, including a change in the Contractor's Provider Network that renders

the Contractor unable to provide one (1) or more covered items and services within the access to care standards set forth in this section, with the goal of providing notice to the CMT at least sixty (60) Days prior to the effective date of any such change.

2.7.1.13. Enrollees must be assured choice of all providers, including the LCM or Care Coordinator and others that will participate in their ICT.

2.7.1.14. RI EOHHS and CMS will monitor access to care and the prevalence of needs indicated through Enrollee assessments, and, based on those findings, may require that the Contractor initiate further Provider Network expansion over the course of the Demonstration.

2.7.2. Network Provider Requirements

2.7.2.1. All network providers must serve the target population.

2.7.2.2. All providers' physical sites must ensure safe and appropriate physical access to the building, services and equipment and flexibility in scheduling to accommodate the needs of Enrollees.

2.7.2.3. The Contractor shall ensure that its network providers are responsive to the linguistic, cultural, ethnic, racial, sexual orientation, religious, age, gender, gender identity, and other unique needs of any minority, homeless population, Enrollees with disabilities (both congenital and acquired disabilities), or other special population served by the Contractor. This responsiveness includes the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those with a vision or hearing impairment.

2.7.2.4. The Contractor shall ensure that multilingual network providers and, to the extent that such capacity exists within the Contractor's Service Area, all network providers, understand and comply with their obligations under state or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist network providers to meet these obligations.

2.7.2.5. The Contractor shall ensure that network providers and interpreters/translators are available for those within the Contractor's Service Area who are deaf, or vision- or hearing-impaired.

2.7.2.6. The Contractor shall make best efforts to ensure that minority-owned or controlled agencies and organizations are represented in the Provider Network.

2.7.2.7. Network Provider Enrollment. The Contractor shall assure that all network providers that provide Medicare Covered Services are eligible to be enrolled as Medicare providers, State licensed and not excluded from Medicare in order to submit Claims for reimbursement or otherwise participate in the Medicare Program.

2.7.2.8. The Contractor shall ensure that the Provider Network provides female Enrollees with direct access to a women's health specialist, including an obstetrician or gynecologist, within the Provider Network for Covered Services necessary to provide women's routine and preventive health care services. This shall include contracting with, and offering to female Enrollees, women's health specialists as PCPs.

2.7.2.9. The Contractor agrees that all of its network providers will accept Enrollees for treatment. Contractor agrees to have policies and procedures in place such that any provider in the network who refuses to accept an Enrollee for treatment cannot accept non-Enrollees for treatment and remain in the network. Contractor also agrees to accept responsibility for ensuring that network providers do not intentionally segregate Enrollees in any way from other persons receiving services. A violation of these terms may be considered a material breach and any such material breach may be grounds for termination.

2.7.3. Health Care Professional Contracting

2.7.3.1. The Contractor must contract only with qualified or licensed Health Care Professionals who continually meet federal and State requirements, as applicable, and the qualifications contained in Appendix C.

2.7.3.2. The Contractor shall not establish selection policies and procedures for Health Care Professionals that discriminate against particular Health Care Professionals that serve high-risk populations or specialize in conditions that require costly treatment.

2.7.3.3. Paid Family caregivers will be allowed in accordance with the Self-Directed Care Provision, Medicaid Policy listed on the RI EOHHS website.

2.7.3.4. If the Contractor declines to include individuals or groups of Health Care Professionals in its Provider Network, the Contractor must give the affected Health Care Professionals written notice of the reason for its decision.

2.7.3.5. Nothing in this contract should be construed to require the Contractor: to contract with Health Care Professionals beyond the number necessary to meet the needs of Enrollees; preclude the Contractor from using different reimbursement amounts for different specialties or for different Health Care Professionals in the same specialty; preclude the Contractor from establishing measures that are designed to maintain quality of services, control costs and are consistent with its responsibilities to Enrollees; or allow the Contractor to reimburse FQHC/RHCs at a rate less than that paid for comparable services provided by non-FQHC/RHC based Health Care Professionals.

2.7.3.6. Notwithstanding the provision of Section 2.8.10, the Contractor is expected to utilize selective contracting and/or preferred provider initiatives as appropriate in order to secure the best price for services while maintaining quality and timely access.

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

2.7.3.8. For LTSS, during the first year of the Demonstration, the Contractor must extend contracts to every willing Health Care Professional that accepts the Contractor's contract provisions, and meets all applicable licensing, credentialing and other Medicaid requirements.

2.7.3.8.1. After the first year of the Demonstration, the Contractor may establish quality standards and may contract only with those Health Care Professionals that meet such standards. Health Care Professionals must be informed (1) of any such quality standards no later than ninety (90) days after the start of the Demonstration and (2) that RI EOHHS has given prior approval of the quality standards. Any such quality standards that are not established within ninety (90) days after the start of the Demonstration must be in effect for twelve (12) months before the Contractor may terminate a contract of a Health Care Professional based on a failure to meet such quality standards. RI EOHHS may grant exceptions to these contracting requirements for reasons other than failure to meet the quality standards. The Contractor must transition Enrollees, or have a plan to transition Enrollees, to new Health Care Professionals prior to terminating contracts with Health Care Professionals.

2.7.3.9. Excluded Providers

2.7.3.9.1. The Contractor may not contract with, or otherwise pay for any items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished, under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, XIX, or XX, pursuant to Sections 1128,1128A, 1156, or 1824(j)(2) of the Social Security Act, and regulations at 42 C.F.R. Part 1001 et. seq., or that has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 C.F.R. §1001.1801 and §1001.1901. Federal financial participation is not available for any amounts paid to the Contractor if the Contractor could be excluded from participation in Medicare or Medicaid under Section 1128(b)(8)(B) of the Social Security Act or for any of the reasons listed in 42 C.F.R. §431.55(h);

2.7.3.9.2. The Contractor may not contract with, or otherwise pay for any items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, XIX, or XX pursuant to section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person);

2.7.3.9.3. The Contractor shall, at a minimum, check the OIG LEIE, Medicare Exclusion Database (MED), and the System for Awards Management (SAM) (the successor to the EPLS) for its Health Care Professionals at least monthly, before contracting with the Health Care Professional, and at the time of a Health Care Professional's credentialing and recredentialing.

2.7.3.9.4. If a provider is terminated or suspended from the RI EOHHS Medicaid Program, Medicare, or another state's Medicaid program or is the subject of a State or federal licensing action, the Contractor shall terminate, suspend, or decline a provider from its Provider Network as appropriate.

2.7.3.9.5. Upon notice from RI EOHHS or CMS, the Contractor shall not authorize any providers who are terminated or suspended from participation in the Rhode Island Medicaid Program, Medicare, or from another state's Medicaid program, to treat Enrollees and shall deny payment to such providers for services provided. In addition:

2.7.3.9.6. The Contractor shall notify CMS and RI EOHHS, via the CMT, when it terminates, suspends, or declines a provider from its Provider Network because of Fraud, integrity, or quality;

2.7.3.9.7. The Contractor shall notify CMS and RI EOHHS on a quarterly basis when a provider fails credentialing or re-credentialing because of a program integrity reason or Adverse Benefit Determination reason, and shall provide related and relevant information to CMS and RI EOHHS as required by CMS, RI EOHHS, or state or federal laws, rules, or regulations.

2.7.3.9.8. The Contractor is prohibited from paying for an item or service (other than an emergency item or service furnished in an emergency room of a hospital): furnished by an individual or entity to whom RI EOHHS has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless RI EOHHS determines that there is good cause not to suspend such payments.

2.7.3.9.9. The Contractor is prohibited from paying for an item or service with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

2.7.3.9.9.1.

2.7.3.10. Non-Allowed Terms of Health Care Professional Contracts

2.7.1.1.1. The Contractor shall not require as a condition of participation/contracting with Health Care Professionals in the network a Health Care Professional's terms of panel participation with other Contractors.

2.7.3.10.1. The Contractor shall not include in its Health Care Professional contracts any provision that directly or indirectly prohibits, through incentives or other means, limits, or discourages network Health Care Professional from participating as network or non-network Health Care Professionals in any Provider Network other than the Contractor's Provider Network(s).

2.7.3.11. Health Care Professional Credentialing, Re-credentialing, and Board Certification

2.7.3.11.1. The Contractor shall implement written policies and procedures that comply with the requirements of 42 C.F.R. §§ 422.204 and 438.214(b) regarding the selection, retention and exclusion of Health Care Professionals, credentialing and recredentialing requirements and nondiscrimination, and meet, at a minimum, the requirements below.

2.7.3.11.2. The Contractor shall credential and re-credential Health Care Professionals, except as provided in Section 2.1.1 of this Contract, in accordance with NCQA credentialing standards as well as applicable State and federal requirements.

2.7.3.11.3. In order to minimize administrative burdens on the Contractor and Health Care Professionals, the Contractor must employ a single, uniform Health Care Professional credentialing application that will be developed with the input from the Contractor and stakeholders, meet Medicare contracting requirements, and be approved by the RI EOHHS.

2.7.3.11.4. Re-credentialing shall occur every three (3) years (thirty-six (36) months). At re-credentialing and on a continuing basis, the Contractor shall verify minimum credentialing requirements and monitor Enrollee complaints and Appeals, quality of care and quality of service events, and medical record review. The re-credentialing process shall take into consideration various forms of data including, but not limited to, Grievances, results of quality reviews Utilization Management information, and Enrollee satisfaction surveys.

2.7.3.11.5. The Contractor's standards for licensure and certification shall be included in its participating Provider Network contracts with its network Health Care Professionals which must be secured by current subcontracts or employment contracts.

2.7.3.11.6. The Contractor shall ensure that all Health Care Professionals are credentialed prior to becoming network Health Care Professionals and that a site visit is conducted as appropriate for initial credentialing;

2.7.3.11.7. The Contractor shall not establish Health Care Professional selection policies and procedures that discriminate against particular Health Care Professionals that serve high-risk populations or specialize in conditions that require costly treatment;

2.7.3.11.8. The Contractor shall ensure that no credentialed Health Care Professionals engages in any practice with respect to any Enrollee that constitutes unlawful discrimination under any other state or federal law or regulation, including, but not limited to, practices that violate the provisions of 45 C.F.R. Part 80, 45 C.F.R. Part 84, and 45 C.F.R. Part 90;

2.7.3.11.9. The Contractor shall obtain disclosures from all network Health Care Professionals and applicants in accordance with 42 C.F.R. 455 Subpart B and 42 C.F.R.§ 1002.3, including but not limited to obtaining such information through Health Care Professional enrollment/application forms and credentialing and re-credentialing packages, upon the Health Care Professional executing a network agreement, within thirty-five (35) Days of any change of ownership of the disclosing entity and maintain such disclosed information in a manner which can be periodically searched by the Contractor for exclusions and provided to RI EOHHS or CMS in accordance with this Contract, including this Section, and relevant State and federal laws and regulations; and

2.7.3.11.10. In accordance with 42 C.F.R.§ 455.106, before the Contractor enters into or renews a Health Care Professional agreement or at any time upon written request by RI EOHHS or CMS, the Health Care Professional must disclose the identity of a person who has ownership or controlling interest in the Health Care Professional, or is an agent or managing employee of the Health Care Professional and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Federal Title XX program since the inception of these program. Any individual is considered to have ownership or controlling interest in a Health Care Professional entity if it has direct ownership of five (5%) percent or more, or is a managing employee (such as a general manager, business manager, administrator, or director) who exercises managerial or operational control over the entity or who directly or indirectly conducts the day-to-day operations of the entity as defined in section 1126(b) of the Social Security Act and under 42 C.F.R. §1001.1001. (a)(1). The Contractor shall promptly notify RI EOHHS and CMS in writing within ten (10) business Days in the event that the Contractor identifies an excluded individual with an ownership or control interest.

2.7.3.11.11. The Contractor shall include the consideration of performance indicators obtained through the quality improvement plan (QIP), Utilization Management program, Grievance and Appeals system, and Enrollee satisfaction surveys in the Contractor's recredentialing process.

2.7.3.11.12. The Contractor shall submit its written policies and procedures annually to RI EOHHS, if amended, and shall demonstrate to RI EOHHS, by reporting annually, that all Health Care Professionals within the Contractor's Health Care Professional and pharmacy network are credentialed according to such policies and procedures. The Contractor shall maintain written policies that:

2.7.3.11.12.1. Designate and describe the department(s) and person(s) at the Contractor's organization who will be responsible for Health Care Professional credentialing and re-credentialing;

2.7.3.11.12.2. Document the processes for the credentialing and re-credentialing of licensed physicians and all other licensed or certified Health Care Professionals who participate in the Contractor's Provider Network to perform the services agreed to under this Contract. At a minimum, the scope and structure of the processes shall be consistent with recognized managed care industry standards such as those provided by the NCQA and relevant State regulations.

2.7.3.11.13. Board Certification Requirements

2.7.3.11.13.1. The Contractor shall maintain a policy with respect to board certification for PCPs and specialty Health Care Professionals participating in the Provider Network.

2.7.4. Health Care Professional Payment and Reimbursement

2.7.4.1. The Contractor must demonstrate to RI EOHHS, including through submission of reports as may be requested by RI EOHHS, use of Alternative Payment Methods that will advance the delivery system

innovations inherent in this model, incentivize quality care, and improve health outcomes for Enrollees. Notwithstanding the foregoing, nothing herein shall be construed to conflict with the requirements of 42 U.S.C. 1395w-111, Sec. 1860D-11(i).

2.7.4.1.1.1. The Contractor must include shared savings program for both community-based and facility-based LTSS providers.

2.7.4.2. Payments to Nursing Facilities

2.7.4.2.1. The Contractor will comply with the requirements of R.I. Gen. Laws § 40-8.13-5 et seq.

2.7.4.3. The Contractor ensures that it contracts with or has a payment arrangement with all nursing facilities in which any Eligible Beneficiary may enter.

2.7.4.4. FQHCs Reimbursements – The contract provides that if a MMP enters into a contract for the provision of services with a Federally–qualified health center (FQHC) or a rural health clinic (RHC), the MMP shall provide payment that is not less than the level and amount of payment which the MMP would make for the services if the services were furnished by a provider which is not a FQHC or RHC.

2.7.4.4.1. The Contractor shall ensure that its payments to FQHCs for services to Enrollees are no less than the sum of:

2.7.4.4.1.1. The level and amount of payment that the Contractor would make for such services if the services had been furnished by an entity providing similar services that was not a FQHC; and

2.7.4.4.1.2. The amount that Rhode Island Medicaid would have paid in Cost Sharing if the Enrollee were in FFS.

2.7.4.5. Out of Network Reimbursement Rules

2.7.4.5.1. For reimbursement of out-of-network emergent or Urgent Care services, as defined by 42 C.F.R. §§ 424.101 and 405.400, respectively, the Health Care Professional is required to accept as payment in full by the Contractor the amounts the Health Care Professional could collect for that service if the beneficiary were enrolled in original Medicare or Medicaid FFS. However, the Contractor is not required to reimburse the Health Care Professional more than the Health Care Professional's charge for that service. The original Medicare reimbursement amounts for providers of services (as defined by section 1861(u) of the Act) do not include payments under 42 C.F.R. §§ 412.105(g) and 413.76. A section 1861(u) provider of services may be paid an amount that is less than the amount it could receive if the beneficiary were enrolled in original Medicare or Medicaid FFS if the provider expressly notifies the Contractor in writing that it is billing an amount less than such amount. The Contractor must maintain balance billing protections.

2.7.4.5.2. The Contractor may authorize other out-of-network services to promote access to and continuity of care. For services that are part of the traditional Medicare benefit package, prevailing Medicare Advantage policy will apply, under which the Contractor shall pay non-contracting Health Care Professionals section 1861(u) providers of services the amount the provider could collect for that service if the beneficiary were enrolled in original Medicare (less any payments under 42 C.F.R. §§ 412.105(g) and 413.76 for section 1861(u) providers), regardless of the setting and type of care for authorized out-of-network services.

2.7.4.6. Non-Payment and Reporting of Provider Preventable Conditions

2.7.4.6.1. The Contractor agrees to take such action as is necessary in order for RI EOHHS to comply with and implement all federal and State laws, regulations, policy guidance, and Rhode Island policies and procedures relating to the identification, reporting, and non-payment of Provider Preventable Conditions, as defined in 42 U.S.C. 1396b-1 and regulations promulgated thereunder.

2.7.4.6.2. As a condition of payment, the Contractor shall develop and implement policies and procedures for the identification, reporting, and non-payment of Provider Preventable Conditions. Such policies and procedures shall be consistent with federal law, including but not limited to 42 C.F.R. §§ 434.6(a)(12), 438.3(g), and 447.26, and be consistent with RI EOHHS policies, procedures, and guidance on Provider Preventable Conditions.

2.7.4.6.3. The Contractor's policies and procedures shall also be consistent with the following:

2.7.4.6.3.1. The Contractor shall not pay a Health Care Professional for a Provider Preventable Condition.

2.7.4.6.3.2. The Contractor shall require, as a condition of payment from the Contractor, that all Health Care Professionals comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by the Contractor and/or RI EOHHS.

2.7.4.6.3.3. The Contractor shall not impose any reduction in payment for a Provider Preventable Condition when the condition defined as a Provider Preventable Condition for a particular Enrollee existed prior to the Health Care Professional initiation of treatment for that Enrollee.

2.7.4.6.3.4. A Contractor may limit reductions in Health Care Professional payments to the extent that the following apply:

2.7.1.1.1.1.1. The identified Provider Preventable Condition would otherwise result in an increase in payment;

2.7.1.1.1.1.2. The Contractor can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the Provider Preventable Condition;

2.7.4.6.3.5. The Contractor shall ensure that its non-payment for Provider Preventable Conditions does not prevent Enrollee access to services;

2.7.4.6.3.6. As directed by RI EOHHS, and in consultation with CMS, the Contractor shall develop and implement process for ensuring non-payment or recovery of payment for preventable hospital readmissions; and.

2.7.4.6.3.7. The Contractor shall report all identified Provider Preventable Conditions in a form and format specified by RI EOHHS within seven (7) calendar Days from occurrence.

2.7.5. Network Management

2.7.5.1. The Contractor shall develop and implement a strategy to manage the Provider Network with a focus on access to services for Enrollees, quality, consistent practice patterns, recovery and resilience, independent living philosophy, Cultural Competence, integration and cost effectiveness. The management strategy shall address all Health Care Professional. At a minimum, such strategy shall include:

2.7.5.1.1. A system for the Contractor and network providers to identify and establish improvement goals and periodic measurements to track network providers' progress toward those improvement goals;

2.7.5.1.2. Conducting on-site visits to network providers for quality management and quality improvement purposes, and for assessing meaningful compliance with ADA requirements; and

2.7.5.1.3. Ensuring that its Provider Network is adequate to assure access to all Covered Services, and that all Health Care Professional are appropriately credentialed, maintain current licenses, and have appropriate locations to provide the Covered Services.

2.7.5.2. The Contractor shall not limit or prohibit Health Care Professional - based marketing activities or provider affiliation information addressed by §§ 70.11.1 and 70.11.2 of the Medicare Marketing Guidelines. The Contractor shall not prohibit a Health Care Professional from informing Enrollees of the Health Care Professional's affiliation or change in affiliation.

2.7.5.3. The Contractor shall establish and conduct an ongoing process for enrolling in their Provider Network willing and qualified Health Care Professionals who meet the Contractor's requirements and with whom mutually acceptable provider contract terms, including with respect to rates, are reached.

2.7.5.4. The Contractor shall maintain a protocol that shall facilitate communication to and from providers and the Contractor, and which shall include, but not be limited to, a provider newsletter and periodic provider meetings.

2.7.5.5. Except as otherwise required or authorized by CMS, RI EOHHS, or by operation of law, the Contractor shall ensure that Health Care Professionals receive thirty (30) Days advance notice in writing of policy and procedure changes, and maintain a process to provide education and training for Health Care Professionals regarding any changes that may be implemented, prior to the policy and procedure changes taking effect.

2.7.5.6. The Contractor shall work in collaboration with Health Care Professionals to actively improve the quality of care provided to Enrollees, consistent with the Quality Improvement Plan and all other requirements of this Contract.

2.7.5.7. The Contractor shall perform an annual review to assure that the Health Care Professionals under contract with the First Tier, Downstream, and Related Entities are qualified to perform the services covered under this contract. The Contractor shall collect sufficient information from Health Care Professionals to assess compliance with the ADA.

2.7.6. Health Care Professional Education and Training

2.7.6.1. Prior to any Enrollment of Enrollees under this Contract and thereafter, the Contractor shall educate its Provider Network regarding the Contractor's policies and procedures for the Demonstration

2.7.6.2. The Contractor must educate its Provider Network about its responsibilities for the integration and coordination of Covered Services.

2.7.6.3. The Contractor must inform its Provider Network about its policies and procedures, especially regarding in and out-of-network referrals.

2.7.6.4. The Contractor must inform its Provider Network about its service delivery model and Covered Services, Flexible Benefits, excluded services (carved-out) and policies, procedures, and any modifications to these items.

2.7.6.5. The Contractor must inform its Provider Network about the procedures and timeframes for Enrollee complaints and Enrollee Appeals as described in Sections 2.10 and 2.11 herein.

2.7.6.6. The Contractor must inform its Provider Network about its quality improvement efforts and the providers' role in such a program.

2.7.6.7. The Contractor shall educate its Provider Network about the medical home model and the importance of using it to integrate all aspects of each Enrollee's care, as well as how to become a Medical Home.

2.7.6.8. The Contractor shall offer educational and training programs that cover topics or issues including, but not limited to, the following:

2.7.6.8.1. Eligibility standards, eligibility verification, and benefits;

2.7.6.8.2. The role of RI EOHHS (or its authorized agent) regarding Enrollment and disenrollment;

2.7.6.8.3. Special needs of Enrollees that may affect access to and delivery of services, to include, at a minimum, transportation needs;

2.7.6.8.4. ADA compliance, accessibility and accommodations;

2.7.6.8.5. The rights and responsibilities pertaining to:

2.7.6.8.5.1. Grievance and Appeals procedures and timelines; and

2.7.6.8.5.2. Procedures for identifying, preventing and reporting Fraud, waste, neglect, abuse, exploitation, and critical incidents;

2.7.6.8.6. References to Medicaid and Medicare manuals, memoranda, and other related documents;

2.7.6.8.7. Payment policies and procedures including information on no balance billing;

2.7.6.8.8. PCP training on identification of and coordination of LTSS and behavioral health services;

2.7.6.8.9. Cultural competencies;

2.7.6.8.10. Person-centered planning processes taking into consideration the specific needs of subpopulations of Enrollees;

2.7.6.8.11. Conflict-free Care Management;

2.7.6.8.12. Billing instructions which are in compliance with the Demonstration encounter data submission requirements; and

2.7.6.8.13. Marketing practice guidelines and the responsibility of the provider when representing the Contractor.

2.7.6.9. The Contractor must train its medical, behavioral, and LTSS providers on disability literacy, including, but not limited to the following information:

2.7.6.9.1. Various types of chronic conditions prevalent within the target population;

2.7.6.9.2. Awareness of personal prejudices;

2.7.6.9.3. Legal obligations to comply with the ADA requirements;

2.7.6.9.4. Definitions and concepts, such as communication access, medical equipment access, physical access, and access to programs;

2.7.6.9.5. Types of barriers encountered by the target population;

2.7.6.9.6. Training on person-centered planning and self-determination, the social model of disability, the independent living philosophy, and the recovery model;

2.7.6.9.7. Use of evidence-based practices and specific levels of quality outcomes; and

2.7.6.9.8. Working with Enrollees with mental health diagnoses, including crisis prevention and treatment.

2.7.6.10. Provider Manual: The provider manual shall be a comprehensive online reference tool for Health Care Professionals and staff regarding, but not limited to, administrative, prior authorization, and referral processes, Claims and encounter data submission processes, and plan benefits. The provider manual shall also address topics such as clinical practice guidelines, availability and access standards, Care Management programs and Enrollee rights, including Enrollees rights not to be balanced billed. The Contractor must include in the provider manual a provision explaining that the Contractor may not limit a Health Care Professional's communication with Enrollees as provided in Section 2.7.5.2.

2.7.6.11. Provider and Pharmacy Directory. The Contractor shall make its provider and pharmacy directory available to Health Care Professionals via the Contractor's web-portal.

2.7.6.12. The Contractor shall educate Health Care Professionals through a variety of means including, but not limited to, alerts or similar written issuances, about their legal obligations under State and federal law to communicate with Enrollees and Eligible Beneficiaries with limited English proficiency, including the provision of interpreter services, and the resources available to help providers comply with those obligations. All such written communications shall be subject to review at RI EOHHS's and CMS' discretion.

2.7.7. Dementia Care Management Training

2.7.7.1. The Contractor shall develop policies and procedures to train:

2.7.7.1.1. Specially designated care coordination staff in dementia Care Management including but not limited to:

2.7.7.1.2. Understanding dementia;

2.7.7.1.3. Symptoms and progression;

2.7.7.1.4. Understanding and managing behaviors and communication problems caused by dementia;

2.7.7.1.5. Caregiver stress and its management; and

2.7.7.1.6. Community resources for Enrollees and caregivers.

2.7.8. Subcontracting Requirements

2.7.8.1. The Contractor remains fully responsible for meeting all of the terms and requirements of the Contract regardless of whether the Contractor subcontracts for performance of any Contract responsibility. The Contractor shall require each First Tier, Downstream or Related Entity to meet all terms and requirements of the Contract that are applicable to such First Tier, Downstream or Related Entity. No subcontract will operate to relieve the Contractor of its legal responsibilities under the Contract.

2.7.8.2. The Contractor is responsible for the satisfactory performance and adequate oversight of its First Tier, Downstream and Related Entities. First Tier, Downstream and Related Entities are required to meet the same federal and State financial and program reporting requirements as the Contractor. The Contractor is required to evaluate any potential Contractor prior to delegation, pursuant to 42 C.F.R. § 438.230; provided, however, that such review shall be satisfied by applicable NCQA accreditation of a First Tier, Downstream, or Related Entity. Additional information about subcontracting requirements is contained in Appendix C.

2.7.8.3. The Contractor must establish contracts and other written agreements between the Contractor and First Tier, Downstream and Related Entities for Covered Services not delivered directly by the Contractor or its employees.

2.8. Enrollee Access to Services

2.8.1. General

2.8.1.1. The Contractor must authorize, arrange, coordinate and ensure the provision of all Medically Necessary Services for Enrollees, as specified in Section 2.4 and Appendix A, in accordance with the

requirements of the Contract. Services shall be available twenty-four (24) hours a Day, seven (7) Days a week when medically necessary.

2.8.1.2. The Contractor must offer adequate choice and availability of primary, specialty, acute care, behavioral health and LTSS providers that meet CMS and RI EOHHS standards as provided for in Section 2.5 and 2.7;

2.8.1.3. The Contractor must at all times cover the appropriate level of service for all Emergency Services and non-Emergency Services in an appropriate setting;

2.8.1.4. All urgent and symptomatic office visits must be available to Enrollees within twenty-four (24) hours. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs, but not requiring immediate attention;

2.8.1.5. All non-symptomatic office visits, with the exception of behavioral health, must be available to Enrollees within thirty (30) calendar Days; the Contractor agrees to make services available within five (5) business Days for diagnosis or treatment of a non-emergent, non-urgent mental health or substance abuse condition.

2.8.1.6. Network providers shall offer hours of operation that are no less than the hours of operation offered to individuals who are not Enrollees.

2.8.1.7. Enrollees with special needs may have an ongoing clinical relationship with a particular specialist who serves as the principal coordinating provider for an Enrollee's special health care needs and who plays a critical role in managing that Enrollee's care on a regular basis. Contractor shall have policies and procedures whereby the Enrollee is ensured facilitated and timely access to such principal coordinating provider. As described in Section 2.7, this specialist may serve as the Enrollee's PCP. Where the specialist serving as the principal coordinating provider is not the PCP, the Contractor shall require communication and collaboration between the PCP and the specialist serving as the principal coordinating provider. For Enrollees with special health care needs determined through an assessment by appropriate Health Care Professionals, consistent with 42 C.F.R. § 438.208(c) (2), who needs a course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow Enrollees to directly access a specialist (for example through a standing referral or an approved number of visits) as appropriate for the Enrollee's condition and identified needs.

2.8.1.8. When a PCP or any medical, behavioral health or LTSS provider is terminated from the Contractor or leaves the network for any reason, the Contractor must make a good faith effort to give written notification of termination of such provider, within fifteen (15) Days after receipt or issuance of the termination notice, to each Enrollee who received his or her care from, or was seen on a regular basis by, the terminated PCP or any other medical, behavioral or LTSS provider. For terminations of PCPs, the Contractor must also report the termination to RI EOHHS and provide assistance to the Enrollee in selecting a new PCP within fifteen (15) calendar Days. For Enrollees who are receiving treatment for a chronic or ongoing medical condition or LTSS, the Contractor shall ensure that there is no disruption in services provided to the Enrollee.

2.8.1.9. When the Food and Drug Administration (FDA) determines a drug to be unsafe, the Contractor shall remove it from the formulary immediately. The Contractor must make a good faith effort to give written notification of removal of this drug from the formulary and the reason for its removal, within five (5) Days after the removal, to each Enrollee with a current or previous prescription for the drug. The Contractor must also make a good faith effort to call, within three (3) calendar Days, each Enrollee with a current or previous prescription for the drug; a good faith effort must involve no fewer than three (3) phone call attempts at different times of day.

2.8.1.10. If the Contractor's network is unable to provide necessary medical services covered under the Contract to a particular Enrollee, the Contractor must adequately and timely cover these services out of network for the Enrollee, for as long as the Contractor is unable to provide them. The Contractor must ensure that cost to the Enrollee is no greater than it would be if the services were furnished within the network.

2.8.1.11. The criteria the Contractor employs in the creation of selective provider networks must be transparent to EOHHS, and must be reviewed and approved by EOHHS prior to the implementation of network changes. If a Selective Network is to be created, Contractor must create selective networks that comply with EOHHS' Selective Network Guidelines.

2.8.1.12. The Contractor shall establish mechanisms to ensure compliance by providers, monitor providers regularly to determine compliance and take correction action if there is a failure to comply. The Contractor shall have a system in place to monitor and document access and

appointment scheduling standards. The Contractor shall use statistically valid sampling methods for monitoring compliance with appointment/access standards specific above and shall promptly address and access deficiencies.

2.8.2. Services Not Subject to Prior Approval

2.8.2.1. The Contractor will assure coverage of Emergency Medical Conditions and Urgent Care services. The Contractor must not require prior approval for the following services:

2.8.2.1.1. Any services for Emergency Conditions as defined in 42 C.F.R §§ 422.113(b)(1) and 438.114(a) (which includes emergency behavioral health care);

2.8.2.1.2. Urgent Care sought outside of the Service Area;

2.8.2.1.3. Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the contracted medical provider is unavailable or inaccessible;

2.8.2.1.4. Family planning services;

2.8.2.1.5. Out-of-area renal dialysis services; and

2.8.2.1.6. Prescription drugs as required in Appendix D.

2.8.3. Authorization of Services

2.8.3.1. The Contractor shall authorize services as in accordance with 42 C.F.R. § 438.210.

2.8.3.2. For the processing of requests for initial and continuing authorizations of Covered Services, the Contractor and any First Tier, Downstream, and Related Entities shall:

2.8.3.2.1. Have in place and follow written policies and procedures;

2.8.3.2.2. Have in place procedures to allow Enrollees to initiate requests for provision of services;

2.8.3.2.3. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions;

2.8.3.2.4. Ensure adherence to the requirements of conflict free Care Management; and

2.8.3.2.5. Consult with the requesting provider when appropriate.

2.8.3.3. The Contractor shall ensure that Enrollees have access to timely authorization of Medically Necessary Services twenty-four (24) hours per Day, including, if necessary, the transfer of the Enrollee who presented to an emergency department with an Emergency Medical Condition that has been Stabilized. The Contractor's Medical Necessity guidelines must, at a minimum, be no more restrictive than Medicare standards for acute services and prescription drugs and Medicaid standards for LTSS and community mental health and substance abuse services.

2.8.3.4. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a Health Care Professional who has appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment. Behavioral health service denials must be rendered by board-certified or board-eligible psychiatrists or by a clinician licensed with the same or similar specialty as the behavioral health service being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist. The Contractor shall notify the Health Care Professional and shall provide the Enrollee with written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

2.8.3.5. The Contractor shall assure that all behavioral health authorization and Utilization Management activities are in compliance with 42 U.S.C. § 1396u-2(b)(8). Contractor must comply with the requirements for demonstrating parity for both Cost Sharing (co-payments) and treatment limitations between mental health and substance use disorder and medical/surgical inpatient, outpatient and pharmacy benefits.

2.8.3.6. The Contractor shall authorize LTSS to meet Enrollees' need for assistance with ADLs and IADLs. The Contractor may consider the Enrollee's need for physical assistance as well as prompting or monitoring in order for the Enrollee to perform an ADL or IADL. Authorizations must consider the medical and independent living need of the Enrollee.

2.8.3.7. The Contractor must make authorization decisions in the following timeframes and provide notice that meet the timing requirements set forth in 42 C.F.R. § 438.404:

2.8.3.7.1. For standard authorization decisions, provide notice as expeditiously as the Enrollee's health condition requires and no later than fourteen (14) calendar Days after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar Days. Such extension shall only be allowed if:

2.8.3.7.1.1. The Enrollee or the Health Care Professional requests an extension, or

2.8.3.7.1.2. The Contractor can justify (to the satisfaction of RI EOHHS and/or CMS upon request) that:

2.8.3.7.1.2.1. The extension is in the Enrollee's interest; and

2.8.3.7.1.2.2. There is a need for additional information where:

2.8.3.7.1.2.2. 1. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.8.3.7.1.2.2. 2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.8.3.7.2. For expedited service authorization decisions, where the Health Care Professional indicates or the Contractor determines that following the standard timeframe in Section 2.8.3.1.1 could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make a decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than seventy-two (72) hours after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar Days. Such extension shall only be allowed if:

2.8.3.7.2.1. The Enrollee or the Health Care Professional requests an extension; or

2.8.3.7.2.2. The Contractor can justify (RI EOHHS and/or CMS upon request) that:

2.8.3.7.2.2.1. The extension is in the Enrollee's interest; and

2.8.3.7.2.2.2. There is a need for additional information where:

2.8.3.7.2.2.2. 1. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.8.3.7.2.2.2. 2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar Days.

2.8.4. Behavioral Health Service Authorization Policies and Procedures

2.8.4.1. The Contractor shall:

2.8.4.1.1. Review and update annually, at a minimum, the behavioral health clinical criteria and other clinical protocols that the Contractor may develop and utilize in its clinical case reviews and Care Management activities. Submit any modifications to RI EOHHS annually for review and approval. In its review and update process, the Contractor shall consult with clinical experts either within its own clinical and medical staff or medical consultants outside of the Contractor's organization, who are familiar with standards and practices of mental health and substance use treatment in Rhode Island. The Contractor shall ensure that clinical criteria are based on current research, relevant quality standards and evidence-based models of care.

2.8.4.1.2. Review and update annually and submit for RI EOHHS approval, at a minimum, its behavioral health services authorization policies and procedures.

2.8.4.1.3. Develop and maintain Behavioral Health Inpatient Services authorization policies and procedures, which shall, at a minimum, contain the following requirements:

2.8.4.1.3.1. If prior authorization is required for any Behavioral Health Inpatient Services admission for acute care, assure the availability of such prior authorization twenty-four (24) hours a Day, seven (7) Days a week; access to a reviewer and response to a request for authorization is within established timeliness standards aligned with the level of urgency of the request, ensuring the safety of an Enrollee at all times;

2.8.4.1.3.2. A plan and a system in place to direct Enrollees to the least restrictive environment and the least intensive yet the most clinically appropriate service to safely and adequately treat the Enrollee;

2.8.4.1.3.3. A process to render an authorization and communicate the authorized length of stay to the Enrollee, facility, and attending physician for all behavioral health emergency inpatient admissions verbally within thirty (30) minutes, and within two (2) hours for non-emergency inpatient authorization and in writing within twenty-four (24) hours of admission;

2.8.4.1.3.4. Processes to ensure safe placement for Enrollees who require Behavioral Health Inpatient Services when no inpatient beds are available, including methods and places of care to be utilized while Enrollee is awaiting an inpatient bed and to avoid delay of onset of treatment to minimize risk to Enrollee;

2.8.4.1.3.5. A system to provide concurrent clinical reviews for continued stay in Behavioral Health Inpatient Services. Contractor to monitor Medical Necessity for the clinical need for continued stay, and progress toward and achievement of Behavioral Health Inpatient Services treatment goals and objectives;

2.8.4.1.3.6. Verification and authorization of all adjustments to Behavioral Health Inpatient Services treatment plans based on updated clinical reports of Enrollee's status and response to existing treatment plan; and

2.8.4.1.3.7. Processes to ensure that treatment and discharge needs are addressed at the time of initial authorization and concurrent review, and that treatment planning includes coordination with the PCP and other service providers, such as community-based mental health services providers, as appropriate.

2.8.4.1.4. Develop and maintain Behavioral Health Outpatient Services policies and procedures which shall include, but are not limited to, the following:

2.8.4.1.4.1. Policies and procedures to authorize Behavioral Health Outpatient Services for initial and ongoing requests for outpatient care;

2.8.4.1.4.2. Policies and procedures to authorize Behavioral Health Outpatient Services based upon behavioral health clinical criteria, based on current research, relevant quality standards and evidence-based models of care; and

2.8.4.1.4.3. Review and update annually, at a minimum, and submit for RI EOHHS approval, its Behavioral Health Outpatient Services policies and procedures.

2.8.5. Authorization of LTSS

2.8.5.1. The Contractor must develop an authorization process that complies with RI EOHHS guidelines for the LTSS listed in Appendix A.

2.8.6. Utilization Management

2.8.6.1. The Contractor's Utilization Management programs shall comply with CMS requirements and timeframes for historically Medicare primary paid services in addition to the requirements for historically Medicaid primary paid services.

2.8.6.2. Staffing of all Utilization Management activities shall include, but not be limited to, a medical director or medical director designee. The Contractor shall also have a medical director's designee for behavioral health Utilization Management. This designee shall be board certified or board-eligible in psychiatry and be available twenty-four (24) hours per Day, seven (7) Days a week for consultation and decision-making with the Contractor's clinical staff and Health Care Professionals.

2.8.6.2.1. Utilization Management staffing shall be in compliance with all federal, State, and local professional licensing requirements and include the following: representative from appropriate specialty areas (at minimum cardiology, epidemiology, ob/gyn, psychiatry, and substance abuse disorders;

2.8.6.2.2. Have at least two (2) or more years in managed care or peer review activities or both;

2.8.6.2.3. Have no disciplinary actions or other type of sanction ever taken against them in any state or territory, by the relevant professional licensing board or Medicare and Medicaid; and

2.8.6.2.4. Have no legal sanctions related to his or her professional practice, including but not limited to malpractice actions resulting in entry of judgment against him or her, unless otherwise agreed to by Medicare and RI EOHHS.

2.8.6.3. Ensure that clinicians conducting Utilization Management are coordinating behavioral health services and making behavioral health service authorization decisions have training and experience in the specific area of behavioral health service for which they are coordinating and authorizing behavioral health services. The Contractor shall ensure that the clinical coordinating and authorizing mental health services, substance abuse disorders, and services for Enrollees with co-occurring disorder shall have experience and training within each specialty.

2.8.6.4. Ensure that clinicians conducting Utilization Management for LTSS have experience and training on LTSS.

2.8.6.5. The Contractor must have a written Utilization Management program description which includes procedures to evaluate medical necessity, criteria used, information source, and the process used to review and approve or deny the provision of medical and long-term care services. The Contractor's Utilization Management program must ensure consistent application of review criteria for authorization decisions; and must consult with the requesting Health Care Professional when appropriate. The program shall demonstrate that Enrollees have equitable access to care across the network and that Utilization Management decisions are made in a fair, impartial, and consistent manner that serves the best interests of the Enrollees and in accordance with the conflict free Care Management requirements. The program shall reflect the standards for Utilization Management from the most current NCQA Standards when applicable. The program must have mechanisms to detect under-utilization and/or over-utilization of care including, but not limited to, provider profiles. The Utilization Management program shall be submitted annually to RI EOHHS and upon revision.

2.8.6.6. The Contractor shall have in place policies and procedures that at a minimum:

2.8.6.6.1. Routinely assess the effectiveness and the efficiency of the Utilization Management program;

2.8.6.6.2. Evaluate the appropriate use of medical technologies, including medical procedures, diagnostic procedures and technology, behavioral health treatments, pharmacy formularies, and devices;

2.8.6.6.3. Target areas of suspected inappropriate service utilization (detect over and under-utilization);

2.8.6.6.4. Routinely generate provider profiles regarding utilization patterns and compliance with utilization review criteria and policies (including a system to identify utilization patterns by significant data elements and established outlier criteria for all services);

2.8.6.6.5. Compare Enrollee and provider utilization with norms for comparable individuals and network providers;

2.8.6.6.6. Routinely monitor inpatient admissions, emergency room use, ancillary, out-of-area services and out-of-network services as well as Behavioral Health Inpatient and Outpatient Services and diversionary services;

2.8.6.6.7. Ensure that treatment and discharge planning are addressed at the time of authorization and concurrent review and that the treatment planning includes coordination with PCP, other Health Care Professionals and other supports identified by the Enrollee as appropriate;

2.8.6.6.8. Conduct retrospective and peer reviews of the medical records of selected cases to assess the medical necessity and whether services were authorized and billed in accordance with requirements;

2.8.6.6.9. Clinical appropriateness of care and duration and level of care; and

2.8.6.6.10. Referral of suspected cases of Health Care Professional or Enrollee fraud or abuse to Medicare and RI EOHHS.

2.8.6.7. The Contractor's Utilization Management activities shall include:

2.8.6.7.1. Referrals and coordination of Covered Services;

2.8.6.7.2. Authorization of Covered Services, including modification of denial or request for such services; assisting providers to effectively provide inpatient discharge planning; behavioral health treatment and discharge planning; monitoring and assuring the appropriate utilization of specialty services, including behavioral health;

2.8.6.7.3. Providing training and supervision to the Contractor's Utilization Management clinical staff and Health Care Professionals on the standard application of medical necessity criteria and Utilization Management policies and procedures to ensure that staff maintain and improve their clinical skills;

2.8.6.7.4. Utilization Management policies, practices and data reporting to ensure that it is standardized across all Health Care Professionals within the Provider Network; and

2.8.6.7.5. The consistent application and implementation of the Contractor's clinical criteria and guidelines including the behavioral health clinical criteria approved by CMS and/or RI EOHHS.

2.8.6.8. If the Contractor delegates responsibilities for Utilization Management to a First Tier, Downstream or Related Entity, the contract must have a mechanism in place to ensure that these standards are met by the First Tier, Downstream or Related Entity.

2.8.6.9. The Contractor shall assume responsibility for all Covered Services authorized by RI EOHHS, CMS or a previous Contractor, which are rendered after the Enrollment effective date.

2.8.6.10. The Contractor shall establish a prior authorization process for adult day care services that includes a review of minimum standards of eligibility as defined below. The Contractor must establish this process and provide evidence of compliance to RI EOHHS. The prior authorization process must include a review of at least the following:

2.8.6.10.1. The Enrollee must have a medical or mental dysfunction that involves one or more physiological systems and indicates a need for nursing care, supervision, therapeutic services, support services, and/or socialization.

2.8.6.10.2. The Enrollee must require services in a structured adult day care setting.

2.8.6.10.3. The Enrollee must have a personal physician that will attest to the Enrollee's need.

2.8.6.10.4. The Contractor shall ensure that its adult day care service providers complete a health assessment for admission; establish an oversight and monitoring process that involves a licensed nurse; and provides standard and ad hoc reporting on this service.

2.8.7. Emergency and Post-stabilization Care Coverage

2.8.7.1. The Contractor's Provider Network must ensure access to twenty-four (24) hour Emergency Services for all Enrollees, whether they reside in institutions or in the community. The Contractor must cover and pay for any services obtained for Emergency Medical Conditions in accordance with 42 C.F.R. § 438.114(c).

2.8.7.2. The Contractor shall cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the Contractor, consistent with Section 2.7.4.5.1.

2.8.7.2.1. Payment shall be done within sixty (60) calendar Days after the Claim has been submitted. The Contractor must ensure that cost to the Enrollee is no greater than it would be if the services were furnished within the network.

2.8.7.3. The Contractor shall:

2.8.7.3.1. Have a process established to notify the PCP (or the designated covering Health Care Professional) of an Emergency Condition within one (1) business Day after the Contractor is notified by the Health Care Professional. If the Contractor is not notified by the Health Care Professional within ten (10) calendar Days of the Enrollee's presentation for Emergency Services, the Contractor may not refuse to cover Emergency Services.

2.8.7.3.2. Have a process to notify the PCP of required Urgent Care within twenty-four (24) hours of the Contractor being notified.

2.8.7.3.3. Record summary information about Emergency Medical Conditions and Urgent Care services in the Enrollee Medical Record no more than eighteen (18) hours after the PCP is notified, and a full report of the services provided within two (2) business Days.

2.8.7.4. The Contractor shall not deny payment for treatment for an Emergency Medical Condition, pursuant to 42 C.F.R. § 438.114.

2.8.7.5. The Contractor shall not deny payment for treatment of an Emergency Medical Condition if a representative of the Contractor instructed the Enrollee to seek Emergency Services.

2.8.7.5.1. Contractor may not deny payment for treatment obtained when an Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 C.F.R. § 438.114(a) of the definition of Emergency Medical Condition.

2.8.7.6. The Contractor shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

2.8.7.7. The Contractor shall require Health Care Professionals to notify the Enrollee's PCP of an Enrollee's screening and treatment, but may not refuse to cover Emergency Services based on their failure to do so.

2.8.7.8. An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Enrollee.

2.8.7.9. The attending emergency physician, or the Health Care Professional actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently Stabilized for transfer or discharge. That determination is binding on the Contractor if:

2.8.7.9.1. Such transfer or discharge order is consistent with generally accepted principles of professional medical practice; and

2.8.7.9.2. Is a Covered Service under the Contract.

2.8.7.10. The Contractor shall cover and pay for Post-stabilization Care Services in accordance with 42 C.F.R. §§ 438.114(e) and 422.113(c).

2.8.7.11. Contractor shall cover Post-Stabilization Services provided by the Health Care Professional in any of the following situations:

2.8.7.11.1. The Contractor authorized such services;

2.8.7.11.2. Such services were administered to maintain the Enrollee's Stabilized condition within one (1) hour after a request to the Contractor for authorization of further Post-Stabilization Services; or

2.8.7.11.3. The Contractor does not respond to a request to authorize further Post-Stabilization Care Services within one (1) hour, the Contractor could not be contacted, or the Contractor and the treating Health Care Professional cannot reach an agreement concerning the Enrollee's care and a Health Care Professional is unavailable for a consultation, in which case the treating Health Care Professional must be permitted to continue the care of the Enrollee until a Health Care Professional is reached and either concurs with the treating Health Care Professional's plan of care or assumes responsibility for the Enrollee's care.

2.8.8. Emergency Medical Treatment and Labor Act (EMTALA)

2.8.8.1. The Contractor and Health Care Professionals shall comply with EMTALA, which, in part, requires:

2.8.8.1.1. Qualified hospital medical personnel to provide appropriate medical screening examinations to any individual who "comes to the emergency department," as defined in 42 C.F.R.§ 489.24(b); and,

2.8.8.1.2. As applicable, to provide individuals stabilizing treatment or, if the hospital lacks the capability or capacity to provide stabilizing treatment, appropriate transfers.

2.8.8.1.3. The Contractor's contracts with its Health Care Professionals must clearly state the Health Care Professional's EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA.

2.8.9. Linguistic Competency

2.8.9.1. The Contractor must demonstrate linguistic competency in its dealing, both written and verbal, with Enrollees and must understand that linguistic differences between the Health Care Professional and the Enrollee cannot be permitted to present barriers to access and quality health care and demonstrate the ability to provide quality health care across a variety of cultures.

2.8.9.2. Interpreter/Translation Services

2.8.9.2.1. During the Enrollment process, RI EOHHS will seek to identify Enrollees who speak a language other than English as their primary language. RI EOHHS will notify the Contractor when it knows of Enrollees who do not speak English as a primary language who have either selected or been assigned to the Contractor's MMP.

2.8.9.2.2. The Contractor must make available vital written materials, as specified in the Medicare-Medicaid marketing guidance, in Prevalent Languages. The Contractor is responsible for a true translation of materials prior-approved in English by RI EOHHS and CMS, subject to RI EOHHS and CMS oversight. The Contractor will forward all translated materials to applicable Enrollees.

2.8.9.2.3. The Contractor shall make available interpreter services for all Enrollees who speak a non- English language as a primary language. Interpreter services shall be made available by telephone and, as practical and necessary, in-person to ensure that Enrollees are able to communicate with the Contractor and its Healthcare Professionals and receive all covered benefits in a timely manner. Enrollees shall have the option of in-person interpreter services when accessing Covered Services if planned sufficiently in advance. Advance notice must be defined as no less than forty-eight (48) hours for non-English language interpreter services and two (2) weeks for deaf and hard of hearing interpreter services.

2.8.9.2.4. In addition, the Contractor agrees to conform with the standards outlined in the ADA for purposes of communicating with, including about Carved-Out Services, and providing accessible services to Enrollees with visual impairments, hearing impairments, and/or physical disabilities, in accordance with Section 2.8.10.

2.8.10. Access for Enrollees with Disabilities

2.8.10.1. The Contractor must reasonably accommodate persons and shall ensure that the programs and services are as accessible (including

physical and geographic access) to an individual with disabilities as they are to an individual without disabilities.

2.8.10.2. The Contractor must have policies and procedures in place to assure compliance with the ADA, including but not limited to:

2.8.10.2.1. Ensuring that physical, communication, and programmatic barriers do not inhibit individuals with disabilities from obtaining all Covered Services from the Contractor;

2.8.10.2.2. Ensuring that individuals with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the individual and include but are not limited to:

2.8.10.2.2.1. Providing large print (at least 16-point font) versions of all written materials to individuals with visual impairments;

2.8.10.2.2.2. Ensuring that all written materials are available in formats compatible with optical recognition software;

2.8.10.2.2.3. Reading notices and other written materials to individuals upon request;

2.8.10.2.2.4. Assisting individuals in filling out forms over the telephone;

2.8.10.2.2.5. Ensuring effective communication to and from individuals with disabilities through email, telephone, and other electronic means;

2.8.10.2.2.6. Providing TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for Enrollees who are Deaf and hard of hearing;

2.8.10.2.2.7. Using TTY/TDD devices for the deaf and hard of hearing, qualified American Sign Language (ASL) interpreters and alternative cognitively accessible communication for persons with cognitive limitations;

2.8.10.2.2.8. Ensuring that interpreter services are made available by telephone and, as practical and necessary, in person to ensure that enrollees are able to communicate with the contractor and its providers to receive all covered benefits in a timely manner;

2.8.10.2.2.9. Providing flexibility in scheduling to accommodate the needs of the Enrollees;

2.8.10.2.2.10. Providing individualized forms of assistance.

2.8.10.2.2.11. Ensuring safe and appropriate physical access to buildings, services and equipment; and

2.8.10.2.2.12. Demonstrating compliance with the ADA by conducting an independent survey or site review of facilities for both physical and programmatic accessibility, documenting any deficiencies in compliance and monitoring correction of deficiencies.

2.9. Enrollee Services

2.9.1. Enrollee Service Representatives (ESRs)

2.9.1.1. The Contractor must employ ESRs trained to answer Enrollee inquiries and concerns from Enrollees and Eligible Beneficiaries, consistent with the requirements of 42 CFR§§ 422.111(h) and 423.128(d).

2.9.1.2. ESRs must be trained to answer Enrollee inquiries and concerns from Enrollees and prospective Enrollees;

2.9.1.3. ESRs must be trained in the use of TTY, Video Relay services, remote interpreting services, providing accessible PDF materials, and other Alternative Formats;

2.9.1.4. ESRs must be capable of speaking directly with, or arranging for an interpreter to speak with, Enrollees in their primary language, including ASL, or through an alternative language device or telephone translation service;

2.9.1.5. ESRs must inform callers that interpreter services are free and be made aware of the process, including advance notice requirements, for scheduling interpreter services to ensure that Enrollees are able to communicate with providers and receive benefits in a timely manner;

2.9.1.6. ESRs must be knowledgeable about Contractor, Medicaid, Medicare, and the terms of the Contract, including the Covered Services listed in Appendix A;

2.9.1.7. ESRs must be available to Enrollees to discuss and provide assistance with resolving Enrollee complaints;

2.9.1.8. ESRs must have access to the Contractor's Enrollee database, RI EOHHS eligibility verification system and an electronic provider and pharmacy directory;

2.9.1.9. ESRs must make oral interpretation services available free-of-charge to Enrollees in all non-English languages spoken by Enrollees, including ASL;

2.9.1.10. ESRs must maintain the availability of services, such as TTY services, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters and other services for Deaf and hard of hearing Enrollees;

2.9.1.11. ESRs must demonstrate sensitivity to culture, including disability culture and the independent living philosophy;

2.9.1.12. ESRs must provide assistance to Enrollees with cognitive impairments; for example, ESRs must provide written materials in simple, clear language at or below sixth (6th) grade reading level, and individualized guidance from ESRs to ensure materials are understood;

2.9.1.13. ESRs must provide reasonable accommodations needed to assure effective communication and provide Enrollees with a means to identify their disability to the Contractor;

2.9.1.14. ESRs must maintain employment standards and requirements (e.g., education, training, and experience) for Enrollee Services department

staff and provide a sufficient number of staff to meet defined performance objectives; and

2.9.1.15. ESRs must ensure that ESRs make available to Enrollees and Eligible Beneficiaries, upon request, information concerning the following:

2.9.1.15.1. The identity, locations, qualifications, and availability of providers;

2.9.1.15.2. Enrollees' rights and responsibilities;

2.9.1.15.3. The procedures available to an Enrollee and provider(s) to challenge or Appeal the failure of the Contractor to provide a Covered Service and to Appeal any Adverse Benefit Determinations (denials);

2.9.1.15.4. How to access oral interpretation services and written materials in Prevalent Languages and Alternative Formats;

2.9.1.15.5. Information on all Covered Services and other available services or resources (e.g., State agency services) either directly or through referral or authorization;

2.9.1.15.6. The procedures for an Enrollee to Opt-Out of the Demonstration;

2.9.1.15.7. Information on all Contractor Covered Services and other available services or resources (e.g., State agency services) either directly or through referral or authorization; and

2.9.1.15.8. How to access the Enrollee Ombudsman, the State Enrollee call center, and 1-800-Medicare.

2.9.2. Enrollee Service Telephone Responsiveness

2.9.2.1. The Contractor must operate a call center during normal business hours seven (7) Days a week, consistent with the required Marketing Guidelines and the Medicare-Medicaid marketing guidance.

2.9.2.1.1. ESRs must be available Monday through Friday during normal business hours, consistent with the required Medicare Marketing Guidelines and the Medicare-Medicaid marketing guidance. The Contractor may use alternative call center technologies on Saturdays, Sundays, and State and federal holidays.

2.9.2.1.2. A toll-free TTY number or state relay service must be provided.

2.9.2.2. Call Center Performance

2.9.2.2.1. The Contractor's ESRs must answer eighty (80%) percent of all Enrollee telephone calls within thirty (30) seconds or less.

2.9.2.2.2. The Contractor must limit average hold time to two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person.

2.9.2.2.3. The Contractor must limit the disconnect rate of all incoming calls to five (5%) percent.

2.9.2.2.4. The Contractor must have a process to measure the time from which the telephone is answered to the point at which an Enrollee reaches an ESR capable of responding to the Enrollee's question in a manner that is sensitive to the Enrollee's language and cultural needs.

2.9.2.3. Informational calls to the Contractor's call centers that become sales/Enrollment calls at the proactive request of the Enrollee or Eligible Beneficiary must be transferred to RI EOHHS' authorized agent.

2.9.3. Coverage Determinations and Appeals Call Center Requirements

2.9.3.1. The Contractor must operate a toll-free call center with live customer service representatives available to respond to Health Care Professionals and Enrollees for information related to requests for coverage under Medicare and Medicaid, and Medicare and Medicaid

Appeals (including requests for Medicare and Medicaid exceptions and prior authorizations).

2.9.3.2. The Contractor is required to provide immediate access to requests for Medicare and Medicaid covered benefits and services, including Medicare and Medicaid coverage determinations and redeterminations, via its toll-free call centers.

2.9.3.3. The coverage determination and Appeals call centers must operate during normal business hours as specified in the Medicare Marketing Guidelines and the Medicare-Medicaid marketing guidance.

2.9.3.4. The Contractor must accept requests for Medicare and Medicaid coverage, including Medicare and Medicaid coverage determinations /redeterminations, outside of normal business hours, but is not required to have live customer service representatives available to accept such requests outside normal business hours.

2.9.3.5. Voicemail may be used outside of normal business hours provided that the message:

2.9.3.5.1. Indicates that the mailbox is secure;

2.9.3.5.2. Lists the information that must be provided so the case can be worked (e.g., Health Care Professional identification, Enrollee identification, type of request (coverage determination or Appeal), Health Care Professional support for an exception request, and whether the Enrollee is making an expedited or standard request);

2.9.3.5.3. For coverage determination calls (including exceptions requests), articulates and follows a process for resolution within twenty-four (24) hours of call for expedited requests and seventy-two (72) hours for standard requests; and

2.9.3.5.4. For Appeals calls, information articulates the process information needed and provide for a resolution within seventy-two (72) hours for Expedited Appeal requests and fifteen (15) calendar Days for standard Appeal requests.

2.9.3.6. Provider Accessibility:

2.9.3.6.1. The Contractor shall require PCPs and specialty Health Care Professional contracts to provide coverage for their respective practices twenty-four (24) hours a Day, seven (7) Days a week and have a published after hours telephone number; voicemail alone after hours is not acceptable.

2.9.4. Nurse Advice Line

2.9.4.1. The Contractor must provide a twenty-four (24) hour per Day, seven (7) Days per week toll-free system with access to a registered nurse who:

2.9.4.1.1. Has immediate access to the Enrollee Medical Record on file with the Contractor;

2.9.4.1.2. Is able to provide medical advice and guidance to Enrollees and respond to Enrollee questions about health or medical concerns;

2.9.4.1.3. Has the experience and knowledge to provide clinical triage;

2.9.4.1.4. Is able to provide options other than waiting until business hours or going to the emergency room;

2.9.4.1.5. Is able to provide access to oral interpretation services available as needed, free-of-charge; and

2.9.4.1.6. Is able to obtain Physician support and advice, including by contacting the Contractor's medical director, if needed.

2.9.5. Enrollee Advisory Committee

2.9.5.1. The Contractor shall establish an Enrollee advisory committee that will provide regular feedback to the Contractor's governing board on issues of Demonstration management and Enrollee care. The Contractor shall ensure that the Enrollee advisory committee:

2.9.5.1.1. Meets at least quarterly throughout the Demonstration.

2.9.5.1.2. Is comprised of Enrollees, Family members of Enrollees and other caregivers that reflect the diversity of the Demonstration population, including individuals with disabilities.

2.9.5.2. The Contractor shall also include Enrollee Ombudsman reports in quarterly updates to the Enrollee advisory committee and shall participate in all statewide stakeholder and oversight meetings as requested by RI EOHHS and/or CMS.

2.10. Enrollee Grievance

2.10.1. Grievance Filing

2.10.1.1. Internal Grievance Filing: An Enrollee, or an authorized representative, may file an internal Enrollee Grievance at any time with the Contractor or its providers by calling or writing to the Contractor or provider. If the internal Enrollee Grievance is filed with a provider, the Contractor must require the provider to forward it to the Contractor.

2.10.1.2. External Grievance Filing: The Contractor shall inform Enrollees that they may file an external Grievance through 1-800 Medicare. The Contractor must display a link to the electronic Grievance form on the Medicare.gov Internet Web site on the Contractor's main Web page per 42 C.F.R. § 422.504(b)(15)(ii). The Contractor must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee Grievance may be filed.

2.10.1.3. External Grievances filed with RI EOHHS shall be forwarded to the CMT and entered into the CMS complaints tracking module, which will be accessible to the Contractor.

2.10.1.4. Authorized representatives may file Grievances on behalf of Enrollees to the extent allowed under applicable federal or State law.

2.10.2. Grievance Administration

2.10.2.1. Internal (plan level) Grievance

2.10.2.1.1. The Contractor must have a formally structured Grievance system, consistent with 42 C.F.R. § 438 Subpart F, for addressing Enrollee Grievances, including Grievances regarding reasonable accommodations and access to services under the ADA.

2.10.2.1.2. The Contractor must maintain written records of all Grievance activities, and notify CMS and RI EOHHS of all internal Enrollee Grievances. The Contractor must also submit to RI EOHHS, in the format required by RI EOHHS, a quarterly report summarizing all Grievances and disposition of those Grievances.

2.10.2.1.3. The Contractor must submit its Grievance procedures to RI EOHHS for prior approval. The Grievance procedures must meet the following standards:

2.10.2.1.3.1. Timely acknowledgement of receipt of each Enrollee Grievance;

2.10.2.1.3.2. Timely review of each Enrollee Grievance;

2.10.2.1.3.3. Response with a resolution, electronically, orally or in writing, to each Enrollee Grievance within a reasonable time, but no later than thirty (30) Days after the Contractor receives the Grievance; and

2.10.2.1.3.4. Expedited response with a resolution, orally or in writing, within twenty four (24) hours after the Contractor receives the Grievance, to each Enrollee Grievance whenever Contractor extends the Appeals timeframe or Contractor refuses to grant a request for an expedited Appeal; and

2.10.2.1.3.5. Availability to Enrollees of information about Enrollee Grievance and Appeals, as described in Subsection 2.11, including reasonable assistance in completing any forms or other procedural steps, which shall include interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

2.10.2.1.3.6. Ensure that the individuals who make decisions on Grievances that involve denial of expedited resolution of an Appeal or on Grievances that involve clinical issues were not involved in any previous level of review or decision making, and who, if deciding on any of the following, are Health Care Professionals who have appropriate clinical expertise, as determined by the RI EOHHS and CMS, in treating the Enrollee's condition or disease.

2.11. Enrollee Appeals

2.11.1. General Requirements

2.11.1.1. All Contractors shall utilize and all Enrollees may access the existing Part D Appeals process, as described in Appendix D. Consistent with existing rules, Part D Appeals will be automatically forwarded to the CMS Medicare Independent Review Entity (IRE) if the Contractor misses the applicable adjudication timeframe. The CMS IRE is contracted by CMS. The Contractor must maintain written records of all Appeal activities, and notify CMS and RI EOHHS of all internal Appeals.

2.11.1.2. The Contractor agrees to be fully compliant with all State and federal laws, regulations, and policies governing the State Fair Hearing process, and all statutory and regulatory timelines related thereto. This includes the requirements for both standard and expedited requests. The Contractor shall be financially liable for all judgments, penalties, costs and fees related to an Appeal in which the Contractor has failed to comply fully with said requirements. The Contractor must maintain written records of all Appeal activities, and notify CMS and RI EOHHS of all internal Appeals. The Contractor must maintain documents in accordance with the record retention requirements outlined in Section 5.4.

2.11.2. Integrated/Unified Non-Part D Appeals Process Overview

2.11.2.1. Notice of Adverse Action or Notice of Adverse Benefit Determination – In accordance with 42 C.F.R. §§ 438.404, 422.568, and 422.570, the Contractor must give the Enrollee written notice of any Adverse Action or Adverse Benefit Determination. Such notice shall be provided at least ten (10) days in advance of the date of its action, in

accordance with 42 C.F.R. § 438.404. An Enrollee or a provider acting on behalf of an Enrollee and with the Enrollee's written consent may Appeal the Contractor's decision to deny, terminate, suspend, or reduce services. In accordance with 42 C.F.R. §§ 438.402 and 422.574, an Enrollee or provider action on behalf of an Enrollee and with the Enrollee's consent may also Appeal the Contractor's delay in providing or arranging for a Covered Service.

2.11.2.2. The Contractor's Appeal procedures must: (i) be submitted to the CMT in writing for Prior Approval by CMS and RI EOHHS; (ii) provide for resolution with the timeframes specified herein; and (iii) assure the participation of individuals with authority to require corrective action. Appeals procedures must be consistent with 42 C.F.R. § 422.560 et seq. and 42 C.F.R. § 438.400 et seq., 42 C.F.R. 431.200 et seq, and MCAR Sections 0374, 0375, and 0110.

2.11.2.3. The Contractor shall review its Appeal procedures at least annually for the purpose of amending such procedures when necessary.

2.11.2.4. The Contractor shall amend its procedures only upon receiving Prior Approval from RI EOHHS.

2.11.2.5. An Enrollee may appoint in writing any authorized representative, including, but not limited to, a guardian, caretaker relative, friend, legal counsel, or provider, to represent the Enrollee throughout the Appeal process. The Contractor shall provide a form and instructions on how an Enrollee may appoint a representative. The Contractor shall consider the Enrollee, the Enrollee's authorized representative, or the representative of the Enrollee's estate as parties to the Appeal. The Contractor shall provide such parties an opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The Contractor shall allow such parties an opportunity, before and during the Appeal process, to examine the Enrollee's case file, including medical records and any other documents and records.

2.11.2.6. Integrated Notice

2.11.2.6.1. Enrollees will be notified of all applicable Demonstration, Medicare and Medicaid Appeal rights through a single notice. The form and content of the notice must be prior approved by CMS and RI EOHHS. The Contractor shall notify the Enrollee of its decision at least 10 days in advance of the effective date of its action. The notice must explain:

2.11.2.6.1.1. The action the Contractor has taken or intends to take;

2.11.2.6.1.2. The reasons for the action;

2.11.2.6.1.3. The citation to the regulations supporting such action;

2.11.2.6.1.4. The Enrollee's or the provider's right to file an internal Appeal with the Contractor and that exhaustion of the Contractor's internal Appeal processes is a prerequisite to filing an external Appeal to Medicare or to State Fair Hearing;

2.11.2.6.1.5. Procedures for exercising Enrollee's rights to Appeal;

2.11.2.6.1.6. The Enrollee's right to request a State Fair Hearing in accordance with 42 C.F.R. § 438.408(f) and as described herein in Section 2.11.5.2;

2.11.2.6.1.7. The Enrollee's right to request an external review pursuant to RI DOH utilization review regulations, R23-17.12-1-UR as described herein in Section 2.11.5.3;

2.11.2.6.1.8. Circumstances under which expedited resolution is available and how to request it; and

2.11.2.6.1.9. If applicable, the Enrollee's rights to have benefits continue pending the resolution of the Appeal, and the circumstances under which the Enrollee may be required to pay the costs of these services.

2.11.2.6.2. Written material must use easily understood language and format, be available in Alternative Formats and in an appropriate manner that takes into consideration those with special needs. All Enrollees and Eligible Beneficiaries must be informed that information is available in Alternative Formats and how to access those formats.

2.11.2.6.3. Written notice must be translated for the individuals who speak Prevalent Languages, in accordance with Section 2.13.2.1.

2.11.2.6.4. Written notices must include language clarifying that oral interpretation and Alternative Formats are available for all languages and how to access it.

2.11.2.7. Appeal levels

2.11.2.7.1. Initial Appeals (internal Appeal) will be filed with the Contractor, in accordance with authorization timeframes detailed at 2.11.3.2.

2.11.2.7.2. Internal Appeals for traditional Medicare A and B services that are not fully in favor of the Enrollee will be automatically forwarded to the Medicare Independent Review Entity (IRE) by the Contractor.

2.11.2.7.3. The Contractor may only offer a single level of internal Appeals for both Medicare and Medicaid services.

2.11.2.7.4. Subsequent Appeals for services covered by RI EOHHS only (including but not limited to, LTSS, and behavioral health) may be made to the RI EOHHS State Fair Hearing Office after the internal Appeal has been completed if the Enrollee disagrees with the outcome of any part of the Contractor decision.

2.11.2.7.5. Subsequent Appeals for services covered by RI EOHHS only (including but not limited to, LTSS, and behavioral health) may also be made to the Rhode Island external review entity per RI DOH utilization review regulations R23-17.12-1-UR after the internal Appeal has been completed.

2.11.2.7.6. After the internal Appeal, Appeals for services for which Medicare and Medicaid overlap (including, but not limited to, Home Health, DME and skilled therapies, but excluding Part D) will be auto-forwarded to the IRE by the Contractor.

2.11.2.7.7. After the internal Appeal for Medicare and Medicaid overlap services, an Enrollee may file a request for a hearing with the RI EOHHS State Fair Hearing Office.

2.11.2.7.8. After the internal Appeal for Medicare and Medicaid overlap services, an Enrollee may also file a request for a hearing with the Rhode Island external review entity per RI DOH utilization review regulations, R23-17.12-1-UR.

2.11.2.7.9. If an Appeal is filed with both the IRE and either the Rhode Island external review entity or RI EOHHS State Fair Hearing Office, any determination in favor of the Enrollee will bind the Contractor and will require payment by the Contractor for the service or item in question granted in the Enrollee's favor which is closest to the Enrollee's relief requested on Appeal. Where it is unclear which determination is closest to the Enrollee's relief requested on Appeal, the Enrollee will be offered the opportunity to select the determination that will be binding. If the Enrollee needs assistance in selecting a determination, the Contractor shall refer the Enrollee to the Long-Term Care Ombudsman or Enrollee Ombudsman.

2.11.2.7.10. Prescription Drugs

2.11.2.7.10.1. Part D Appeals may not be filed with the RI EOHHS State Fair Hearing Office or the Rhode Island external review entity.

2.11.2.7.10.2. Appeals related to drugs excluded from Part D that are covered by Medicaid must be filed with the Contractor in accordance with MCAR Sections 0374 0375, 1311 and 0110.

2.11.2.8. Continuation of Benefits Pending an Appeal and State Fair Hearing

2.11.2.8.1. The Contractor must provide continuing benefits for all prior approved non-Part D benefits that are terminated or modified pending internal Contractor Appeals, per timeframes and conditions in 42 C.F.R. § 438.420. This means that such benefits will continue to be provided by providers to Enrollees and that the Contractors must continue to pay providers for providing such services or benefits pending an internal Appeal.

2.11.2.8.2. For all Appeals filed with the RI EOHHS State Fair Hearing Office, an Enrollee may request to have covered benefits continue pending resolution of the Appeal. RI EOHHS will make a determination on continuation of services in accordance with the RI EOHHS' existing regulations as found in MCAR 0110.30.20 and in accordance with 42 C.F.R. §§ 438.420 and 431.230.

2.11.2.8.3. If the Contractor decides in the Enrollee's favor and reverses the Contractor's decision, the Contractor must authorize the service under dispute as expeditiously as the Enrollee's health condition requires but no later than seventy-two (72) hours from the date the Contractor receives the notice reversing the decision.

2.11.2.8.4. If the Contractor or the state hearing officer reverses a decision to deny authorization of Covered Services, and the Enrollee received the disputed services while the Appeal was pending, the Contractor must pay for those services in accordance with state rules and policy.

2.11.2.8.5. If services were furnished while the Appeal or State Fair Hearing was pending, the Contractor may recover the cost of the continuation of services furnished to the Enrollee while the Appeal was pending if the final resolution of the Appeal upholds the Contractor's action in accordance with 42 C.F.R. §§ 438.420 and 431.230(b).

2.11.3. Internal (Plan-level) Appeals

2.11.3.1. Initial Appeals must be filed with the Contractor. The filing of an internal Appeal and exhaustion of the Contractor's internal Appeal process is a prerequisite to filing an external Appeal to Medicare or Medicaid.

2.11.3.2. An Enrollee may file an oral or written Appeal with the Contractor within sixty (60) calendar Days following the date of the notice of Adverse Action or Adverse Benefit Determination that generates such Appeal.

2.11.3.3. Standard Appeals

2.11.3.3.1. The Contractor's Appeals process must include the following requirements:

2.11.3.3.1.1. Acknowledge receipt of each Appeal within five (5) calendar Days.

2.11.3.3.1.2. Ensure that the individuals who make decisions on Appeals were not involved in any previous level of review or decision making, and who, if deciding on any of the following, are Health Care Professionals who have appropriate clinical expertise, as determined by the RI EOHHS and CMS, in treating the Enrollee's condition or disease: (a) an Appeal of a denial that is based on lack of medical necessity; or (b) any Appeal that involves clinical issues.

2.11.3.3.1.3. Provide that oral inquiries seeking to Appeal an action are treated as Appeals (to establish the earliest possible filing date for the Appeal) and must be confirmed in writing unless the Enrollee or the provider appealing on the Enrollee's behalf requests expedited resolution.

2.11.3.3.1.4. Provide the Enrollee an opportunity to present evidence and allegations of fact or law in person as well as in writing. (The Contractor must inform the Enrollee of the limited time available for this, especially in the case of expedited resolution.)

2.11.3.3.1.5. Provide the Enrollee and his or her representative opportunity, before and during the Appeals process, to examine the Enrollee's case file, including any medical records and any other documents and records considered during the Appeals process.

2.11.3.3.1.6. Consider the Enrollee, representative or estate representative of a deceased Enrollee as parties to the Appeal.

2.11.3.3.2. For Appeals filed with the Contractor, the Contractor must accept oral appeals from the Enrollee. If the Enrollee does not request an Expedited Appeal pursuant to 42 C.F.R. § 438.410, the Contractor will provide the Enrollee with written confirmation of any oral appeal request.

2.11.3.3.3. The Contractor shall respond in writing to standard Appeals as expeditiously as the Enrollee's health condition requires and shall not exceed thirty (30) calendar Days from the initial date of receipt of the Appeal. The Contractor may extend this timeframe by up to an additional fourteen (14) calendar Days if the Enrollee requests the extension or if the Contractor provides written evidence satisfactory to RI EOHHS that a delay in rendering the decision is in the Enrollee's interest and there is a need for additional information. For any Appeals decisions not rendered within thirty (30) calendar Days where the Enrollee has not requested an extension, the Contractor shall provide written notice to the Enrollee of the reason for the delay.

2.11.3.3.4. The Contractor shall resolve all requests for payment Appeals by the latest of sixty (60) Days as required by 42 C.F.R. § 422.590(b).

2.11.3.4. Expedited Appeals

2.11.3.4.1. The Contractor shall establish and maintain an expedited review process for Appeals where either the Contractor or the Enrollee's provider determines that the time expended in a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function. The Contractor shall ensure that punitive action is neither taken against a provider that requests an expedited resolution nor supports the Enrollee's Appeal. In instances where the Enrollee's request for an Expedited Appeal is denied, the Appeal must be transferred to the timeframe for standard resolution of Appeals. Reasonable efforts must be made to give oral notice of the denial and a written notice of the denial to the Enrollee within two (2) calendar Days.

2.11.3.4.2. The Contractor shall issue decisions for Expedited Appeals as expeditiously as the Enrollee's health condition requires, not to exceed seventy-two (72) hours from the initial receipt of the Appeal. The Contractor may extend this timeframe by up to an additional fourteen (14) calendar Days if the Enrollee requests the extension or if the Contractor provides evidence satisfactory to RI EOHHS that a delay in rendering the decision is in the Enrollee's interest. For any extension not requested by the Enrollee, the Contractor shall provide written notice to the Enrollee of the reason for the delay. The Contractor shall make reasonable efforts to provide the Enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the Enrollee and shall follow-up within two (2) calendar Days with a written notice of action.

2.11.3.4.3. The Expedited Appeal process must include the same requirements as the Standard Appeal process that are described in Sections 2.11.3.3.1.2 through 2.11.3.3.1.6.

2.11.3.5. All Appeal decisions must be in writing and shall include, but not be limited to, the following information:

2.11.3.5.1.1. The decision reached by the Contractor;

2.11.3.5.1.2. The date of decision;

2.11.3.5.1.3. For Appeals not resolved wholly in favor of the Enrollee or not fully granting relief Enrollee is seeking;

2.11.3.5.1.3.1. The right to request a State Fair Hearing and/or State External Review and how to do so if appropriate;

2.11.3.5.1.3.2. Notification that the Appeal has been sent to the Medicare IRE if appropriate; and

2.11.3.5.1.3.3. The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the Enrollee may be held liable for the cost of those services if the hearing decision upholds the Contractor.

2.11.4. External Appeals

2.11.4.1. The CMS Independent Review Entity (IRE)

2.11.4.1.1. If, on the internal Appeal, the Contractor does not decide fully in the Enrollee's favor within the relevant time frame, the Contractor shall automatically forward the case file regarding Medicare services or Medicare and Medicaid overlap services to the CMS Independent Review Entity (IRE) for a new and impartial review. The CMS IRE is contracted by CMS.

2.11.4.1.2. For standard External Appeals, the CMS IRE will send the Enrollee and the Contractor a letter with its decision within 30 calendar Days after it receives the case from the Contractor, or at the end of up to a fourteen (14) calendar Day extension, and a payment decision within sixty (60) calendar Days.

2.11.4.1.3. If the CMS IRE decides in the Enrollee's favor and reverses the Contractor's decision, the Contractor must authorize the service under dispute as expeditiously as the Enrollee's health condition requires but no later than seventy-two (72) hours from the date the Contractor receives the notice reversing the decision.

2.11.4.1.4. For expedited external Appeals, the CMS IRE will send the Enrollee and the Contractor a letter with its decision within seventy-two (72) hours after it receives the case from the Contractor (or at the end of up to a fourteen (14) calendar Day extension).

2.11.4.1.5. If the Contractor or the Enrollee disagrees with the CMS IRE's decision, further levels of Appeal are available, including a hearing before an Administrative Law Judge and a review by the HHS Departmental Appeals Board. The Contractor must comply with any requests for information or participation from such further Appeal entities.

2.11.4.2. The Medicaid State Fair Hearing Process

2.11.4.2.1. If the Contractor's internal Appeal decision is not fully in the Enrollee's favor or not fully granting relief to the Enrollee, the Enrollee may appeal to the RI EOHHS Fair Hearing Office. Such appeals may be made in writing via US Mail, fax transmission, hand-delivery or electronic transmission or by telephone in accordance with 42 C.F.R. § 431.221 and MCAR Section 0110.

2.11.4.2.2. External Appeals to the RI EOHHS State Fair Hearing Office that qualify as Expedited Appeals shall be resolved within seventy-two (72) hours or as expeditiously as the Enrollee's condition requires in accordance with MCAR 0110.30.30.

2.11.4.2.3. External Appeals to the RI EOHHS State Fair Hearing Office that do not qualify as expedited shall be resolved or a decision issued in accordance with MCAR Section 0110 and §42 CFR 431.244(f).

2.11.4.2.4. The right to a RI EOHHS State Fair Hearing Office including an explanation of how to obtain a hearing, and representation rules at a hearing must be explained to the Enrollee by the Contractor in accordance with MCAR 0110.30.05 and §42 CFR 431.206.

2.11.4.2.5. Appeals to the RI EOHHS State Fair Hearing Office must be filed within one hundred and twenty (120) Days beginning on the fifth (5th) Day after the date on the notice of resolution of internal Appeal, unless the time period is extended by RI EOHHS upon a finding of "good cause" in accordance with MCAR Section 0110.

2.11.4.2.6. Parties to the Appeal to the RI EOHHS State Fair Hearing include the Contractor, the Enrollee, the Enrollee's representative or estate representative of a deceased Enrollee.

2.11.4.3. Rhode Island External Review

2.11.4.3.1. The Enrollee may also appeal pursuant to the external appeals process outlined in the RI DOH Rules and Regulations for the Utilization of Health Care Services regulations R23-17.12-1-U, Section 7.

2.11.5. Hospital Discharge Appeals

2.11.5.1. The Contractor must comply with the hospital discharge appeal requirements at 42 C.F.R. §§ 422.620-422.622.

2.11.5.2. The Enrollee has the right to request a review by a QIO of any hospital discharge notice. The notice includes information on filing the QIO Appeal. The Enrollee must contact the QIO before he/she leaves the hospital but no later than the planned discharge date.

2.11.5.3. If the Enrollee asks for immediate review by the QIO, the Enrollee will be entitled to this process instead of the standard Appeals process described above. The Contractor must ensure that the Enrollee receives the Detailed Notice of Discharge (CMS-10066). Note: An Enrollee may file an oral or written request for an expedited seventy-two (72) hour Contractor Appeal if the Enrollee has missed the deadline for requesting the QIO review.

2.11.5.4. The QIO will make its decision within one (1) full working Day after it receives the Enrollee's request, medical records, and any other information it needs to make its decision.

2.11.5.5. If the QIO agrees with the Contractor's decision, the Contractor is not responsible for paying the cost of the hospital stay beginning at noon of the calendar Day following the day the QIO notifies the Enrollee of its decision.

2.11.5.6. If the QIO overturns the Contractor's decision, the Contractor must pay for the remainder of the hospital stay.

2.11.6. Additional Medicare QIO Rights

2.11.6.1. The Contractor must comply with the termination of services Appeal requirements for Enrollees receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facility, or home health agency, consistent with 42 C.F.R. §§ 422.624 and 422.626.

2.12. Quality Improvement Program

2.12.1.1. The Contractor shall:

2.12.1.1.1. Deliver quality care that enables Enrollees to stay healthy, improve their health, prevent and manage chronic illnesses and disabilities, and maintain/improve their quality of life. Quality care refers to:

2.12.1.1.2. Quality of physical health care, including primary and specialty care;

2.12.1.1.3. Quality of behavioral health care focused on recovery, resiliency and rehabilitation;

2.12.1.1.4. Quality of LTSS;

2.12.1.1.5. Adequate access and availability to primary, behavioral health care, pharmacy, specialty health care, and LTSS providers and services;

2.12.1.1.6. Continuity and coordination of care across all care and services settings, and for transitions in care; and

2.12.1.1.7. Enrollee experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum.

2.12.1.2. 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:

2.12.1.2.1. Quantitative and qualitative data collection and data-driven decision-making;

2.12.1.2.2. Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

2.12.1.2.3. Feedback provided by Enrollees and network providers in the design, planning, and implementation of its CQI activities; and

2.12.1.2.4. Issues identified by the Contractor, RI EOHHS and/or CMS; and

2.12.1.3. Ensure that the quality improvement (QI) requirements of this Contract are applied to the delivery of primary and specialty health care services, behavioral health services, and LTSS including Care Management, pharmacy, non-medical and flexible services.

2.12.2. QI Program Structure

2.12.2.1. The Contractor shall structure its QI program for the Demonstration separately from any of its existing Medicaid, Medicare, or Commercial lines of business. For example, required measures for this Demonstration must be reported for the Demonstration population only. Integrating the reporting for the Demonstration population into the reporting for another line of business shall not be acceptable.

2.12.2.2. The Contractor shall maintain a well-defined QI organizational and program structure that supports the application of the principles of CQI to all aspects of the Contractor's service delivery system. The QI program must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. The Contractor's QI organizational and program structure shall comply with all applicable provisions of 42 C.F.R. § 438, including Subpart E, Quality Measurement and Improvement; External Quality Review; 42 C.F.R. § 422, Subpart D Quality Improvement, and shall meet the quality management and improvement criteria described in the most current NCQA Medicaid Health Plan Accreditation Requirements.

2.12.2.3. The Contractor shall:

2.12.2.3.1. Establish a set of QI functions and responsibilities that are clearly defined and that are proportionate to, and adequate for, the planned number and types of QI initiatives and for the completion of QI initiatives in a competent and timely manner;

2.12.2.3.2. Ensure that such QI functions and responsibilities are assigned to individuals with the appropriate skill set to oversee and implement an organization-wide, cross-functional commitment to, and application of, CQI to all clinical and non-clinical aspects of the Contractor's service delivery system;

2.12.2.3.3. Seek the input of Health Care Professionals representing the composition of the Contractor's Provider Network in developing functions and activities;

2.12.2.3.4. Establish internal processes to ensure that the quality management (QM) activities for primary, specialty, and behavioral health services, and LTSS, including Care Management, pharmacy, non-medical and flexible services, reflect utilization across the network and include all of the activities in this Section 2.12 of this Contract and, in addition, the following elements:

2.12.2.3.4.1. A process to utilize Health Plan Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Services (CAHPS), the Health Outcomes Survey (HOS) and other measurement results in designing QI activities;

2.12.2.3.4.2. A medical record review process for monitoring Provider Network compliance with policies and procedures, specifications and appropriateness of care consistent with the utilization control requirements of 42 C.F.R. Part 456. Such process shall include the sampling method used which shall be proportionate to utilization by service type. The Contractor shall submit its process for medical record reviews and the results of its medical record reviews to RI EOHHS;

2.12.2.3.4.3. A process to measure clinical reviewer consistency in applying clinical criteria to Utilization Management activities, using inter-rater reliability measures;

2.12.2.3.4.4. A process for including Enrollees and their families in QM activities, as evidenced by participation in consumer advisory boards; and

2.12.2.3.5. Have in place a written description of the QI Program that delineates the structure, goals, and objectives of the Contractor's QI initiatives. Such description shall:

2.12.2.3.5.1. Address all aspects of health care, including specific reference to behavioral health care and to LTSS, with respect to monitoring and improvement efforts, and integration with physical health care. Behavioral health and LTSS aspects including Care Management, pharmacy and other services of the QI program may be included in the QI description, or in a separate QI Plan referenced in the QI description;

2.12.2.3.5.2. Address the roles of the designated physician(s), behavioral health clinician(s), and LTSS providers including Care Management, pharmacy and other services, with respect to QI program;

2.12.2.3.5.3. Identify the resources dedicated to the QI program, including staff, or data sources, and analytic programs or IT systems; and

2.12.2.3.5.4. Include organization-wide policies and procedures that document processes through which the Contractor ensures clinical quality, access and availability of health care and services, and continuity and coordination of care. Such processes shall include, but not be limited to, Appeals and Grievances and Utilization Management.

2.12.2.3.6. Submit to RI EOHHS and CMS an annual QI Work Plan that shall include the following components or other components as directed by RI EOHHS and CMS:

2.12.2.3.6.1. Planned clinical and non-clinical initiatives;

2.12.2.3.6.2. The objectives for planned clinical and non-clinical initiatives;

2.12.2.3.6.3. The short and long term time frames within which each clinical and non-clinical initiative's objectives are to be achieved;

2.12.2.3.6.4. The individual(s) responsible for each clinical and non-clinical initiative;

2.12.2.3.6.5. Any issues identified by the Contractor, RI EOHHS, Enrollees, and providers, and how those issues are tracked and resolved over time;

2.12.2.3.6.6. Program review process for formal evaluations that address the impact and effectiveness of clinical and non-clinical initiatives at least annually; and

2.12.2.3.6.7. Process for correcting deficiencies.

2.12.2.3.7. Evaluate the results of QI initiatives at least annually, and submit the results of the evaluation to the CMT. The evaluation of the QI program initiatives shall include, but not be limited to, the results of activities that demonstrate the Contractor's assessment of the quality of physical and behavioral health care rendered, the effectiveness of LTSS services, including Care Management, pharmacy and other services and accomplishments and compliance and/or deficiencies in meeting the previous year's annual QI Work Plan; and

2.12.2.3.8. Maintain sufficient and qualified staff employed by the Contractor to manage the QI activities required under the Contract, and establish minimum employment standards and requirements (e.g. education, training, and experience) for employees who will be responsible for QM. QI staff shall include:

2.12.2.3.8.1. At least one designated physician, who shall be a medical director or associate medical director, at least one designated behavioral health clinician, and a professional with expertise in the assessment and delivery of LTSS with substantial involvement in the QI program;

2.12.2.3.8.2. A qualified individual to serve as the Demonstration QI director who will be directly accountable to the Contractor's executive team and, in addition, if the Contractor offers multiple products or services in multiple states, will have access to the Contractor's executive leadership team. This individual shall be responsible for:

2.12.2.3.8.2.1. Overseeing all QI activities related to Enrollees, ensuring compliance with all such activities, and maintaining accountability for the execution of, and performance in, all such activities;

2.12.2.3.8.2.2. Maintaining an active role in the Contractor's overall QI structure; and

2.12.2.3.8.2.3. Ensuring the availability of staff with appropriate expertise in all areas, as necessary for the execution of QI activities including, but not limited to, the following:

2.12.2.3.8.2.3. 1. Physical and behavioral health care;

2.12.2.3.8.2.3. 2. Pharmacy management;

2.12.2.3.8.2.3. 3. Care Management;

2.12.2.3.8.2.3. 4. LTSS;

2.12.2.3.8.2.3. 5. Financial;

2.12.2.3.8.2.3. 6. Statistical/analytical;

2.12.2.3.8.2.3. 7. Information systems;

2.12.2.3.8.2.3. 8. Marketing, publications;

2.12.2.3.8.2.3. 9. Enrollment; and

2.12.2.3.8.2.3. 10. Operations management;

2.12.2.3.9. Actively participate in, or assign staff to actively participate in, QI workgroups and other meetings, including any quality management workgroups or activities that may be facilitated by RI EOHHS, or its designee, that may be attended by representatives of RI EOHHS, the Contractor, and other entities, as appropriate; and

2.12.2.3.10. Serve as liaison to, and maintaining regular communication with Contractor QI representatives. Responsibilities shall include, but are not limited to, promptly responding to requests for information and/or data relevant to all QI activities.

2.12.3. QI Activities

2.12.3.1. The Contractor shall engage in performance measurement and quality improvement projects, designed to achieve, through ongoing measurement and intervention, significant improvements, sustained over time, in clinical care and non-clinical care processes, outcomes and Enrollee experience. This will include the ability to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

2.12.3.2. The Contractor's QI program must include a health information system to collect, analyze, and report quality performance data as described in 42 C.F.R. §§ 438.242(a) and (b), 422.516(a) and 423.514.

2.12.3.3. Performance Measurement

2.12.3.3.1. Contractor shall perform and report the quality and utilization measures identified by CMS and RI EOHHS and in accordance with requirements in the MOU between CMS and the State of Rhode Island on July 28, 2015, Figure 7-1 Core Quality Measures, in the state-specific reporting requirements, and as articulated in Section 4 this Contract and shall include, but are not limited to:

2.12.3.3.1.1. All HEDIS, HOS and CAHPS data, as well as all other measures specified in Figure 7-1 Core Quality Measures of the MOU referenced above (Figure 7-1), the state-specific reporting requirements, and Section 4. HEDIS, HOS and CAHPS must be reported consistent with Medicare requirements. All existing Part D metrics will be collected as well. Additional details, including technical specifications, will be provided in annual guidance for the upcoming reporting year.

2.12.3.3.2. Contractor shall not modify the reporting specifications methodology prescribed by CMS and RI EOHHS without first obtaining CMS and the state's RI EOHHS's written approval. Contractor must obtain an independent validation of its findings by a recognized entity, e.g., NCQA-certified auditor, as approved by CMS and RI EOHHS. CMS and RI EOHHS (or its designee) will perform an independent validation of at least a sample of Contractor's findings.

2.12.3.3.3. Contractor shall monitor other performance measures not specifically stated in this Contract that are required by CMS. RI EOHHS will use its best efforts to notify Contractor of new CMS requirements.

2.12.3.3.4. The Contractor shall collect annual data and contribute to all Demonstration QI-related processes, as directed by RI EOHHS and CMS, as follows:

2.12.3.3.4.1. Collect and submit to RI EOHHS, CMS and/or CMS' Contractors, in a timely manner, data for the measures specified in Section 4, Figure 7-1 of the MOU and the state-specific reporting requirements;

2.12.3.3.4.2. Contribute to all applicable RI EOHHS and CMS data quality assurance processes, which shall include, but not be limited to, responding, in a timely manner, to data quality inadequacies identified by RI EOHHS and rectifying those inadequacies, as directed by RI EOHHS;

2.12.3.3.4.3. Contribute to RI EOHHS and CMS data regarding the individual performance of the Contractor with respect to the noted measures; and

2.12.3.3.4.4. Contribute to RI EOHHS processes culminating in the publication of any additional technical or other reports by RI EOHHS related to the noted measures.

2.12.3.3.5. The Contractor shall demonstrate how to utilize results of the measures specified in Section 4, Figure 7-1 of the MOU and the state-specific reporting requirements in designing QI initiatives.

2.12.3.4. Enrollee Experience Surveys:

2.12.3.4.1. The Contractor shall conduct Enrollee experience survey activities, as directed by RI EOHHS and/or CMS, as follows:

2.12.3.4.1.1. Conduct, as directed by RI EOHHS and CMS, an annual CAHPS survey using an approved CAHPS vendor;

2.12.3.4.1.2. The Contractor shall demonstrate best efforts to utilize Enrollee experience survey results in designing QI initiatives.

2.12.4. QI Project Requirements

2.12.4.1.1. The Contractor shall implement and adhere to all processes relating to the QI project requirements, as directed by RI EOHHS and CMS, as follows:

2.12.4.1.1.1. During the Enrollment year and annually thereafter, Contractor will identify applicable representatives to serve on a quality collaborative with RI EOHHS. This collaborative will determine QI initiatives to begin in Year 1 of the Demonstration and annually thereafter;

2.12.4.1.1.2. In accordance with 42 C.F.R. §438.330 (d) and 42 C.F.R. § 422.152 (d), collect information and data in accordance with QI Project Requirement specifications for its Enrollees; using the format and submission guidelines specified by RI EOHHS and CMS in annual guidance provided for the upcoming contract year;

2.12.4.1.1.3. Implement the QI project requirements, in a culturally competent manner, to achieve objectives as specified by RI EOHHS and CMS;

2.12.4.1.1.4. Evaluate the effectiveness of QI interventions;

2.12.4.1.1.5. Plan and initiate processes to sustain achievements and continue improvements;

2.12.4.1.1.6. Submit to RI EOHHS and CMS, comprehensive written reports, using the format, submission guidelines and frequency specified by RI EOHHS and CMS. Such reports shall include information regarding progress on QI Project Requirements, barriers encountered and new knowledge gained. As directed by RI EOHHS and CMS, the Contractor shall present this information to RI EOHHS and CMS at the end of the QI requirement project cycle as determined by RI EOHHS and CMS; and

2.12.4.1.1.7. In accordance with 42 C.F.R. §422.152 (c), develop a chronic care improvement program (CCIP) and establish criteria for participation in the program. The CCIP must be relevant to and target the Contractor's population. Although the Contractor has the flexibility to choose the design of their CCIPs, RI EOHHS and CMS may require them to address specific topic areas.

2.12.4.2. CMS-Specified Performance Measurement and Performance Improvement Projects

2.12.4.2.1. The Contractor shall conduct additional performance measurement or performance improvement projects if mandated by CMS pursuant to 42 C.F.R. § 438.330(a)(2).

2.12.5. External Quality Review (EQR) Activities

2.12.5.1. The Contractor shall take all steps necessary to support the EQRO contracted by RI EOHHS and the QIO to conduct EQR activities, in accordance with 42 C.F.R. § 438.358 and 42 C.F.R. § 422.153. EQR activities shall include, but are not limited to:

2.12.5.1.1. Annual validation of performance measures reported to RI EOHHS, as directed by RI EOHHS, or calculated by RI EOHHS;

2.12.5.1.2. Annual validation of QI projects required by RI EOHHS and CMS; and

2.12.5.1.3. At least once every three (3) years, review of compliance with standards mandated by 42 C.F.R. Part 438, Subpart E, and at the direction of RI EOHHS, regarding access, structure and operations, and quality of care and services furnished to Enrollees. The Contractor shall take all steps necessary to support the EQRO and QIO in conducting EQR activities including, but not limited to:

2.12.5.1.3.1. Designating a qualified individual to serve as project director for each EQR activity who shall, at a minimum:

2.12.5.1.3.1.1. Oversee and be accountable for compliance with all aspects of the EQR activity;

2.12.5.1.3.1.2. Coordinate with staff responsible for aspects of the EQRO activity and ensure that staff respond to requests by the EQRO, QIO, RI EOHHS, and/or CMS staff in a timely manner;

2.12.5.1.3.1.3. Serve as the liaison to the EQRO, QIO, RI EOHHS and CMS and answer questions or coordinate responses to questions from the EQRO, QIO, CMS and RI EOHHS in a timely manner; and

2.12.5.1.3.1.4. Ensure timely access to information systems, data, and other resources, as necessary for the EQRO and/or QIO to perform the EQR activity and as requested by the EQRO, QIO, CMS or RI EOHHS.

2.12.5.1.4. Participating in Contractor-specific and cross-Contractor meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and RI EOHHS;

2.12.5.1.5. Implementing actions, as directed by RI EOHHS and/or CMS, to address recommendations for QI made by the EQRO or QIO, and sharing outcomes and results of such activities with the EQRO or QIO, RI EOHHS, and CMS in subsequent years; and

2.12.5.1.6. Participating in any other activities deemed necessary by the EQRO and/or QIO and approved by RI EOHHS and CMS.

2.12.6. QI for Utilization Management Activities

2.12.6.1. The Contractor shall utilize QI to ensure that it maintains a well-structured Utilization Management program that supports the application of fair, impartial and consistent Utilization Management determinations.

2.12.6.2. The QI activities for the Utilization Management program shall include:

2.12.6.2.1. Assurance that such Utilization Management mechanisms do not provide incentives for those responsible for conducting Utilization Management activities to deny, limit, or discontinue Medically Necessary Services;

2.12.6.2.2. At least one (1) designated senior physician, who may be a medical director, associate medical director, or other practitioner assigned to this task, at least one (1) designated behavioral health practitioner, who may be a medical director, associate medical director, or other practitioner assigned to this task, and a professional with expertise in the assessment and delivery of LTSS representative of the Contractor or First Tier, Downstream, or Related Entity, with substantial involvement in the Utilization Management program; and

2.12.6.2.3. A written document that delineates the structure, goals, and objectives of the Utilization Management program and that describes how the Contractor utilizes QI processes to support its Utilization Management program. Such document may be included in the QI description, or in a separate document, and shall address how the Utilization Management program fits within the QI structure, including how the Contractor collects Utilization Management information and uses it for QI activities.

2.12.7. Clinical Practice Guidelines

2.12.7.1. The Contractor shall adopt, disseminate, and monitor the use of clinical practice guidelines relevant to Enrollees that:

2.12.7.1.1.1. Are based on valid and reliable clinical evidence or a consensus of Health Care Professionals or professionals with expertise in the assessment and delivery of LTSS in the relevant field, community-based support services or the Contractor's approved behavioral health performance specifications and clinical criteria;

2.12.7.1.1.2. Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines, or are developed with involvement of board-certified providers from appropriate specialties or professionals with expertise in the assessment and delivery of LTSS;

2.12.7.1.1.3. Do not contradict existing Rhode Island-promulgated regulations or requirements as published by the RI EOHHS or other State agencies;

2.12.7.1.1.4. Prior to adoption, have been reviewed by the Contractor's medical director, as well as other Contractor practitioners and network providers, as appropriate; and

2.12.7.1.1.5. Are reviewed and updated, as appropriate, or at least every two (2) years.

2.12.7.2. Guidelines shall be reviewed and revised, as appropriate based on changes in national guidelines, or changes in valid and reliable clinical evidence, or consensus of health care and LTSS professionals and providers;

2.12.7.3. For guidelines that have been in effect two (2) years or longer, the Contractor must document that the guidelines were reviewed with appropriate practitioner involvement, and were updated accordingly;

2.12.7.4. Disseminate, in a timely manner, the clinical guidelines to all new network providers, to all affected providers, upon adoption and revision, and, upon request, to Enrollees and Eligible Beneficiaries. The Contractor shall make the clinical and practice guidelines available via the Contractor's web site. The Contractor shall notify Health Care Professionals of the availability and location of the guidelines, and shall notify Health Care Professionals whenever changes are made;

2.12.7.5. Establish explicit processes for monitoring the consistent application of clinical and practice guidelines across Utilization Management decisions, Enrollee education, and coverage of services; and

2.12.7.6. Submit to RI EOHHS a listing and description of clinical guidelines adopted, endorsed, disseminated, and utilized by the Contractor, upon request.

2.12.8. QI Workgroups

2.12.8.1. As directed by RI EOHHS, the Contractor shall actively participate in QI workgroups that are led by RI EOHHS, including any QM workgroups or activities, attended by representatives of RI EOHHS, RI EOHHS-Contractors, and other entities, as appropriate, and that are designed to support QI activities and to provide a forum for discussing relevant issues. Participation may involve contributing to QI initiatives identified and/or developed collaboratively by the workgroup.

2.12.8.2. RI EOHHS Directed Performance Incentive Program

2.12.8.2.1. RI EOHHS and CMS will require that the Contractor meet specific performance requirements in order to receive payment of withheld amounts over the course of the Contract. These withhold measures are detailed in Section 4.4.7.

2.12.8.2.2. In order to receive any withhold payments, the Contractor shall comply with all RI EOHHS and CMS withhold measure requirements while maintaining satisfactory performance on all other Contract requirements.

2.12.8.3. Enrollee Incentives

2.12.8.3.1. The Contractor may implement Enrollee incentives, as appropriate and subject to RI EOHHS approval, to promote engagement in specific behaviors (e.g., guideline-recommended clinical screenings and PCP visits, Wellness Initiatives). The Contractor shall:

2.12.8.3.1.1. Take measures to monitor the effectiveness of such Enrollee incentives, and to revise incentives as appropriate, with consideration of Enrollee feedback;

2.12.8.3.1.2. Submit to RI EOHHS, at the direction of RI EOHHS, ad hoc report information relating to planned and implemented Enrollee incentives and assure that all such Enrollee incentives comply with all applicable Medicare-Medicaid marketing guidance, as well as State and federal laws.

2.12.8.4. Behavioral Health Services Outcomes

2.12.8.4.1. The Contractor shall require behavioral health providers to measure and collect clinical outcomes data, to incorporate that data in treatment data available to the Contractor, upon request;

2.12.8.4.2. The Contractor's behavioral health provider contracts shall require the provider to make available behavioral health clinical assessment and outcomes data for QM and network management purposes;

2.12.8.4.3. The Contractor shall use outcome measures based on behavioral health care best practices. As directed by RI EOHHS, the Contractor shall collaborate with behavioral health providers to develop outcome measures that are specific to each behavioral health service type. Such outcome measures may include:

2.12.8.4.3.1. Recidivism;

2.12.8.4.3.2. Adverse occurrences;

2.12.8.4.3.3. Treatment drop-out;

2.12.8.4.3.4. Length of time between admissions; and

2.12.8.4.3.5. Treatment goals achieved.

2.12.8.5. External Audit/Accreditation Results

2.12.8.5.1. The Contractor shall submit to RI EOHHS, at RI EOHHS' direction, a summary of its accreditation status and the results, if any, in addition to the results of other quality-related external audits, if any.

2.12.8.5.1.1. The Contractor shall require that their external auditor, in the Annual Report of Independent Auditors, specifically address their review and testing of the Contractor's risk share/gain share financial reports and the Contractor's receivable and/or payable to/from RI EOHHS as of December 31 of each year.

2.12.8.6. Health Information System

2.12.8.6.1. The Contractor shall maintain a health information system or systems consistent with the requirements established in the Contract and that supports all aspects of the QI Program.

2.12.9. Evaluation Activities

2.12.9.1. RI EOHHS, CMS and its designated agent(s) will conduct periodic evaluations of the Demonstration over time from multiple perspectives using both quantitative and qualitative methods.

2.12.9.2. The evaluations will be used for program improvement purposes and to assess the Demonstration's overall impact on various outcomes including (but not limited to) Enrollment/disenrollment patterns, Enrollee access and quality of care experiences, utilization and costs by service type (e.g., inpatient, outpatient, home health, prescription drugs, nursing facility, and home and community-based LTSS), and program staff and provider experiences.

2.12.9.3. As such, the evaluations will include surveys, site visits, analysis of Claims and encounter data, focus groups, key informant interviews, and document reviews. The Contractor shall participate in evaluation activities as directed by CMS and/or RI EOHHS and provide information or data upon request.

2.13. Marketing, Outreach, and Enrollee Communications Standards

2.13.1. Requirements, General

2.13.1.1. The Contractor is subject to rules governing marketing and Enrollee communications as specified under Section 1851(h) of the Social Security Act; 42 CFR §422.111, §422.2260 et. seq., §423.120(b) and (c), §423.128, §423.2260, and § 438.10 et. seq.; and the Medicare Marketing Guidelines, with the following exceptions or modifications:

2.13.1.1.1. The Contractor must refer to RI EOHHS' authorized agent any Eligible Beneficiaries who inquire about Demonstration eligibility or Enrollment, although the Contractor may provide Enrollees and Eligible Beneficiaries with information about the Contractor's plan and its benefits prior to referring a request regarding eligibility or Enrollment to the RI EOHHS authorized agent;

2.13.1.1.2. The Contractor must make available to CMS and RI EOHHS, upon request, current schedules of all educational events conducted by the Contractor to provide information to Enrollees or Eligible Beneficiaries;

2.13.1.1.3. The Contractor must convene all educational and marketing/sales events at sites within the Contractor's Service Area that are physically accessible to all Enrollees or Eligible Beneficiaries, including persons with disabilities and persons using public transportation.

2.13.1.1.4. The Contractor may not offer financial or other incentives, including private insurance, to induce Enrollees or Eligible Beneficiaries to enroll with the Contractor or to refer a friend, neighbor, or other person to enroll with the Contractor;

2.13.1.1.5. The Contractor may not directly or indirectly conduct door-to-door, telephone, or other unsolicited contacts consistent with the Medicare Marketing Guidelines and the Rhode Island Marketing Guidance for the ICI Demonstration;

2.13.1.1.6. The Contractor may conduct outbound telephone calls with Enrollees and with Eligible Beneficiaries enrolled in other products offered by the Contractor;

2.13.1.1.7. An individual appointment must only be set up at the request of the Enrollee or his/her authorized representative. A Contractor can offer an individual appointment to an Enrollee that has contacted the Contractor to request assistance or information. However, the Contractor is prohibited from making unsolicited offers of individual appointments; and

2.13.1.1.8. The Contractor must make reasonable efforts to conduct an appointment in the Enrollee's preferred location. The Contractor cannot require that an individual appointment occur in an Enrollee's home.

2.13.1.1.9. The Contractor may not use any Marketing, Outreach, or Enrollee Communications materials that contain any assertion or statement (whether written or oral) that:

2.13.1.1.9.1. The Enrollee or Eligible Beneficiary must enroll with the Contractor in order to obtain benefits or in order not to lose benefits; and

2.13.1.1.9.2. The Contractor is endorsed by CMS, Medicare, Medicaid, the Federal government, and RI EOHHS.

2.13.1.1.10. Annually, the Contractor shall present its marketing plan to RI EOHHS for review and approval. If there are substantial/material changes, the Contractor shall submit its revised marketing plan to RI EOHHS for review and approval.

2.13.2. Requirements for Materials

2.13.2.1. The Contractor's Marketing, Outreach, and Enrollee Communications materials must be:

2.13.2.1.1. Made available in Alternative Formats, upon request and as needed to assure effective communication for blind and vision-impaired Enrollees, as described in 42 C.F.R. § 438.10(d)(1)(ii);

2.13.2.1.2. Provided in a manner, format and language that may be easily understood by persons with limited English proficiency, low literacy, or for those with intellectual and developmental disabilities or cognitive impairments;

2.13.2.1.2.1. No marketing, outreach, or enrollee communications material shall be used unless it achieves a Flesch Score of forty (40) or better (at or below a 6th grade reading level). The material must set forth the Flesch Score and certify compliance with this standard. These requirements shall not apply to language that is mandated by Federal or State laws, regulations or agencies.

2.13.2.1.3. Translated into Prevalent Languages for all vital materials, as specified in the Medicare-Medicaid marketing guidance and annual guidance to Contractors on specific translation requirements for their Service Areas;

2.13.2.1.4. As applicable, mailed with non-English language taglines that alert Enrollees with limited English proficiency to the availability of language assistance services, free of charge, and how those services can be obtained, consistent with the requirements of 45 CFR Part 92.

2.13.2.1.5. As applicable, mailed with a non-discrimination notice or statement, consistent with the requirements of 45 CFR Part 92.

2.13.2.1.6. Distributed to the Contractor's entire Service Area as specified in Appendix H of this Contract.

2.13.3. Requirements for the Submission, Review, and Approval of Materials

2.13.3.1. The Contractor must receive prior approval of all marketing and Enrollee Communications materials in categories of materials that CMS and RI EOHHS require to be prospectively reviewed. Contractor materials may be designated as eligible for the File & Use process, as described in 42 C.F.R. §422.2262(b) and §423.2262(b), and will therefore be exempt from prospective review and approval by both CMS and RI EOHHS. CMS and RI EOHHS may agree to defer to one or the other Party for review of certain types of marketing and Enrollee Communications, as agreed in advance by both parties. The Contractor must submit all materials that are consistent with the definition of marketing materials at 42 C.F.R. § 422.2260, whether prospectively reviewed or not, via the CMS HPMS Marketing Module.

2.13.3.2. CMS and RI EOHHS may conduct additional types of review of Contractor Marketing, Outreach, and Enrollee Communications activities, including, but not limited to:

2.13.3.2.1. Review of on-site marketing facilities, products, and activities during regularly scheduled Contract compliance monitoring visits.

2.13.3.2.2. Random review of actual Marketing, Outreach, and Enrollee Communications pieces as they are used in the marketplace.

2.13.3.2.3. For "cause" review of materials and activities when Complaints are made by any source, and CMS or RI EOHHS determine it is appropriate to investigate.

2.13.3.2.4. "Secret shopper" activities where CMS or RI EOHHS request Contractor materials, such as Enrollment packets.

2.13.3.3. Beginning of Marketing, Outreach and Enrollee Communications Activity

2.13.3.3.1. The Contractor may not begin Marketing, Outreach, and Enrollee Communications activities to new Enrollees more than ninety (90) Days prior to the effective date of Enrollment for the Contract year.

2.13.3.3.2. In addition, for the first year of the Demonstration, the Contractor may not begin marketing activity until the Contractor has entered into this contract, passed the joint CMS-RI EOHHS Contractor Readiness Review, and is connected to CMS Enrollment and payment systems such that the Contractor is able to receive payment and Enrollments.

2.13.4. Requirements for Dissemination of Materials

2.13.4.1. Consistent with the timelines specified in the Medicare Marketing Guidelines and the Medicare-Medicaid marketing guidance, the Contractor must provide Enrollees with the following materials which, with the exception of the material specified in Section 2.13.4.1.4 below, must also be provided annually thereafter:

2.13.4.1.1. An Evidence of Coverage (EOC)/Member Handbook document that is consistent with the requirements at 42 C.F.R. §§438.10, 422.111, and 423.128; includes information about all Covered Services, as outlined below, and that uses the model document developed by CMS and RI EOHHS.

2.13.4.1.1.1. Enrollee rights (see Appendix B);

2.13.4.1.1.2. An explanation of the Enrollee Medical Record and the process by which clinical information, including diagnostic and medication information, will be available to key caregivers;

2.13.4.1.1.3. How to obtain a copy of the Enrollee's Medical Record;

2.13.4.1.1.4. How to obtain access to specialty, behavioral health, pharmacy and long-term services and supports providers;

2.13.4.1.1.5. How to obtain services and prescription drugs for Emergency Conditions and Urgent Care in and out of the Provider Network and in and out of the Service Area; including:

2.13.4.1.1.6. What constitutes Emergency Medical Condition, Emergency Services, and Post-stabilization Services, with reference to the definitions is 42 C.F.R. §438.114(a);

2.13.4.1.1.7. The fact that prior authorization is not required for Emergency Services;

2.13.4.1.1.8. The process and procedures for obtaining Emergency Services, including the use of the 911 telephone system or its local equivalent;

2.13.4.1.1.9. The locations of any emergency settings and other locations at which providers and hospitals furnish Emergency Services and Post-Stabilization Services covered under the Contract;

2.13.4.1.1.10. That the Enrollee has a right to use any hospital or other setting for emergency care; and

2.13.4.1.1.11. That the Post-stabilization Care Services rules at C.F.R. §422.113(c) apply.

2.13.4.1.1.12. Information about Advance Directives (at a minimum those required in 42 C.F.R. §§ 489.102 and 422.128), including

2.13.4.1.1.12.1. Enrollee rights under the law of the State of Rhode Island;

2.13.4.1.1.12.2. The Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience;

2.13.4.1.1.12.3. That Complaints concerning noncompliance with the advance directive requirements may be filed with RI EOHHS;

2.13.4.1.1.12.4. Designating a health care proxy, and other mechanisms for ensuring that future medical decisions are made according to the desire of the Enrollee; and

2.13.4.1.1.12.5. The Contractor must update materials to reflect any changes in state law as soon as possible, but no later than ninety (90) Days after the effective date of change.

2.13.4.1.1.13. How to obtain assistance from ESRs;

2.13.4.1.1.14. How to file Grievances and Internal and External Appeals, including:

2.13.4.1.1.14.1. Grievance, Appeal and State Fair Hearing procedures and timeframes;

2.13.4.1.1.14.2. Toll free numbers that the Enrollee can use to file a Grievance or an Appeal by phone, the process for filing an Appeal or Grievance in writing and information on the State's Fair Hearing process.

2.13.4.1.1.15. That when requested by the Enrollee, benefits will continue at the plan level for all benefits, and if the Enrollee files an Appeal or a request for State Fair Hearing within the timeframes specified for filing, the Enrollee may be required to pay to RI EOHHS the cost of services furnished while the Appeal is pending, if the final decision is adverse to the Enrollee; and

2.13.4.1.1.16. How the Enrollee can identify who the Enrollee wants to receive written notices of denials, terminations, and reductions;

2.13.4.1.1.17. How to obtain assistance with the Appeals processes through the ESR and other assistance mechanisms as RI EOHHS or CMS may identify, including the Enrollee Ombudsman;

2.13.4.1.1.18. The extent to which, and how Enrollees may obtain benefits, including Family planning services, from out-of-network providers;

2.13.4.1.1.19. How and where to access any benefits that are available under the Rhode Island Medicaid State plan or applicable waivers but are not covered under the Contract;

2.13.4.1.1.20. How to change providers; and

2.13.4.1.1.21. How to disenroll voluntarily.

2.13.4.1.1.22. How to obtain information regarding Physician Incentive Plans; and

2.13.4.1.1.23. How to obtain information on the Contractor's structure and operations.

2.13.4.1.2. A Summary of Benefits (SB) that contains a concise description of the important aspects of enrolling in the Contractor's plan, as well as the benefits offered under the Contractor's plan, including any Cost Sharing, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits, and is consistent with the model document developed by CMS and RI EOHHS. The SB should provide sufficient detail to ensure that Enrollees understand the benefits to which they are entitled. For new Enrollees, the SB is required only for individuals enrolled through Passive Enrollment. For current Enrollees, the SB must be sent with the Annual Notice of Change (ANOC) as described in the Medicare-Medicaid marketing guidance.

2.13.4.1.3. A combined provider and pharmacy directory that is consistent with the requirements in Section 2.13.7, or a distinct and separate notice on how to access this information online and how to request a hard copy, as specified in Section 2.13.7, Chapter 4 of the Medicare Managed Care Manual, and the Medicare-Medicaid marketing guidance.

2.13.4.1.4. A single identification (ID) card, compliant with the requirements at 42 C.F.R. §§ 423.120(c) and 422.111(i), for accessing all Covered Services under the Contractor that uses the model document developed by CMS and RI EOHHS;

2.13.4.1.5. A comprehensive, integrated formulary that includes prescription drugs and over-the-counter products required to be covered by Medicare Part D and RI EOHHS' outpatient prescription drug benefit and that uses the model document developed by CMS and RI EOHHS.

2.13.4.1.6. The procedures for an Enrollee to Opt-Out of the Demonstration.

2.13.4.2. The Contractor must provide the following materials to current Enrollees on an ongoing basis:

2.13.4.2.1. An Annual Notice of Change (ANOC) that summarizes all major changes to the Contractor's covered benefits from one Contract year to the next, and that uses the model document developed by CMS and the RI EOHHS.

2.13.4.2.2. A single ID card for accessing all Covered Services under the Contractor;

2.13.4.3. The Contractor must provide all Medicare Part D required notices, with the exception of the late enrollment penalty notices and the creditable coverage notices required under Chapter 4 of the Prescription Drug Benefit Manual, and the late LIS Rider required under Chapter 13 of the Prescription Drug Benefit Manual.

2.13.4.4. Consistent with the requirement at 42 C.F.R. §423.120(b)(5), the Contractor must provide Enrollees with at least sixty (60) Days

advance notice regarding changes to the comprehensive, integrated formulary.

2.13.4.5. The Contractor must ensure that all information provided to Enrollees and Eligible Beneficiaries (and Families when appropriate) is provided in a manner and format that is easily understood and that is:

2.13.4.5.1. Made available in large print (at least 16 point font) to Enrollees as an Alternative Format, upon request;

2.13.4.5.2. For vital materials, made available in Prevalent Languages.

2.13.4.5.3. Written with cultural sensitivity and at or below a sixth (6th) grade reading level; and

2.13.4.5.4. Available in Alternative Formats, according to the needs of Enrollees and Eligible Beneficiaries, including Braille, oral interpretation services in non-English languages, as specified in Section 2.8.9.2 of this Contract; audio-recordings; ASL video clips; and other alternative media, as requested.

2.13.5. Materials in the Welcome Packet

2.13.5.1. For Passive Enrollments, the Contractor shall send the following materials for Enrollee receipt at least thirty (30) Days prior to the Enrollee's effective date of coverage:

2.13.5.1.1. Contractor-specific Summary of Benefits.

2.13.5.1.2. A comprehensive integrated formulary that includes prescription drugs and over-the-counter products required to be covered by Medicare Part D and RI EOHHS' outpatient prescription drug benefit and that uses the model document developed by CMS and RI EOHHS.

2.13.5.1.3. A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and Flexible Benefits, or a distinct and separate notice on how to access the information online and how to request a hard copy, as specified in section 2.13.7, Chapter 4 of the Medicare Managed Care Manual, and the Medicare-Medicaid marketing guidance.

2.13.5.1.4. Proof of health insurance coverage so that the Enrollee may begin using Contractor services as of the effective date. This proof must include the 4Rx prescription drug data necessary to access benefits. This proof of coverage is not the same as the Evidence of Coverage document described in the State-specific Demonstration marketing guidelines. The proof of coverage may be in the form of an Enrollee ID card, the Enrollment form, and/or a notice to the Enrollee. As of the effective date of Enrollment, the Contractor's systems should indicate active membership.

2.13.5.2. For Passive Enrollment, the Contractor must send the following for Enrollee receipt no later than the last calendar day of the month prior to the effective date of coverage:

2.13.5.2.1. An Enrollee ID card, compliant with the requirements at 42 CFR 423.120(c) and 422.111(i), for accessing all Covered Services under the Contractor, which includes the following:

2.13.5.2.1.1. Contractor Name

2.13.5.2.1.2. Twenty-four (24) hour Contractor telephone number for use in urgent or emergent medical situations

2.13.5.2.1.3. Telephone number for Enrollee Services (if different)

2.13.5.2.1.4. PCP name and telephone number.

2.13.5.2.2. A Member Handbook (Evidence of Coverage) to ensure that the individual has sufficient information about Contractor benefits to make an informed decision prior to the Enrollment effective date.

2.13.5.3. For the individuals who opt in to the Demonstration, the Contractor shall provide the following materials for Enrollee receipt no later than eight (8) calendar Days from receipt of RI EOHHS confirmation of Enrollment or by the last calendar day of the month prior to the effective date, whichever occurs later:

2.13.5.3.1. A Contractor-specific Member Handbook (Evidence of Coverage)

2.13.5.3.2. A comprehensive, integrated formulary that includes prescription drugs and over-the-counter products required to be covered by Medicare Part D and RI EOHHS' outpatient prescription drug benefit and that uses the model document developed by CMS and RI EOHHS.

2.13.5.3.3. A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and Flexible Benefits, or a distinct and separate notice on how to access the information online and how to request a hard copy, as specified in section 2.13.7, Chapter 4 of the Medicare Managed Care Manual, and the Medicare-Medicaid marketing guidance.

2.13.5.3.4. An Enrollee ID card, compliant with the requirements at 42 C.F.R. § 423.120(c) and § 422.111(i), for accessing all Covered Services under the Contractor, which includes the following:

2.13.5.3.4.1. Contractor Name

2.13.5.3.4.2. Twenty-four (24) hour Contractor telephone number for use in urgent or emergent medical situations

2.13.5.3.4.3. Telephone number for Enrollee Services (if different)

2.13.5.3.4.4. PCP name and telephone number.

2.13.5.3.5. For Enrollment requests received late in the month, see §30.4.2 of the Enrollment Guidance (After the Effective Date of Coverage) for more information.

2.13.5.4. For all Enrollments, regardless of how the Enrollment request is made, the Contractor must explain:

2.13.5.4.1. The charges for which the prospective Enrollee will be liable (e.g., coinsurance for Medicaid benefits in Contractor, if applicable; LIS copayments for Part D covered drugs), if this information is available at the time the acknowledgement notice is issued (confirmation notices and combination acknowledgement/confirmation notices must contain this information).

2.13.5.4.2. The prospective Enrollee's authorization for the disclosure and exchange of necessary information between the Contractor, RI EOHHS, and CMS.

2.13.5.4.3. The requirements for use of the Contractor's network providers.

2.13.5.4.4. The effective date of coverage and how to obtain services prior to the receipt of an ID card (if the Contractor has not yet provided the ID card).

2.13.5.5. CMS and RI EOHHS will jointly approve all Demonstration Enrollment notices to ensure complete and accurate information is provided in concert with other Medicare communications, such as the Medicare & You handbook. CMS may also send a jointly-approved notice to individuals, and will coordinate such notice with any RI EOHHS notice(s).

2.13.6. Initial Enrollee Contact and Orientation

2.13.6.1. The Contractor shall provide an orientation to Enrollee within thirty (30) calendar Days of the initial date of Enrollment. The orientation shall include:

2.13.6.1.1. Materials and a welcome call;

2.13.6.1.1.1. The welcome call requirement is waived for Enrollees residing in nursing facilities, I/DD group homes or mental health group homes. In lieu of the individual Enrollee welcome call, the Contractor shall make at least two (2) attempts, on different Days, to make a welcome call to designated staff at each I/DD or mental health group home where the Enrollee resides. The Contractor shall also conduct a site visit or an orientation visit to the I/DD or mental health group home within sixty (60) Days of the Enrollee's Enrollment effective date.

2.13.6.1.1.2. For new Enrollees who are residents of nursing facilities greater than ninety (90) Days, the Contractor shall make at least two (2) attempts, on different Days, to make a welcome call to designated staff at each nursing facility. The Contractor shall conduct a new Enrollee orientation, either by phone or in-person, with Enrollees who are identified as having a discharge opportunity.

2.13.6.1.2. For Enrollees without a current PCP identified at the time of Enrollment, assisting the Enrollee to identify and if desired retain their current PCP or choose a PCP;

2.13.6.1.3. Working with the Enrollee to schedule an IHS or CFNA (see Section 2.6); and

2.13.6.1.4. Any pre-Enrollment materials specified in Section 2.13 that, due to a late month Enrollment request, were not provided prior to the time of Enrollment.

2.13.6.2. The Contractor shall assist the Enrollee in choosing an in-network PCP when the Enrollee's current PCP is not in network and refuses to become a network provider or enter into a single-case out-of-network agreement where applicable.

2.13.6.2.1. The Enrollee must choose a new PCP by the end of the six (6) month continuity of care period or after the ICP is developed (if applicable). If the Enrollee has not chosen an in-network PCP by that time, the Contractor shall choose one for the Enrollee. Long-stay nursing facility residents will be exempt from this requirement.

2.13.6.3. The Contractor shall make available to Enrollees, Family, caregivers, and designated representatives, as appropriate, any Enrollment and orientation materials upon request and with consent of the Enrollee;

2.13.6.4. The Contractor shall provide non-written orientation in a format such as telephone calls, home visits, video screenings, or group presentations to Enrollees for whom written materials are not appropriate,

2.13.6.5. The Contractor shall notify its Enrollees:

2.13.6.5.1. That translations of written information are available in Prevalent Languages or Alternative Formats;

2.13.6.5.2. That interpretation services are available free of charge for any Enrollees and Eligible Beneficiaries who speak a language other than English and for Enrollees and Eligible Beneficiaries who are hearing impaired;

2.13.6.5.3. How Enrollees can access interpretation services;

2.13.6.5.4. How Enrollees can access non-written materials described in Section 2.13.2.1 above; and

2.13.6.5.5. How Enrollees can make a standing request to receive all future notifications and communication in a specified Alternative Format.

2.13.6.6. The Contractor shall ensure that all orientation materials are provided in a manner and format that may be easily understood, including

providing written materials in Prevalent Languages and oral interpretation services when requested.

2.13.7. Requirements for the Provider and Pharmacy Network Directory

2.13.7.1. Maintenance and Distribution: The Contractor must:

2.13.7.1.1. Maintain a combined provider and pharmacy network directory that uses the model document developed by CMS and RI EOHHS;

2.13.7.1.2. Provide either a copy or a distinct and separate notice about how to access the information online and how to request a hard copy as specified in Chapter 4 of the Medicare Managed Care Manual and the Medicare-Medicaid marketing guidance, to all new Enrollees at the time of Enrollment and annually thereafter;

2.13.7.1.3. When there is a significant change to the network, the Contractor must provide notice, as specified in Chapter 4 of the Medicare Managed Care Manual and Medicare-Medicaid marketing guidance;

2.13.7.1.4. Ensure an up-to-date copy is available on the Contractor's website, consistent with the requirements at 42 C.F.R. §§ 422.111(h) and 423.128(d);

2.13.7.1.5. Consistent with 42 C.F.R. § 422.111(e), make a good faith effort to provide written notice of termination of a contracted provider or pharmacy at least thirty (30) calendar Days before the termination effective date to all Enrollees who regularly use the provider or pharmacy's services; if a contract termination involves a PCP, all Enrollees who are patients of that PCP must be notified; and

2.13.7.1.6. Include written and oral offers of such provider and pharmacy directory in its outreach and orientation sessions for new Enrollees.

2.13.7.2. Content of Provider and Pharmacy Directory

2.13.7.2.1. The provider and pharmacy directory must include, at a minimum, the following information for all providers in the Contractor's Provider Network:

2.13.7.2.1.1. The names, addresses, and telephone numbers of all current network providers, and the total number of each type of provider, consistent with 42 C.F.R. § 422.111(h).

2.13.7.2.1.2. As applicable, network providers with areas of training in and experience treating:

2.13.7.2.1.2.1. Persons with physical disabilities, chronic illness, HIV/AIDS, and/or persons with serious mental illness;

2.13.7.2.1.2.2. Individuals who are homeless;

2.13.7.2.1.2.3. Individuals who are Deaf or hard-of-hearing and blind or visually impaired;

2.13.7.2.1.2.4. Persons with co-occurring disorders; and

2.13.7.2.1.2.5. Other specialties.

2.13.7.2.1.3. For network providers that are health care professionals or non-facility based and, as applicable, for facilities and facility-based network providers, office hours, including the names of any network provider sites open after 5:00 p.m. (Eastern Time) weekdays and on weekends;

2.13.7.2.1.4. As applicable, whether the health care professional or non-facility based network provider has completed cultural competence training;

2.13.7.2.1.5. For network providers that are health care professionals or non-facility based and, as applicable, for facilities and facility-based network providers, licensing information, such as license number or National Provider Identifier;

2.13.7.2.1.6. Whether the network provider has specific accommodations for people with physical disabilities, such as wide entry, wheelchair access, accessible exam rooms and tables, lifts, scales, bathrooms and stalls, grab bars, or other accessible equipment;

2.13.7.2.1.7. Whether the provider is accepting new patients as of the date of publication of the directory;

2.13.7.2.1.8. Whether the network provider is on a public transportation route;

2.13.7.2.1.9. Any languages other than English, including ASL, spoken by network providers or offered by skilled medical interpreters at the provider's site;

2.13.7.2.1.10. For behavioral health providers, training in and experience treating trauma, child welfare, and substance use;

2.13.7.2.1.11. A description of the roles of the ICT and the process by which Enrollees select and change PCPs.

2.13.7.2.2. The directory must include, at a minimum, the following information for all pharmacies in the Contractor's pharmacy network:

2.13.7.2.2.1. The names, addresses, and telephone numbers of all current network providers and pharmacies; and

2.13.7.2.2.2. Instructions for the Enrollee to contact the Contractor's toll-free Enrollee Services telephone line (as described in Section 2.9) for assistance in finding a convenient pharmacy.

2.14. Financial Requirements

2.14.1. Financial Viability

2.14.1.1. Consistent with Section 1903 (m) of the Social Security Act, and regulations found at 42 C.F.R. §§ 422.402 and 438.116, the Contractor shall meet all State and federal financial soundness requirements. These include:

2.14.1.1.1. The Contractor must provide assurances that its provision against the risk of insolvency is adequate to ensure that its Enrollees will not be liable for the Contractor's debts, if the Contractor becomes insolvent.

2.14.1.1.2. The Contractor must produce adequate documentation satisfying RI EOHHS that it has met its Solvency requirements.

2.14.1.1.3. The Contractor must also maintain reserves to remain solvent for a forty-five (45) Day period, and provide satisfactory evidence to RI EOHHS of such reserves.

2.14.2. Compliance with Rhode Island Department of Business Regulation (DBR) Standards

2.14.2.1. The Rhode Island DBR regulates the financial stability of all licensed Health Plans in the State. The Contractor, therefore, agrees to comply with all Rhode Island DBR standards, including but not limited to:

2.14.2.1.1. The Contractor must submit quarterly and annual National Association of Insurance Commissioners (NAIC) reports that are prepared for submission to the NAIC and the DBR. These reports are required to be submitted to RI EOHHS at the same time that they are reported to the DBR.

2.14.2.1.2. The Contractor is required to submit to RI EOHHS audited and certified annual financial statement with full opinions and notes. The statement must include any management letter from the independent public accountant prepared with respect to the audit performed and certification of the financial statement. The financial statement and any management letter must cover the entity that is contracting with CMS and RI EOHHS or encompass the entity in the parent corporation's statement which must be submitted in full. The audited and certified financial statement is due by the first day of May.

2.14.2.1.3. To monitor financial performance and Solvency, the Contractor must also submit monthly financial statements and any subsidiary statements that better supports monthly financial activity. All monthly financial statements are due within thirty (30) Days after the financial close of the month.

2.14.2.1.4. The Contractor is also required to submit monthly reports for risk corridor reporting per the terms and conditions of this Contract. The risk corridor reports are due within forty-five (45) Days after the close of the month.

2.14.2.1.5. Additional reports may be required at any time as a result of special circumstances or events, special studies, review and analysis of reports, audits conducted by regulatory agencies, and any significant changes in financial position or performance.

2.14.3. Financial Benchmarks

2.14.3.1. As part of its oversight activities, the State has established financial viability criteria, or benchmarks, to be used in measuring and tracking the fiscal status of Health Plans. The areas in which financial benchmarks have been established include the following:

2.14.3.1.1. Current ratio;

2.14.3.1.2. Plan equity per Enrollee;

2.14.3.1.3. Administrative expenses as a percent of capitation;

2.14.3.1.4. Net medical costs as a percent of capitation; and

2.14.3.1.5. IBNR and RBUC levels, including Days Claims outstanding

2.14.3.2. The Contractor agrees to provide RI EOHHS with any information that in necessary for calculating financial benchmark levels in a manner prescribed by the State. The Contractor also agrees to comply with corrective actions ordered by the State to address any identified deficiencies with respect to financial benchmarks.

2.14.4. Other Financial Requirements

2.14.4.1. The Contractor must cover continuation of services to Enrollees for duration of period for which payment has been made to the Contractor, as well as for inpatient admissions up until discharge.

2.14.4.2. As part of its accounting and budgeting function, the Contractor shall establish an actuarially sound process for estimating and tracking IBNR Claims. The Contractor shall also reserve funds by major categories of service, e.g., hospital inpatient and hospital outpatient, to cover both IBNR and reported but unpaid Claims (RBUC). As part of the reserving methodology, the Contractor shall conduct "look backs" at least annually to assess its reserving methodology and make adjustments as necessary.

2.14.4.3. The Contractor agrees to have a Claims processing system and Management Information System (MIS) sufficient to support provider payments and financial data reporting requirements. The Contractor also shall be prepared to document its ability to expand Claims processing or MIS capacity should either or both systems be exceeded through the Enrollment of members.

2.14.4.4. RI EOHHS will retain responsibility for disproportionate share payments to hospitals, if any; the Contractor shall not be responsible for these payments.

2.15. Data Submissions, Reporting Requirements, and Survey

2.15.1. General Requirements for Data

2.15.1.1. The Contractor must provide and require its First Tier, Downstream and Related Entities to provide:

2.15.1.1.1. All information CMS and RI EOHHS require under the Contract related to the performance of the Contractor's responsibilities, including non-medical information for the purposes of research and evaluation;

2.15.1.1.2. Any information CMS and RI EOHHS require to comply with all applicable federal or State laws and regulations; and

2.15.1.1.3. Any information CMS or RI EOHHS require for external rapid cycle evaluation including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee Complaints and Appeals and Enrollment/disenrollment rates.

2.15.1.2. General Reporting Requirements

2.15.1.2.1. The Contractor must:

2.15.1.2.1.1. Submit to RI EOHHS applicable RI EOHHS reporting requirements in compliance with this Contract and 42 C.F.R. §§ 438.604 and 438.606;

2.15.1.2.1.2. Submit to CMS applicable Medicare reporting requirements in compliance with 42 C.F.R. §§ 422.516, § 423.514;

2.15.1.2.1.3. Submit to CMS all applicable Contractor reporting requirements;

2.15.1.2.1.4. Submit to CMS and RI EOHHS all required reports and data in accordance with the specifications, templates and time frames described in this Contract;

2.15.1.2.1.5. Report HEDIS, HOS, and CAHPS data, as well as measures related to long-term services and supports. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements for HEDIS, plus additional Medicaid measures required by RI EOHHS. All existing Part D metrics will be collected as well. Such measures shall include a combined set of core measures that the Contractor must report to CMS and RI EOHHS;

2.15.1.2.1.6. Upon request, submit to CMS and RI EOHHS any internal reports that the Contractor uses for internal management. Such reports shall include, but not be limited to, internal reports that analyze the medical/loss ratio, financial stability, or other areas where standard compliance reports indicate a problem in performance;

2.15.1.2.1.7. Pursuant to 42 C.F.R. § 438.3(g), comply with any reporting requirements on Provider Preventable Conditions in the form and frequency as may be specified by RI EOHHS; and

2.15.1.2.1.8. Provide to CMS and RI EOHHS, in a form and format approved by CMS and RI EOHHS and in accordance with the timeframes established by CMS and RI EOHHS, all reports, data or other information CMS and RI EOHHS determine are necessary for compliance with provisions of the Affordable Care Act of 2010, Subtitle F, Medicaid Prescription Drug Coverage, and applicable implementing regulations and interpretive guidance.

2.15.1.2.1.9. Submit at the request of CMS or RI EOHHS additional ad hoc or periodic reports or analyses of data related to the Contract.

2.15.2. Information Management and Information Systems

2.15.2.1. General

2.15.2.1.1. The Contractor shall:

2.15.2.1.1.1. Maintain information systems (Systems) that will enable the Contractor to meet all of RI EOHHS's requirements as outlined in this Contract. The Contractor's Systems shall be able to support current RI EOHHS requirements, and any future IT architecture or program changes. Such requirements include, but are not limited to, the following RI EOHHS standards:

2.15.2.1.1.1.1. The RI EOHHS Unified Process Methodology User Guide;

2.15.2.1.1.1.2. The User Experience and Style Guide Version 2.0;

2.15.2.1.1.1.3. Information Technology Architecture Version 2.0; and

2.15.2.1.1.1.4. Enterprise Web Accessibility Standards 2.0.

2.15.2.1.1.2. Ensure a secure, HIPAA-compliant exchange of Enrollee information between the Contractor and RI EOHHS and any other entity deemed appropriate by RI EOHHS. Such files shall be transmitted to RI EOHHS through secure FTP, HTS, or a similar secure data exchange as determined by RI EOHHS;

2.15.2.1.1.3. Develop and maintain a website that is accurate and up-to-date, and that is designed in a way that enables Enrollees and providers to quickly and easily locate all relevant information;

2.15.2.1.1.4. The Contractor shall cooperate with RI EOHHS in its efforts to verify the accuracy of all Contractor data submissions to RI EOHHS;

2.15.2.1.1.5. Any information and/or data required by this Contract and submitted to CMS and/or HCA shall be certified by the Contractor as follows:

2.15.2.1.1.5.1. The information and/or data shall be certified by one of the following:

2.15.2.1.1.5.1. 1. The Contractor's chief executive officer;

2.15.2.1.1.5.1. 2. The Contractor's chief financial officer;

2.15.2.1.1.5.1. 3. An individual who has delegated authority to sign for, and who reports directly to, the Contractor's chief executive officer or chief financial officer.

2.15.2.1.1.6. Actively participate in any RI EOHHS Systems Workgroup, as directed by RI EOHHS. The Workgroup shall meet in the location and on a schedule determined by RI EOHHS

2.15.2.1.1.7. Pursuant to RIGL § 23-17 .17-10, Contractor shall submit timely data exchange files to the Rhode Island All Payer Claims Database (RI-APCD), according to the schedule that is established by the RI-APCD.

2.15.2.2. Design Requirements

2.15.2.2.1. The Contractor shall comply with RI EOHHS requirements, policies, and standards in the design and maintenance of its Systems in order to successfully meet the requirements of this Contract.

2.15.2.2.2. The Contractor's Systems shall interface with RI EOHHS MMIS system, the RI EOHHS Virtual Gateway, and other RI EOHHS IT architecture.

2.15.2.2.3. The Contractor shall have adequate resources to support the MMIS interfaces. The Contractor shall demonstrate the capability to successfully send and receive interface files. Interface files include, but are not limited to:

2.15.2.2.3.1. Files from the Contractor to RI EOHHS or its designated vendor:

2.15.2.2.3.1.1. Provider file

2.15.2.2.3.1.2. 837 Claim file

2.15.2.2.3.1.3. 834 client PCP file

2.15.2.2.3.1.4. NCPDP drug Claims

2.15.2.2.3.2. Files from RI EOHHS or its designated vendor to the Contractor:

2.15.2.2.3.2.1. Provider file response

2.15.2.2.3.2.2. 277CA Claim status file

2.15.2.2.3.2.3. 834 daily file

2.15.2.2.3.2.4. 834 full file

2.15.2.2.3.2.5. NCPDP response file

2.15.2.2.3.2.6. Web upload and download reports

2.15.2.2.3.2.6. 1. 999 report

2.15.2.2.3.2.6. 2. SUB report

2.15.2.2.3.2.6. 3. TA1 report

2.15.2.2.3.2.6. 4. Functional ACK report

2.15.2.2.4. The Contractor shall conform to HIPAA compliant standards for data management and information exchange.

2.15.2.2.5. The Contractor shall demonstrate controls to maintain information integrity.

2.15.2.2.6. The Contractor shall maintain appropriate internal processes to determine the validity and completeness of data submitted to RI EOHHS.

2.15.3. Accepting and Processing Assessment Data

2.15.3.1. System Access Management and Information Accessibility Requirements

2.15.3.1.1. The Contractor shall make all Systems and system information available to authorized CMS, RI EOHHS and other agency staff as determined by CMS or RI EOHHS to evaluate the quality and effectiveness of the Contractor's data and Systems.

2.15.3.1.2. The Contractor is prohibited from sharing or publishing CMS or RI EOHHS data and information without prior written consent from CMS or RI EOHHS.

2.15.3.2. System Availability and Performance Requirements

2.15.3.2.1. The Contractor shall ensure that its Enrollee and provider web portal functions and phone-based functions are available to Enrollees and providers twenty-four (24) hours a Day, seven (7) Days a week, except for ordinary downtime for maintenance and other downtime not to exceed two (2%) percent. The Contractor shall notify RI EOHHS and CMS at least five (5) business Days prior to scheduled downtime.

2.15.3.2.2. The Contractor shall draft an alternative plan that describes access to Enrollee and provider information in the event of system failure. Such plan shall be contained in the Contractor's continuity of operations plan (COOP) and shall be updated annually and submitted to RI EOHHS upon request. In the event of System failure or unavailability, the Contractor shall notify RI EOHHS upon discovery and implement the COOP immediately.

2.15.3.2.3. The Contractor shall preserve the integrity of Enrollee-personal health information (PHI) data that resides in both a live and archived environment.

2.16. Encounter Reporting

2.16.1. Requirements

2.16.1.1. The Contractor must meet any diagnosis and/or encounter reporting requirements that are in place for Medicare Advantage plans and Medicaid managed care organizations, pursuant to 42 C.F.R § 438.600 et seq., as may be updated from time to time.

2.16.1.2. Furthermore, the Contractor's Systems shall generate and transmit encounter data files according to additional specifications as may be provided by CMS or RI EOHHS and updated from time to time.

2.16.1.3. CMS and RI EOHHS will provide technical assistance to the Contractor for developing the capacity to meet encounter reporting requirements.

2.16.1.4.

The Contractor shall:

2.16.1.4.1. Collect and maintain one hundred (100%) percent encounter data for all Covered Services provided to Enrollees, including from any subcapitated sources. Such data must be able to be linked to RI EOHHS eligibility data;

2.16.1.4.2. Successfully submit ninety-five (95%) percent of encounter data;

2.16.1.4.2.1. All data that was not able to be successfully processed will need to be reviewed by the Contractor, and re-submitted, if applicable. The Contractor is responsible for providing monthly reports on encounter data submission.

2.16.1.4.3. Participate in site visits and other reviews and assessments by CMS and RI EOHHS, or its designee, for the purpose of evaluating the Contractor's collection and maintenance of encounter data;

2.16.1.4.4. Upon request by CMS, RI EOHHS, or their designee, provide medical records of Enrollees and a report from administrative databases of the encounters of such Enrollees in order to conduct validation assessments. Such validation assessments may be conducted annually;

2.16.1.4.5. Produce encounter data according to the specifications, format, and mode of transfer reasonably established by CMS, RI EOHHS, or their designee, in consultation with the Contractor. Such encounter data shall include elements and level of detail determined necessary by CMS and RI EOHHS. As directed by CMS and RI EOHHS, such encounter data shall also include the national provider identifier of the ordering and referring physicians and professionals and any national drug code (NDC);

2.16.1.4.6. Submit complete, timely, reasonable and accurate encounter data to CMS and RI EOHHS no less frequently than monthly and in the form and manner specified by RI EOHHS and CMS. CMS will forward encounter data directly to RI EOHHS;

2.16.1.4.7. Submit encounter data that meets minimum standards for completeness and accuracy as defined by CMS and RI EOHHS. The Contractor must also correct and resubmit encounters as necessary;

2.16.1.4.8. Report as a voided Claim in the monthly encounter data submission any Claims that the Contractor pays, and then later determines should not have paid.

2.16.1.4.9. If CMS, RI EOHHS, or the Contractor, determines at any time that the Contractor's encounter data is not complete and accurate, the Contractor shall:

2.16.1.4.9.1. Notify CMS and RI EOHHS that the data is not complete or accurate, and provide an action plan and timeline for resolution;

2.16.1.4.9.2. Submit for CMS and RI EOHHS approval, within a time frame established by CMS and RI EOHHS, which shall in no event exceed thirty (30) Days from the day the Contractor identifies or is notified that it is not in compliance with the encounter data requirements, a corrective action plan to implement improvements or enhancements to bring the accuracy and/or completeness to an acceptable level;

2.16.1.4.9.3. Implement the CMS and RI EOHHS-approved corrective action plan within a time frame approved by CMS and RI EOHHS, which shall in no event exceed thirty (30) Days from the date that the Contractor submits the corrective action plan to and receives approval from CMS and RI EOHHS; and

2.16.1.4.9.4. Participate in a validation study to be performed by CMS, RI EOHHS, and/or their designee, following the end of a twelve-month period after the implementation of the corrective action plan to assess whether the encounter data is complete and accurate. The Contractor may be financially liable for such validation study.

Section 3. CMS and RI EOHHS Responsibilities

3.1. Administration

3.1.1. CMS and RI EOHHS will designate a CMT that will include at least one representative from CMS and at least one contract manager from RI EOHHS authorized and empowered to represent CMS and RI EOHHS about all aspects of the Contract. Generally, the CMS part of the team will include the State lead from the Medicare Medicaid Coordination Office (MMCO), Regional Office lead from the Consortium for Medicaid and Children's Health Operations (CMCHO), and an account manager from the Consortium for Health Plan Operations (CMHPO). The CMS representatives and RI EOHHS representatives will act as liaisons between the Contractor and CMS and RI EOHHS for the duration of the Contract.

3.1.2. The CMT will:

3.1.2.1. Monitor compliance with the terms of the Contract including issuance of joint notices of non-compliance/enforcement.

3.1.2.2. Coordinate periodic audits and surveys of the Contractor;

3.1.2.3. Receive and respond to complaints;

3.1.2.4. Conduct regular meetings with the Contractor;

3.1.2.5. Coordinate requests for assistance from the Contractor and assign CMS and RI EOHHS staff with appropriate expertise to provide technical assistance to the Contractor;

3.1.2.6. Coordinate requests for assistance from the Contractor and assign CMS and RI EOHHS staff with appropriate expertise to provide technical assistance to the Contractor;

3.1.2.7. Make best efforts to resolve any issues applicable to the Contract identified by the Contractor, CMS, or RI EOHHS; and

3.1.2.8. Inform the Contractor of any discretionary action by CMS or RI EOHHS under the provisions of the Contract;

3.1.2.9. Coordinate review of marketing materials and procedures; and

3.1.2.10. Coordinate review of Grievance and Appeals data, procedures,

3.1.3. CMS and RI EOHHS will review, approve, and monitor the Contractor's Outreach and orientation materials and procedures;

3.1.4. CMS and/or RI EOHHS will review, approve, and monitor the Contractor's complaint and Appeals procedures;

3.1.5. CMS and RI EOHHS will apply one or more of the sanctions provided in Section 5.3, including termination of the Contract in accordance with Section 5.5, if CMS and the RI EOHHS determine that the Contractor is in violation of any of the terms of the Contract stated herein;

3.1.6. CMS and RI EOHHS will conduct site visits as determined necessary by CMS and RI EOHHS to verify the accuracy of reported data;

3.1.7. CMS and RI EOHHS will coordinate the Contractor's external quality reviews conducted by the EQRO; and,

3.2. Performance Evaluation

3.2.1. CMS and RI EOHHS will, at their discretion:

3.2.1.1. Evaluate, through inspection or other means, the Contractor's compliance with the terms of this Contract, including but not limited to the reporting requirements in Sections 2.16 and Appendix D, the quality, appropriateness, and timeliness of services performed by the Contractor and its Provider Network. CMS and RI EOHHS will provide the Contractor with the written results of these evaluations;

3.2.1.2. Conduct periodic audits of the Contractor, including, but not limited to an annual independent external review and an annual site visit;

3.2.1.3. Conduct annual Enrollee surveys and provide the Contractor with written results of such surveys; and

3.2.1.4. Meet with the Contractor at least semi-annually to assess the Contractor's performance.

3.3. Enrollment and Disenrollment Systems

3.3.1. CMS and RI EOHHS will maintain systems to provide Enrollment and disenrollment information to the Contractor and continuous verification of eligibility status.

3.3.2. Enrollment Vendor

3.3.2.1. RI EOHHS or its designee shall assign a staff person(s) who shall have responsibility to:

3.3.2.1.1. Develop generic materials to assist Eligible Beneficiaries in choosing whether to enroll in the Demonstration. Said materials shall present the Contractor's Demonstration Plan in an unbiased manner to Eligible Beneficiaries to enroll in the Contractor. RI EOHHS may collaborate with the Contractor in developing Contractor-specific materials;

3.3.2.1.2. Present the Contractor in an unbiased manner to Eligible Beneficiaries or those seeking to transfer from one delivery system to another. Such presentation(s) shall ensure that Eligible Beneficiaries are informed prior to Enrollment of the following:

3.3.2.1.2.1. The rights and responsibilities of participation in the Demonstration;

3.3.2.1.2.2. The nature of the Contractor's care delivery system, including, but not limited to the Provider Network, the CFNA, other applicable assessments, and the ICT;

3.3.2.1.2.3. Orientation and other Enrollee services made available by the Contractor;

3.3.2.1.3. Enroll, disenroll, and process transfer requests of Enrollee in the Contractor, including completion of RI EOHHS' Enrollment and disenrollment forms;

3.3.2.1.4. Ensure that Enrollees are informed at the time of Enrollment or transfer of their right to terminate their Enrollment voluntarily at any time, unless otherwise provided by federal law or waiver;

3.3.2.1.5. Be knowledgeable about the Contractor's policies, services, and procedures; and

3.3.2.1.6. At its discretion, develop and implement processes and standards to measure and improve the performance of the RI EOHHS Enrollment vendor staff. RI EOHHS shall monitor the performance of the RI EOHHS Enrollment vendor.

3.3.3. Beneficiary Notification

3.3.3.1. RI EOHHS will send notices to Eligible Beneficiaries to opt-in to the Demonstration prior to the first effective Enrollment date. In addition:

3.3.3.1.1. RI EOHHS will provide notice of the option to select Contractor's MMP at least sixty (60) calendar Days prior to the effective date of each wave of Passive Enrollment and will accept Opt-Out requests through the last day of the month prior to the effective date of Enrollment. This notice will explain the Enrollee's options, including the option to decline Passive Enrollment into the Contractor's MMP, or once enrolled, to request disenrollment from the Demonstration.

3.3.3.1.2. Thirty (30) calendar Days prior to each Passive Enrollment effective date, a second notice will be provided to Enrollees who have not responded to the initial notice. The notice will include the name of the MMP into which the Enrollee would be enrolled unless he/she Opts-Out of the Demonstration. RI EOHHS will proceed with Passive Enrollment into the identified MMP for Enrollees who do not Opt-Out.

3.3.3.1.3. Any time an individual requests to Opt-Out of Passive Enrollment or disenroll from the Demonstration, RI EOHHS will send a letter confirming the Opt-Out and providing information on the benefits available to the Enrollee once they have Opted Out or disenrolled.

3.3.3.2. RI EOHHS will ensure that the PACE program is known to Eligible Beneficiaries as an integrated program alternative to the Demonstration, within the geographic area where PACE is offered. The option of PACE Enrollment will be specified in outreach and educational materials about the Demonstration and will be incorporated into the Enrollment Counselor scripts and protocols consistent with geographic limitations.

3.4. Medicaid LTSS Eligibility and Care Plans

3.4.1. RI EOHHS has sole authority for determining LTSS eligibility. RI EOHHS will conduct all Medicaid LTSS eligibility assessments and reassessments. RI EOHHS is responsible for all level of care determinations and redeterminations.

3.4.2. RI EOHHS is responsible for initially developing the LTSS Care Plan. The RI EOHHS case manager will complete the LTSS Care Plan and provide service authorizations as is currently done in the RI EOHHS LTSS system.

3.4.3. RI EOHHS will develop a transition process for the Contractor to receive the RI EOHHS LTSS Care Plan and a process by which they can provide input or ask questions about the RI EOHHS LTSS Care Plan.

Section 4. Payment and Financial Provisions

4.1. General Financial Provisions

4.1.1. Capitation Payments

4.1.1.1. CMS and RI EOHHS will each contribute to the total Capitation Payment paid to the Contractor. CMS and RI EOHHS will each make monthly payments for each Enrollee to the Contractor for their portion of the capitated rate, in accordance with the rates of payment and payment provisions set forth herein and subject to all applicable Federal and State laws, regulations, rules, billing instructions, and bulletins, as amended.

4.1.1.2. The Contractor will receive three monthly payments for each Enrollee: one amount from CMS reflecting coverage of Medicare Parts A/B services (Medicare Parts A/B Component); one amount from CMS reflecting coverage Medicare Part D services (Medicare Part D Component); and, a third amount from RI EOHHS reflecting coverage of Medicaid services (Medicaid Component).

4.1.1.3. The Medicare Parts A/B payment will be risk adjusted using the Medicare Advantage CMS-HCC Model. The Medicare Part D payment will be risk adjusted using the Part D RxHCC Model. The Medicaid Component will utilize the rate cell methodology described in Section 4.2.

4.1.1.4. CMS and RI EOHHS will provide the Contractor with a rate report for their Medicare Parts A/B, Part D and Medicaid payments on an annual basis for the upcoming calendar year. Updates of the Medicaid portion of the rate will take place at least once at the beginning of the State Fiscal Year on July 1st.

4.1.1.5. On a regular basis, CMS will provide RI EOHHS with the Contractor-level payment information included in the Medicare Plan Payment Report. The use of such information by RI EOHHS will be limited to financial monitoring, performing financial audits, and related activities, unless otherwise agreed to by CMS and the Contractor. On a regular basis, RI EOHHS will also provide to CMS Contractor-level plan payment informaiton including the Medicaid Capitation Payments.

4.1.2. Demonstration Year Dates

4.1.2.1. Capitation Rate updates will take place as on January 1st of each calendar year for the Medicare rate component and on a State Fiscal

Year (SFY) basis for the Medicaid rate component, or more frequently, as described in this section; however, savings percentages (see Section 4.2.3) and quality withhold percentages (see Section 4.4.7) will be applied based on final Demonstration Years, as follows:

4.1.2.1.1. Demonstration Year 1:
No sooner than May 1, 2016 – December 31, 2017

4.1.2.1.2. Demonstration Year 2:
January 1, 2018 – December 31, 2018

4.1.2.1.3. Demonstration Year 3:
January 1, 2019 – December 31, 2019

4.1.2.1.4. Demonstration Year 4:
January 1, 2020 – December 31, 2020

4.2. Capitated Rate Structure

4.2.1. Medicaid Component of the Capitation Payment

4.2.1.1. RI EOHHS shall pay the Contractor a monthly capitation amount (the Medicaid Component) based on the rate cell of the Enrollee, a sum equal to the product of the approved Capitation Rate and the number of Enrollees enrolled in that category:

4.2.1.1.1. Except as provided in Sections 4.6.1.1 through 4.6.3.1, an Enrollee's rate cell will be determined by his or her status as of the first Day of the month.

4.2.1.1.2. RI EOHHS will use its eligibility system to determine an Enrollee's Medicaid Component rate cell. When there are delays in changes to an Enrollee's Medicaid Component rate in RI EOHHS' eligibility system, RI EOHHS will adjust past Medicaid Component payments as needed.

4.2.1.2. The baseline spending data used for calculating the Medicaid Component consists of the Medicaid capitation rates for RHO. These rates are based on the three most recently available State fiscal years of Medicaid FFS Claims data and Medicaid managed care encounter data for Medicare-Medicaid beneficiaries who met RHO eligibility criteria during the historical baseline period. Completion factors are calculated and applied to the baseline data, in order to include expenditures for services that were incurred but

not reported (IBNR) in the available data. The data are then adjusted for known policy and program changes that will be in effect during the Contract period, as well as any differences in services covered under the Demonstration, as compared to the historical baseline period. The completed and adjusted data are trended forward to the midpoint of the Contract period and used to develop Capitation Rates. All steps in this process are subject to CMS review.

4.2.1.3. The Capitation Payments are based on the rate cell structure and are automatically generated by the RI EOHHS information system at the rates established in this Contract. Any and all costs incurred by the Contractor in excess of the Capitation Payment will be borne in full by the Contractor, subject to the risk mitigation strategies in accordance with Section 4.4.

Exhibit 1 Medicaid Rate Cell Categories

Capitation Cell	Rating Category	Description
Community Non-LTSS	Community Non-LTSS	Individuals who are living in the community and not receiving LTSS
LTSS	Community LTSS	Individuals who are living in the community and receiving LTSS
LTSS	Facility LTSS	Individuals receiving LTSS in a nursing facility and have been in a nursing facility for more than 90 Consecutive Days
I/DD	I/DD	Individuals identified as having intellectual and developmental disabilities (I/DD)
SPMI	SPMI	Individuals identified as having severe and persistent mental illness (SPMI)

Note: The community LTSS and facility LTSS rating categories will be blended and reimbursed as a single Capitation Rate cell based on the Contractor's original assignment mix of Enrollees in

the community LTSS and facility LTSS population cohorts, adjusted for the targeted Enrollment mix.

4.2.2. Medicare Component of the Capitation Rate

4.2.2.1. Medicare will pay the Contractor a monthly capitation amount for the Medicare Parts A/B services (the Medicare A/B Component), risk adjusted using the Medicare Advantage CMS-HCC Model and the CMS-HCC ESRD Model, except as specified in Section 4.2.4. Medicare will also pay the Contractor a monthly capitation amount for Medicare Part D services, risk adjusted using the Part D RxHCC Model (the Medicare Part D Component).

4.2.2.2. Medicare A/B Component

4.2.2.2.1. The Medicare baseline spending for Parts A/B services are a blend of the Medicare Advantage projected payment rates and the Medicare FFS standardized county rates for each year, weighted by the proportion of the target population that will be transitioning from each program into the Demonstration. The Medicare Advantage baseline spending will include costs that would have occurred absent the Demonstration, such as quality bonus payments for applicable Medicare Advantage plans. The FFS county rates will generally reflect amounts published with the April Medicare Advantage Final Rate Announcement. CMS may adjust the Medicare FFS standardized county rates as necessary to calculate accurate payment rates for the Demonstration. To the extent that the published FFS county rates do not conform with current law in effect for Medicare during an applicable payment month, and to the extent that such nonconformance would have a significant fiscal impact on the Demonstration, CMS will update the baseline (and therefore the corresponding payment rate) to calculate and apply an accurate payment rate for such month. Such update may take place retroactively, as needed.

4.2.2.2.2. Separate baselines will exist for Enrollees meeting the Medicare ESRD criteria. For Enrollees with ESRD in the dialysis or transplant status phases, the Medicare Parts A/B baseline will be the ESRD dialysis state rate. For Enrollees in the functioning graft status phase, the Medicare Parts A/B baseline will be the Medicare Advantage 3.5% bonus county rate (benchmark) for the applicable county.

4.2.2.2.3. Both baseline spending and payment rates under the Demonstration for Medicare Parts A/B services will be calculated as per member per month (PMPM) standardized amounts for each county participating in the Demonstration for each year. Enrollee risk scores will be applied to the standardized rates at the time of payment.

4.2.2.2.4. The Medicare A/B Component will be updated annually consistent with annual FFS estimates and Medicare Advantage rates released each year with the annual rate announcement.

4.2.2.3. Medicare Part D

4.2.2.3.1. The Medicare Part D baseline for the Part D Direct Subsidy will be set at the Part D national average monthly bid amount (NAMBA) for the calendar year. CMS will estimate an average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts; these payments will be reconciled after the end of each payment year in the same manner as for all Part D sponsors. The CY 2017 Part D NAMBA is $61.08.

4.2.2.3.2. The monthly Medicare Part D Component for an Enrollee can be calculated by multiplying the Part D NAMBA by the RxHCC risk score assigned to the individual, and then adding to this estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts.

4.2.3. Aggregate Savings Percentages

4.2.3.1. Aggregate savings percentages will be applied equally, as follows, to the baseline spending amounts for the Medicare Parts A/B

Component and the Medicaid Component of the capitated rate, provided that such savings percentages may be adjusted in accordance with Section 4.4.5.7.

4.2.3.1.1. Demonstration Year 1: 1%

4.2.3.1.2. Demonstration Year 2: 1.25%

4.2.3.1.3. Demonstration Year 3: 3%

4.2.3.1.4. Demonstration Year 4: 3%

4.2.3.2. Capitation Rate updates will take place on January 1st of each calendar year; however, savings percentages will be calculated and applied based on Demonstration Years.

4.2.3.3. Savings percentages will not be applied to the Part D component of the rate. CMS will monitor Part D costs closely on an ongoing basis. Any material change in Part D costs relative to the baseline may be factored into future year savings percentages.

4.2.4. Risk Adjustment Methodology

4.2.4.1. Medicare Parts A/B: The Medicare Parts A/B Component will be risk adjusted based on the risk profile of each Enrollee. Except as specified below, the existing Medicare Advantage CMS-HCC and CMS-HCC ESRD risk adjustment methodology will be used for the Demonstration.

4.2.4.1.1. In calendar year 2016, CMS will calculate and apply a coding intensity adjustment reflective of all Demonstration Enrollees. This will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Demonstration Enrollees in 2016 with Medicare Advantage experience in 2015, prior to the Demonstration.

4.2.4.1.2. In calendar year 2017, CMS will apply an appropriate coding intensity adjustment reflective of all Demonstration Enrollees. This will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Demonstration Enrollees in CY 2017 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's Enrollment phase-in as of September 30, 2016.

4.2.4.1.3. After calendar year 2017, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all Demonstration Enrollees.

4.2.4.1.4. The coding intensity adjustment factor will not be applied during the Demonstration to risk scores for Enrollees with an ESRD status of dialysis or transplant, consistent with Medicare Advantage policy.

4.2.4.2. Medicare Part D: The Medicare Part D national average bid amount will be risk adjusted in accordance with existing Part D RxHCC methodology. The estimated average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts will not be risk adjusted.

4.2.4.3. Medicaid: The Medicaid component will employ rating categories described in Exhibit 1.

4.3. Risk Mitigation Approaches

4.3.1. Risk Corridors

4.3.1.1. Risk corridors will be established for Demonstration Years 1, 2, and 3.

4.3.1.2. The Demonstration will use a tiered Contractor-level symmetrical risk corridor to include the combined Medicare Parts A/B and Medicaid components.

4.3.1.3. Total Adjusted Expenditures and Total Adjusted Capitation Rate Revenue will be calculated as in Sections 4.3.1.7 and 4.3.1.8 to establish payment or recoupment under the risk corridor.

4.3.1.4. The risk corridors will be reconciled after application of any risk adjustment methodologies (e.g. CMS-HCC) and as if the Contractor had received the full quality withhold payment.

4.3.1.5. Process for collecting cost information for interim and final risk corridor settlement.

4.3.1.5.1. CMS and RI EOHHS will evaluate encounter data, cost data, and Contractor financial reports, as set forth in Sections 4.3.1.11.1.1 and 4.3.1.11.2.1, to determine the Contractor's incurred costs.

4.3.1.6. Risk Corridor Shares. The Medicare and Medicaid contributions to risk corridor payments or recoupments will be in proportion to their contributions to the Total Adjusted Capitation Rate Revenue, except as described below:

4.3.1.6.1. Medicare Contribution to Risk Corridor

4.3.1.6.1.1. Prior to risk corridor calculations, CMS will analyze FFS Medicare expenditures relative to the risk adjusted county FFS rates for the population enrolled in the Demonstration to calculate a ratio of the risk-adjusted Medicare FFS county rates to Medicare FFS costs ("Rate-to-FFS Ratio"). One ratio will be calculated for the entire Demonstration area.

4.3.1.6.1.2. If that analysis shows a Rate-to-FFS Ratio for the risk adjustment model for the entire Demonstration area between 0.98 and 1.02, the maximum Medicare payment/recoupment will equal 2% of the risk-adjusted Medicare contribution to the Total Adjusted Capitation Rate Revenue in DY1, 1.5% of the risk-adjusted Medicare contribution to the Total Adjusted Capitation Rate Revenue in DY2, and 1% of the risk-adjusted Medicare contribution to the Total Adjusted Capitation Rate Revenue in DY3.

4.3.1.6.1.3. If the analysis shows a Rate-to-FFS Ratio for the risk adjustment model greater than 1.02 and there are plan losses, Medicare participation in the risk corridor will be limited to 1% of the risk-adjusted Medicare contribution to the Total Adjusted Capitation Rate Revenue in each year.

4.3.1.6.1.4. If the analysis shows a Rate-to-FFS Ratio for the risk adjustment model less than 0.98 and there are plan losses, Medicare participation in the risk corridor settlement will be adjusted. First, Medicare will make payment to the Contractor of the lesser of the Medicare amount necessary to bring the predictive value to 0.98 or the total plan losses. For Medicare, participation in the risk corridor bands will be capped at 2% of the risk-adjusted Medicare contribution to the Total Adjusted Capitation Rate Revenue in DY1, 1.5% of the risk-adjusted Medicare contribution to the Total Adjusted Capitation Rate Revenue in DY2, and 1% of the risk-adjusted Medicare contribution to the Total Adjusted Capitation Rate Revenue in DY3; in such scenarios, the risk-adjusted Medicare contribution to the Total Adjusted Capitation Rate Revenue will be adjusted to incorporate the payment associated with the Rate-to-FFS Ratio analysis.

4.3.1.6.1.5. If the analysis shows a Rate-to-FFS Ratio for the risk adjustment model less than 0.98 and there are plan gains, Medicare recoupment in the risk corridor will be limited to 1% of the risk-adjusted Medicare contribution to the Total Adjusted Capitation Rate Revenue in each year.

4.3.1.6.1.6. If the analysis shows a Rate-to-FFS Ratio predictive value for the risk adjustment model greater than 1.02 and there are plan gains, Medicare participation in the risk corridor will be adjusted. First, Medicare will recoup from the Contractor the lesser of the Medicare amount necessary to bring the predictive value to 1.02 or the total plan gains. For any remaining gains after that recoupment, the risk corridor bands in Section 4.3.1.5.4 will apply. Medicare recoupment under the risk corridor bands will be capped at 2% of the risk-adjusted Medicare contribution to the Total Adjusted Capitation Rate Revenue in DY1, 1.5% of the risk-adjusted Medicare contribution to the Total Adjusted Capitation Rate Revenue in DY2, and 1% of the risk-adjusted Medicare contribution to the Total Adjusted Capitation Rate Revenue in DY3; in such scenarios, the Medicare baseline will be adjusted to incorporate the recoupment associated with the Rate-to-FFS Ratio analysis.

4.3.1.6.2. Medicaid Component.

4.3.1.6.2.1. The maximum Medicaid payment/recoupment equals 2% of the Medicaid contribution to the Total Adjusted Capitation Rate Revenue in Demonstration Year 1, 1.5% of the Medicaid contribution to the Total Adjusted Capitation Rate Revenue in Demonstration Year 2, and 1% of the Medicaid contribution to the Total Adjusted Capitation Rate Revenue in Demonstration Year 3.

4.3.1.7. Total Adjusted Expenditures are the Contractor's actual amount incurred for expenditures for Covered Services and non-service expenditures, including both administrative and care management costs. Expenditures included in risk corridor calculations shall be in compliance with 42 C.F.R. § 422.2400 except that the following expenses incurred by the Contractor will be excluded for purposes of the gain/loss calculation:

4.3.1.7.1. The amount of incentive and bonus payments made to Health Care Professionals and provider pay-for-performance incentive arrangements that were not approved by CMS and RI EOHHS;

4.3.1.7.2. General operating expenditures, as defined by 42 C.F.R. § 422.2400, that exceed 15% of the Total Adjusted Capitation Rate Revenue, inclusive of any quality withholds whether or not they were paid to the Contractor; and

4.3.1.7.3. Start-up costs, defined as costs incurred by the Contractor prior to the start of the Demonstration.

4.3.1.8. Total Adjusted Capitation Rate Revenue is the sum of the monthly capitation payments for the applicable Demonstration Year (reflecting coverage of Medicare Parts A/B services and Medicaid services, pursuant to Appendix A of this contract). This includes the application of risk adjustment methodologies, as described in Section 4.2.4 and will be calculated as if the Contractor had received the full quality withhold payment.

4.3.1.9. In the event the Contractor qualifies to both make a risk corridor payment to CMS and RI EOHHS, as well as an MLR remittance as described in Section 4.3.2, the risk corridor calculation will be net of any MLR remittances.

4.3.1.10. Risk Corridors Tiers

4.3.1.10.1. Gains and losses are calculated as the Total Adjusted Capitation Rate Revenue minus Total Adjusted Expenditures. CMS and RI EOHHS will use the following risk corridor bands for each Demonstration Year to address the Contractor's potential aggregate gains/losses across all capitation cells.

4.3.1.10.1.1. Demonstration Year 1:

4.3.1.10.1.1.1.	Greater than 5% gain/loss, the Contractor would bear 10% of the risk/reward; RI EOHHS and CMS would share in the other 90% as described in Section 4.3.1.6, above.

4.3.1.10.1.1.2. Between 1.5% and 5% gain/loss, the Contractor would bear 30% of the risk/reward; RI EOHHS and CMS would share in the other 70% as described in Section 4.3.1.6, above.

4.3.1.10.1.1.3. Between 0 and 1.5% gain/loss, the Contractor would bear 100% of the risk/reward.

4.3.1.10.1.2. Demonstration Year 2:

4.3.1.10.1.2.1. Greater than 6% gain/loss, the Contractor would bear 10% of the risk/reward; RI EOHHS and CMS would share in the other 90% as described in Section 4.3.1.6, above.

4.3.1.10.1.2.2. Between 2% and 6% gain/loss, the Contractor would bear 30% of the risk/reward; RI EOHHS and CMS would share in the other 70% as described in Section 4.3.1.6, above.

4.3.1.10.1.2.3. Between 0 and 2% gain/loss, Contractor the Contractor would bear 100% of the risk/reward.

4.3.1.10.1.3. Demonstration Year 3:

4.3.1.10.1.3.1. Greater than 7% gain/loss, the Contractor would bear 100% of the risk/reward.

4.3.1.10.1.3.2. Between 2.5% and 7% gain/loss, Contractor the Contractor would bear 30% of the risk/reward; RI EOHHS and CMS would share in the other 70% as described in Section 4.3.1.6, above.

4.3.1.10.1.3.3. Between 0 and 2.5% gain/loss, Contractor the Contractor would bear 100% of the risk/reward.

4.3.1.11. Risk Sharing Settlement: CMS and RI EOHHS shall determine an interim and final settlement of payments made by the Contractor to CMS and EOHHS or by CMS and RI EOHHS to the Contractor under this section.

4.3.1.11.1. Interim Settlement: CMS and RI EOHHS shall determine an Interim Settlement based on three (3) months of claims run-out beyond the end of each Demonstration Year and an IBNR estimate.

4.3.1.11.1.1. For the purpose of the interim settlement, the Contractor will jointly provide to CMS and RI EOHHS the following within one hundred twenty (120) calendar Days following the end of each Demonstration Year:

4.3.1.11.1.1.1. A complete and accurate report of Total Adjusted Expenditures for Enrollees in the applicable Demonstration Year;

4.3.1.11.1.1.2. A complete and accurate report of Total Adjusted Expenditures, based on category of services, for Enrollees based on claims incurred for the applicable Demonstration Year, including three (3) months of claims run-out;

4.3.1.11.1.1.3.	The Contractor's best estimate of any claims IBNR for claims run-out beyond three (3) months and any IBNR completion factors by category of service;
4.3.1.11.1.1.4.	A complete and accurate report of Part D revenue and expenditures, as required under 42 C.F.R. § 423.514(a)(1);
4.3.1.11.1.1.5.	A complete and accurate report reflecting any recoveries from other payors outside of claims adjudication that are not reflected in the report Total Adjusted Expenditures, including those pursuant to coordination of benefits, third party liability, rebates, supplemental payments, adjustments in claims paid, adjustments from providers including adjustments to claims paid, and Enrollee contributions to care (as described in Section 4.4.3);
4.3.1.11.1.1.6.	A complete and accurate report of net reinsurance costs that are included in the reported Total Adjusted Expenditures; and
4.3.1.11.1.1.7.	Encounter data, as required under Section 2.16 of this Contract.

4.3.1.11.1.2. CMS and RI EOHHS shall provide the Contractor with an interim reconciliation under the risk corridor arrangement within one hundred eighty (180) calendar Days following the end of Demonstration Year 1, unless otherwise permitted by CMS. Any balance due between the Contractor and CMS and RI EOHHS shall be paid within sixty (60) Days of the Contractor receiving the Interim Reconciliation from CMS and EOHHS.

4.3.1.11.1.3. The Contractor shall provide any additional information upon request from CMS and EOHHS necessary to calculate Total Adjusted Expenditures.

4.3.1.11.2. Final Settlement: CMS and RI EOHHS shall determine a final settlement based on fifteen (15) months of claims run-out and an IBNR estimate.

4.3.1.11.2.1. For the purpose of the final settlement, the Contractor will jointly provide to CMS and RI EOHHS the following within four hundred eighty (480) calendar Days following the end of the applicable Demonstration Year:

4.3.1.11.2.1.1. A complete and accurate report of Total Adjusted Expenditures for Enrollees in the applicable Demonstration Year;

4.3.1.11.2.1.2. A complete and accurate report of Total Adjusted Expenditures, based on category of services, for Enrollees based on claims incurred for the applicable Demonstration Year, including fifteen (15) months of claims run-out;

4.3.1.11.2.1.3.	The Contractor's best estimate of any claims incurred but not reported for claims run-out beyond fifteen (15) months and any IBNR completion factors by category of service;
4.3.1.11.2.1.4.	A complete and accurate report of Part D revenue and expenditures, as required under 42 C.F.R. § 423.514(a)(1) of this Contract;
4.3.1.11.2.1.5.	A complete and accurate report reflecting any recoveries from other payors outside of claims adjudication that are reflected in the report Total Adjusted Expenditures, including those pursuant to coordination of benefits, third party liability, rebates, supplemental payments, adjustment in claims paid, adjustments from providers including adjustments to claims paid, and Enrollee contributions to care (as described in Section 4.4.3);
4.3.1.11.2.1.6.	A complete and accurate report of net reinsurance costs that are included in the reported Total Adjusted Expenditures;
4.3.1.11.2.1.7.	Financial Reports;
4.3.1.11.2.1.8.	Encounter data, as required under Section 2.16 of this contract.

4.3.1.11.2.2. CMS and RI EOHHS shall provide the Contractor with a final reconciliation under the risk corridor arrangement by within five hundred and ten (510) calendar Days following the end of the applicable Demonstration Year. Any balance due between the Contractor and CMS and RI EOHHS, net of any payments made for the Interim Settlement, shall be paid within sixty (60) Days of the Contractor receiving the final reconciliation from CMS and RI EOHHS; and

4.3.1.11.2.3. The Contractor shall provide any additional information upon request from CMS and RI EOHHS necessary to calculate Total Adjusted Expenditures.

4.3.1.11.3. Interim and final settlement amounts shall be calculated for each Demonstration Year; however, any Demonstration Year 1 payment will be contingent upon the Contractor's participation in Demonstration Year 2, and any Demonstration Year 2 payment will be contingent upon the Contractor's participation in Demonstration Year 3, unless otherwise permitted by RI EOHHS and CMS.

4.3.2. Medical loss ratio (MLR)

4.3.2.1. The Contractor has a minimum target medical loss ratio (MLR) of eighty-five percent (85%).

4.3.2.2. If the MLR calculated as set forth below is less than the minimum target MLR, the Contractor shall refund to RI EOHHS and CMS an amount equal to the difference between the calculated MLR and the minimum target MLR (expressed as a percentage) multiplied by the coverage year revenue. RI EOHHS and CMS shall calculate an aggregate MLR for Enrollees under this Contract, and shall provide to the Contractor the amount to be refunded, if any, to RI EOHHS and CMS respectively. Any refunded amounts will be distributed back to the Medicaid and Medicare programs, with the amount to each payor based on the proportion between the Medicare and Medicaid Components. At the option of CMS and RI EOHHS, separately, any amount to be refunded may be recovered either by requiring the Contractor to make a payment or by an offset to future Capitation Payment. The MLR calculation shall be determined as set forth below; however, RI EOHHS and CMS may adopt NAIC

reporting standards and protocols after giving written notice to the Contractor.

4.3.2.3. MLR will be based on the 42 C.F.R. §§ 422.2400 et seq and 423.2400 et seq except that the numerator in the MLR calculation will include:

4.3.2.3.1. All Covered Services required in the Demonstration under Section 2.4 and Appendix A;

4.3.2.3.2. Any services purchased in lieu of more costly Covered Services and consistent with the objectives of the Demonstration; and

4.3.2.3.3. Activities that improve health care quality, as defined by 42 C.F.R. §§ 422.2430.

4.3.2.4. The revenue used in the MLR calculation will consist of the Capitation payments, as adjusted pursuant to Section 4.2.4, due from RI EOHHS and CMS for services provided during the coverage year. Revenue will include amounts withheld pursuant to Section 4.4.6 and Section 4.4.7, regardless of whether the Contractor actually receives the amount in Section 4.4.6 and Section 4.4.7.

4.3.2.5. Data Submission. The Contractor shall submit to RI EOHHS and CMS, in the form and manner prescribed by RI EOHHS and CMS, the necessary data to calculate and verify the MLR after the end of the coverage year.

4.3.2.6. Medical Loss Ratio Calculation. Within ninety (90) Days following the six (6) month Claims run-out period following the coverage year, RI EOHHS and CMS shall calculate the MLR by dividing the benefit expense by the revenue. The MLR shall be expressed as a percentage rounded to the second decimal point. The Contractor shall have sixty (60) Days to review the MLR calculation. Each Party shall have the right to review all data and methodologies used to calculate the MLR.

4.3.2.7. Coverage Year. The coverage year shall be the Demonstration Year. The MLR calculation shall be prepared using all data available from the coverage year, including IBNR and six (6) months of run-out for benefit expense (excluding sub-capitation paid during the run-out months).

4.3.2.8. Medicaid Medical Loss Ratio. If at any point for Medicaid rating periods beginning on or after July 1, 2017, the joint MLR covering both Medicare and Medicaid, as described above in 4.3.2, ceases, the Contractor is required to calculate and report their MLR experience for Medicaid, consistent with the requirements at 42 C.F.R. §§438.4, 438.5, 438.8 and 438.74.

4.4. Payment Terms

4.4.1. Medicare Components

4.4.1.1. The Medicare Parts A/B Component will be the product of the Enrollee's CMS-HCC risk score multiplied by the relevant standard county payment rate (or the ESRD dialysis state rate by the HCC ESRD risk score, as applicable). The Medicare Part D Component will be the product of the Enrollee's RxHCC risk score multiplied by the Part D National Average Monthly Bid Amount, with the addition of the estimated average monthly prospective payment.

4.4.2. Medicaid Component

4.4.2.1. The Medicaid component for each rate cell will be product of the number of Enrollees in each category multiplied by the payment rate for that rate cell.

4.4.3. Timing of Capitation Payments

4.4.3.1. On or before the fifth calendar Day of every month, CMS and RI EOHHS will each make monthly Capitation Payments to the Contractor. If an individual is enrolled with the Contractor on the first Day of a month, the Contractor has the responsibility of providing Covered Services to that Enrollee for that month, even if the Enrollee moves to another locality. If the Enrollee moves to a locality outside of the Contractor's Service Area, the Enrollee will be disenrolled from the Contractor at the end of the month of change. Any and all costs incurred by the Contractor in excess of the Capitation Payment will be borne in full by the Contractor except as otherwise provided for in Section 4.3.1 and 4.3.2. The Contractor shall accept RI EOHHS's electronic transfer of funds to receive Capitation Payments.

4.4.3.2. Enrollments

4.4.3.2.1. On or before the fifth calendar Day of every month CMS will make monthly prospective per Enrollee per month Capitation Payment to the Contractor. The PMPM Capitation Payment for a particular month will reflect payment for the beneficiaries with effective Enrollment into the Contractor's Demonstration plan as of the first Day of that month.

4.4.3.2.2. On or before the fifth calendar Day of every month RI EOHHS will make monthly prospective per Enrollee per month Capitation Payments to the Contractor for the next month's expected Enrollment with a subsequent payment or recoupment to reconcile any variation between expected and actual Enrollment.

4.4.3.3. Disenrollments

4.4.3.3.1. The final per Enrollee per month Capitation Payment made by CMS and RI EOHHS to the Contractor for each Enrollee will be for the month: a) in which the disenrollment was submitted, b) the Enrollee loses eligibility, or c) the Enrollee dies (see Section 2.3.6).

4.4.4. Enrollee Contribution to Care Amounts

4.4.4.1. When an Enrollee's income exceeds an allowable amount, he or she must contribute toward the cost of their LTSS. This contribution, known as the Patient Pay amount, is required for individuals residing in a nursing facility and for those receiving home & community-based LTSS. Patient Pay is required to be calculated for every individual receiving nursing facility or community-based LTSS, although not every eligible individual will end up having to pay each month.

4.4.4.2. RI EOHHS will provide information to the Contractor that identifies Enrollees who are required to pay a Patient Pay amount and the amount of the obligation as part of the monthly transition report. RI EOHHS Capitation Payments to the Contractor for Enrollees who are required to pay a Patient Pay Amount will be net of the monthly Patient Pay amount. It is the responsibility of the LTSS provider(s) to collect the Patient Pay amount from Enrollees and the Contractor shall reduce reimbursements to LTSS providers equal to the Patient Pay amount each month.

4.4.5. Modifications to Capitation Rates

4.4.5.1. CMS and RI EOHHS will jointly notify the Contractor in advance and in writing as soon as practical, but in no event less than thirty (30) Days prior to processing the change to the Capitation Rate, of any proposed changes to the Capitation Rates, and the Contractor shall accept such changes as payment in full as described in Section 4.7. Any mid-year rate changes would be articulated in a rate report.

4.4.5.2. Rates will be updated using a similar process for each calendar year. Subject to Section 4.4.5.3 below, changes to the Medicare and Medicaid baselines (and therefore to the corresponding payment rate) outside of the annual Medicare Advantage and Part D rate announcement and annual Medicaid rate update will be made only if and when CMS and RI EOHHS jointly determine the change is necessary to calculate accurate payment rates for the Demonstration. Such changes may be based on the following factors: shifts in Enrollment assumptions; major changes or discrepancies in Federal law and/or State policy used in the development of baseline estimates; and changes to coding intensity.

4.4.5.3. For changes solely affecting the Medicare program baseline, CMS will consult with RI EOHHS prior to making any adjustment, but RI EOHHS concurrence will not be required. CMS will update baselines by amounts necessary to best effectuate accurate payment rates for each month, as identified by the independent CMS Office of the Actuary.

4.4.5.4. Subject to Section 4.4.5.3 above, if other statutory changes enacted after the annual baseline determination and rate development process are jointly determined by CMS and RI EOHHS to have a material change in baseline estimates for any given payment year, baseline estimates and corresponding standardized payment rates shall be updated outside of the annual rate development process.

4.4.5.5. CMS and/or RI EOHHS will make changes to baseline estimates within thirty (30) Days of identification of the need for such changes, and changes will be applied, if necessary on a retrospective basis, to effectuate accurate payment rates for each month.

4.4.5.6. Changes to the savings percentages will be made if and when CMS and RI EOHHS jointly determine that changes in Part D spending have resulted in materially higher or lower savings that need to be recouped through higher or lower savings percentages applied to the Medicare A/B baselines.

4.4.5.7. In the event that the Contractor experiences annual losses in Demonstration Year 1 exceeding 3% of the Total Adjusted Capitation Rate Revenue, in the aggregate over all regions in which the Contractor participates, the savings percentage for Demonstration Year 3 will be reduced to 1.5%. Revenue will include Medicare A/B revenue and Medicaid revenue, including any reconciliation and risk adjustment. Annual losses will be calculated as if the Contractor had received the full quality withhold payment and any other offsets defined in this contract.

4.4.5.8. Any material changes in the Medicaid State plan, including pertaining to Covered Services, payment schedules and related methodologies, shall be reflected in corresponding Capitation Payment adjustments. The Contractor will not be required to implement such changes without advance notice and corresponding adjustment in the Capitation Payment. In addition, to the extent other Medicaid costs are incurred absent the Demonstration, such costs shall be reflected in corresponding Capitation Payment adjustments.

4.4.6. Implementation of Alternative Payment Methods

4.4.6.1. RI EOHHS and CMS are committed to expanding new health care payment models aimed at improving health care quality and reducing cost by progressively moving away from volume based payments to value based payment arrangements that incorporate quality thresholds and shared savings and/or risk arrangements, as well as by creating partnerships with organizations using accountable care delivery models that integrate medical care, behavioral health, substance use disorders, community health, public health, social determinants, related social services, and LTSS. Under the Demonstration, RI EOHHS for Demonstration Years 2, 3, and 4 will withhold a percentage of the Medicaid Component of the Capitation Rate, subject to the degree that the Contractor has implemented Alternative Payment Methods with providers that are compliant with RI EOHHS standards, as set forth in *RI EOHHS Alternative Payment Methodology Guidelines for Medicaid Managed Care Organizations*.

4.4.6.2. Offsets to Capitation related to Value Based Purchasing contracts

4.4.6.2.1. During Demonstration Year 1 Contractor is expected to develop Alternative Payment Methods with providers that include the components outlined in Section 4.4.6.1 and that are deemed compliant with RI EOHHS requirements.

4.4.6.2.2. For Demonstration Year 1, the Contractor shall report to EOHHS no later than December 31, 2017 the value of total payments through Alternative Payment Methods to Health Care Professionals for Medicaid, Medicare Part A, and Medicare Part B services covered under this Contract.

4.4.6.2.3. For Demonstration Year 2, Contractor shall have in effect Alternative Payment Arrangements with a value of not less than 50% of total payments to Health Care Professionals for Medicaid, Medicare Part A, and Medicare Part B services covered under this Contract.

4.4.6.2.3.1. In Demonstration Year 2, RI EOHHS will withhold 1% of capitation amounts. The withheld amounts will be repaid as monthly adjusting payments subject to the Contractor demonstrating that it has met the requirement in Section 4.4.6.2.3. If Contractor does not meet the requirement in Section 4.4.6.2.3, RI EOHHS shall retain the withheld amount.

4.4.6.2.4. For Demonstration Years 3 and 4, at least 80% of the Contractor's payments to providers for Medicaid, Medicare Part A, and Medicare Part B services covered under this Contract shall be made through RI EOHHS approved Alternative Payment Methods.

4.4.6.2.4.1. In Demonstration Years 3 and 4, RI EOHHS will withhold 1% of capitation amounts. The withheld amounts will be repaid as monthly adjusting payments subject to the Contractor demonstrating that it has met the requirement in Section 4.4.6.2.4. If Contractor does not meet the requirement in Section 4.4.6.2.4, RI EOHHS shall retain the withheld amount.

4.4.7. Quality Withhold Policy

4.4.7.1. Under the Demonstration, both CMS and RI EOHHS will withhold a percentage of their respective components of the Capitation Rate, with the exception of Part D Component amounts. The withheld amounts will be repaid subject to the Contractor's performance consistent with established quality thresholds.

4.4.7.2. CMS and RI EOHHS will evaluate the Contractor's performance according to the specified metrics required in order to earn back the quality withhold for a given year.

4.4.7.3. Whether or not the Contractor has met the quality requirements in a given year will be made public.

4.4.7.4. Additional details regarding the quality withholds, including more detailed specifications, required thresholds and other information regarding the methodology will be made available in separate technical guidance.

4.4.7.5. Determination of whether the Contractor has met required quality withhold requirements will be based solely on those measures that can appropriately be calculated based on actual enrollment volume during the Demonstration Year.

4.4.7.6. Quality Withhold Percentages.

4.4.7.6.1. Aggregate quality withhold percentages will be applied equally, as follows, to the baseline spending amounts for the Medicare Parts A/B Component and the Medicaid Component of the capitated rate:

4.4.7.6.1.1. Demonstration Year 1: 1.0%

4.4.7.6.1.2. Demonstration Year 2: 2.0%

4.4.7.6.1.3. Demonstration Year 3: 3.0%

4.4.7.6.1.4. Demonstration Year 4: 3.0%

4.4.7.7. Withhold Measures in Demonstration Year 1

4.4.7.7.1. Exhibit 2 below identifies the withhold measures for Demonstration Year 1. Together, these will be utilized as the basis for the withhold amount defined in Section 4.4.7.6.1.1. Additional details, including technical specifications, withhold methodology and required benchmarks, is provided in the *Medicare-Medicaid Capitated Financial Alignment Model Quality Withhold Technical Notes* and in subsequent guidance.

4.4.7.7.2. For Demonstration Year 1, which crosses calendar years, the Contractor will be evaluated to determine whether it has met quality withhold requirements at the end of both Calendar Year 2016 and Calendar Year 2017. The determination in CY 2016 will be based solely on those measures that can appropriately be calculated based on the actual Enrollment volume during CY 2016. Consistent with such evaluations, the withheld amounts will be repaid separately for each calendar year.

Exhibit 2 Quality Withhold Measures for Demonstration Year 1

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Assessments	Percent of Enrollees with initial assessments completed within 90 Days of enrollment.	CMS-defined Process Measure	X	
Consumer Governance Board	Establishment of consumer advisory board or consumer inclusion on governance board, consistent with contract requirements.	CMS-defined Process Measure	X	
Encounter Data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS-defined Process Measure	X	
LTC Nursing Facility Diversion	Percentage of Nursing Facility Residents with low care needs (reported for LTC stay residents)	AARP LTSS Scorecard		X
SNF Discharges to the Community	The percentage of all new nursing facility admissions from a hospital who are discharge back to the community alive and remain out of SNF for the next 30 Days	AHCA		X

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
SNF Hospital Admissions	The percentage of individuals during their SNF stay that are sent back to any hospital (including both inpatient and observation status admissions but excluding ED only visits) for any reason as indicated on the MDS discharge assessment from a facility within 30 Days of admission to facility	AHCA		X
Rhode to Home Eligibility	Number of members transitioned out of a nursing facility and to the community who are eligible for the Rhode to Home program	State defined process measure		X
Out-of-plan Services	Reporting of the number of Enrollee discharges from, and placements into, residential settings involving out-of-plan services, including residential services for Enrollees with intellectual and developmental disabilities (I/DD).	State-specified Measure		X
Person-Centered Care Plan	Percent of Enrollees with care plans within required timeframes.	CMS/State defined process measure		X

4.4.7.8. Withhold Measures in Demonstration Years 2, 3, and 4

4.4.7.8.1. Exhibit 3 below identifies the withhold measures for Demonstration Year 2, Demonstration Year 3, and Demonstration Year 4. Together, these will be utilized as the basis the withhold amounts defined in Section 4.4.7.6.1.2, Section 4.4.7.6.1.3, and Section 4.4.7.6.1.4. Additional details, including technical specifications, withhold methodology and required benchmarks will be provided in subsequent guidance.

4.4.7.8.2. Payment will be based on performance on the quality withhold measures listed in Exhibit 3 below.

4.4.7.8.3. If the Contractor is unable to report at least three (3) of the quality withhold measures listed in Exhibit 3 for a given year due to low Enrollment or inability to meet other reporting criteria, alternative measures will be used in the quality withhold analysis. Additional information about this policy is available in separate technical guidance.

Exhibit 3 Quality Withhold Measures for Demonstration Years 2, 3, and 4

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Customer Service (DY 2 Only)	Percent of the best possible score the Contractor earned on how easy it is for members to get information and help from the plan when needed: • In the last 6 months, how often did your health plan's customer service give you the information or help you needed? • In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms for your health plan easy to fill out?	AHRQ/CAHPS	X	

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Getting Appointments and Care Quickly (DY 2 Only)	Percent of best possible score the Contractor earned on how quickly members get appointments and care: • In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? • In the last 6 months,how often did you get an appointment for a check-up or routine care as soon as you needed? • In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?	AHRQ/CAHPS	X	
Annual Flu Vaccine	Percent of Enrollees who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS	X	
Controlling Blood Pressure	Percentage of Enrollees 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (140/90) for members 18-59 years of age and 60-85 years of age with diagnosis of diabetes or (150/90) for members 60-85 without a diagnosis of diabetes during the measurement year.	NCQA/HEDIS	X	
Encounter Data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS-defined Process Measure	X	

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Follow-up After Hospitalization for Mental Illness	Percentage of discharges for Enrollees 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X	
Part D Medication Adherence for Diabetes Medications	Percent of Enrollees with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X	
Plan All-Cause Hospital Readmissions	Percent of Enrollees discharged from a hospital stay who were readmitted to a hospital within 30 Days, either for the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X	
Reducing the Risk of Falling	Percent of Enrollees with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS	X	
	.			
Care for Older Adults – Medication Review	Percent of Enrollees whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year.	NCQA/HEDIS		X

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Care for Older Adults – Functional Status Assessment	Percent of Enrollees whose doctor has done a functional status assessment to see how well they are doing activities of daily living (such as dressing, eating, and bathing).	NCQA/HEDIS		X
Care for Older Adults – Pain Screening	Percent of Enrollees who had a pain screening or pain management plan at least once during the year.	NCQA/HEDIS		X
Care for Older Adults – Advance Care Plan	Percent of Enrollees who had an advance care plan during the measurement year.	NCQA/HEDIS		X
LTC Nursing Facility Diversion	Percentage of Nursing Facility Residents with low care needs (reported for LTC stay residents)	AARP LTSS Scorecard		X
SNF Discharges to the Community	The percentage of all new nursing facility admissions from a hospital who are discharge back to the community alive and remain out of SNF for the next 30 Days	AHCA		X
SNF Hospital Admissions	The percentage of individuals during their SNF stay that are sent back to any hospital (including both inpatient and observation status admissions but excluding ED only visits) for any reason as indicated on the MDS discharge assessment from a facility within 30 Days of admission to facility	AHCA		X
Rhode to Home Eligibility	Number of members transitioned out of a nursing facility and to the community who are eligible for the Rhode to Home program	State defined process measure		X

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	The percentage of members with a new episode of alcohol or other drug (AOD) treatment who received the following: • Initiation of AOD treatment • Engagement of AOD treatment	NCQA/HEDIS		X
Percent of High-Risk Residents with Pressure Ulcers (Long Stay)	The percentage of long-stay, high-risk residents with Stage II-IV pressure ulcers	MDS Data		X
Percent of long stay residents who received an antipsychotic medication	Numerator: Long-stay residents with a selected target assessment where the following condition is true: antipsychotic medications received Denominator: All long-stay residents with a selected target assessment, except those with exclusions	MDS Data		X

4.4.8. Suspension of Payments

4.4.8.1. RI EOHHS may suspend payments to the Contractor in accordance with 42 C.F.R. § 455.23, *et seq.* as determined necessary or appropriate by RI EOHHS.

4.5. Transitions between Rating Categories and Risk Score Changes

4.5.1. Rating Category Changes

4.5.1.1. The Medicaid Component of the Capitation Rates will be updated following a change in an Enrollee's status relative to the rate cells in Section 4.2.1. On a monthly basis, as part of Capitation Payment processing, the rating category of each Enrollee will be determined.

4.5.2. Medicare Risk Score Changes

4.5.2.1. Medicare CMS-HCC, HCC-ESRD, and RxHCC risk scores will be updated consistent with prevailing Medicare Advantage regulations and processes.

4.6. Reconciliation

4.6.1. General

4.6.1.1. CMS and RI EOHHS will implement a process to reconcile Enrollment and Capitation Payments for the Contractor that will take into consideration the following circumstances:

4.6.1.1.1. Transitions between rate cells;

4.6.1.1.2. Retroactive changes in eligibility, rate cells, or Enrollee contribution amounts;

4.6.1.1.3. Changes in CMS-HCC and RxHCC risk scores; and,

4.6.1.1.4. Changes through new Enrollment, disenrollment, or death.

4.6.1.1. The reconciliation may identify underpayments or overpayments to the Contractor.

4.6.2. Medicaid Capitation Reconciliation

4.6.2.1. Retroactive adjustments to Enrollment and payment shall be forwarded to the Contractor as soon as possible upon receipt of updated/corrected information. The Contractor shall pay for all Covered Services for Enrollees without regard to timeliness of the adjustment. The Contractor shall assure correct payment to providers as a result of Enrollment updates/corrections. RI EOHHS shall assure correct payment to the Contractor for any retroactive Enrollment adjustments.

4.6.3. Medicare Capitation Reconciliation

4.6.3.1. Medicare capitation reconciliation will comply with prevailing Medicare Advantage and Part D regulations and processes.

4.6.3.2. Final Medicare Reconciliation and Settlement

4.6.3.2.1. In the event the Contractor terminates or non-renews this Contract, CMS' final settlement phase for terminating contracts applies. This final settlement phase lasts for a minimum of eighteen (18) months after the end of the calendar year in which the termination date occurs. This final settlement will include reconciliation of any demonstration-specific payments or recoupments, including those related to quality withholds, risk corridors, and medical loss ratios, as applicable, that are outstanding at the time of termination.

4.6.4. Audits/Monitoring

4.6.4.1. CMS and RI EOHHS will conduct periodic audits to validate rate cell assignments or other coding. Audits may be conducted by a peer review organization or other entity assigned this responsibility by CMS and RI EOHHS.

4.7. Payment in Full

4.7.1. General

4.7.1.1. The Contractor must accept as payment in full for all Covered Services the Capitation Rate(s) and the terms and conditions of payment set forth herein except as otherwise provided for in Appendix A.

4.7.1.2. Notwithstanding any contractual provision or legal right to the contrary, the three parties to this Contract (CMS, RI EOHHS and the Contractor), for this Demonstration agree there shall be no redress against either of the other two parties, or their actuarial contractors, over the actuarial soundness of the Capitation Rates.

4.7.1.3. By signing this contract, the Contractor accepts that the Capitation Rate(s) offered is reasonable; that operating within this Capitation Rate(s) is the sole responsibility of the Contractor; and that while data is made available by the Federal Government and RI EOHHS to the Contractor, any entity participating in the Demonstration must rely on their own resource to project likely experience under the Demonstration.

Section 5. Additional Terms and Conditions

5.1. Administration

5.1.1. Notification of Administrative Changes

5.1.1.1. The Contractor must notify CMS and RI EOHHS through HPMS of all changes affecting the key functions for the delivery of care, the administration of its program, or its performance of Contract requirements. The Contractor must notify CMS and RI EOHHS in HPMS no later than thirty (30) calendar Days prior to any significant change to the manner in which services are rendered to Enrollees, including but not limited to reprocurement or termination of a First Tier, Downstream and Related Entity pursuant to Appendix C. The Contractor must notify CMS and RI EOHHS in HPMS of all other changes no later than five (5) business Days prior to the effective date of such change.

5.1.2. Assignment

5.1.2.1. The Contractor may not assign or transfer any right or interest in this Contract to any successor entity or other entity without the prior written consent of CMS and RI EOHHS, which may be withheld for any reason or for no reason at all.

5.1.3. Independent Contractor

5.1.3.1. The Contractor, its employees, First Tier, Downstream and Related Entities, and any other of its agents in the performance of this Contract, shall act in an independent capacity and not as officers or employees of the federal government, RI EOHHS, or its authorized agents.

5.1.3.2. The Contractor must ensure it evaluates the prospective First Tier, Downstream and Related Entities' abilities to perform activities to be delegated.

5.1.4. Subrogation

5.1.4.1. Subject to CMS and RI EOHHS lien and third-party recovery rights, the Contractor must:

5.1.4.1.1. Be subrogated and succeed to any right of recovery of an Enrollee against any person or organization, for any services, Supplies, or both provided under this Contract up to the amount of the benefits provided hereunder;

5.1.4.1.2. Require that the Enrollee pay to the Contractor all such amounts recovered by suit, settlement, or otherwise from any third person or his or her insurer to the extent of the benefits provided hereunder, up to the value of the benefits provided hereunder. The Contractor may ask the Enrollee to:

5.1.4.1.2.1. Take such action, furnish such information and assistance, and execute such instruments as the Contractor may require to facilitate enforcement of its rights hereunder, and take no action prejudicing the rights and interest of the Contractor hereunder; and

5.1.4.1.2.2. Notify the Contractor hereunder and authorize the Contractor to make such investigations and take such action as the Contractor may deem appropriate to protect its rights hereunder whether or not such notice is given.

5.1.5. Prohibited Affiliations

5.1.5.1. In accordance with 42 USC §1396 u-2(d)(1), the Contractor shall not knowingly have an employment, consulting, or other agreement for the provision of items and services that are significant and material to the Contractor's obligations under this Contract with any person, or affiliate of such person, who is excluded, under federal law or regulation, from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five (5) percent of the Contractor's equity or be permitted to serve as a director, officer, or partner of the Contractor. Federal financial participation (FFP) is not available for any amounts paid to the Contractor if the Contractor could be excluded from participation in Medicare or Medicaid under section 1128(b)(8)(B) of the Social Security Act or for any of the reasons listed in 42 C.F.R. §431.55(h).

5.1.6. Disclosure Requirements

5.1.6.1. The Contractor must disclose to CMS and RI EOHHS information on ownership and control, business transactions, and persons convicted of

crimes in accordance with 42 C.F.R. Part 455, Subpart B. The Contractor must obtain federally required disclosures from all network providers and applicants in accordance with 42 C.F.R. 455 Subpart B, and 42 C.F.R. §§ 438.214 and 1002.3, and as specified by RI EOHHS, including but not limited to obtaining such information through provider Enrollment forms and credentialing and recredentialing packages. The Contractor must maintain such disclosed information in a manner which can be periodically searched by the Contractor for exclusions and provided to RI EOHHS in accordance with this Contract and relevant state and federal laws and regulations. In addition, the Contractor must comply with all reporting and disclosure requirements of 42 U.S.C. § 1396b(m)(4)(A) if the Contractor is not a federally qualified health maintenance organization under the Public Health Service Act. In addition, the Contractor shall make the information reported pursuant to 42 U.S.C. 1396b(m)(4)(A) available to its Enrollees upon reasonable request.

5.1.7. Physician Incentive Plans

5.1.7.1. The Contractor may, in its discretion, operate a physician incentive plan only if:

5.1.7.1.1. No single physician is put at financial risk for the costs of treating an Enrollee that are outside the physician's direct control;

5.1.7.1.2. No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically appropriate services furnished to an individual Enrollee; and

5.1.7.1.3. The applicable stop/loss protection, Enrollee survey, and disclosure requirements of 42 C.F.R. Part 417 are met.

5.1.7.2. The Contractor and its First Tier, Downstream and Related Entities must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438.3(i), and 1003. The Contractor must submit all information required to be disclosed to CMS and the RI EOHHS in the manner and format specified by CMS and the RI EOHHS which, subject to federal approval, must be consistent with the format required by CMS for Medicare contracts.

5.1.7.3. The Contractor shall be liable for any and all loss of federal financial participation (FFP) incurred by RI EOHHS that results from the

Contractor's or its sub-Contractors' failure to comply with the requirements governing physician incentive plans at 42 C.F.R. Parts 417, 434 and 1003; however, the Contractor shall not be liable for any loss of FFP under this provision that exceeds the total FFP reduction attributable to Enrollees in the Contractor's plan, and the Contractor shall not be liable if it can demonstrate, to the satisfaction of CMS and RI EOHHS, that it has made a good faith effort to comply with the cited requirements.

5.1.8. Physician Identifier

5.1.8.1. The Contractor must require each physician providing Covered Services to Enrollees under this Contract to have a unique identifier in accordance with the system established under 42 U.S.C. § 1320d-2(b). The Contractor must provide such unique identifier to CMS and RI EOHHS for each of its PCPs in the format and time-frame established by CMS and RI EOHHS in consultation with the Contractor.

5.1.9. Timely Provider Payments

5.1.9.1. The Contractor must make timely payments to its providers, including Indian Health Care Providers. The Contractor must include a prompt payment provision in its contracts with providers and suppliers, the terms of which are developed and agreed to by both the Contractor and the relevant provider. The Contractor must ensure that ninety (90%) percent of payment Claims, which can be processed without obtaining additional information from the physician or from a third party (a "Clean Claim"), from physicians who are in individual or group practice or all Indian Health Care Providers will be paid within thirty (30) Days of the date of receipt of the Claim. In addition, ninety-nine (99%) percent of all Claims must be paid within ninety (90) Days of receipt. The Contractor and its providers may by mutual agreement, in writing, establish an alternative payment schedule. The date of receipt is the date the Contractor receives the claim, as indicated by its date stamp on the claim.

5.1.10. Protection of Enrollee-Provider Communications

5.1.10.1. In accordance with 42 USC §1396 u-2(b)(3), the Contractor shall not prohibit or otherwise restrict a Health Care Professional or clinical First Tier, Downstream, or Related Entity from advising an Enrollee about the health status of the Enrollee or medical care or treatment options for the Enrollee's condition or disease; information the Enrollee needs in order to decide among all relevant treatment options; risk, benefits and consequences of treatment or non-treatment; and/or the Enrollee's rights to participate in decisions about his or her health

care, including the right to refuse treatment and to express preferences about future treatment decisions, regardless of whether benefits for such care or treatment are provided under the Contract, if the Health Care Professional or clinical First Tier, Downstream, or Related Entity is acting within the lawful scope of practice.

5.1.11. Protecting Enrollee from Liability for Payment

5.1.11.1. The Contractor must:

5.1.11.1.1. In accordance with 42 C.F.R. § 438.106, not hold an Enrollee liable for:

5.1.11.1.1.1. Debts of the Contractor, in the event of the Contractor's insolvency;

5.1.11.1.1.2. Covered Services provided to the Enrollee in the event that the Contractor fails to receive payment from CMS or RI EOHHS for such services; or

5.1.11.1.1.3. Payments to a clinical First Tier, Downstream and Related Entity in excess of the amount that would be owed by the Enrollee if the Contractor had directly provided the services;

5.1.11.1.2. Not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise provided in A.3 of Appendix A;

5.1.11.1.3. Not deny any service provided under this Contract to an Enrollee for failure or inability to pay any applicable charge;

5.1.11.1.4. Not deny any service provided under this Contract to an Enrollee who, prior to becoming eligible for the Demonstration, incurred a bill that has not been paid; and

5.1.11.1.5. Ensure Provider Network compliance with all Enrollee payment restrictions, including balance billing restrictions, and develop and implement a plan to identify and revoke or provide other specified remedies for any Enrollee of the Contractor's Provider Network that does not comply with such provisions.

5.1.12. Moral or Religious Objections

5.1.12.1. The Contractor is not required to provide, reimburse for, or provide coverage of, a counseling or referral service that would otherwise be required if the Contractor objects to the service on moral or religious grounds. If the Contractor elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows:

5.1.12.1.1. To RI EOHHS;

5.1.12.1.2. With its application for a contract;

5.1.12.1.3. Whenever it adopts the policy during the term of the contract; and

5.1.12.1.4. The information provided must be:

5.1.12.1.4.1. Consistent with the provisions of 42 C.F.R. § 438.10

5.1.12.1.4.2. Provided to Potential Enrollees before and during Enrollment; and

5.1.12.1.4.3. Provided to Enrollees within ninety (90) Days after adopting the policy with respect to any particular service

5.1.13. Third Party Liability Comprehensive Health Coverage

5.1.13.1. General Requirements

5.1.13.1.1. Enrollees will not be disenrolled due to comprehensive health coverage.

5.1.13.1.2. Under Section 1902 (a)(25) of the Social Security Act (42 U.S.C. §1396 a (a)(25)), the State is required to take all reasonable measures to identify legally liable third parties and pursue verified resources. The Contractor shall take responsibility for identifying and pursuing Enrollees' comprehensive health coverage. Any moneys recovered by third parties shall be retained by the Contractor and identified monthly to RI EOHHS and CMS. In such cases, the Contractor shall reimburse RI EOHHS for any Capitation Payments made by RI EOHHS to the Contractor for any relevant period. The Contractor shall notify RI EOHHS and CMS with five (5) business Days of any Enrollees identified to have comprehensive health coverage.

5.1.14. Medicaid Drug Rebate

5.1.14.1. Non-Part D covered outpatient drugs dispensed to Enrollees shall be subject to the same rebate requirements as RI EOHHS is subject under Section 1927 of the Social Security Act and RI EOHHS shall collect such rebates from pharmaceutical manufacturers.

5.1.14.2. The Contractor shall submit to RI EOHHS, on a timely and periodic basis, information on the total number of units of each dosage form and strength and package size by National Drug Code of each non-Part D covered outpatient drug dispensed to Enrollees for which the Contractor is responsible for coverage and other data as RI EOHHS determines necessary.

5.1.15. Federal Awards

5.1.15.1. If the Contractor has Agreements and/or Federal Awards which in aggregate are at least seven hundred and fifty thousand federal dollars ($750,000) in any fiscal year, including under this Agreement, an audit must be performed in accordance with federal requirements as outlined above (2 C.F.R. § 200.500 et seq.).

5.2. Confidentiality

5.2.1. Statutory Requirements

5.2.1.1. The Contractor understands and agrees that CMS and RI EOHHS may require specific written assurances and further agreements regarding the security and Privacy of protected health information that are deemed necessary to implement and comply with standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as implemented in 45 C.F.R., parts 160 and 164. The Contractor further represents and agrees that, in the performance of the services under this Contract, it will comply with all legal obligations as a holder of personal data under any and all applicable EOHHS confidentiality policies, business associate agreements and/or data use agreements recognizing a personal right to confidential personal health information pursuant to R. I. Gen. Laws §5-37.3-1 et seq. The Contractor represents that it currently has in place policies and procedures that will adequately safeguard any confidential personal data obtained or created in the course of fulfilling its obligations under this Contract in accordance with applicable State and Federal laws. The Contractor is required to design, develop, or operate a system of records on individuals, to accomplish an agency function subject to the Privacy Act of 1974, Public Law 93-579, December 31, 1974 (5 U.S.C.552a) and applicable agency regulations. Violation of the Act may involve the imposition of criminal penalties.

5.2.2. Personal Data

5.2.2.1. The Contractor must inform each of its employees having any involvement with personal data or other confidential information, whether with regard to design, development, operation, or maintenance of the laws and regulations relating to confidentiality.

5.2.3. Data Security

5.2.3.1. The Contractor must take reasonable steps to ensure the physical security of personal data or other confidential information under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Enrollee names.

5.2.3.2. The Contractor must put all appropriate administrative, technical, and physical safeguards in place before the start date to protect the Privacy and security of protected health information in accordance with 45 C.F.R. §164.530(c).

5.2.3.3. The Contractor must meet the security standards, requirements, and implementation specifications as set forth in 45 C.F.R. Part 164, Subpart C, the HIPAA Security Rule.

5.2.3.4. The Contractor must follow the National Institute for Standards and Technology (NIST) Guidelines for the Risk Management Framework (RMF) to establish an information security program in accordance with the Federal Information Security Management Act (FISMA).

5.2.4. Return of Personal Data

5.2.4.1. The Contractor must return any and all personal data, with the exception of medical records, furnished pursuant to this Contract promptly at the request of CMS or RI EOHHS in whatever form it is maintained by the Contractor.

5.2.4.2. Upon the termination or completion of this Contract, the Contractor shall not use any such data or any material derived from the data for any purpose, and, where so instructed by CMS or RI EOHHS will destroy such data or material.

5.2.5. Destruction of Personal Data

5.2.5.1. For any PHI received regarding an Eligible Beneficiary referred to the Contractor by RI EOHHS but who does not enroll in Contractor's plan, the Contractor must destroy the PHI in accordance with standards set forth in NIST Special Publication 800-88, Guidelines for Media Sanitizations, and all applicable State and federal privacy and security laws including HIPAA and its related implementing regulations, at 45 C.F.R. Parts 160, 162, and 164, as may be amended from time to time.

5.2.5.2. The Contractor shall also adhere to standards described in OMB Circular No. A-130, Appendix III-Security of Federal Automated Information Systems and NIST Federal Information Processing Standard 200 entitled "Minimum Security Requirements for Federal Information and Information Systems" while in possession of all PHI.

5.2.6. Research Data

5.2.6.1. The Contractor must seek and obtain prior written authorization from CMS and RI EOHHS for the use of any data pertaining to this Contract for research or any other purposes not directly related to the Contractor's performance under this Contract.

5.2.6.2. Any and all Contractor disclosure of data to any researcher shall be governed by an applicable Business Associate Agreement or Data Use Agreement between the Contractor and the researcher.

5.3. General Terms and Conditions

5.3.1. Applicable Law

5.3.1.1. The term "applicable law," as used in this Contract, means, without limitation, all federal and State law, and the regulations, policies, procedures, and instructions of CMS and RI EOHHS all as existing now or during the term of this Contract. All applicable law is hereby incorporated into this Contract by reference.

5.3.2. Sovereign Immunity

5.3.2.1. Nothing in this Contract will be construed to be a waiver by the State of Rhode Island or CMS of its rights under the doctrine of sovereign immunity and the Eleventh Amendment to the United States Constitution.

5.3.3. Advance Directives

5.3.3.1. Nothing in this Contract shall be interpreted to require an Enrollee to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services under the Medicare or Medicaid program.

5.3.4. Loss of Licensure

5.3.4.1. If, at any time during the term of this Contract, the Contractor or any of its First Tier, Downstream or Related Entities incurs loss of licensure at any of the Contractor's facilities or loss of necessary federal or State approvals, the Contractor must report such loss to CMS and RI EOHHS. Such loss may be grounds for termination of this Contract under the provisions of Section 5.5.

5.3.5. Indemnification

5.3.5.1. The Contractor shall defend, indemnify, and hold harmless CMS, the federal government, the State of Rhode Island, and their agencies, officers, employees, agents and volunteers from and against any and all liability, loss, damage, costs, or expenses which CMS and or RI EOHHS may sustain, incur, or be required to pay, arising out of or in connection with any negligent action, inaction, or willful misconduct

of the Contractor, any person employed by the Contractor, or any of its First Tier, Downstream, or Related Entities provided that:

5.3.5.1.1. The Contractor is notified of any Claims within a reasonable time from when CMS and RI EOHHS become aware of the Claim; and

5.3.5.1.2. The Contractor is afforded an opportunity to participate in the defense of such Claims.

5.3.6. Prohibition against Discrimination

5.3.6.1. In accordance with 42 U.S.C. §1396 u-2(b)(7), the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification of any Health Care Professional in the Contractor's Provider Network who is acting within the scope of the provider's license or certification under applicable federal or State law, solely on the basis of such license or certification. This section does not prohibit the Contractor from including Health Care Professionals in its Provider Network to the extent necessary to meet the needs of the Contractor's Enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Contractor.

5.3.6.2. The Contractor shall abide by all federal and State laws, regulations, and orders that prohibit discrimination because of race, color, religion, sex, sexual orientation, gender identity, national origin, ancestry, age, physical or mental disability, including, but not limited to, the Federal Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, the Federal Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975 and the Rhode Island Fair Employment Practices Act, RIGL 28-5-1 et. al.

5.3.6.3. The Contractor further agrees to take affirmative action to ensure that no unlawful discrimination is committed in any manner including, but not limited to, the delivery of services under this Contract.

5.3.6.4. The Contractor will not discriminate against Eligible Beneficiaries or Enrollees on the basis of health status or need for health services.

5.3.6.5. The Contractor will provide each Health Care Professional or group of Health Care Professionals whom it declines to include in its Provider Network written notice of the reason for its decision.

5.3.6.6. Nothing in Section 5.3.6.5 above may be construed to require the Contractor to contract with Health Care Professionals beyond the number necessary to meet the needs of its Enrollees; precludes the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or precludes the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees.

5.3.6.7. If a complaint or Claim against the Contractor is presented to RI EOHHS for handling discrimination complaints, the Contractor must cooperate with in the investigation and disposition of such complaint or Claim.

5.3.7. Anti-Boycott Covenant

5.3.7.1. During the time this Contract is in effect, neither the Contractor nor any affiliated company, as hereafter defined, must participate in or cooperate with an international boycott, as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended, or engage in conduct declared to be unlawful. Without limiting such other rights as it may have, CMS and RI EOHHS will be entitled to rescind this Contract in the event of noncompliance with this Section.

5.3.7.2. As used herein, an affiliated company is any business entity directly or indirectly owning at least fifty-one (51%) percent of the ownership interests of the Contractor.

5.3.8. Information Sharing

5.3.8.1. During the course of an Enrollee's Enrollment or upon transfer or termination of Enrollment, whether voluntary or involuntary, and subject to all applicable federal and State laws, the Contractor must arrange for the transfer, at no cost to CMS, RI EOHHS, or the Enrollee, of medical information regarding such Enrollee to any subsequent Health Care Professional of medical services to such Enrollee, as may be requested by the Enrollee or such Health Care Professional or directed by CMS and RI EOHHS the Enrollee, regulatory agencies of the State of Rhode Island, or the United States Government. With respect to Enrollees who are in the custody of the State, the Contractor must provide, upon reasonable request of the State agency with custody of the Enrollee, a copy of said Enrollee's medical records in a timely manner.

5.3.9. Other Contracts

5.3.9.1. Nothing contained in this Contract must be construed to prevent the Contractor from operating other comprehensive health care plans or providing health care services to persons other than those covered hereunder; provided, however, that the Contractor must provide CMS and RI EOHHS with a complete list of such plans and services, upon request. CMS and RI EOHHS will exercise discretion in disclosing information that the Contractor may consider proprietary, except as required by law. Nothing in this Contract may be construed to prevent CMS or RI EOHHS from contracting with other comprehensive health care plans, or any other provider, in the same Service Area.

5.3.10. Counterparts

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

5.3.11. Entire Contract

5.3.11.1. This Contract constitutes the entire agreement of the parties with respect to the subject matter hereof, including all Attachments and Appendices hereto, and supersedes all prior agreements, representations, negotiations, and undertakings not set forth or incorporated herein. The terms of this Contract will prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring.

5.3.12. No Third-Party Rights or Enforcement

5.3.12.1. No person not executing this Contract is entitled to enforce this Contract against a Party hereto regarding such Party's obligations under this Contract.

5.3.13. Corrective Action Plan

5.3.13.1. If, at any time, CMS and RI EOHHS reasonably determine that the Contractor is deficient in the performance of its obligations under the Contract, CMS and RI EOHHS may require, in writing, that the Contractor to develop and submit a corrective action plan that is designed to correct such deficiency. Within five (5) business Days of receipt, Contractor shall issue a corrective action plan to RI EOHHS that addresses the deficiencies identified by RI EOHHS. Upon receipt of the Contractor's corrective action plan, CMS and RI EOHHS shall approve, disapprove, or require modifications to the corrective action plan, in writing and within five business days of receipt of the corrective action plan, based on their reasonable judgment as to

whether the corrective action plan will correct the deficiency. Upon receipt of RI EOHHS approval of the corrective action plan, the Contractor must promptly and diligently implement the corrective action plan as approved by CMS and RI EOHHS. Failure to implement the corrective action plan or promptly develop a corrective action plan acceptable to CMS and RI EOHHS may subject the Contractor to termination of the Contract by CMS and RI EOHHS or other intermediate sanctions as described in Section 5.3.14.

5.3.14. Intermediate Sanctions and Civil Monetary Penalties

5.3.14.1. In addition to termination under Section 5.5, CMS and RI EOHHS may, impose any or all of the sanctions in Section 5.3.14 upon any of the events below; provided, however, that CMS and RI EOHHS will only impose those sanctions they determine to be reasonable and appropriate for the specific violations identified.

5.3.14.2. Sanctions may be imposed in accordance with regulations that are current at the time of the sanction.

5.3.14.3. Sanctions may be imposed in accordance with this section if the Contractor:

5.3.14.3.1. Fails substantially to provide Covered Services required to be provided under this Contract to Enrollees;

5.3.14.3.2. Imposes charges on Enrollees in excess of any permitted under this Contract;

5.3.14.3.3. Discriminates among Enrollees or individuals eligible to enroll on the basis of health status or need for health care services, race, color or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin;

5.3.14.3.4. Misrepresents or falsifies information provided to CMS, RI EOHHS and its authorized representatives, Enrollees, Eligible Beneficiaries , or its Provider Network;

5.3.14.3.5. Fails to comply with requirements regarding physician incentive plans (see Section 5.1.7);

5.3.14.3.6. Fails to comply with federal or State statutory or regulatory requirements related to this Contract;

5.3.14.3.7. Violates restrictions or other requirements regarding marketing;

5.3.14.3.8. Fails to comply with QM requirements consistent with Section 2.12;

5.3.14.3.9. Fails to comply with any corrective action plan required by CMS and RI EOHHS;

5.3.14.3.10. Fails to comply with financial Solvency requirements;

5.3.14.3.11. Fails to comply with reporting requirements; or

5.3.14.3.12. Fails to comply with any other requirements of this Contract.

5.3.14.4. Such sanctions may include:

5.3.14.4.1. Intermediate sanctions and civil monetary penalties consistent with 42 C.F.R. § 422 Subpart O;

5.3.14.4.2. Intermediate sanctions consistent with 42 C.F.R. § 438.702;

5.3.14.4.3. Financial penalties consistent with 42 C.F.R. § 438.704;

5.3.14.4.4. Financial penalties for non-compliance not corrected by the specified date, RI EOHHS may assess damages up to the amount of two thousand five hundred dollars ($2,500.00) per day after the due date until the non-compliance is corrected;

5.3.14.4.5. The appointment of temporary management to oversee the operation of the Contractor in those circumstances set forth in 42 U.S.C. §1396 u-2(e)(2)(B);

5.3.14.4.6. Suspension of Enrollment (including assignment of Enrollees);

5.3.14.4.7. Suspension of payment to the Contractor;

5.3.14.4.8. Disenrollment of Enrollees;

5.3.14.4.9. Suspension of marketing; and

5.3.14.4.10. Denial of payment as set forth in 42 C.F.R. § 438.730.

5.3.14.5. If CMS or RI EOHHS have identified a deficiency in the performance of a First Tier, Downstream or Related Entity and the Contractor has not successfully implemented an approved corrective action plan in accordance with Section 5.3.13, CMS and RI EOHHS may:

5.3.14.5.1. Require the Contractor to subcontract with a different First Tier, Downstream or Related Entity deemed satisfactory by CMS and RI EOHHS; or

5.3.14.5.2. Require the Contractor to change the manner or method in which the Contractor ensures the performance of such contractual responsibility.

5.3.14.6. Before imposing any intermediate sanctions consistent with 42 C.F.R. § 438.710,, RI EOHHS and CMS must give the Contractor timely written notice that explains the basis and nature of the sanction and other due process protections that RI EOHHS and CMS elect to provide.

5.3.15. Effect of Invalidity of Clauses

5.3.15.1. If any clause or provision of this Contract is officially declared to be in conflict with any federal or State law or regulation, that clause or provision will be null and void and any such invalidity will not affect the validity of the remainder of this Contract.

5.3.16. Conflict of Interest

5.3.16.1. Neither the Contractor nor any First Tier, Downstream or Related Entity may, for the duration of the Contract, have any interest that will conflict, as determined by CMS and RI EOHHS with the performance of services under the Contract, or that may be otherwise anticompetitive. Without limiting the generality of the foregoing, CMS and RI EOHHS require that neither the Contractor nor any First Tier, Downstream, or Related Entity has any financial, legal, contractual or other business interest in any entity performing Contractor Enrollment functions for RI EOHHS. The Contractor further certifies that it will comply with Section 1932(d) of the Social Security Act.

5.3.17. Insurance for Contractor's Employees

5.3.17.1. The Contractor must agree to maintain at the Contractor's expense all insurance, from an insurance company duly authorized to do business in Rhode Island, the minimum coverage levels required by law for its employees, including worker's compensation and unemployment compensation, and must provide CMS and RI EOHHS with certification of same upon request. The Contractor, and its professional personnel providing services to Enrollees, must obtain and maintain appropriate professional liability insurance coverage. The Contractor must, at the request of CMS or RI EOHHS, provide certification of professional liability insurance coverage. Minimum coverage levels are set forth below:

5.3.17.1.1. Professional Liability Insurance

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

5.3.17.1.2. Worker's Compensation

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

5.3.17.1.3. Minimum Liability and Property Damage Insurance

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

5.3.17.1.4. Errors and Omissions Insurance

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

5.3.17.1.5. Reinsurance

5.3.17.1.5.1. Contractor shall obtain, pay for, and keep in force reinsurance for the reimbursement of excess costs incurred by an Enrollee. The level at which the Contractor establishes reinsurance must be consistent with sound business practices under the financial condition of the Contractor. RI EOHHS reserves the right to review the Contractor's reinsurance coverage and to require changes to that coverage in the form of lower thresholds based on the Contractor's overall financial condition. Contractor may not change the reinsurance thresholds without the prior written consent of RI EOHHS.

5.3.17.1.6. Evidence of Coverage

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

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

5.3.18. Waiver

5.3.18.1. The Contractor, CMS, or RI EOHHS shall not be deemed to have waived any of its rights hereunder unless such waiver is in writing and signed by a duly authorized representative. No delay or omission on the part of the Contractor, CMS, or RI EOHHS in exercising any right shall operate as a waiver of such right or any other right. A waiver on any occasion shall not be construed as a bar to or waiver of any right or remedy on any future occasion. The acceptance or approval by CMS and RI EOHHS of any materials including but not limited to, those materials submitted in relation to this Contract, does not constitute waiver of any requirements of this Contract.

5.3.19. Section Headings

5.3.19.1. The headings of the sections of this Contract are for convenience only and will not affect the construction hereof.

5.4. Record Retention, Inspection, and Audits

5.4.1. General

5.4.1.1. The Contractor must maintain books, records, documents, and other evidence of administrative, medical, and accounting procedures and practices for ten years from the end of the final Contract period or completion of audit, whichever is later. If records are related to a case in litigation, then these records should be retained during litigation and for a period of seven (7) years after the disposition of litigation.

5.4.1.2. The Contractor must make the records maintained by the Contractor and its Provider Network, as required by CMS and RI EOHHS and other regulatory agencies, available to CMS and RI EOHHS and its agents, designees or Contractors or any other authorized representatives of the RI EOHHS or the United States Government, or their designees or Contractors, at such times, places, and in such manner as such entities may reasonably request for the purposes of financial or medical audits, inspections, and examinations, provided that such activities are conducted during the normal business hours of the Contractor.

5.4.1.3. The Contractor further agrees that the Secretary of the U.S. Department of Health and Human Services or his or her designee, the Governor or his or her designee, Comptroller General or his or her designee, and the State Auditor or his or her designee have the right at reasonable times and upon reasonable notice to examine the books, records, and other compilations of data of the Contractor and its First Tier, Downstream and Related Entities that pertain to: the ability of the Contractor to bear the risk of potential financial losses; services performed; or determinations of amounts payable.

5.4.1.4. The Contractor must make available, for the purposes of record maintenance requirements, its premises, physical facilities and equipment, records relating to its Enrollees, and any additional relevant information that CMS or RI EOHHS may require, in a manner that meets CMS and RI EOHHS' record maintenance requirements.

5.4.1.5. The Contractor must comply with the right of the U.S. Department of Health and Human Services, the Comptroller General, and their designees to inspect, evaluate, and audit records through ten years from the final date of the Contract period or the completion of audit, whichever is later, in accordance with Federal and State requirements.

5.5. Termination of Contract

5.5.1. General

5.5.1.1. In the event the Contractor materially fails to meet its obligations under this Contract or has otherwise violated the laws, regulations, or rules that govern the Medicare or the Rhode Island Medicaid programs, including the denial of NCQA accreditation to the Contractor, CMS and RI EOHHS shall consider this to be cause for termination of the Agreement.

5.5.1.2. CMS or RI EOHHS may take any or all action under this Contract, law, or equity, including but not limited to immediate termination of this Contract. CMS or RI EOHHS may terminate the contract in accordance with regulations that are current at the time of the termination.

5.5.2. Plan and RI EOHHS/CMS Initiated Termination

5.5.2.1. The Contractor, RI EOHHS, and CMS each shall have the right to terminate the Contract in the event that RI EOHHS and/or CMS and the Contractor fail to reach agreement on the monthly Capitation Rates. For rates related to Calendar Year 2016, the Contractor shall have the right to terminate this Contract without penalty if the Contractor notifies RI EOHHS and CMS no later than (10) Business Days following the release of the final Medicare and Medicaid Components of the Capitation Rates. Upon receipt of a request from the Contractor to terminate this Contract pursuant to this provision, RI EOHHS and/or CMS may notify the Contractor that they will immediately commence discussions to attempt to reach agreement on the monthly Capitation Rates. Such discussions may continue for a period of ninety (90) days (or such longer period as RI EOHHS and/or CMS may allow).

5.5.3. Termination without Prior Notice

5.5.3.1. Without limiting the above, if CMS and RI EOHHS determine that participation of the Contractor in the Medicare or the Rhode Island Medicaid program or in the Demonstration, may threaten or endanger the health, safety, or welfare of Enrollees or compromise the integrity of the Medicare or the Rhode Island Medicaid program, CMS or RI EOHHS, without prior notice, may immediately terminate this Contract, suspend the Contractor from participation, withhold any future payments to the Contractor, or take any or all other actions under this Contract, law, or equity.

Such action may precede beneficiary Enrollment into any Contractor, and shall be taken upon a finding by CMS or RI EOHHS that the Contractor has not achieved and demonstrated a state of readiness that will allow for the safe and efficient provision of Medicare-Medicaid services to Enrollees.

5.5.3.2. United States law will apply to resolve any Claim of breach of this Contract.

5.5.4. Termination with Prior Notice

5.5.4.1. CMS or RI EOHHS may terminate this Contract without cause upon no less than 90 days prior written notice to the other Party specifying the termination date, unless applicable law requires otherwise. Per Section 5.9, plans may choose to non-renew prior to the end of each term pursuant to 42 C.F.R. § 422.506(a), except in Demonstration Year 1, in which the Contractor may choose to non-renew the contract as of December 31, 2017 provided the Contractor gives notice before August 1, 2017, and may terminate the Contract by mutual consent of CMS and RI EOHHS at any time pursuant to 42 C.F.R. § 422.508. In considering requests for termination under 42 C.F.R. § 422.508, CMS and RI EOHHS consider, among other factors, financial performance and stability in granting consent for termination. Any written communications or oral scripts developed to implement the requirements of 42 C.F.R. § 422.506(a) must be submitted to and approved by CMS and RI EOHHS prior to their use.

5.5.4.2. Pursuant to 42 C.F.R. §§ 422.506(a)(4) and 422.508(c), CMS considers Contractor termination of this Contract with prior notice as described in Section 5.5.3 and non-renewal of this Contract as described in Section 5.9 to be circumstances warranting special consideration, and will not prohibit the Contractor from applying for new Medicare Advantage contracts or Service Area expansions for a period of two (2) years due to termination.

5.5.5. Termination pursuant to Social Security Act § 1115A(b)(3)(B).

5.5.6. Termination for Cause

5.5.6.1. Any Party may terminate this Agreement upon ninety (90) Days' notice due to a material breach of a provision of this Contract unless CMS or RI EOHHS determines that a delay in termination would pose an imminent and serious risk to the health of the individuals enrolled with the Contractor or the Contractor experiences financial difficulties so severe that its ability make

necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its Enrollees, whereby CMS or RI EOHHS may expedite the termination.

5.5.6.2. Pre-termination Procedures: Before terminating a Contract under 42 C.F.R. §422.510 and §438.708, the Contractor may request a pre-termination hearing or develop and implement a corrective action plan. CMS or RI EOHHS must:

5.5.6.2.1. Give the Contractor written notice of its intent to terminate, the reason for termination, and a reasonable opportunity of at least thirty (30) calendar Days to develop and implement a corrective action plan to correct the deficiencies; and/or

5.5.6.2.2. Notify the Contractor of its Appeal rights as provided in 42 C.F.R. §422 Subpart N and §438.710.

5.5.7. Termination due to a Change in Law

5.5.7.1. In addition, CMS or RI EOHHS may terminate this Contract upon thirty (30) Days' notice due to a material change in law, or with less or no notice if required by law.

5.5.8. Continued Obligations of the Parties

5.5.8.1. In the event of termination, expiration, or non-renewal of this Contract, or if the Contractor otherwise withdraws from the Medicare or Rhode Island Medicaid programs, the Contractor shall continue to have the obligations imposed by this Contract or applicable law. These include, without limitation, the obligations to continue to provide Covered Services to each Enrollee at the time of such termination or withdrawal until the Enrollee has been disenrolled from the Contractor's Plan; provided, however, that CMS and RI EOHHS will exercise best efforts to complete all disenrollment activities within six (6) months from the date of termination or withdrawal.

5.5.8.2. In the event that this Contract is terminated, expires, or is not renewed for any reason:

5.5.8.2.1. If CMS or RI EOHHS, or both, elect to terminate or not renew the Contract, CMS and RI EOHHS will be responsible for notifying all Enrollees covered under this Contract of the date of termination and the process by which those Enrollees will continue to receive care. If the Contractor elects to terminate or not renew the Contract, the Contractor

will be responsible for notifying all Enrollees and the general public, in accordance with federal and State requirements;

5.5.8.2.2. The Contractor must return to CMS and RI EOHHS all payments advanced to the Contractor for Enrollees after the effective date of their disenrollment within thirty (30) days of receipt; and

5.5.8.2.3. The Contractor must supply to CMS and RI EOHHS all information necessary for the payment of any outstanding Claims determined by CMS and RI EOHHS to be due to the Contractor, and any such Claims will be paid in accordance with the terms of this Contract.

5.6.Order of Precedence

5.6.1. Order of Precedence Rules

5.6.1.1. The following documents are incorporated into and made a part of this Contract, including all appendices:

5.6.1.1.1. Capitated Financial Alignment Application, a document issued by CMS and subject to modification each program year

5.6.1.1.2. Memorandum of Understanding, a document between CMS and the State of Rhode Island Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (October 25, 2013);

5.6.1.1.3. The RI EOHHS Medicaid ICI for the Rhody Health Options Program Letter of Interest (LOI) #7461245;

5.6.1.1.4. The Contractor's response to the RI EOHHS Medicaid ICI for the Rhody Health Options Program Letter of Interest (LOI) #7461245;

5.6.1.1.5. Any State or federal Requirements or Instructions released to MMPs. Examples include the annual rate report, Medicare-Medicaid Marketing Guidance, Enrollment Guidance, and Reporting Requirements.

5.6.1.2. In the event of any conflict among the documents that are a part of this Contract, including all appendices, the order of priority to interpret the Contract shall be as follows:

5.6.1.2.1. The Contract terms and conditions, including all appendices;

5.6.1.2.2. Capitated Financial Alignment Application;

5.6.1.2.3. The Memorandum of Understanding between CMS and RI EOHHS;

5.6.1.2.4. RI EOHHS Medicaid ICI for the Rhody Health Options Program Letter of Interest (LOI) #7461245;

5.6.1.2.5. The Contractor's response to the RI EOHHS Medicaid ICI for the Rhody Health Options Program Letter of Interest (LOI) #7461245,

5.6.1.2.6. Any State or federal Requirements or Instructions released to MMPs. Examples include the annual rate report, Medicare-Medicaid Marketing Guidance, and Enrollment Guidance.

5.6.1.3. In the event of any conflict between this Contract and the MOU, the Contract shall prevail.

5.7. Amendments

5.7.1. Amendment Process

5.7.1.1. The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein.

5.7.1.2. By mutual agreement, the parties may amend this Contract where such amendment does not violate federal or State statutory, regulatory, or waiver provisions, provided that such amendment is in writing, signed by authorized representatives of both parties, and attached hereto.

5.8. Written Notices

5.8.1. Contacts

5.8.1.1. Notices to the parties as to any matter hereunder will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand to the contacts in this Section. Copies may be delivered to the designated entities by email at the discretion of the sender.

To: Centers for Medicare and Medicaid Services
Medicare-Medicaid Coordination Office
7500 Security Boulevard, S3-13-23
Baltimore, MD 21244

To: State of Rhode Island and Providence Plantations:
Executive Office of Health and Human Services
Eric Beane, Secretary
Virks Building
3 West Road
Cranston, RI 02920
Eric.Beane@ohss.ri.gov

Email Copies To:
Deborah George, Esq. Deborah.George@ohss.ri.gov
Patrick M. Tigue Patrick.Tigue@ohss.ri.gov

To: Neighborhood Health Plan of Rhode Island
Peter M. Marino, Chief Executive Officer
910 Douglas Pike
Smithfield, RI 02917
pmarino@nhpri.org

Email Copies to: Douglas D. Byrd dbyrd@nhpri.org

5.9. Contract Term

5.9.1. Contract Effective Date

5.9.1.1. This Contract shall be in effect through December 31, 2017, and, so long as the Contractor has not provided CMS with a notice of intention not to renew, and CMS/RI EOHHS have not provided the Contractor with a notice of intention not to renew, pursuant to 42 C.F.R. § 422.506, shall be renewed in one year terms, through December 31, 2020.

5.9.1.2. This Contract shall be in effect starting on the date on which all Parties have signed the Contract and shall be effective, unless otherwise terminated, through December 31, 2017. The Contract shall be renewed in one-year terms through December 31, 2020, so long as the Contractor has not provided CMS and RI EOHHS with a notice of intention not to renew, pursuant to 42 C.F.R. 422.506 or Section 5.5, above.

5.9.1.3. At the discretion of CMS and upon notice to the Parties, this Contract may be terminated, or the effectuation of the Contract Operational Start Date may be delayed, if Rhode Island has not received all necessary approvals from CMS or, as provided in

Section 2.2.1 of this Contract, if the Contractor is determined not to be ready to participate in the Demonstration.

5.9.1.4. Rhode Island may not expend federal funds for, or award federal funds to, the Contractor until Rhode Island has received all necessary approvals from CMS. Rhode Island may not make payments to Contractor by using federal funds, or draw federal Medical Assistance Payment (FMAP) funds, for any services provided, or costs incurred, by Contractor prior to the later of the approval date for any necessary State Plan and waiver authority, the Readiness Review approval, or the Contract Operational Start Date.

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Section 6. Signatures

In Witness Whereof, CMS, RI EOHHS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

Peter Marino

Chief Executive Officer

Neighborhood Health Plan of Rhode Island

3/16/18

Date

REVIEWED BY LEGAL Initials Date 4/1/18

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In Witness Whereof, CMS, RI EOHHS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

Eric Beane

Eric Beane

Secretary

Executive Office of Health and Human Services

2/20/18

Date

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In Witness Whereof, CMS, RI EOHHS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

3/20/2018

Kathryn Coleman — Date

Director

Medicare Drug & Health Plan Contract Administration Group

Centers for Medicare & Medicaid Services

United States Department of Health and Human Services

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In Witness Whereof, CMS, RI EOHHS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

Richard R McGreal

Richard McGreal

Associate Regional Administrator

Centers for Medicare & Medicaid Services

United States Department of Health and Human Services

2-20-18

Date

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Appendix A. Covered Services

A.1 Medical Necessity: The Contractor shall provide services to Enrollees as follows:

A.1.1 Authorize, arrange, coordinate, and provide to Enrollee all Medically Necessary Covered Services as specified in Section 2.4, in accordance with the requirements of the Contract.

A.1.2 Provide all Covered Services that are Medically Necessary, including but not limited to, those Covered Services that:

A.1.2.1 Prevent, diagnose, or treat health impairments;

A.1.2.2 Attain, maintain, or regain functional capacity.

A.1.3 Not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of diagnosis, type of illness, or condition of the Enrollee.

A.1.4 Not deny authorization for a Covered Service that the Enrollee or the Health Care Professional demonstrates is Medically Necessary.

A.1.5 The Contractor may place appropriate limits on a Covered Service on the basis of Medical Necessity, or for the purpose of Utilization Management, provided that the furnished services can reasonably be expected to achieve their purpose. The Contractor's Medical Necessity guidelines must, at a minimum, be:

A.1.5.1 Developed with input from practicing Health Care Professionals in the Contractor's Service Area;

A.1.5.2 Developed in accordance with standards adopted by national accreditation organizations;

A.1.5.3 Developed in accordance with the definition of Medically Necessary Services in Section 1.83;

A.1.5.4 Updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice;

A.1.5.5 Evidence-based, if practicable; and

A.1.5.6 Applied in a manner that considers the individual health care needs of the Enrollee.

A.1.6 The Contractor's Medical Necessity guidelines, program specifications and service components for Behavioral Health and Substance Abuse Treatment

Services must, at a minimum, be submitted to RI EOHHS annually for approval no later than thirty (30) days prior to the start of a new Demonstration Year, and no later than thirty (30) days prior to any change.

A.1.7 The Contractor must offer Enrollees any additional non-medical programs and services available to a majority of the Contractor's commercial population, if any, on the same terms and conditions on which those programs and services are offered to the commercial population, unless otherwise agreed upon in writing by RI EOHHS and the Contractor, such as health club discounts, etc. The Contractor's Capitation Rate shall not include the costs of such programs and services.

A.1.8 Offer and provide to all Enrollees any and all non-medical programs and services specific to Enrollees for which the Contractor has received RI EOHHS approval.

A.2 Covered Services: The Contractor agrees to provide Enrollees access to the following Covered Services:

A.2.1 All services provided under The Rhode Island State Plan, excluding those services otherwise excluded or limited in A.4, A.5 or A.6 of this Appendix.

A.2.2 All services provided under Medicare Part A

A.2.3 All services provided under Medicare Part B

A.2.4 All services provided under Medicare Part D

A.2.5 Pharmacy products that are covered by RI EOHHS and may not be covered under Medicare Part D, including:

A.2.5.1 Over-the-counter (OTC) drugs as specified by RI EOHHS.

A.2.5.2 "Miscellaneous" drugs for indications that may not be covered by Part D (dronabinol, megestrol, oxandrolone, somatropin); and

A.2.5.3 Prescription vitamins and minerals as specified by RI EOHHS.

A.2.6 Contractor is encouraged to offer a broader drug formulary than minimum requirements.

A.2.7 The Contractor may offer cost effective alternative services/equipment to Enrollees, where those services/equipment are not identified as an in-plan benefit, when the State has determined that the use of such alternative services/equipment is medically appropriate and cost effective. The Contractor may not require the Enrollee to accept an in lieu of service in the place of a covered service. The Contractor may provide all the in lieu of services

identified below without obtaining prior approval from EOHHS. If the Contractor seeks to provide an in lieu of service that is not listed below, the Contractor must obtain a prior authorization from EOHHS to deliver the proposed service.

A.2.8 "In lieu of services or setting" are alternative services or settings that are not included in the State Plan or otherwise covered by the contract but are medically appropriate, cost-effective substitutes for State Plan services or settings included within a contract. EOHHS identifies the following services as those services, which the Contractor may provide to members without obtaining prior approval from EOHHS. If the Contractor seeks to provide cost-effective alternative services not listed below, it must obtain prior written approval from EOHHS.

SERVICES APPROVED BY EOHHS AS IN LIEU OF SERVICES	**SERVICE FOR WHICH THE IN LIEU OF SERVICE IS OFFERED AS AN ALTERNATIVE**
• Chiropractic Services • Acupuncture • Massage Therapy • Yoga • Meditation classes for purpose of pain management	• Medications for treating pain • Invasive procedures including surgical procedures
• Medication management services which include: o Ensuring compliance with medication regime o Prepacking medication boxes o Creating reference guide describing medications and dosages	• Extended Skilled Nursing Services.
• Nutritional Programs which include: o Weight Reduction Programs for Obesity o Therapeutic counseling o Group support programs	• Gastric By-pass Surgery • Weight Reduction Medications prescribed by a licensed provider
• Meals on Wheels-Meal delivery for persons who are in danger of malnutrition and/or have limited mobility or access to transportation	• Preventive homecare services. • Homemaking services up to 6 hrs/wk
• Home care hours greater than 6 hours to prevent increases in level of care or institutionalization	• Long Term Care placements

SERVICES APPROVED BY EOHHS AS IN LIEU OF SERVICES	SERVICE FOR WHICH THE IN LIEU OF SERVICE IS OFFERED AS AN ALTERNATIVE
• Medically appropriate smart phone applications	• Face to Face office visit with a licensed provider
• Therapeutic Light Boxes	• Antidepressant medication management for seasonal depression

A.2.9 The Contractor must follow the procedures below for obtaining prior approval for in lieu of services not identified in A.2.8.:

A.2.9.1 Requests for prior authorization must be submitted by the Contractor only.

A.2.9.2 Requests for prior authorization must be submitted through completion of the "Request for Cost-Effective Alternative (CEA)" form along with any accompanying documentation. Submission must be send by secure email to the designated member of EOHHS.

A.2.9.3 To ensure EOHHS has the opportunity to adequately consider all requests for in lieu of services, the Contractor should submit the request at least 30 days prior to the desired date of service.

A.2.10 Value Add Services: services/equipment which are not in the State Plan but are cost effective, improve health and clinically appropriate. Contractor is authorized to offer alternative services and value add services/equipment where such services are cost effective and clinically appropriate, including interventions intended to address social determinants of health. The provision of value add services is not included in determining the capitation rate.

A.3 Cost-sharing for Covered Services

A.3.1 Except as described below, cost-sharing of any kind is not permitted in this Demonstration.

A.3.2 Cost Sharing for Part D drugs.

A.3.2.1 Co-pays charged by the Contractor for Part D drugs must not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy.

A.3.2.2 The Contractor may establish lower cost-sharing for prescription drugs than the maximum allowed.

A.3.3 Cost Sharing for Medicaid Services.

A.3.3.1 For Medicaid services beyond the pharmacy Cost Sharing described here, the Contractor will not charge Cost Sharing to Enrollees above levels established under the State Plan.

A.3.3.2 The Contractor is free to waive Medicaid Cost Sharing.

A.3.3.3 For Enrollees who are residents of Nursing Facilities or receiving community-based LTSS, the Contractor may require the Enrollee to contribute to the cost of Nursing Facility or community-based LTSS care the amount listed for the Enrollee on the RI EOHHS 834 daily file, which will be transmitted daily to the Demonstration Plan.

A.4 Limitations on Covered Services. The following services and benefits shall be limited as Covered Services:

A.4.1 Termination of pregnancy may be provided only as allowed by applicable State and federal law and regulation (42 C.F.R. Part 441, Subpart E).

A.4.2 Sterilization services may be provided only as allowed by State and federal law (see 42 C.F.R. Part 441, Subpart F).

A.5 Excluded Services. The following services are carved out of the Covered Services benefits. The Contractor agrees to coordinate and refer for these services as necessary.

A.5.1 Dental services

A.5.2 Non-emergency transportation services (Non-emergency transportation is coordinated by the Contractor).

A.5.3 Residential services for I/DD Enrollees

A.5.4 Home Stabilization Services

A.6 Non-Covered Services

A.6.1 Experimental procedures

A.6.2 Abortion services, except to preserve the life of the woman, or in cases of rape or incest

A.6.3 Private rooms in hospitals (unless medically necessary)

A.6.4 Cosmetic surgery (please see A.2.2 and A.2.3)

A.6.5 Infertility treatment services (please see A.2.2 and A.2.3)

A.6.6 Medications for sexual or erectile dysfunction

A.7 Medicaid Covered Services

SERVICE	SCOPE OF BENEFIT (ANNUAL)
Inpatient Hospital Care	Up to 365 days per year based on medical necessity. RI EOHHS shall be responsible for inpatient admissions or authorizations while the Enrollee was in Medicaid fee-for-service, prior to the Enrollee's enrollment in Contractor's MMP. Contractor shall be responsible for inpatient admissions or authorizations, even after the Enrollee has been disenrolled from Contractor's MMP and enrolled in another health plan or re-enrolled into Medicaid fee-for-service, until the management of the Enrollee's care is formally transferred to the care of another health plan, another program option, or fee-for-service Medicaid.
Outpatient Hospital Services	Covered as needed, based on medical necessity. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting. (Contractor has the option to deliver these types of services in other appropriate settings.)
Physical Therapy Evaluation and Services	Physical therapy evaluation for home accessibility appliances or devices by an individual with a State-approved licensing or certification. Preventive physical therapy services are available prior to surgery if evidence-based practice has demonstrated that the therapy will enhance recovery or reduce rehabilitation time.
Physician Services	Covered as needed, based on medical necessity, including primary care, specialty care, obstetric and newborn care. Up to one (1) annual and five (5) gynecology visits annually to a network Health Care Professional for family planning is covered without a PCP referral.
Care Management Services	Services that assist Enrollees in gaining access to needed Covered and non-Covered Services, as well as needed social, educational, and other services, regardless of the funding source for the services to which access is gained. LCMs and Care Coordinators are responsible for ongoing monitoring of the provision of services included in the Enrollee's ICP and other care plans. LCMs and Care Coordinators initiate and oversee the process of assessment and reassessment of the significant changes in client circumstances.
Family Planning Services	Enrollees have freedom of choice of providers of Family planning services.

Prescription Drugs	Covered when prescribed by a Health Care Professional. Generic substitution only unless provided for otherwise as described in the *Medicaid Managed Care Pharmacy Benefit Plan Protocols.*
Non-Prescription Drugs	Covered when prescribed by a Health Care Professional. Limited to non-prescription drugs, as described in the *Medicaid Managed Care Pharmacy Benefit Plan Protocols*. Includes nicotine cessation Supplies ordered by a Health Care Professional. Includes Medically Necessary nutritional supplements ordered by a Health Care Professional.
Laboratory Services	Covered when ordered by a Health Care Professional , including urine drug screens
Radiology Services	Covered when ordered by a Health Care Professional.
Diagnostic Services	Covered when ordered by a Health Care Professional.
Mental Health and Substance Use Disorder Treatment-Outpatient/Inpatient	Covered as needed for all Enrollees. Covered services include a full continuum of mental health and substance use disorder (MH/SUD) treatment, including but not limited to: community-based narcotic treatment; methadone, community- or hospital-based detox; MH/SUD residential treatment; mental health psychiatric rehabilitative residence (MHPRR); psychiatric rehabilitation day programs; Assertive Community Treatment (ACT); as described in in the following State documents: Integrated Health Homes Rhode Island SMI Program Description and Integrated Health Home (IHH) and Assertive Community Treatment (ACT) Program Provider Billing Manual; Integrated Health Home (IHH) as described in the following State documents: Integrated Health Homes Rhode Island SMI Program Description and Integrated Health Home (IHH) and Assertive Community Treatment (ACT) Program Provider Billing Manual; and services for individuals at CMHCs.

Home Health Services	Covered when provided at a beneficiary's place of residence, on his or her physician's orders as part of a written plan of care that the physician reviews every 60 days except for DME as specified at 440.70(b)(3). Nursing services, home health aide services and DME are required services. Physical therapy, occupational therapy, or speech pathology and audiology services are optional services the State can provide. Home Health services should not prohibit a beneficiary from receiving home health services in any setting in which normal life activities take place, other than a hospital; nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home Health services cannot be limited to services furnished to beneficiaries who are homebound.
Emergency Room Service and Emergency Transportation Services	Covered both in- and out-of-State, for Emergency Services (Section 2.8), or when authorized by a Contractor's Health Care Professional, or in order to assess whether a condition warrants treatment as an Emergency Service.
Nursing Home Care and Skilled Nursing Facility Care	Covered when ordered by a Health Care Professional, up to 365 days a year. All skilled and custodial care covered.
Services of Other Practitioners	Covered if referred by a Health Care Professional. Practitioners certified and licensed by the State of Rhode Island including nurse practitioners, physicians' assistants, social workers, licensed dietitians, psychologists and licensed nurse midwives.
Podiatry Services	Covered as ordered by a Health Care Professional.
Optometry Services	Benefit is limited to examinations that include refractions and provision of eyeglasses if needed once every two (2) years. Eyeglass lenses are covered more than once in two (2) years only if Medically Necessary. Eyeglass frames are covered only every two (2) years. Annual eye exams are covered for Enrollees who have diabetes. Other Medically Necessary treatment visits for illness or injury to the eye are covered.

Oral Health	*Inpatient:* Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by an Enrollee in an inpatient setting. *Outpatient:* Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by an Enrollee in an outpatient hospital setting. *Oral Surgery:* Treatment covered as Medically Necessary, as detailed in the *Schedule of In-Plan Oral Health Benefits*.
Hospice Services	Covered as ordered by a Health Care Professional.
Durable Medical Equipment (DME)	Covered as ordered by a Contractor's physician as medically necessary, except if the DME qualifies as a residential service for I/DD Enrollees (see Section A.5 in this Appendix A).
Adult Day Health	Covered as needed based on Medical Necessity. 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.
Nutrition Services	Covered as delivered by a licensed dietitian for certain medical conditions as defined in Appendix I and as referred by a Health Care Professional.
Group/Individual Education Programs	Including healthy lifestyles/weight management, wellness, weight loss, and tobacco cessation programs and services.
Interpreter Services	Covered as needed.
Transplant Services	Covered when ordered by a Health Care Professional.

HIV/AIDS Non-Medical Targeted Care Management for People Living with HIV/AIDS (PLWH/As) and Those That Are at High Risk for Acquiring HIV	Covered for Enrollees living with HIV/AIDS and for those at high risk for acquiring HIV. These services provide a series of consistent and required steps such that all Enrollees are provided with an intake, assessment, and care plan. Health Care Professionals must utilize an acuity index to monitor Enrollee severity. Care Management services are specifically defined as services furnished to assist Enrollees who reside in a community setting or are transitioning to a community setting to gain access to needed medical, social, educational and other services, such as housing and transportation. Targeted Care Management can be furnished without regard to Medicaid State-wideness or comparability requirements. This means that targeted Care Management services may be limited to a specific group of individuals (e.g., HIV/AIDS, by age or health/mental health condition) or a specific area of the State. Services may include but are not limited to; - Benefits/entitlement counseling and referral activities to assist eligible Enrollees to obtain access to public and private programs for which they may be eligible - All types of Care Management encounters and communications (face-to-face, telephone contact, other) - Categorical populations designated as high risk, such as sex workers A series of metrics and quality performance measures for both HIV Care Management for PLWH/As and those at high risk for HIV will be collected by Health Care Professionals and are required outcomes for delivering this service. The Contractor shall provide reporting on these services to RI EOHHS, at a frequency determined by RI EOHHS. Services do not involve coordination and follow up of medical treatments.

AIDS Medical Case Management	Medical Care Management services (including treatment adherence) are a range of patient-centered services that link Enrollees with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are components of medical Care Management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the Enrollee's and other key Family members' needs and personal support systems. Medical Care Management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: 1) Intake; 2) Assessment of service needs; 3) Development of a comprehensive ICP; 4) Coordination of services required to implement the ICP; 5) Monitoring the ICP to assess the efficacy of the plan; and 6) Periodic re-evaluation and adaptation of the plan as necessary over the time the Enrollee is enrolled in services. It includes Enrollee-specific advocacy and/or review of utilization of services. This includes all types of Care Management including face-to-face, phone contact, and any other form of communication. A series of metrics and quality performance measures for HIV medical Care Management for PLWH/As will be collected by Health Care Professionals and are required outcomes for delivering this service. The Contractor shall provide reporting on these services to RI EOHHS, at a frequency determined by RI EOHHS.

Court-Ordered Mental Health and Substance Abuse Treatment – Criminal Court	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 Contractor may conduct utilization review on the length of stay. The Contractor 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 service that must be provided in totality as a Covered Service: • 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 (e.g., probation officer, clinical social worker). • Condition of medical parole: Person is released to treatment as a condition of their parole, by the parole board.

Court-Ordered Mental Health and Substance Abuse Treatment – Civil Court	All civil (mental health court) court-ordered treatment must be provided in totality as a Covered Service. Contractor must follow all regulations promulgated pursuant to R.I. Gen. Laws §40.1-1 et seq., Behavioral Healthcare, Developmental Disabilities and Hospitals, and R. I. Gen. Laws §40.1-5 et seq., Mental Health Law, including R.I. Gen. Laws §40.1-5.5 et seq. Treatment may be ordered at the following facilities: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro Children's Hospital), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, community mental health centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than seven (7) calendar Days, will be disenrolled from the Contractor's MMP at the end of the month, and be re-assigned into Medicaid FFS. Court-ordered treatment that is not an in-plan benefit or provided by a non-network Health Care Professional is not the responsibility of the Contractor. The Contractor must offer appropriate transitional Care Management to persons upon discharge and coordinate and/or arrange for Medically Necessary Covered Services to be in place after a court order expires. Civil court-ordered treatment can be from the result of: a) Voluntary admission b) Emergency certification c) Civil court certification
Telemedicine	As described in Section 2.4.1.10.1.
Opioid treatment program Health Home	Covered as needed for opioid dependent Enrollees who are receiving or who meet criteria for medication assisted treatment and have or are at risk for another chronic health condition. Coverage by the Contractor is contingent upon CMS approval of the State Plan Amendment for this service.
Minor Environmental Modifications	Minor modifications to the home may include grab bars, versa frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats, and other simple devices or appliances, such as eating utensils, transfer bath bench, shower chair, aids for personal care (e.g., reachers), and standing poles to improve home accessibility adaption, health, or safety.
Environmental Modifications (Home Accessibility Adaptations)	Physical adaptations to the home of the Enrollee or the Enrollee's family that are necessary to ensure the health, welfare, and safety of the Enrollee or that enable the Enrollee to attain or retain capability for independence or self-care in the home and to avoid institutionalization, and are not covered or available under any other

	funding source. A completed home assessment by a specially trained and certified rehabilitation professional is also required. Such adaptations may include the installation of modular ramps, grab-bars, vertical platform lifts and interior stair lifts. Excluded are those adaptations that are of general utility, and are not of direct medical or remedial benefit to the member. Excluded are any re-modeling, construction, or structural changes to the home, i.e. (changes in load bearing walls or structures) that would require a structural engineer, architect and/or certification by a building inspector. Adaptations that add to the total square footage of the home are excluded from this benefit. All adaptations shall be provided in accordance with applicable state or local building codes and prior approved on an individual basis by the Contractor is required. Items should be of a nature that they are transferable if a member moves from his/her place of residence.
Special Medical Equipment (Minor Assistive Devices)	Specialized medical equipment and Supplies to include: (a) devices, controls, or appliances, which enable Enrollees to increase their ability to perform ADLs; and (b) Devices, controls, or appliances that enable the Enrollee to perceive, control, or communicate with the environment in which they live. All items shall meet applicable standards of manufacture, design, and installation. Provision of specialized medical equipment requires prior approval on an individual basis by the Contractor.

Preventive Services

Homemaker	Services that consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him/herself or others in the home. Homemakers shall meet such standards of education and training established by the State for the provision of these activities.
Physical Therapy Evaluation and Services	Physical therapy evaluation for home accessibility appliances or devices by an individual with a State-approved licensing or certification. Preventive physical therapy services are available prior to surgery if evidence-based practice has demonstrated that the therapy will enhance recovery or reduce rehabilitation time.
Respite	Temporary caregiving services given to an Enrollee unable to care for himself/herself because of the absence or need for relief of those persons normally providing the care. Respite services can be provided in the Enrollee's home or in a facility approved by the State, such as a hospital, nursing facility, adult day services center, foster home, or community residential facility. An Enrollee qualifies for these respite services if he/she requires the services of a professional or qualified technical health professional or requires assistance with at least two (2) ADLs.

Long Term Services and Supports

Homemaker	Services that consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the state for the provision of these activities.
Meals on Wheels (Home Delivered Meals)	The delivery of hot meals and shelf staples to the Enrollee's residence. Meals are available to Enrollees unable to care for their nutritional needs because of a functional dependency/disability and who require this assistance to live in the community. Meals provided under this service will not constitute a full daily nutritional requirement. Meals must provide a minimum of one-third of the current recommended dietary allowance. Provision of home delivered meals will result in less assistance being authorized for meal preparation for individual participants, if applicable.
Personal Emergency Response (PERS)	An electronic device that enables certain Enrollees at high risk of institutionalization to secure help in an emergency. The Enrollee may also wear a portable "help" button to allow for mobility. The system is connected to the Enrollee's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center, as specified by RI EOHHS. This service includes coverage for installation and a monthly service fee. Health Care Professionals are responsible to insure the upkeep and maintenance of the devices/systems.
Skilled Nursing Services (LPN Services)	LPN services provided under the supervision of a registered nurse. LPN services are available to Enrollees who require interventions beyond the scope of certified nursing assistant (CNA) duties. LPN services are provided in accordance with the nurse practice act under the supervision of a registered nurse. This service is aimed at Enrollees who have achieved a measure of medical stability despite the need for chronic care nursing interventions.

Community Transition Services	Community transition services are non-recurring set-up expenses for Enrollees who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the Enrollee is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable an Enrollee to establish a basic household that do not constitute room and board and may include: security deposits that are required to obtain a lease on an apartment or home; essential household furnishings, and moving expense; set-up fees or deposits for utility or service access; and services necessary for the Enrollee's health and safety and activities to assess need arrange for and procure needed resources. Community transition services are furnished only to the extent that they are reasonable and necessary as determined through the Community Transition Plan development process and clearly identified in the Community Transition Plan and the Enrollee is unable to meet such expense or when the services cannot be obtained from other sources. They do not include ongoing shelter expenses, food, regular utility charges, household appliances, or items intended for recreational purposes.
Residential Supports	Assistance with acquisition, retention, or improvement in skills related to ADLs, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the Enrollee to reside in their own home and a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance (where applicable), or upkeep and improvement.
Day Supports	Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Day supports focus on enabling the Enrollee to attain or maintain his/her maximum functioning level and are coordinated with any other services identified in the Enrollee's LTSS Care Plan.
Supported Employment	Includes activities needed to sustain paid work by individuals receiving waiver services, including supervision, transportation and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision, and training required by individuals receiving services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

RIte @ Home (Supported Living Arrangements-Shared Living)	Personal care and services, homemaker, chore, attendant care, companion services, and medication oversight (to the extent permitted under State law) provided in a private home by a principal care provider who lives in the home. Supported living arrangements are furnished to Enrollees who receive these services in conjunction with residing in the home. Separate payment will not be made for homemaker or chore services furnished to an Enrollee receiving supported living arrangements, since these services are integral to and inherent in the provision of adult foster care services.
Private Duty Nursing	Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law and as identified in the LTSS Care Plan. These services are provided to an Enrollee at home.
Supports for Consumer Direction (Supports Facilitation)	Focuses on empowering Enrollees to define and direct their own personal assistance needs and services; guides and supports, rather than directs and manages, the Enrollee through the service planning and delivery process. The facilitator counsels, facilitates, and assists in development of a self-directed care plan which includes both paid and unpaid services and supports designed to allow the Enrollee to live in the home and participate in the community. A back-up plan is also developed to assure that the needed assistance will be provided in the event that regular services identified in the self-directed care plan are temporarily unavailable.
Self-Directed Goods and Services	Self-directed goods and services are services, equipment or Supplies not otherwise provided through LTSS or through the Medicaid State Plan that address an identified need and are in the approved self-directed care plan (including improving and maintaining the Enrollee's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services and/or promote inclusion in the community; and/or the item or service would increase the Enrollee's ability to perform ADLs or IADLs and/or increase the person's safety in the home environment; and, alternative funding sources are not available. Individual goods and services are purchased from the Enrollee's self-directed budget through the fiscal intermediary when approved as part of the self-directed care plan. Examples include a laundry service for a person unable to launder and fold clothes or a microwave for a person unable to use a stove due to his/her disability. This will not include any good/service that would be restrictive to the Enrollee or strictly experimental in nature.

Financial Management Services (Fiscal Intermediary)	Payroll services for Personal Choice program Enrollees; responsible for all taxes, fees, and insurances required for the Personal Choice program Enrollee to act as an employer of record; manage all non-labor related payments for goods and services authorized in the participant's approved spending plan; assure that all payments made under the Demonstration comply with the Enrollee's approved spending plan and conduct criminal background and abuse registry screens of all Enrollee's employees.
Senior Companion (Adult Companion Services)	Non-medical care, supervision and socialization, provided to a functionally impaired adult Enrollee. Companions may assist or supervise the Enrollee with such tasks as meal preparation, laundry and shopping. The provision of companion services does not entail hands-on nursing care. Companions may also perform light housekeeping tasks, which are incidental to the care and supervision of the Enrollee. This service is provided in accordance with a therapeutic goal in the LTSS Care Plan.

Assisted Living	Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed community care facility in conjunction with residing in the facility. This service includes twenty-four (24) hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility but the care provided by these other entities supplements that provided by the community care facility and does not supplant it. Personalized care is furnished to Enrollees who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the Enrollee, except when a physician or mental health professional has certified in writing that the Enrollee is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room, or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The Enrollee retains the right to assume risk, tempered only by the Enrollee's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each Enrollee to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect. Costs of room and board are excluded from payments for assisted living services.

Personal Care Assistance Services	Provide direct support in the home or community to Enrollees in performing tasks they are functionally unable to complete independently due to disability, based on the LTSS Care Plan and/or the self-directed care plan. Services include: • Enrollee assistance with ADLs, such as grooming, personal hygiene, toileting bathing, and dressing • Assistance with monitoring health status and physical condition • Assistance with preparation and eating of meals (not the cost of the meals itself) • Assistance with housekeeping activities (e.g., bed making, dusting, vacuuming, laundry, grocery shopping, cleaning) • Assistance with transferring, ambulation, and use of special mobility devices • Assisting the Enrollee by directly providing or arranging transportation (If providing transportation, the personal care assistant must be verified as having a valid driver's license and liability coverage).

Respite	Respite can be defined as a service provided to Enrollees unable to care for themselves that is furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the Enrollee. Federal financial participation is not claimed for the cost of room and board as respite services are provided in a private home setting, which may be in the Enrollee's home or occasionally in the respite provider's private residence, depending on Family preference and case-specific circumstances. When an individual is referred to a RI EOHHS-certified respite agency, a respite agency staff person works with the Family to assure they have the requisite information and/or tools to participate and manage the respite services, The Enrollee/Family will already have an allocation of hours that has been recommended and approved by RI EOHHS. These hours will be released in six (6) month increments. The Enrollee/Family will determine how they wish to use these hours. Patterns of potential usage might include: intermittent or occasional use; routine use of a few hours each week; planned weekends away; a single block of hours that might allow the rest of the Family to spend a few days together; or some combination of the above. The Enrollee's/Family's plan will be incorporated into a written document that will also outline whether the Enrollee/Family wants help with recruitment, the training needed by the respite worker, the expectations of the Enrollee/Family relative to specific training and orientation to the home, and expectations relative to documenting the respite worker's time. Each eligible Enrollee may receive up to one hundred (100) hours of respite services in a year. Additional hours may be available for urgent situations, at the discretion of the Contractor.
Rehabilitation Services	Physical, occupational and speech therapy services may be provided with Health Care Professional orders by RI DOH licensed outpatient rehabilitation centers. These services supplement home health and outpatient hospital clinical rehabilitation services when the Enrollee requires specialized rehabilitation services not available from a home health or outpatient hospital provider.

Appendix B. Enrollee Rights

B.1 The Contractor must have written policies regarding the Enrollee rights specified in this appendix, as well as written policies specifying how information about these rights will be disseminated to Enrollee. Enrollee must be notified of these rights and protections at least annually, and in a manner that takes in to consideration cultural considerations, Functional Status and language needs. Enrollee rights include, but are not limited to, those rights and protections provided by 42 C.F.R. §§ 438.100, 438.400, 42 C.F.R. §422 Subpart C, and the RI EOHHS Memorandum of Understanding (MOU).

B.2 Specifically, Enrollee must be guaranteed:

B.2.1 The right to be treated with dignity and respect.

B.2.2 The right to be afforded privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law.

B.2.3 The right to be provided a copy of his or her medical records, upon request, and to request corrections or amendments to these records, as specified in 45 C.F.R. part 164.

B.2.4 The right not to be discriminated against based on race, ethnicity, national origin, religion, sex, age, sexual orientation, gender identity, medical or Claims history, mental or physical disability, genetic information, or source of payment.

B.2.5 The right to have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed.

B.2.6 Access to an adequate network of primary and specialty providers who are capable of meeting the Enrollee's needs with respect to physical access, and communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting.

B.2.7 The right to choose a plan and provider at any time, including a plan outside of the Demonstration, and have that choice be effective the first calendar Day of the following month.

B.2.8 The right to have a voice in the governance and operation of the integrated system, provider or health plan, as detailed in this three-way Contract.

B.2.9 The right to participate in all aspects of care and to exercise all rights of Appeal.

B.2.10 Enrollee have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse

treatment if desired, and must be appropriately informed and supported to this end. Specifically, Enrollee must:

B.2.10.1 Receive an assessment (IHS, CFNA, Discharge Opportunity Assessment, or Wellness Assessment, as applicable), upon Enrollment in a plan and to participate in the development and implementation of an ICP. The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, an evaluation of the Enrollee's strengths and weaknesses, and a plan for managing and coordination Enrollee's care. Enrollee, or their designated representative, also has the right to request a reassessment by the interdisciplinary team, and be fully involved in any such reassessment.

B.2.10.2 Receive complete and accurate information on his or her health and functional status by the ICT.

B.2.10.3 Be provided information on all program services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking in to consideration Enrollee's condition and ability to understand. An Enrollee who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:

B.2.10.3.1 Before Enrollment.

B.2.10.3.2 At Enrollment.

B.2.10.3.3 At the time an Enrollee's needs necessitate the disclosure and delivery of such information in order to allow the Enrollee to make an informed choice.

B.2.10.4 Be encouraged to involve caregivers or Family Enrollees in treatment discussions and decisions.

B.2.10.5 Have advance directives explained and to establish them, if the Enrollee so desires, in accordance with 42 C.F.R. §§ 489.100 and 489.102.

B.2.10.6 Receive reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer.

B.2.10.7 Be afforded the opportunity file an Appeal if services are denied that he or she thinks are medically indicated, and to be able to

ultimately take that Appeal to an independent external system of review.

B.2.10.8 The right to receive medical and non-medical care from a team that meets the Enrollee's needs, in a manner that is sensitive to the Enrollee's language and culture, and in an appropriate care setting, including the home and community.

B.2.10.9 The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

B.2.10.10 Each Enrollee is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the Contractor and its providers or the State agency treat the Enrollee.

B.2.10.11 The right to receive timely information about plan changes. This includes the right to request and obtain the information listed in the orientation materials at least once per year, and the right to receive notice of any significant change in the information provided in the orientation materials at least thirty (30) Days prior to the intended effective date of the change.

B.2.10.12 The right to be protected from liability for payment of any fees that are the obligation of the Contractor.

B.2.10.13 The right to be afforded information on Cost Sharing responsibilities (if applicable; may be included as an insert).

B.2.10.14 The right not to be charged any Cost Sharing for Medicare Parts A and B services.

Appendix C. Relationship With First Tier, Downstream, And Related Entities

C.1 Contractor shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on Contractor's behalf related to the operation of the Demonstration are in compliance with 42 C.F.R. §§422.504, 423.505, 438.3(k), and 438.230(b).

C.2 Contractor shall specifically ensure:

C.2.1 HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect and books, contracts, computer or other electronic systems, including medical records and documentation of the First Tier, Downstream and Related Entities; and

C.2.2 HHS's, the Comptroller General's, or their designees right to inspect, evaluate, and audit any pertinent information for any particular contract period for ten years from the expiration of the Contract or from the date of completion of any audit, whichever is later.

C.3 Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities contain the following:

C.3.1 Enrollee protections that include prohibiting providers from holding an Enrollee liable for payment of any fees that are the obligation of the Contractor;

C.3.2 Language that any services or other activity performed by a First Tier, Downstream and Related Entities is in accordance with the Contractor's contractual obligations to CMS and RI EOHHS;

C.3.3 Language that specifies the delegated activities and reporting requirements;

C.3.4 Language that provides for revocation of the delegation activities and reporting requirements or specifies other remedies in instances where CMS, RI EOHHS or the Contractor determine that such parties have not performed satisfactorily;

C.3.5 Language that specifies the performance of the parties is monitored by the Contractor on an ongoing basis and Contractor may impose corrective action as necessary;

C.3.6 Language that specifies the First Tier, Downstream and Related Entities agree to safeguard Enrollee. Privacy and confidentiality of Enrollee health records; and

C.3.7 Language that specifies the First Tier, Downstream and Related Entities must comply with all Federal and State laws, regulations and CMS and RI EOHHS instructions.

C.4 Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that are for credentialing of Health Care Professionals contains the following language:

C.4.1 The credentials of Health Care Professionals affiliated with the Party or Parties will be either reviewed by the Contractor; or

C.4.2 The credentialing process will be reviewed and approved by the Contractor and the Contractor must audit the credentialing process on an ongoing basis.

C.5 Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that delegate the selection of providers must include language that the Contractor retains the right to approve, suspend, or terminate any such arrangement.

C.6 Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall state that neither the Contractor nor the provider has the right to terminate the contract without cause and shall require the provider to provide at least 60 days' notice to the Contractor and assist with transitioning Enrollee to new providers, including sharing the Enrollee's medical record and other relevant Enrollee information as directed by the Contractor or Enrollee.

C.7 Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall state that the Contractor shall provide a written statement to a provider of the reason or reasons for termination with cause.

C.8 Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for Health Care Professionals include additional provisions. Such contracts or arrangements must contain the following:

C.8.1 Language that the Contractor is obligated to pay contracted Health Care Professionals under the terms of the contract between the Contractor and the Health Care Professional. The contract must contain a prompt payment provision, the terms of which are developed and agreed to by both the Contractor and the relevant Health Care Professional;

C.8.2 Language that services are provided in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds;

C.8.3 Language that Health Care Professionals abide by all Federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and Enrollment information;

C.8.4 Language that Health Care Professionals ensure that medical information is released in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas;

C.8.5 Language that Health Care Professionals maintain Enrollee Medical Records and information in an accurate and timely manner;

C.8.6 Language that Health Care Professionals ensure timely access by Enrollee to the records and information that pertain to them; and

C.8.7 Language that Enrollee will not be held liable for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Enrollee.

C.8.8 Language that clearly state the Health Care Professionals EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA.

C.8.9 Language prohibiting Health Care Professionals, including, but not limited to PCPs, from closing or otherwise limiting their acceptance of Enrollee as patients unless the same limitations apply to all commercially insured Enrollees.

C.8.10 Language that prohibits the Contractor from refusing to contract or pay an otherwise eligible Health Care Professionals for the provision of Covered Services solely because such Health Care Professional has in good faith:

C.8.10.1 Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the Contractor's health benefit plans as they relate to the needs of such Health Care Professional's patients; or

C.8.10.2 Communicated with one or more of his or her prospective, current or former patients with respect to the method by which such Health Care Professional is compensated by the Contractor for services provided to the patient.

C.8.11 Language that states the Health Care Professionals is not required to indemnify the Contractor for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the Contractor based on the Contractor's management decisions, utilization review provisions or other policies, guidelines or actions.

C.8.12 Language that states the Contractor shall require Health Care Professionals to comply with the Contractor's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services.

C.8.13 Language that states that the Contractor shall encourage all Health Care Professionals to enroll as a user of CurrentCare, including hospital alerts.

C.8.14 Language that states that the Contractor shall require network Health Care Professionals to submit to the DOH laboratory all specimens for HIV testing and mycobacteria (TB) analysis.

C.8.15 Language that states the Contractor shall notify Health Care Professionals in writing of modifications in payments, modifications in Covered Services or modifications in the Contractor's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of the Health Care Professionals, and the effective date of the modifications. The notice shall be provided 30 days before the effective date of such modification unless such other date for notice is mutually agreed upon between the Contractor and the provider or unless such change is mandated by CMS or RI EOHHS without 30 days prior notice.

C.8.16 Language that states that Health Care Professionals shall not bill patients for charges for Covered Services other than pharmacy co-payments, if applicable.

C.8.17 Language that states that no payment shall be made by the Contractor to a Health Care Professional for a Provider Preventable Condition; and

C.8.18 As a condition of payment, the Health Care Professional shall comply with the reporting requirements as set forth in 42 C.F.R. § 447.26(d) and as may be specified by the Contractor. The Health Care Professional shall comply with such reporting requirements to the extent the Health Care Professional directly furnishes services.

C.9 Contractor shall ensure that contracts or arrangements with First Tier, Downstream and Related Entities for Health Care Professionals do not include incentive plans that include a specific payment to a provider as an inducement to deny, reduce, delay, or limit specific, Medical Necessary Services and;

C.9.1 The Health Care Professional shall not profit from provision of Covered Services that are not Medically Necessary or medically appropriate.

C.9.2 The Contractor shall not profit from denial or withholding of Covered Services that are Medically Necessary or medically appropriate.

C.10 Nothing in this section shall be construed to prohibit contracts that contain incentive plans that involve general payments such as Capitation Payments or shared risk agreements that are made with respect to physicians or physician groups or which are made with respect to groups of Contractor if such agreements, which impose risk on such physicians or physician groups for the costs of medical care, services and equipment provided or authorized by another physician or health care provider, comply with paragraph D.11, below.

C.11 The Contractor shall ensure that contracts or arrangements with First Tier, Downstream and Related Entities for Health Care Professionals includes language that prohibits the Contractor from imposing a financial risk on Health Care Professionals for the costs of medical care, services or equipment provided or authorized by another Physician or Health Care Professional such contract includes specific provisions with respect to the following:

C.11.1 Stop-loss protection;

C.11.2 Minimum patient population size for the Physician or Physician group; and

C.11.3 Identification of the health care services for which the Physician or Physician group is at risk.

C.11.4 The Contractor shall ensure that all First Tier, Downstream and Related Entities must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, and 1003, and § 438.3(i).

C.12 The Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for laboratory testing sites providing services include an additional provision that such laboratory testing sites must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

C.13 The Contractor shall ensure that contracts or arrangements with First Tier, Downstream and Related Entities includes language that requires its First Tier, Downstream, and Related Entities to agree, to subrogate to RI 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, etc., on behalf of RI EOHHS, through the Rhode Island Attorney General's Office. Contractor is entitled to recoveries that are the direct result of a similar legal suit filed by 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 RI EOHHS or by the Rhode Island Department of Attorney General.

C.14 Nothing in this section shall be construed to restrict or limit the rights of the Contractor to include as providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious non-medical providers.

Appendix D. Part D Addendum

ADDENDUM TO CAPITATED FINANCIAL ALIGNMENT CONTRACT PURSUANT TO SECTIONS 1860D-1 THROUGH 1860D-43 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS"), the State of Rhode Island, acting by and through the Department of Health & Human Services (hereinafter referred to as RI EOHHS), and Neighborhood Health Plan of Rhode Island, a Medicare-Medicaid managed care organization (hereinafter referred to as Contractor) agree to amend the contract governing Contractor's operation of a Medicare-Medicaid Plan described in § 1851(a)(2)(A) of the Social Security Act (hereinafter referred to as "the Act") to include this addendum under which Contractor shall operate a Voluntary Medicare Prescription Drug Plan pursuant to §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act.

ARTICLE I
VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN

A. Contractor agrees to operate one or more Medicare Voluntary Prescription Drug Plans as described in its application and related materials submitted to CMS for Medicare approval, including but not limited to all the attestations contained therein and all supplemental guidance, and in compliance with the provisions of this addendum, which incorporates in its entirety the *2013 Capitated Financial Alignment Application* , released on March 29, 2012 (hereinafter collectively referred to as "the addendum"). Contractor also agrees to operate in accordance with the regulations at 42 C.F.R. Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation identified above, as well as all other applicable Federal statutes, regulations, and policies. This addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of this contract and any regulations or policies implementing or interpreting such statutory or regulatory provisions.

B. CMS agrees to perform its obligations to Contractor consistent with the regulations at 42 C.F.R. Part423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation, as well as all other applicable Federal statutes, regulations, and policies.

C. CMS agrees that it will not implement, other than at the beginning of a calendar year, regulations under 42 C.F.R. Part 423 that impose new, significant regulatory requirements on Contractor. This provision does not apply to new requirements mandated by statute.

D. This addendum is in no way intended to supersede or modify 42 C.F.R., Parts 417, 422, 423, 431, or 438. Failure to reference a regulatory requirement in this addendum does not affect the applicability of such requirements to Contractor, RI EOHHS, and CMS.

ARTICLE II
FUNCTIONS TO BE PERFORMED BY CONTRACTOR

A. ENROLLMENT

Contractor agrees to enroll in its Medicare-Medicaid plan only Eligible Beneficiaries as they are defined in 42 C.F.R. §423.30(a) and who have met the Demonstration requirements and have elected to or have been passively enrolled in Contractor's Capitated Financial Alignment benefit.

A. PRESCRIPTION DRUG BENEFIT

1. Contractor agrees to provide the required prescription drug coverage as defined under 42 C.F.R. §423.100 and, to the extent applicable, supplemental benefits as defined in 42 C.F.R. §423.100 and in accordance with Subpart C of 42 C.F.R. Part 423. Contractor also agrees to provide Part D benefits as described in Contractor's Part D plan benefit package(s) approved each year by CMS (and in the Attestation of Benefit Plan and Price, attached hereto).

2. Contractor agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality assurance activities related to the delivery of Part D services as required by 42 C.F.R. §423.505(b)(25).

B. DISSEMINATION OF PLAN INFORMATION

1. Contractor agrees to provide the information required in 42 C.F.R. §423.48.

2. Contractor acknowledges that CMS releases to the public summary reconciled Part D Payment data after the reconciliation of Part D Payments for the contract year as provided in 42 C.F.R. §423.505(o).

3. Contractor certifies that all materials it submits to CMS under the File and Use Certification authority described in the Medicare Marketing Guidelines are accurate, truthful, not misleading, and consistent with CMS marketing guidelines.

C. QUALITY ASSURANCE/UTILIZATION MANAGEMENT

1. Contractor agrees to operate quality assurance, drug Utilization Management, and medication therapy management programs, and to support electronic prescribing in accordance with Subpart D of 42 C.F.R. Part 423.

2. Contractor agrees to address Complaints received by CMS against the Contractor as required in 42 C.F.R. §423.505(b)(22) by:

(a) Addressing and resolving Complaints in the CMS Complaint tracking system; and

(b) Displaying a link to the electronic Complaint form on the Medicare.gov Internet Web site on the Part D plan's main Web page.

D. APPEALS AND GRIEVANCES

Contractor agrees to comply with all requirements in Subpart M of 42 C.F.R. Part 423 governing coverage determinations, Grievances and Appeals, and formulary exceptions and the relevant provisions of Subpart U governing reopenings. Contractor acknowledges that these requirements are separate and distinct from the Appeals and Grievances requirements applicable to Contractor through the operation of its Medicare Parts A and B and Medicaid benefits.

E. PAYMENT TO Contractor

Contractor and CMS and RI EOHHS agree that payment paid for Part D services under the addendum will be governed by the rules in Subpart G of 42 C.F.R. Part 423.

F. PLAN BENEFIT SUBMISSION AND REVIEW

If Contractor intends to participate in the Part D program for the next program year, Contractor agrees to submit the next year's Part D plan benefit package including all required information on benefits and cost-sharing, by the applicable due date, as provided in Subpart F of 42 C.F.R. Part 423 so that CMS, RI EOHHS and Contractor may conduct negotiations regarding the terms and conditions of the proposed benefit plan renewal. Contractor acknowledges that failure to submit a timely plan benefit package under this section may affect the Contractor's ability to offer a plan, pursuant to the provisions of 42 C.F.R. §422.4(c).

G. COORDINATION WITH OTHER PRESCRIPTION DRUG COVERAGE

1. Contractor agrees to comply with the coordination requirements with State Pharmacy Assistance Programs (SPAPs) and plans that provide other prescription drug coverage as described in Subpart J of 42 C.F.R. Part 423.

2. Contractor agrees to comply with Medicare Secondary Payer procedures as stated in 42 C.F.R. §423.462.

H. SERVICE AREA AND PHARMACY ACCESS

1. Contractor agrees to provide Part D benefits in the Service Area for which it has been approved by CMS and RI EOHHS (as defined in Appendix H) to offer Medicare Parts A and B benefits and Medicaid benefits utilizing a pharmacy network and formulary approved by CMS and RI EOHHS that meet the requirements of 42 C.F.R. §423.120.

2. Contractor agrees to provide Part D benefits through out-of-network pharmacies according to 42 C.F.R. §423.124.

3. Contractor agrees to provide benefits by means of point-of-service systems to adjudicate prescription drug Claims in a timely and efficient manner in compliance with CMS standards, except when necessary to provide access in underserved areas, I/T/U pharmacies (as defined in 42 C.F.R. §423.100), and long-term care pharmacies (as defined in 42 C.F.R. §423.100) according to 42 C.F.R. §423.505(b)(17).

4. Contractor agrees to contract with any pharmacy that meets Contractor's reasonable and relevant standard terms and conditions according to 42 C.F.R. §423.505(b)(18).

I. EFFECTIVE COMPLIANCE PROGRAM/PROGRAM INTEGRITY

Contractor agrees that it will develop and implement an effective compliance program that applies to its Part D-related operations, consistent with 42 C.F.R. §423.504(b)(4)(vi).

J. LOW-INCOME SUBSIDY

Contractor agrees that it will participate in the administration of subsidies for low-income subsidy eligible individuals according to Subpart P of 42 C.F.R. Part 423.

K. Enrollee Financial Protections

Contractor agrees to afford its Enrollees protection from liability for payment of fees that are the obligation of Contractor in accordance with 42 C.F.R. §423.505(g).

L. Relationship with first tier, downstream, and related Entities

1. Contractor agrees that it maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this addendum.

2. Contractor shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on Contractor's behalf related to the operation of the Part D benefit are in compliance with 42 C.F.R. §423.505(i).

M. Certification of Data That Determine Payment

1. Contractor must provide certifications in accordance with 42 C.F.R. §423.505(k).

N. Contractor REIMBURSEMENT TO PHARMACIES

1. If Contractor uses a standard for reimbursement of pharmacies based on the cost of a drug, Contractor will update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of the drug.

2. Contractor will issue, mail, or otherwise transmit payment with respect to all Claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only, or are located in, or contract with, a long-term care facility) within 14 days of receipt of

an electronically submitted Claim or within 30 days of receipt of a Claim submitted otherwise.

3. Contractor must ensure that a pharmacy located in, or having a contract with, a long-term care facility will have not less than 30 days (but not more than 90 days) to submit Claims to Contractor for reimbursement.

ARTICLE III
RECORD RETENTION AND REPORTING REQUIREMENTS

A. Record Maintenance and access

Contractor agrees to maintain records and provide access in accordance with 42 C.F.R. §§ 423.505 (b)(10) and 423.505(i)(2).

B. GENERAL REPORTING REQUIREMENTS

Contractor agrees to submit information to CMS according to 42 C.F.R. §§423.505(f) and 423.514, and the "Final Medicare Part D Reporting Requirements," a document issued by CMS and subject to modification each program year.

C. CMS and Contractor License For Use of Contractor Formulary

Contractor agrees to submit to CMS and RI EOHHS the Contractor's formulary information, including any changes to its formularies, and hereby grants to the Government, and any person or entity who might receive the formulary from the Government, a non-exclusive license to use all or any portion of the formulary for any purpose related to the administration of the Part D program, including without limitation publicly distributing, displaying, publishing or reconfiguration of the information in any medium, including www.medicare.gov, and by any electronic, print or other means of distribution.

ARTICLE IV
HIPAA PROVISIONS

A. Contractor agrees to comply with the confidentiality and Enrollee Medical Record accuracy requirements specified in 42 C.F.R. §423.136.

B. Contractor agrees to enter into a business associate agreement with the entity with which CMS has contracted to track Medicare beneficiaries' true out-of-pocket costs.

ARTICLE V
ADDENDUM TERM AND RENEWAL

A. Term of ADDENDUM

1. This addendum is effective from the date of CMS' authorized representative's signature through December 31, 2016 This addendum shall be renewable for successive one-year periods thereafter according to 42 C.F.R. §423.506.

B. Qualification to renew ADDENDUM

1. In accordance with 42 C.F.R. §423.507, Contractor will be determined qualified to renew this addendum annually only if—

   (a) Contractor has not provided CMS or RI EOHHS with a notice of intention not to renew in accordance with Article VII of this addendum, and

   (b) CMS or RI EOHHS has not provided Contractor with a notice of intention not to renew.

2. Although Contractor may be determined qualified to renew its addendum under this Article, if Contractor, CMS, and RI EOHHS cannot reach agreement on the Part D plan benefit package under Subpart F of 42 C.F.R. Part 423, no renewal takes place, and the failure to reach agreement is not subject to the Appeals provisions in Subpart N of 42 C.F.R. Parts 422 or 423. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

ARTICLE VI
NONRENEWAL OF ADDENDUM

A. Nonrenewal by Contractor

Contractor may non-renew this addendum in accordance with 42 C.F.R. §423.507(a).

B. NONRENEWAL BY CMS

CMS may non-renew this addendum under the rules of 42 C.F.R. §423.507(b). (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

ARTICLE VII
MODIFICATION OR TERMINATION OF ADDENDUM BY MUTUAL CONSENT

This addendum may be modified or terminated at any time by written mutual consent in accordance with 42 C.F.R. §423.508. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

ARTICLE VIII
TERMINATION OF ADDENDUM BY CMS

CMS may terminate this addendum in accordance with 42 C.F.R. §423.509. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

ARTICLE IX
TERMINATION OF ADDENDUM BY CONTRACTOR

A. Contractor may terminate this addendum only in accordance with 42 C.F.R. §423.510.

B. If the addendum is terminated under Section A of this Article, Contractor must ensure the timely transfer of any data or files. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

ARTICLE X
RELATIONSHIP BETWEEN ADDENDUM AND CAPITATED FINANCIAL ALIGNMENT CONTRACT

A. Contractor acknowledges that, if it is a Capitated Financial Alignment Contractor, the termination or nonrenewal of this addendum by any Party may require CMS to terminate or non-renew the Contractor's Capitated Financial Alignment contract in the event that such non-renewal or termination prevents Contractor from meeting the requirements of 42 C.F.R. §422.4(c), in which case the Contractor must provide the notices specified in this contract, as well as the notices specified under Subpart K of 42 C.F.R. Part 422.

B. The termination of this addendum by any Party shall not, by itself, relieve the parties from their obligations under the Capitated Financial Alignment contract to which this document is an addendum.

C. In the event that the Contractor's Capitated Financial Alignment contract is terminated or nonrenewed by any Party, the provisions of this addendum shall also terminate. In such an event, Contractor, RI EOHHS and CMS shall provide notice to Enrollees and the public as described in this contract as well as 42 C.F.R. Part 422, Subpart K or 42 C.F.R. Part 417, Subpart K, as applicable.

ARTICLE XI

INTERMEDIATE SANCTIONS

Consistent with Subpart O of 42 C.F.R. Part 423, Contractor shall be subject to sanctions and civil money penalties.

ARTICLE XII
SEVERABILITY

Severability of the addendum shall be in accordance with 42 C.F.R. §423.504(e).

ARTICLE XIII
MISCELLANEOUS

A. DEFINITIONS

Terms not otherwise defined in this addendum shall have the meaning given such terms at 42 C.F.R. Part 423 or, as applicable, 42 C.F.R. Parts 417, 422, 431 or Part 438.

B. ALTERATION TO ORIGINAL ADDENDUM TERMS

Contractor agrees that it has not altered in any way the terms of the Contractor addendum presented for signature by CMS. Contractor agrees that any alterations to the original text Contractor may make to this addendum shall not be binding on the parties.

C. ADDITIONAL CONTRACT TERMS

Contractor agrees to include in this addendum other terms and conditions in accordance with 42 C.F.R. §423.505(j).

D. CMS AND RI EOHHS APPROVAL TO BEGIN MARKETING AND ENROLLMENT ACTIVITIES

Contractor agrees that it must complete CMS operational requirements related to its Part D benefit prior to receiving CMS and RI EOHHS' approval to begin Contractor marketing activities relating to its Part D benefit. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS and RI EOHHS systems to process Enrollment applications (or contracting with an entity qualified to perform such functions on Contractor's behalf) and successfully demonstrating the capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, Contractor must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to send and receive transactions to and from CMS, and 4) check and receive transaction status information.

E. Pursuant to §13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), Contractor agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by §13101 of the ARRA.

F. Contractor agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 C.F.R. §423.505(b)(23).

Appendix E. Data Use Attestation

The Contractor shall restrict its use and disclosure of Medicare data obtained from CMS and RI EOHHS information systems (listed in Attachment A) to those purposes directly related to the administration of the Medicare/Medicaid managed care and/or outpatient prescription drug benefits for which it has contracted with the CMS and RI EOHHS to administer. The Contractor shall only maintain data obtained from CMS and RI EOHHS information systems that are needed to administer the Medicare/Medicaid managed care and/or outpatient prescription drug benefits that it has contracted with CMS and RI EOHHS to administer. The Contractor (or its First Tier, Downstream or other Related Entities) may not re-use or provide other entities access to the CMS information system, or data obtained from the system or RI EOHHS, to support any line of business other than the Medicare/Medicaid managed care and/or outpatient prescription drug benefit for which the Contractor contracted with CMS and RI EOHHS.

The Contractor further attests that it shall limit the use of information it obtains from its Enrollees to those purposes directly related to the administration of such plan. The Contractor acknowledges two exceptions to this limitation. First, the Contractor may provide its Enrollees information about non-health related services after obtaining consent from the Enrollees. Second, the Contractor may provide information about health-related services without obtaining prior Enrollee consent, as long as the Contractor affords the Enrollee an opportunity to elect not to receive such information.

CMS may terminate the Contractor's access to the CMS data systems immediately upon determining that the Contractor has used its access to a data system, data obtained from such systems, or data supplied by its Enrollees beyond the scope for which CMS and the RI EOHHS have authorized under this agreement. A termination of this data use agreement may result in CMS or RI EOHHS terminating the Contractor's Medicare-Medicaid contract(s) on the basis that it is no longer qualified as a Contractor. This agreement shall remain in effect as long as the Contractor remains a Contractor sponsor. This agreement excludes any public use files or other publicly available reports or files that CMS or RI EOHHS make available to the general public on their websites.

Attachment A

The following list contains a representative (but not comprehensive) list of CMS information systems to which the Data Use Attestation applies. CMS will update the list periodically as necessary to reflect changes in the agency's information systems

- Automated Plan Payment System (APPS)
- Common Medicare Environment (CME)
- Common Working File (CWF)
- Coordination of Benefits Contractor (COBC)
- Drug Data Processing System (DDPS)
- Electronic Correspondence Referral System (ECRS)
- Enrollment Database (EDB)
- Financial Accounting and Control System (FACS)
- Front End Risk Adjustment System (FERAS)
- Health Plan Management System (HPMS), including Complaints Tracking and all other modules
- HI Master Record (HIMR)
- Individuals Authorized Access to CMS Computer Services (IACS)
- Integrated User Interface (IUI)
- Medicare Advantage Prescription Drug System (MARx)
- Medicare Appeals System (MAS)
- Medicare Beneficiary Database (MBD)
- Payment Reconciliation System (PRS)
- Premium Withholding System (PWS)
- Prescription Drug Event Front End System (PDFS)
- Retiree Drug System (RDS)
- Risk Adjustments Processing Systems (RAPS)

Appendix F. Model File & Use Certification Form

Pursuant to the contract between the Centers for Medicare & Medicaid Services (CMS), the State of Rhode Island, acting by and through Department of Health & Human Services Contractor (RI EOHHS), and Neighborhood Health Plan of Rhode Island, hereafter referred to as the Contractor, governing the operations of the following health plan: Neighborhood Health Plan of Rhode Island, H9576, the Contractor hereby certifies that all qualified materials for the Demonstration is accurate, truthful and not misleading. Organizations using File & Use Certification agree to retract and revise any materials (without cost to the government) that are determined by CMS or RI EOHHS to be misleading or inaccurate or that do not follow established Medicare Marketing Guidelines, Regulations, and sub-regulatory guidance. In addition, organizations may be held accountable for any beneficiary financial loss as a result of mistakes in marketing materials or for misleading information that results in uninformed decision by a beneficiary to elect the plan. Compliance criteria include, without limitation, the requirements in 42 C.F.R. §.422.2260 – §.422.2276 and 42 C.F.R. § 422.111 for Contractors and the Medicare Marketing Guidelines.

I agree that CMS or RI EOHHS may inspect any and all information including those held at the premises of the Contractor to ensure compliance with these requirements. I further agree to notify CMS and RI EOHHS immediately if I become aware of any circumstances that indicate noncompliance with the requirements described above.

I possess the requisite authority to make this certification on behalf of the Contractor.

3/16/18

Peter Marino, Chief Executive Officer Date

REVIEWED BY LEGAL Initials Date 3/14/18

On behalf of Neighborhood Health Plan of Rhode Island

Appendix G. Medicare Mark License Agreement

THIS AGREEMENT is made and entered into on January 1, 2018

by and between

THE CENTERS FOR MEDICARE & MEDICAID SERVICES (hereinafter "Licensor"),

with offices located at 7500 Security Blvd., Baltimore, MD 21244

and

Neighborhood Health Plan of Rhode Island (hereinafter "Licensee"),

with offices located at 910 Douglas Pike, Smithfield, RI 02917.

CMS Contract ID: H9576

WITNESSETH

WHEREAS, Licensor is the owner of the Medicare Prescription Drug Benefit program, a program authorized under Title XVIII, Part D of the Social Security Act (Part D), Mark (the "Mark").

WHEREAS, Licensee desires to use the Mark on Part D marketing materials (including the identification card) beginning January 1, 2018.

WHEREAS, both parties, in consideration of the premises and promises contained herein and other good and valuable consideration which the parties agree is sufficient, and each intending to be legally bound thereby, the parties agree as follows:

1. Subject to the terms and conditions of this Agreement, Licensor hereby grants to Licensee a non-exclusive right to use the Mark in their Part D marketing materials.

2. Licensee acknowledges Licensor's exclusive right, title, and interest in and to the Mark and will not, at any time, do or cause to be done any act or thing contesting or in any way impairing or tending to impair any part of such right, title, and interest. Licensee acknowledges that the sole right granted under this Agreement with respect to the Mark is for the purposes described herein, and for no other purpose whatsoever.

3. Licensor retains the right to use the Mark in the manner or style it has done so prior to this Agreement and in any other lawful manner.

4. This Agreement and any rights hereunder are not assignable by Licensee and any attempt at assignment by Licensee shall be null and void.

5. Licensor, or its authorized representative, has the right, at all reasonable times, to inspect any material on which the Mark is to be used, in order that Licensor may satisfy itself that the material on which the Mark appears meets with the standards, specifications, and instructions submitted or approved by Licensor. Licensee shall use the Mark without modification and in accordance with the Mark usage policies described within the Medicare Marketing Guidelines. Licensee shall not take any action inconsistent with the Licensor's ownership of the Mark, and any goodwill accruing from use of such Mark shall automatically vest in Licensor.

6. This agreement shall be effective on the date of signature by the Licensee's authorized representative through December 31, 2018, concurrent with the execution of the Part D addendum to the three way contract. This Agreement may be terminated by either Party upon written notice at any time. Licensee agrees, upon written notice from Licensor, to discontinue any use of the Mark immediately. Starting January 1, 2019, this agreement shall be renewable for successive one-year periods running concurrently with the term of the Licensee's Part D contract. This agreement shall terminate, without written notice, upon the effective date of termination or non-renewal of the Licensee's Part D contract (or Part D addendum to a Capitated Financial Alignment Demonstration contract).

7. Licensee shall indemnify, defend and hold harmless Licensor from and against all liability, demands, Claims, suits, losses, damages, infringement of proprietary rights, causes of action, fines, or judgments (including costs, attorneys' and witnesses' fees, and expenses incident thereto), arising out of Licensee's use of the Mark.

8. Licensor will not be liable to Licensee for indirect, special, punitive, or consequential damages (or any loss of revenue, profits, or data) arising in connection with this Agreement even if Licensor has been advised of the possibility of such damages.

9. This Agreement is the entire agreement between the parties with respect to the subject matter hereto.

10. Federal law shall govern this Agreement.

Appendix H. Service Area

The Service Area outlined below is contingent upon the Contractor meeting all Readiness Review requirements for all counties in Rhode Island. CMS and RI EOHHS reserve the right to amend this Appendix to revise the Service Area based on final Readiness Review results or subsequent determinations made by CMS and RI EOHHS. The Service Area consists of the following counties in Rhode Island: Bristol County, Kent County, Newport County, Providence County, and Washington County.

Appendix I. Nutrition Standards for Adults

Criteria for Referral to a Registered Dietitian (RD) or Licensed Dietitian/Nutritionist (LDN) for Adults

1. Referral to a RD or LDN is required pursuant to screening routinely completed as part of periodic health exams as defined below:

SCREENING	**STANDARD FOR REFERRAL TO RD, LDN**
Weight status*:	
Underweight	Body mass index (BMI) $\leq$18.5
Overweight	BMI 25 – 29.9
Obesity	BMI $\geq$ 30
Unintended, clinically significant weight loss	Weight loss $\geq$ 10% of normal body weight
Blood pressure	Diastolic $\geq$ 80 mm Hg Systolic $\geq$ 130 mm Hg
Fasting blood lipids	Cholesterol > 200 mg/dl LDL > 130 mg/dl (for individuals with diabetes, LDL > 100 mg/dl) HDL < 40 mg/dl TG > 150 mg/dl
Blood glucose: Diabetes	Fasting blood glucose >126 mg/dl on two occasions or A1C > 6.5
Pre-diabetes	Fasting blood glucose 100-125 mg/dl on two occasions or A1C > 6.2

3. Referral to a RD or LDN is required as a result of a diagnosis of chronic disease, which can be managed, controlled, or ameliorated through medical nutrition therapy, such as:

DISEASE/CONDITION
Cardiovascular disease
Hypercholesterolemia
Dyslipidemia
Chronic renal disease
Pulmonary disease
Gastrointestinal disease
Diabetes
Pre-diabetes
Obesity
Eating disorders
Hypertension
Autoimmune disease
Anemia
Liver disease/hepatitis
HIV/AIDS
Severe chronic food allergies
Phenylketonuria
Muscular-skeletal disease

3. Referral to a RD or LDN is also required under the following circumstances:

   a. Prescription regimen that has proven impact on nutrient absorption utilization and metabolism, e.g., phenytoin, phenobarbital, MAO inhibitors, warfarin
   b. Other conditions as medically necessary

Appendix J. Standards for Community-Based Organization Performing Peer Navigator Services for Enrollees

For Peer Navigator Services, the Contractor shall contract with a community-based entity that meets the following qualifications.

- Ability to establish and maintain a productive partnership with Contractor.

- Ability to integrate and coordinate Peer Navigator services with the care provided through the Contractor. The community-based entity must assign a specific supervisor and specific Peer Navigator staff to the Enrollees in order to foster that integration and coordination of care and to establish staff familiarity.

- Hire and maintain diverse and qualified full-time and/or part-time Peer Navigators, as required to meet Enrollee needs based on a caseload not exceeding thirty-five (35) to forty (40) Enrollees per full-time equivalent.

- All staff hires are contingent on successful background checks through nationally recognized organizations (e.g. BCI)

- Train and prepare Peer Navigators to provide services to Enrollees. The training protocols shall be approved by RI EOHHS and the Contractor and shall include, but not be limited to: organizational training protocols; confidentiality and Appeal process requirements; motivational interviewing; the program overview/training; the BHDDH substance abuse treatment guidelines and programming including recovery coach training materials.

- Provide Peer Navigators with on-going training, technical support and supervision in providing peer navigation services, as needed and specified in RI EOHHS and Contractor training and operational requirements.

- Supervisors and Peer Navigators will be expected to provide assistance with Enrollees outreach and engagement. The assigned supervisor and Peer Navigators will conduct IHS' and CFNAs as needed.

- Ensure that federal and State requirements related to the confidentiality of protected health information are complied with and that the appropriate releases of information and informed consent exists from the Enrollee.

- Maintain a policy and procedures manual for Peer Navigator services that at minimum includes:
    - Receipt and logging of incoming referrals
    - Assignment of referral to Peer Navigators
    - Monitoring Peer Navigator and supervisor caseloads and performance
    - Communication between Peer Navigator and the Contractor
    - Tracking and reporting Peer Navigator services
    - Discharge of Enrollees from Care Management

- Maintain Rhode Island-based central office space for program administration purposes and space for meetings between Enrollees and Peer Navigators, when necessary (Although these meetings may occur at provider sites, community sites, or in Enrollee homes).

- Conduct initial outreach of Enrollees within five (5) business Days of referral from the Contractor.

- Submit monthly reports to the Contractor on contract performance including information on referrals received, Enrollees served, referral and linkages made to services, the status of Enrollees, and other key elements related to the efficacy of contract services

- Meet future Contract requirements as agreed upon with the Contractor throughout the Contract period.

Supervisor Responsibilities

A supervisor shall be assigned to supervise Peer Navigators assigned to Enrollees. The supervisor performs as a day-to-day liaison to the Contractor and is essential in the development and maintenance of a positive working relationship between the Contractor and the community-based entity. The supervisor and Peer Navigators act in concert with and as an adjunct to the Contractor's Care Management staff and therefore, the supervisor's role is essential in assuring that Peer Navigator services are integrated and coordinated with the care provided by the Contractor.

Supervisors shall also perform the following activities:

- Review the cases referred by the Contractor.
- Oversight and assure completion of IHSs and/or CFNA.
- Assign Peer Navigator specific cases based on Enrollee needs.
- Monitor Peer Navigator caseloads and performance.
- Provide on-going technical assistance, supervision and training to Peer Navigators.
- Provide each Peer Navigator with intensive supervision weekly for the first sixty (60) Days of their employment and biweekly thereafter, as needed.
- Initially accompany new Peer Navigators to meetings with Enrollees and periodically thereafter, as required and accompany Peer Navigators on difficult cases, as needed.
- Discuss difficult cases or resolve pressing issues, daily.
- At a minimum, conduct group meetings twice monthly with all Peer Navigators to review cases and to discuss available community resources.
- Track and summarize Peer Navigator services provided and Enrollees served.
- Monitor contract compliance and the overall performance of the Peer Navigator services.

Peer Navigator Responsibilities

The Peer Navigator shall be a problem solver, teacher and peer of the Enrollee who has intimate knowledge of available community resources; ability to link Enrollees with a total array of resources

that assist members overcome barriers to proper use of the health care system; the skills and experience to assist Enrollees to be responsible, accountable and self-sufficient; and relate to Enrollees and serve as their mentor and coach to achieve the desired outcomes. The Peer Navigator must be able to function as an extension of the Care Management team and, at the same time, be an advocate for the Enrollee. Specifically the Peer Navigator shall perform the following activities:

- Conduct IHS and in-person CFNAs
  - Assist in locating and engaging Enrollees.
  - Complete IHS' and CFNAs with Enrollees.
  - Collaborate with appropriate Contractor staff.

- Develop ICP
  - Contact Contractor staff and providers to obtain details about the case, where necessary.
  - Communicate, collaborate and coordinate on the development of a person centered ICP.
  - Further identify Enrollee's health care status, access and barriers to care.
  - Participates with the Enrollee in developing an action plan to help address and resolve social issues, as appropriate.

- Continue to Outreach and Engage the Enrollee Throughout Treatment Process
  - Contact and meet with Enrollees throughout the treatment process.
  - The Peer Navigator uses motivational interviewing skills to engage with the Enrollee.
  - Assist Enrollees to achieve their goals, objectives and activities/action steps in the ICP.

- Reduce Barriers to Non-Emergent Care
  - Link/reinforce PCMH concept.
  - Link Enrollees to alternatives to the emergency room (e.g., Urgent Care settings) for non-emergent care.
  - Assist/train Enrollees with obtaining, scheduling and rescheduling health care appointments.
  - Assist/train Enrollees in arranging medical appointment transportation.
  - Follow-up with providers to assure appointments are kept.

- Develop Resources to Non-Emergencies and Crises
  - Assist/train Enrollees to access both formal and informal community-based support services (e.g. child care, housing, employment, legal, social services).
  - Teach/coach Enrollees in effective use of community-based health and social service systems
  - Link Enrollees to ongoing social support mechanisms or "social networks" (e.g. group, neighbors, extended Family, associations or other social networks).

- Provide Emotional Support and Serve as a Role Model
  - Assist Enrollees in developing coping skills when needed.

- Serve as a role model and guide Enrollees to practice responsible health behaviors.

- Transition Enrollees to Independence /Case Closure
  - Continue to engage with Enrollees and provide Peer Navigation services until the goals in the ICP are met
  - Provide transitional support (e.g. referral to any specific targeted on-going support services, contact Contractor LCM should problems resurface, assist members with re-engagement if necessary, etc.) at case closure.
  - Maintain records, documentation, and statistics as required by the Contractor, CMS and/or RI EOHHS.

Required Staffing Skills and Qualifications

The specific skills and qualifications of a Peer Navigator shall include the following:

- High school education or higher
- Paraprofessional with personal experience in serving people with special health care needs and people with complex medical problems and chronic conditions
- Possess life experience as a consumer, parent or Family member of a consumer with special needs
- Ability to relate to Medicaid and Medicare beneficiaries and to address barriers to care
- Ability to work collaboratively among Enrollees, Families, treatment providers, and Contractor staff, etc.
- Ability to promote person and Family centered, culturally sensitive care
- Trained in motivating Medicaid and Medicare beneficiaries and serving as a Peer Navigator
- Able to advocate for person and Family centered care
- Skilled/trained to use motivational interviewing with Medicaid and Medicare beneficiaries
- Knowledgeable of Rhode Island health care environment
- Demonstrated prior success in accessing community-based resources in Rhode Island, is preferred
- A person in good community standing

RI EOHHS Approved Training Program

RI EOHHS shall approve all training for Peer Navigators. The training shall include the following:

- Overview of the ICI including: Medicaid 101 understanding emergent health care and alternatives and how to reach the "unreachable Enrollees"
- Overview of other RI EOHHS and DHS programs,
- Orientation to the Contractor
- Motivational interviewing
- Home visiting and safety training
- Being a profession peer
- Navigation – systems, organizations, accessing available services

- DOH initiatives and programs
  - Medical home projects
  - Injury prevention
  - Comprehensive cancer control program
  - Diabetes
  - Immunization
  - Asthma program
  - Adolescent transition
  - Minority health and cultural competencies
  - Initiative for a healthy weight
  - Chronic disease self-management program
- Behavioral health services and programs in RI
- Community and State health and wellness initiatives
- The POINT
- SSA benefits and e-services, employment network
- Public transit
- Rhodes to Independence initiatives
- Rhodes to Independence home modifications
- Programs offered through the Office of Rehabilitation Services
- Governor's Commission on Disabilities
- Rhode Island Council of Community Mental Health Organizations
- Rhode Island Disability Law Center
- Intro to understanding culture and diversity
- Effective communication skills and conflict resolution
- Boundaries, confidentiality and ethical practices
- Overview of substance abuse and recovery
- Employment resources
- Housing (e.g., Section 8, transitional housing, subsidized housing, homeless shelters)
- Care Coordination, documentation and note taking
- Understanding community resources and diverse agencies in Rhode Island
- Overview of BHDDH
- Division of Elderly Affairs programs (e.g., elderly protective services)
- Overview of the Enrollee Ombudsman and the Long-Term Care Ombudsman
- Navigating DME and other resources related to equipment
- Additional training to be determined by the Contractor or RI EOHHS

Appendix K. Nursing Home Transition Including Nursing Home Transition Program Participants and Rhode to Home Requirements

1. Nursing Home Transition Including Rhode to Home

The Contractor shall establish policies, procedures and practices for Enrollees eligible for the Rhode to Home (RTH) demonstration grant and the Nursing Home Transition Program (NHTP).

To participate in NHTP, Enrollees must meet initial NHTP eligibility criteria:

- Is residing in a nursing facility for non-skilled or convalescent care; or
- Was admitted to the nursing facility for skilled care, is still receiving skilled care, and has submitted a Medicaid LTSS eligibility application; and
- Agrees to receive LTSS while residing in the community.

2. RTH Eligibility

Eligibility for the RTH demonstration is determined by federal RTH demonstration requirements. The Contractor shall follow RI EOHHS policies and procedures related to the RTH eligibility process. To identify Enrollees eligible for RTH prior to transition, the Contractor must confirm that the following initial RTH eligibility criteria have been met and submit the appropriate documentation (as established by RI EOHHS) to RI EOHHS for approval:

- Is residing in a nursing facility for at least ninety (90) consecutive Days (not including those Days that were for the sole intent and purpose of receiving short-term rehabilitation);
- Is eligible for Medicaid for at least one (1) Day prior to nursing facility discharge; and
- Provides informed consent, signed by the Enrollee or his/her legal guardian (if applicable), to participate in the RTH demonstration grant.

RI EOHHS establishes all reporting requirements for initial RTH enrollment.

Enrollees that meet all initial RTH eligibility criteria and have signed an informed consent will be deemed RTH enrollees.

To participate in the RTH demonstration grant, the Enrollee must move to a RTH qualified residence that meets the requirements established by CMS. Qualified residences include: (1) an individual's home or apartment-like setting that includes areas for sleeping, bathing, living and kitchen if the home or apartment is owned or leased by the individual or his or her caregiver or Family member; or (2) a group home where no more than four (4) individuals reside.

Additional qualifying criteria must also apply such as: (1) the individual must have the right to choose their service provider; and (2) unless otherwise assessed and identified as a need within the individual's LTSS Care Plan, the residence must offer unrestricted access to the areas within the residence, cannot require notification of absences, and cannot reserve the right to assign apartments

or change apartment assignments.

RI EOHHS establishes all required documentation for participation in the RTH demonstration grant and NHTP. Enrollees who meet all participation criteria will be deemed RTH participants.

The Contractor shall forward all required documentation to RI EOHHS at periodic intervals established by RI EOHHS. Intervals established by RI EOHHS may include, but are not limited to: pre-transition (length of stay in the nursing facility, Medicaid eligibility status, signed consent); immediately after transition (residence documentation); and ongoing care coordination (progress and ongoing review, critical incidents, 24/7 back-up plan, and all additional required reporting as established by RI EOHHS).

The Contractor must track and report to RI EOHHS, in a manner established by RI EOHHS, when an Enrollee's participation in the RTH demonstration grant ends.

3. **Referrals from Minimum Data Set 3.0 (MDS Section Q)**

The Contractor shall receive referrals from the Office of Community Programs, the State Local Contact Agency (LCA), regarding those individuals who indicated through the MDS Section Q that they are interested in learning more about LTSS that may be available in a community-based residence or that they would like to transition to a community-based residence. The Contractor shall utilize the information to identify Enrollees who are interested in receiving LTSS options counseling and report back to RI EOHHS, in a manner established by RI EOHHS, the outcome of each referral.

4. **LTSS Options Counseling**

The Contractor shall coordinate with the Rhode Island's Aging and Disability Resource Center (ADRC) to ensure that LTSS options counseling is provided to Enrollees who are referred through the MDS Section Q process as well as other independent referrals received for individuals living in institutions and community-based residences. LTSS options counseling is provided in a manner that is consistent with the practice established by and provided by the State.

5. **Nursing Facility Referrals**

RI EOHHS requires all referrals to be processed through the Office of Community Programs. Nursing facilities will be reminded to send all Section Q and transition referral to the Office of Community Programs as is the current process. Should the Contractor receive referrals from other sources (e.g., from nursing facility directly, individuals, Family members, Health Care Professionals), the Contractor is required to submit the required referral information to the Office of Community Programs. The Contractor should also proactively review data to identify those Enrollees that have resided in a nursing facility or other specified institutions that are likely candidates to transition to a community-based residence and could potentially receive LTSS in the community. The Contractor conducts a screen of potential candidates who desire to transition to a community-based residence and may be eligible to receive LTSS in the community.

The Contractor shall develop a plan to provide LTSS options counseling and information for potential transition to a community-based residence.

The Contractor shall provide documentation and reports, in the manner established by RI EOHHS, on all Enrollees assessed, the potential ability to transition, barriers to potential transition, and any additional criteria established by RI EOHHS.

Other information that shall be reviewed includes, but is not limited to the Enrollee's length of stay in the nursing facility, assessed needs, eligibility status for Medicaid, and preferred or potential home and community-based residence, including any applicable rental leases as well as other screening criteria established by RI EOHHS.

The Contractor shall submit this information to RI EOHHS.

6. **Affordable Housing**

The Contractor shall develop policies and procedures to identify affordable housing options for Enrollees who are interested in transitioning from nursing facilities (and other institutions as specified by RI EOHHS). The Contractor shall support Enrollees to identify:

- Affordable apartment units listed within public housing authorities.
- Tenant based rental assistance and voucher programs.
- Opportunities for Enrollees to reside in a home or apartment with a caregiver or Family Enrollee.
- Supportive housing models, including but not limited to assisted living residences with affordable units and subsidized housing options with personal care assistance and behavioral health supports.
- Other affordable housing options, including but not limited to low-income housing tax credit programs.

The Contractor shall hire a housing specialist to assist Enrollees who are interested in transitioning from a nursing facility to a community-based residence. The housing specialist should utilize resources on affordable housing options available to individuals across the state, including web-based housing search tools (e.g., HomeLocatorRI.net, Rite Resources, SocialServe.com) and written materials for Enrollees to use in choosing a housing model. The housing specialist will discuss housing alternatives with the Enrollee and assist the Enrollee in choosing a suitable residence that is safe and meets his or her needs. The housing specialist will work with the transition coordinator in assessing the suitability of housing options.

The housing specialist shall have the knowledge and experience in working with housing entities and advocating for individuals' rights in landlord-tenant general contracting practices. The housing specialist should have knowledge and experience related to fair housing regulations, tenant-landlord rights, and reasonable accommodation requests. Additionally, the housing specialist should be familiar with community-based LTSS that can support individuals to reside in the community.

7. **Transitioning Process to a Community-Based Residence**

The Contractor shall designate a lead staff person to serve as a transition coordinator.

The transition coordinator shall ensure the following:

- A comprehensive clinical assessment is conducted that includes, but is not limited to, a clinical assessment conducted by a nurse, a social services assessment that contains a psychosocial evaluation, and a risk assessment.

- A person-centered LTSS Care Plan is developed with the Enrollee to address all of the Enrollee's LTSS needs once he or she transitions to a community-based residence. The person-centered LTSS Care Plan includes but is not limited to the Enrollee's goals and recommendations, services and care to be provided, clinical and non-clinical supports and services, a risk mitigation plan, and a 24/7 emergency back-up plan.

- Transition coordination and Care Management is provided for at least three hundred and sixty-five (365) Days after the date of transition for RTH participants and a minimum of ninety (90) Days for NHTP participants. Transition coordination and Care Management should be provided in a manner that meets the Enrollee's medical and non-medical needs. Transition coordination and Care Management includes non-traditional or specialized Care Management when needed by the Enrollee.

The Contractor's transition coordination and Care Management policies, procedures and practices must be approved by RI EOHHS. The Contractor shall be required to have systems in place to track and document the provision of services and Care Management provided to Enrollees throughout transition process.

The Contractor shall be required to conduct face-to-face visits and/or contact the Enrollee by telephone based upon the following minimum criteria (or more frequently based upon Enrollee's need): (1) a face-to-face visit in the Enrollee's home on the date of discharge from the nursing facility; (2) weekly visits and/or phone calls during the first month of transition with a minimum of two face-to-face visits; and (3) monthly visits and/or phone calls beginning month two through twelve after the individual transitions to a community-based residence for RTH individuals and month two and three for NHTP individuals. For RTH participants, monthly visits and/or phone calls continue until the end date of RTH participation, as tracked by the Contractor. The frequency of face-to-face visits or phone contact should be based on the Enrollee's needs.

The transition coordination and Care Management period shall begin once the Enrollee transitions to a community-based residence and continue for three hundred and sixty-five (365) Days for RTH individuals or ninety (90) Days for NHTP individuals. A RTH participant's transition coordination period may extend beyond three hundred and sixty-five (365) Days if the Enrollee experiences an interruption in their community support services due to hospitalization, critical incident, or other extenuating circumstances.

Transition coordination and Care Management shall also include, but is not limited to, ensuring that a Enrollee's specialized service needs (e.g., physical disabilities, intellectual and/or developmental disabilities, dementia, mental health and substance abuse, chronic homelessness, caregiver support) are met so that Enrollees have the ability to live safely and independently in the community.

Ongoing Care Management should be provided once the Enrollee completes the transition coordination and Care Management period outlined above.

Quality of life surveys must be conducted for all Enrollees transitioning from nursing facilities and other institutions, as defined by RI EOHHS, to community-based residences to ensure that they are receiving the services and supports they need to maintain the quality of life they desire. The Contractor shall conduct quality of life surveys for all transition cases, in the manner established by RI EOHHS and Mathematica (national evaluator) and utilize the quality of life survey tool approved by RI EOHHS.

For Enrollees transitioning from nursing facilities to community-based residences, quality of life surveys are required to be conducted three (3) times per Enrollee: at least three (3) Days prior to transition; eleven (11) months post-discharge from the nursing facility; and twenty-four (24) months post discharge from the nursing facility. For RTH cases, the results of the quality of life survey must be reported to RI EOHHS in the manner established by RI EOHHS. For new enrollees who have had a previous quality of life survey completed under another care delivery system, the Contractor will be responsible for tracking and completing the remainder of the surveys.

8. **Additional Services**

The Contractor shall provide Peer Navigator/peer mentor specialized Care Management services to Enrollees who do not require complex high-level clinical support but need assistance accessing community services. Such Enrollees may include, but are not limited to, individuals with a history of homelessness, veterans, and individuals with I/DD.

RI EOHHS also supports and strongly recommends the use of an ombudsman for Enrollees who receive LTSS and need additional advocacy during their transition period.

9. **Critical Incidences**

For NHTP participants, RI EOHHS will review and monitor critical incidents that impact the Enrollee during the transition coordination and Care Management phase. The Contractor shall submit documentation, in the manner established by RI EOHHS, on all critical incidents, such as hospitalizations, emergency room visits, medication errors, physical abuse, neglect, self-neglect, financial exploitation, police involved incidences, and disasters that result in displacement from home. RI EOHHS shall establish the requirements for incident documentation, review, and ongoing monitoring process. The Contractor shall review all critical incidents as they are identified, including the circumstances surrounding the critical incident and the continued needs of the Enrollee, to ensure that the Enrollee remains safe in his/her home environment.

10. **Home and Community Care Emergency Back-up Plan**

For Enrollees transitioning from an institutional setting to a home and community-based setting, the transition coordinator shall establish an emergency back-up plan with the Enrollee that addresses Enrollee needs twenty-four (24) hours per Day, seven Days per week. The emergency back-up plan should identify key people or agencies that the Enrollee should contact when there is a disruption in the on-going support that is provided to him/her so that the Enrollee can remain safe and able to

function in the community. The transition coordinator may utilize the Enrollee's informal or formal supports in the emergency back-up procedures for the Enrollee. Additionally, the Contractor shall assist the Enrollee in obtaining emergency services and supports in urgent cases where a disruption in on-going support has placed an Enrollee at risk for harm.

11. **Reports to RI EOHHS**

The Contractor shall be required to report, to RI EOHHS at the frequency and in the formats prescribed by RI EOHHS, on all NHTP and RTH participants. This information may include, but is not limited to, referrals, assessments, LTSS Care Plans, transitions, residence information, service provision and care coordination, risk and mitigation plans, critical incidences, 24/7 emergency back up plans, service outcomes, Case Management progress and review updates, encounter data, and other information required by RI EOHHS.

The Contractor shall assist RI EOHHS to monitor benchmarks and program goals for RTH participants. These benchmarks will include a goal to increase the number of individuals participating in a self-directed option. RI EOHHS will establish the baseline number of self-directed program participants. The Contractor will be responsible for increasing the number of Enrollees in the self-directed option by five (5) percent each year and ensuring that ten (10) percent of RTH participants receive LTSS through a self-directed model. The Contractor shall also assist RI EOHHS in meeting the RTH transition benchmarks as outlined in the *Money Follows the Person Operational Protocol* for the Rhode Island RTH demonstration.

12. **RI EOHHS Support**

RI EOHHS shall designate a staff person to work with the Contractor in implementing and operating the NHTP and the RTH demonstration grant. RI EOHHS will share its policies, procedures, protocols, tools, and report systems for the NHTP and the RTH demonstration grant, as well as train Contractor staff. The Contractor will designate a staff person to work with RI EOHHS to implement and ensure on-going compliance with all transition and documentation requirements outlined in this Appendix K and in this Contract.

RI EOHHS will provide technical assistance, oversight and monitoring activities, throughout the duration of the federal RTH demonstration period, regarding all aspects of the RTH demonstration program.