



**Solicitation Information  
March 7, 2014**

**LOI# 7548558**

**TITLE: DENTAL HEALTH PLAN(S) FOR RITE SMILES PROGRAM**

**Submission Deadline: Monday, April 7, 2014 at 10:30 AM (Eastern Time)**

**PRE-BID/ PROPOSAL CONFERENCE: NO  
MANDATORY: N/A**

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

**DATE:**

**LOCATION:**

Questions concerning this solicitation must be received by the Division of Purchases at [David.Francis@purchasing.ri.gov](mailto:David.Francis@purchasing.ri.gov) no later than **Wednesday, March 19, 2014 at 10:00 AM (ET)**. Questions should be submitted in a *Microsoft Word attachment*. Please reference the LOI# on all correspondence. Questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to download this information.

**SURETY REQUIRED: NO**

**BOND REQUIRED: NO**

David J. Francis  
Interdepartmental Project Manager

Applicants must register on-line at the State Purchasing Website at [www.purchasing.ri.gov](http://www.purchasing.ri.gov)

**Note to Applicants:**

Offers received without the entire completed four-page RIVIP Generated Bidder Certification Form attached may result in disqualification.

**THIS PAGE IS NOT A BIDDER CERTIFICATION FORM**

# Table of Contents

SECTION 1: INTRODUCTION .....	3
SECTION 2: BACKGROUND .....	6
2.1 Rhode Island Medicaid Program .....	6
2.2 Evolution of Managed Care .....	7
2.3 RItE Smiles Program.....	8
SECTION 3: SCOPE OF WORK .....	12
3.1 Dental Plan(s) Licensure and Organizational Requirements.....	12
3.2 Member Enrollment and Disenrollment.....	13
3.3 Services/Benefits .....	15
3.4 Care Coordination.....	16
3.5 Provider Network.....	16
3.6 Service Accessibility Standards .....	17
3.7 Member Services .....	18
3.8 Provider Services.....	18
3.9 Dental Management and Quality Assurance .....	18
3.10 Operational Reporting .....	22
3.11 Grievance and Appeals .....	22
3.12 Payments to and from the Dental Plan.....	23
3.13 Financial Standards, Record Retention, and Compliance .....	24
3.14 Model Contract Terms and Conditions.....	25
3.15 Model Contract Addendums .....	26
3.16 Model Contract Attachments .....	26
SECTION 4: TECHNICAL PROPOSAL.....	27
SECTION 5: EVALUATION AND SELECTION .....	34
SECTION 6: PROPOSAL SUBMISSION.....	36
APPENDIX A - ACTUARIALLY SOUND RATE.....	38
APPENDIX B - MODEL CONTRACT .....	39

## **SECTION 1: INTRODUCTION**

The Rhode Island Department of Administration/Office of Purchases, on behalf of the Executive Office of Health and Human Services (EOHHS), is soliciting Technical Proposals from qualified Bidders to serve as the Dental Plan(s) (DP) for the entire Rhode Island Medicaid RIte Smiles program through a managed care model under a capitation contract. This LOI and any subsequent award(s) are governed by the State's General Conditions of Purchase (available via internet at [www.purchasing.ri.gov](http://www.purchasing.ri.gov)).

The initial contract period will begin approximately July 1, 2014 for two years. Contracts may be renewed for up to three additional 12-month periods based on Bidder performance and the availability of funds.

This is a Letter of Interest (LOI) and not a Request for Proposal (RFP) or an Invitation to Bid (ITB). Responses to this LOI will be evaluated on the basis of the relative merits of the technical proposal and Bidder's acceptance of the terms in the Model Contract and the capitation rates, appended to this LOI. There shall be no public opening and reading of responses received by the State of Rhode Island, other than the names of Bidders who have submitted proposals.

### **INSTRUCTIONS AND NOTIFICATIONS TO BIDDERS:**

1. Potential Bidders are advised to review all sections of this LOI carefully and to follow instructions completely, as failure to make a complete submission as described elsewhere herein may result in rejection of the proposal.
2. Alternative approaches and/or methodologies to accomplish the desired or intended results of this procurement are solicited. However, proposals which depart from or materially alter the terms, requirements, or scope of work defined by this LOI will be rejected as being non-responsive.
3. All costs associated with developing or submitting a proposal in response to this LOI or to provide oral or written clarification of its content shall be borne by the Bidder. The State assumes no responsibility for these costs.
4. Proposals are considered to be irrevocable for a period of not less than 120 days following the opening date, and may not be withdrawn, except with the express written permission of the State Purchasing Agent.
5. All pricing submitted will be considered to be firm and fixed unless otherwise indicated herein.
6. Proposals misdirected to other state locations, or which are otherwise not present in the Division at the time of opening for any cause will be determined to be late and will not be considered. For the purposes of this requirement, the official time and date shall be that of the time clock in the reception area of the Division.
7. It is intended that an award pursuant to this LOI will be made to a prime Bidder, or prime Bidders in the various categories, who will assume responsibility for all aspects of the work. Joint venture and cooperative proposals will not be considered. Subcontracts are permitted, provided that their use is clearly indicated in the Bidder's proposal and the subcontractor(s) to be used is identified in the proposal.
8. All proposals should include the Bidder's FEIN or Social Security number as evidenced by a W9, downloadable from the Division's website at [www.purchasing.ri.gov](http://www.purchasing.ri.gov).
9. The purchase of services under an award made pursuant to this LOI will be contingent on the availability of funds.

10. Bidders are advised that all materials submitted to the State for consideration in response to this LOI will be considered to be Public Records as defined in Title 38, Chapter 2 of the General Laws of Rhode Island, without exception, and will be released for inspection immediately upon request once an award has been made.
11. Interested parties are instructed to peruse the Division of Purchases website on a regular basis, as additional information relating to this solicitation may be released in the form of an addendum to this LOI.
12. Equal Employment Opportunity (G.L. 1956 § 28-5.1-1, et seq.) – § 28-5.1-1 Declaration of policy – (a) Equal opportunity and affirmative action toward its achievement is the policy of all units of Rhode Island state government, including all public and quasi-public agencies, commissions, boards and authorities, and in the classified, unclassified, and non-classified services of state employment. This policy applies to all areas where State dollars are spent, in employment, public services, grants and financial assistance, and in state licensing and regulation.
13. In accordance with Title 7, Chapter 1.2 of the General Laws of Rhode Island, no foreign corporation, a corporation without a Rhode Island business address, shall have the right to transact business in the State until it shall have procured a Certificate of Authority to do so from the Rhode Island Secretary of State (401-222-3040). This is a requirement only of the successful Bidder(s).
14. The Bidder should be aware of the State's Minority Business Enterprise (MBE) requirements, which address the State's goal of ten percent (10%) participation by MBE's in all State procurements. For further information visit the website [www.mbe.ri.gov](http://www.mbe.ri.gov)
15. Under HIPAA, a "business associate" is a person or entity, other than a member of the workforce of a HIPAA covered entity, who performs functions or activities on behalf of, or provides certain services to, a HIPAA covered entity that involves access by the business associate to HIPAA protected health information. A "business associate" also is a subcontractor that creates, receives, maintains, or transmits HIPAA protected health information on behalf of another business associate. The HIPAA rules generally require that HIPAA covered entities and business associates enter into contracts with their business associates to ensure that the business associates will appropriately safeguard HIPAA protected health information. Therefore, if a Contractor qualifies as a business associate, it will be required to sign a HIPAA business associate agreement
16. In order to perform the contemplated services related to the Rhode Island Health Benefits Exchange (HealthSourceRI), the Bidder hereby certifies that it is an "eligible entity," as defined by 45 C.F.R. § 155.110, in order to carry out one or more of the responsibilities of a health insurance exchange. The Bidder agrees to indemnify and hold the State of Rhode Island harmless for all expenses that are deemed to be unallowable by the Federal government because it is determined that the Bidder is not an "eligible entity," as defined by 45 C.F.R. § 155.110.
17. Interested parties should be aware that all materials associated with this LOI are subject to the terms of the Freedom of Information Act, the Privacy Act, and all rules, regulations, and interpretations of these Acts, including those from the offices of the Attorney General of the United States, U.S. Department of Health and Human Services (HHS), and CMS.
18. The State reserves the right not to enter into a contract with any interested party of this procurement if the proposals do not respond to State's needs, at the time of review. The State also reserves the right to make use of all ideas contained in the submission, whether future procurements are issued or not, or whether future contracts are awarded or not.
19. Interested parties submitting a proposal shall register on-line at the State Purchasing website at [www.purchasing.ri.us](http://www.purchasing.ri.us).

20. American Recovery and Reinvestment Act of 2009 (ARRA) Supplemental Terms and Conditions. For contracts and sub-awards funded in whole or in part by the American Recovery and Reinvestment Act of 2009. Pub.L.No. 111-5 and any amendments thereto, such contracts and sub-awards shall be subject to the Supplemental Terms and Conditions for Contracts and Sub-awards Funded in Whole or in Part by the American Recovery and Reinvestment Act of 2009. Pub.L.No. 111-5 and any amendments thereto located on the Division of Purchases website at [www.purchasing.ri.us](http://www.purchasing.ri.us).
21. The State reserves the right to amend this LOI at any time with respect to the implementation of Federal Health Reform (Patient Protection and Affordable Care Act- PPACA).
22. It is the policy of the State of Rhode Island that public officials and employees will adhere to the highest standard of ethical conduct; respect the public trust and rights of all persons; be open, accountable, and responsive; avoid the appearance of impropriety; and not use their positions for private gain or advantage.
23. No person subject to the code of ethics will have any interest, financial or otherwise, direct or indirect; engage in any business, employment, transaction, or professional activity; or incur any obligation of any nature which is in substantial conflict with the proper discharge of his/her duties or employment in the public interest and of his/her responsibilities, as prescribed in the laws of this State.
24. No person subject to the code of ethics will accept other employment, which will either impair his/her independence of judgment as to his/her official duties or employment or require him/her, or induce him/her, to disclose confidential information acquired by him/her in the course of, and by reason of, his/her official duties.
25. No person subject to the code of ethics will willfully and knowingly disclose, for pecuniary gain, to any other person, confidential information acquired by him/her in the course of, and by reason of, his/her official duties or employment or use any such information for the purpose of pecuniary gain.
26. No person subject to the code of ethics will use, in any way, his/her public office or confidential information received through his/her holding any public office to obtain financial gain, other than that provided by law, for himself/herself or spouse (if not estranged) or any dependent child or business associate, or any business by which said person is employed or which said person represents.
27. No person subject to this code of ethics, or spouse (if not estranged), or dependent child, or business associate of such person, or any business by which said person is employed or which such person represents, will solicit or accept any gift, loan, political contribution, reward, or promise of future employment based on any understanding that the vote, official action, or judgment of said person would be influenced thereby.
28. No person will give or offer to any person covered by this code of ethics, or to any candidate for public office, or to any spouse (if not estranged), or dependent child, or business associated of such person, or any business by which said person is employed or which such person represents, any gift, loan, political contribution, reward, or promise of future employment based on any understanding that the vote, official action, or judgment of said person would be influenced thereby.
29. In accordance with regulations pursuant to Title 37, Chapter Two, the State's Chief Purchasing Officer is authorized to investigate and resolve conflicts, including, but not limited to, the following measures: (1) reassignment of the State employee involved, (2) termination of the State employee involved, (3) debarment of any/all Bidders involved.

## SECTION 2: BACKGROUND

The Executive Office of Health and Human Services (EOHHS) is the designated single state agency for Medicaid in the State. There are five State Departments and Divisions that expend Medicaid funds: The Executive Office of Health and Human Services (EOHHS); the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH); The Department of Children, Youth and Families (DCYF); the Department of Human Services Division of Elderly Affairs (DEA); and the Department of Health (DOH). EOHHS accounts for approximately seventy-five percent of Medicaid expenditures.

This chapter provides potential Bidders with background information on the Rhode Island Medicaid program and the reasons for this procurement.

### 2.1 Rhode Island Medicaid Program

The Medical Assistance Program, or Medicaid, is a health care entitlement program for the State's low-income population that is jointly funded by the Federal Government and the State of Rhode Island. Medicaid was established in 1965 as Title XIX of the U.S. Social Security Act. EOHHS is the federally required Single State Agency (SSA) responsible for the administration of the Medicaid program in Rhode Island. EOHHS is also comprised of the following Departments: Department of Human Services (DHS), DCYF, DOH, and BHDDH. EOHHS will provide the direction and oversight of the contract resulting from this procurement. In addition to State oversight, the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) monitors the State's Medical Assistance program activities through its regional office in Boston, Massachusetts and its central office in Baltimore, Maryland.

Medicaid is the principal source of health care coverage and services in RI, serving approximately one-third of the State's population within the last five years. Medicaid served over 228,000 Rhode Islanders in State Fiscal Year (SFY) 2012 (with an average of 193,000 enrolled at any one time), at a cost of \$1.783 billion dollars. Medicaid expenditures make up approximately one-quarter of the State's budget. The Federal Medical Assistance Percentage (FMAP) is approximately 50 percent.

Between SFY 2008 and 2012, total Medicaid medical expenditures based on the date of service has increased 1.3 percent per year. This overall expenditure increase is associated with a 2.2 percent average annual increase in enrollment combined with a 0.9 percent overall average decrease in per member per month (PMPM) cost. The increase in enrollment and decrease in PMPM can be added together to determine average annual expenditure growth. Enrollment declined from SFY 2007 through SFY 2009, increased in SFY 2010, SFY 2011 and SFY 2012. This resulted in a negative annual trend. These expenditure trends compare favorably to both national Medicaid expenditures and state commercial insurance cost trends.

The expenditures for each major population group for SFY 2012 are noted below:

- **Adults with disabilities:** represent sixteen (16) percent of the Medicaid population (30,527 individuals) and account for the largest share (37 percent) of Medicaid expenditures (\$662 million) at an average PMPM of \$1,808. The major source of expenditures for this population is residential and rehabilitation services for the developmentally disabled (26 percent) and hospital care (25 percent).
- **Elders:** represent nine (9) percent of the Medicaid population (17,802 individuals) and account for \$476 million or twenty-seven (27) percent of Medicaid expenditures. Elders have the highest average PMPM cost of \$2,230. Nursing facilities account for roughly two-thirds of the expenditures.
- **Children and families:** represent sixty-nine (69) percent of the total Medicaid enrollment (132,511 individuals) and account for twenty-seven (27) percent of the total expenditures (\$474

million).

- **Children with special health care needs (CSHCN):** is a relatively small population (six percent of the recipients) and account for approximately 10 percent of the expenditures (\$170 million). Approximately half of the expenditures for this population are behavioral health services.

Hospitals and nursing homes account for nearly half (46 percent) of all program expenditures (Hospitals account for 27 percent and nursing homes account for 19 percent of the expenditures). Payments to hospitals increased by an average of 4.0 percent per year between SFY 2008 and SFY 2012. Payment to nursing homes increased by 2.0 percent between SFY 2008 and SFY 2012. Expenditures for community and long-term care services accounted for forty-one (41) percent of total Medicaid expenditures or \$724 million.

Medicaid expenditures are highly concentrated. The top seven percent of Medicaid recipients account for over two-thirds of the expenditures. Eighty-one (81) percent of high users (i.e. incurred more than \$25,000 or more of medical Medicaid expenses) were elders and adults with disabilities.<sup>1</sup>

Over the past five years, Medicaid has seen a decline in low cost users and an increase in high cost users of Medicaid services. If this trend continues, it will have a significant impact on future Medicaid expenditures unless appropriate intervention strategies are implemented.

## 2.2 Evolution of Managed Care

When Medicaid began in the mid-1960s, the RI Medicaid program was modeled as a traditional indemnity fee-for-service (FFS) health insurance program. Throughout the years, the State has progressively transitioned from a payer to an active purchaser of care. Central to this has been a focus on improved access and quality along with cost management. Contracting with “accountable” entities provides a structure for measuring and enforcing performance standards. The State has been able to leverage the capabilities of Managed Care Organizations (Health Plans) and the Primary Care Case Management (PCCM) program (in such areas as network capacity, member services, care management and coordination) while maintaining a strong oversight role.

The State’s initial Medicaid managed care program, RItE Care, began in 1994, enrolling over 70,000 low income children and families. A key contractual element was the “mainstreaming” provision, requiring that Health Plans must ensure that if a provider accepted enrollees from commercial lines of business, they must also accept RItE Care enrollees without discrimination. Children in Substitute Care Arrangements: were voluntarily enrolled in RItE Care in December 2000 and Children with Special Health Care Needs (CSHCN) were voluntarily enrolled in RItE Care in 2003. Enrollment for CSHCN became mandatory in 2008.

The RItE Share Program is the State’s Premium Assistance Program under Medicaid where the State purchases employer-sponsored health insurance for RItE Care eligible low income working individuals and their families who are eligible for employer sponsored insurance but could not otherwise afford it. Currently, there are approximately 10,000 individuals in the RItE Share Program. The RItE Share Program reduces the amount of State Medicaid funds that would otherwise be necessary to serve these State residents if the RItE Share Program did not exist.

The Program for All-inclusive Care for the Elderly (PACE) was implemented in December 2005. On average, 200 beneficiaries are enrolled in the State’s fully integrated program for frail elders who are Medicare and Medicaid Eligible (MME) beneficiaries.

The Connect Care Choice (CCC) program was implemented in 2007 as the State’s Primary Care Case Management model to serve the adult populations with complex medical and behavioral health conditions.

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<sup>1</sup> RI Annual Medicaid Expenditure Report- SFY 2012, Executive Office of Health and Human Services, June 2013

The CCC program offers extensive care management services through 17 comprehensive medical home practice sites.

In 2008, voluntary enrollment in Rhody Health Partners was implemented for persons with disabilities. In the fall of 2009, all Medicaid eligible “aged blind and disabled” (ABD) adults without third-party coverage (TPL) who resided in the community were required to either enroll in a Health Plan through the Rhody Health Partners program, or in the State’s FFS Primary Care Case Management (PCCM) program, Connect Care Choice (CCC). Currently, there are over 13,500 enrolled in the Rhody Health Partners Program.

This progression of expanded enrollment in managed care is characterized by enrollment of populations with increasingly complex health needs. Over this period, the contractual requirements of Health Plans have also expanded in terms of program requirements and in covered benefits, as the State has increased the performance requirements of Health Plans for managing the health care needs of complex populations. Health Plans were not required, however, to pay for home and community-based services but did pay for up to 30 days of nursing home stays.

Seventy-seven percent of the Medicaid population is enrolled in a Health Plan and accounts for 49 percent of Medicaid expenditures. (In part this is because the vast majority of managed care enrollees are in the RItE Care program, which has a lower PMPM cost, than the elder or adult disabled populations). The Rhode Island Medicaid Managed Care Plan has consistently been ranked among the best in the nation.

Currently, there are two Health Plans participating in the Medicaid managed care program: (1) Neighborhood Health Plan of Rhode Island (NHPRI), and (2) UnitedHealthcare Community Plan (United). The total enrollment in both of these Health Plans for the RItE Care and Rhody Health Partners (RHP) program was 141,012 on September 30, 2013. NHPRI has 92,848 members (86,848 RItE Care member and the remaining being Rhody Health Partner members). United had 48,164 members (40,710 RItE Care members and the remaining being Rhody Health Partners members).

The total managed care capitation expenditures for SYF 2013 to these Health Plans was \$637 million. RItE Care accounted for \$434 million and Rhody Health Partners accounted for \$203 million.

Currently, there are seventeen CCC practice sites statewide. As of September 2013, the CCC program enrollment totaled 1,638 members. In SFY 2012, the total expenditures for the Connect Care Choice program were \$35.4 million.<sup>2</sup>

EOHHS implemented the Rhody Health Options Program in the Fall of 2013 to serve the ABD and Medicare and Medicaid Eligible (MME) populations. The program builds on, improves, and integrates primary care, acute care, specialty care, behavioral health care and long-term services and supports to better meet the needs of the target populations. It is estimated that 28,000 Rhode Islanders over age 65 and individuals with disabilities/chronic conditions who have Medicaid coverage or Medicare and Medicaid coverage (dual eligibility) are eligible. As of November 1, 2013 almost 4,500 individuals were enrolled in either Rhody Health Options Program in the Neighborhood Health Plan of RI.

Beginning in January 1, 2014, the Health Plans under contract with EOHHS covered the adult expansion population who are eligible for Medicaid under the federal Affordable Care Act (ACA). It is estimated that this involves 55,000 Rhode Islanders.

### **2.3 RItE Smiles Program**

The RItE Smiles program is Rhode Island’s managed care program designed to increase access to and the outcomes of dental services provided to Medicaid children born on or after May 1, 2000. This section provides a brief history of RItE Smiles and presents current information about the program.

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2 ACEMedicaidExpense 20130621.

In the fall of 1998, DHS (which was then the State Agency for Medicaid) established the Medicaid Dental Advisory Committee (MDAC) with the purpose of developing recommendations for improving access to dental services for individuals covered by Rhode Island Medicaid, including children and families enrolled in RItE Care and uninsured working families. The committee included representatives of the Rhode Island Dental Society, Samuels Dental Center, St. Joseph Hospital Dental Program, the Rhode Island Health Center Association, KIDS COUNT, the Rhode Island Foundation, the Rhode Island Dental Hygienist Association, Crossroads RI, the Rhode Island HMO Association, two Rhode Island-based dental benefit managers, private practice dentists, other State agencies, and consumer advocacy groups.

In 1999, MDAC recommended that DHS develop purchasing specifications for a Dental Benefit Manager (DBM). The DBM program was expected to be implemented as an alternative to the FFS dental system for all Medicaid program enrollees, with implementation on an incremental basis beginning with children and families, and enrolling adults with disabilities and the elderly institutions at a later date. Later that year, DHS developed a Request for Proposals (RFP) soliciting a qualified organization to serve as DBM/DHP for Rhode Island Medicaid recipients through a program called *RItE Smiles*. Unfortunately, in 2000, unanticipated growth in RItE Care enrollment diverted the state's focus to containing the overall Medicaid budget, and the solicitation process was put on hold. The State issued a Bid Specification Document to procure the services of a DBM in December 2005.

The RItE Smiles program was implemented in September 1, 2006. RItE Smiles is designed to improve access and augment outcomes of dental services by increasing the number of dental providers participating in the Medicaid program, promoting preventive and primary dental treatment, and reducing the need for high cost restorative and emergency dental procedures.

Today, there are approximately 65,000 members enrolled in RItE Smiles. During September 1, 2012 through August 31, 2013, 56.5 percent of eligible members utilized the program which accounted for 3.10 procedures per claimant and 276 procedures per 1000 members. Over 81 percent of the services were for preventive/diagnostic procedures, which accounted for 54 percent of all payments. By August 2013, over 32,000 members had dental visits; over 29,000 members received preventive dental services and over 2,900 had an urgent care visit.<sup>3</sup>

Today the dental network consists of 283 unique dental providers at 180 separate address locations which represent 587 provider access points. The provider access points are comprised of the following: five endodontic, 474 general dentistry, 11 oral surgeons, 21 orthodontic, 74 pediatric dentists, and two periodontists.<sup>4</sup> In 2006, there were less than 30 dentists providing services to Medicaid children.

These dental providers practice in three types of dental settings: Federally Qualified Health Centers (FQHC), hospital based clinics and private practice settings. The following Table provides the type of dental services provided in these three settings.<sup>5</sup>

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3 UnitedHealthcare Dental-RItESmiles 2013 Annual Report, October 30, 2013 (pages 9, 16, 17).

4 Ibid., page 23.

5 Ibid., page 13.

2013 Utilization Summary by Provider Type	FQHC Utilization Summary		Hospital-Based Utilization Summary		Private Practice Utilization Summary	
	Accessing Members	Paid Procedure Count	Accessing Members	Paid Procedure Count	Accessing Members	Paid Procedure Count
Diagnostic	7070	11868	11051	27284	12901	28589
Preventive	7343	21729	10989	39303	13219	43061
Restorative	1734	3307	3731	10438	3274	8450
Periodontics	10	10	16	21	146	160
Oral Surgery	533	715	1706	3362	1328	2403
Endodontics	107	106	628	465	406	630
Orthodontics	0	0	41	161	401	1033
Prosthodontics	0	0	3	2	0	0
Adjunctive Services	87	85	1776	2463	780	927
<b>Totals</b>	8952	37820	11866	83499	14665	85253

In comparing the RItE Smiles HEDIS®-like results to the NCQA's Quality Compass' national average, the RItE Smiles program ranked above the national Medicaid average in all age categories. In the Age 2-3 range the national average rate was 31.7 with the RItE Smiles rate being 39.3. In the Age 4-6 range the national average rate was 53.65 with the RItE Smiles rate being 65.2. In the Age 7-10 range the national average rate was 57.68 with the RItE Smiles rate being 72.5. In the Age 11-14 range the national average rate was 52.02 with the RItE Smiles rate being 70.06.<sup>6</sup>

The PEW Center on the States reported that only 44 percent of Medicaid-enrolled children in the nation receive any dental services annually. In Rhode Island from 2002 to 2010, the participation rate of children from three to five years old went from 35 to 46 percent, a 31 percent increase. During the same time period, the participation rate of children from six to eight years old went from 50 to 64 percent while the rate for children aged nine and ten jumped from 57 to 71 percent.<sup>7</sup>

The RItE Smiles program continues to get national attention. In 2009 the Centers for Medicare and Medicaid Services (CMS), based on CMS-416 reporting, identified Rhode Island as ranking sixth in the nation for the percentage of children under age 21 who received dental services. Rhode Island's rate of participation was 46 percent in FFY 2008, up from 38 percent in FFY 2006. Nationally, only 35 percent of children under age 21 on Medicaid had at least one dental service in the 2008.

In March 2009, The National Academy of State Health Policy (NASHP) released a new report on access to dental care which included a section devoted to Rhode Island's RItE Smiles Program. The report details the history and outcomes of the RItE Smiles program, with a specific focus on outcomes for young children's

<sup>6</sup> Ibid., page 12.

<sup>7</sup> The Pew Center Report on the States. (2011). *The state of children's dental health: Making coverage matter*. Washington, DC: The Pew Charitable Trusts

dental health.

Also, in February 2010, Rhode Island also garnered national attention when it received an “A” score in the Pew Report “The State of Decay”. Rhode Island met six of eight policy benchmarks aimed at addressing children's dental health needs, making the state a national leader in addressing children's oral health. The report specifically highlighted the success of Rhode Island's RItE Smiles program. The report looked at 8 benchmarks including the scope of dental sealant programs, regulations allowing dental hygienists to place sealants, fluoridated water systems, access to dental care for children enrolled in Medicaid, payment of medical providers for early preventive dental health care, and data tracking on children's dental health.

The RItE Smiles eligible population is defined to consist of different eligibility groups. Qualification for the program is based on a combination of factors, including age, family composition, income level, and insurance status.

Specifically, the Rite Smiles eligibility groups consist of the following:

- **Uninsured Children Born on or After May 1, 2000 under 250 Percent of the Federal Poverty Level (FPL):** This aid category consists of children born on or after May 1, 2000 living in families whose income is under 250 percent of the FPL.
- **Children in Substitute Care:** This aid category includes children in foster care born on or after May 1, 2000, who are currently enrolled in RItE Care on a voluntary basis or are in Medicaid fee-for-service (FFS). These children receive the same benefits as any other children (e.g RI-WORKS/TANF).
- **Children with Special Health Care Needs:** This group includes children on SSI born on or after May 1, 2000, “Katie Beckett” children born on or after May 1, 2000, and children in adoption subsidy born on or after May 1, 2000, who are enrolled in RItE Care currently on a voluntary basis or are in Medicaid FFS. These children also receive the same benefits as other children.

The following children are excluded from participation in this RItE Smiles program irrespective of the membership in the population groups:

- Children residing in a nursing home or an intermediate care facility for the mentally retarded (ICF/MR)
- Children with third-party coverage for dental benefits
- Children residing outside of Rhode Island

These children will continue to access their benefits through the State’s Medicaid FFS system.

The State reserves the right to add new eligibility groups to the RItE Smiles program at any time. The State shall have sole authority for determining whether individuals meet any of the eligibility criteria and therefore are eligible to enroll in a RItE Smiles dental plan. There is no eligibility guarantee period for RItE Smiles eligibility groups. Children will need to be re-certified for Medicaid eligibility as required by State Medical Assistance policy or as individual case circumstances may warrant.

## **SECTION 3: SCOPE OF WORK**

### **General Scope of Work**

The goal of the RIte Smiles Program is to improve access to dental care for eligible children, to increase the percentage of children who receive dental services, to increase the utilization of medically necessary dental services, to provide preventative dental services, to increase dental preventive services to very young children (under age 3) and to provide dental services in multi-practice and private practice settings.

### **Specific Activities / Tasks**

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

- Enroll the covered population and provide the covered dental benefits that represent a continuum of dental care services,
- Maintain a robust provider network that meets Federal and State accessibility standards,
- Provide in-plan benefits and to coordinate out-of-plan benefits that meet individual member needs,
- Capacity to provide in-plan dental management to a diverse population with complex needs,
- Capacity to provide responsive member and provider services,
- Capacity to operate under a risk bearing contract and to meet financial standards,
- Maintain a viable information technology capacity and meet federal and State reporting requirements,
- Attend and preside at meetings with stakeholders on a regular basis, and
- Maintain a grievance and appeals process that meets federal and State requirements.

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

### **3.1 Dental Plan(s) Licensure and Organizational Requirements**

The Bidder must meet all State general requirements as described in Section One.

The Bidder certifies that it is licensed in Rhode Island as an HMO under the provisions of Chapter 2741, “the HMO Act” or that it shall become licensed as a Health Maintenance Organization (HMO) or Health Plan (HP) in the State of Rhode Island by the Rhode Island an Agreement with State. If Bidder is not a licensed HMO in Rhode Island, Bidder certifies that it is either a nonprofit hospital service corporation that is licensed by the Rhode Island Department of Business Regulation (“DBR”) under Chapter 27-19 of the Rhode Island General Laws, a nonprofit medical service corporation that is licensed by DBR under Chapter 27-20 of the Rhode Island General Laws, a nonprofit dental service corporation subject to R.I.G.L. 27-20.1.1 et seq. or another health insurance entity licensed by DBR, and that it meets the following requirements:

- Is certified by the Rhode Island Department of Health as a Health Plan under R23-17.13- CHP; and
- Meets the requirements of Sections 3.4, 5.2, 6.1.4, and 6.4.7 under R23-17.13-CHP; and
- Meets the requirements under R23-17.12: *Rules and Regulations for the Utilization Review of Health Care Services*

If the entity providing the dental benefit management expertise is a separate corporation (e.g., a subsidiary of the Bidder or a subcontractor to which delegation is to be made), then the Bidder assures that entity meets the foregoing requirements.

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

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

The Contractor will become accredited in Rhode Island as a Dental Plan within 12 months after the State has notified the Contractor of an appropriate accreditation body.

The Bidder is in good standing with the Medicare and Medicaid programs.

The Bidder is financially solvent, has the capital, and has the financial resources and management capability to operate under this procurement's risk-based contract that reimburses the successful Bidder with capitation rates.

The Bidder is required to have the staffing capacity with the appropriate expertise. The Bidder is required to have a Dental Director that meets the requirements of the Model Contract. The Bidder must have adequate staffing to complete the administrative procedures, develop an organization structure, maintain a management information system and to perform all the functions required under this contract (e.g. program and service development, member enrollment, member services, claims processing, accounting and finance, quality assurance, dental/medical management and utilization review, provider network development and continuing relations, care management, grievance and appeals systems, etc.).

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

## **3.2 Member Enrollment and Disenrollment**

The Bidder meets all the requirements as described in Section 2.05 of the Model Contract and summarized below. The Bidder must adhere to all enrollment and disenrollment policies, as defined by the State.

### **3.2.1 Overview**

All eligible children will be enrolled in the RIte Smiles program by the State. Following their initial enrollment into the Dental Plan, RIte Smiles children will be restricted to that Dental Plan after the first 90

days unless disenrolled for an acceptable reason.

### **3.2.2 Enrollment**

The Bidder must have State approved written policies, procedures, systems and practices that meet the requirements prescribed in the Model Contract. The State supplies the Contractor on a monthly basis with a list of RIte Smile members.

The Bidder must notify, by mail, members of their enrollment that indicates the effective date and how to access care within 10 calendar days after receiving notification from the State of their enrollment. The Bidder agrees to report any changes in the status of individual member within five days of their becoming known, including but not limited to changes in address or telephone number, out-of-State residence, deaths, household composition (e.g. birth of a child or change in legal guardianship of a minor) and sources of third-party liability. The Bidder must have a process for performing outreach calls and an approach for determining a member's most recent and accurate address and telephone number.

The Bidder agrees to enroll, in the order in which he or she applies or is assigned, any RIte Smiles eligible individual who selects it or is assigned to it, regardless of the individual's age, sex, sexual orientation, ethnicity, language needs, health status, or need for health services. At the same time the Bidder also must agree to enroll any eligible siblings and/or dependents. The only exceptions will be if the member was previously disenrolled from the RIte Smiles Dental Plan as the result of a grievance filed by the Bidder.

The Bidder shall have written policies and procedures for orienting new members to their benefits, how to utilize services in other circumstances, how to register a complaint or file a grievance. These policies and procedures shall take into account the multi-lingual, multi-cultural nature of the population. All enrollment notices, informational materials and instructional materials relating to members should be written at no higher than a sixth-grade level, presented in a manner and format that may be easily understood. All written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who are visually limited or have limited reading proficiency. All members must be informed that information is available in alternative formats and how to access those formats.

The Bidder makes at least four attempts, on different days, and at different times of the day, to make a welcome call to all new members within 30 days of enrollment. Welcome call scripts also solicit whether members have a regular dentist within the network, and whether they have new or existing dental care needs. In the event that a welcome call identifies any new members who have existing health care needs immediate steps will be taken to ensure the member's needs are met. Any scripts developed or used by the Bidder for these purposes are subject to review by EOHHS.

### **3.2.3 Disenrollment**

The State has sole authority for disenrolling members from RIte Smiles, subject to the conditions described in the Model Contract. The Bidder may not disenroll a member. The Bidder refers requests for disenrollment to EOHHS for determination.

### **3.2.4 Materials**

The Bidder issues all RIte Smile members an identification card within ten days after receiving notification from the State of their enrollment. The card includes at least the following information: (1) Bidder's name; (2) toll-free telephone number to call for help in accessing services; and (3) telephone number for Member Services function if different from number 2.

The Bidder mails a Member Handbook to all members within ten days of being notified of their enrollment and updates the Member Handbook when material changes occur as determined by EOHHS. The Bidder includes all the information in the Member Handbook that is required in the Model Contract. The Bidder also agrees to make available Member Handbooks in languages other than English consistent with the interpreter requirements described in the appended Model contract.

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

The Bidder must assure that all materials are written at no higher than a sixth grade level and are culturally appropriate.

### **3.2.6 Marketing**

The Bidder may conduct marketing campaigns for members, subject to the restrictions noted in the *Marketing and Approval of Written Materials, Protocols for Medicaid Managed Care Programs*, issued by the State. Bidder may not display or distribute marketing materials, nor solicit members in any other manner, within 50 feet of eligibility and enrollment offices, unless it has received permission to do so from the State.

The Bidder submits all marketing materials to the EOHHS for approval prior to use. All marketing materials are written at no higher than a sixth-grade level, in a format and a manner that is easily understood, and are culturally appropriate for the population. EOHHS determines whether Dental Plan's marketing plans, procedures, and materials are accurate, and do not mislead, confuse, or defraud either recipients or the State, pursuant to 42 CFR 438.104. When engaged in marketing targeted to RItE Smiles members, the Bidder (1) does not distribute marketing materials to less than the entire service area, (2) does not distribute marketing materials without the approval of the EOHHS, (3) does not seek to influence enrollment in RItE Smiles in conjunction with the sale or offering of private insurance, and (4) does not, directly or indirectly, engage in unsolicited door-to-door, telephone, or other cold call marketing activities.

### **3.2.7 Disenrollment**

The State has sole authority for disenrolling members from RItE Smiles, subject to the conditions described in the Model Contract. The Bidder may not disenroll a member. The Bidder refers requests for disenrollment to EOHHS for determination.

## **3.3 Services/Benefits**

### **3.3.1 General**

The Bidder is required to meet all requirements stated in Section 2.06 of the Model Contract.

Specifically, the Bidder is required to provide a full range of comprehensive dental services as In-Plan Services. These in-plan services are described in Attachment A of the attached Model Contract.

The Bidder is also required to coordinate out-of-plan services that are provided to members and paid for on a fee-for-service basis by the State. These services are described in Attachment B of the attached Model Contract.

Attachment C of the Model Contract identifies the non-covered benefits.

### **3.3.2 Dental Early Periodic Screening, Diagnosis and Treatment (EPSDT)**

The Bidder must provide dental EPSDT services as described in the Model Contract and based on the

Periodicity Schedule in accordance with Attachment D of the Model Contract.

As indicated in the Attachment, Dental EPSDT consists of the following components: screening, diagnosis and treatment, tracking, and follow-up and outreach.

### **3.3.3 Interpreter/Translation Services**

The Bidder makes available interpreter services as described in the Model Contract by telephone or in person, if more than 50 members speak a language other than English as their first language. The Bidder also complies with the requirements of the American Disabilities Act.

### **3.3.4 Member/Provider Communication**

The Bidder may not prohibit, or otherwise restrict, a dental care professional, acting within the lawful scope of practice, from advising or advocating on behalf of a member as described in the Model Contract.

### **3.3.5 Second Opinion**

A RIte Smiles enrolled member is entitled to a second opinion from a qualified dental provider within the network or, if approved by the RIte Smiles dental plan, to a second opinion by a nonparticipating provider outside the network, at no cost to the member.

### **3.3.6 New In-Plan Services**

The State reserves the right to add new in-plan services to RIte Smiles at any time. The State's intent to add any new in-plan service and the terms upon which any new in-plan service would be covered under the Contract will be made according to the notice provisions in the Model Contract. Contractor shall have 45 days from the date of receipt of such notice to either accept or reject in writing the addition of the new in-plan service and the terms proposed. Acceptance is formalized through an amendment to the Contract, as indicted in the Model Contract.

## **3.4 Care Coordination**

The Bidder is required to ensure that it meets the Care Coordination requirements in Section 2.07 of the Model Contract.

The Bidder coordinates all covered dental services, which involves the organizing and marshalling of personnel and other resources needed to carry out all medically necessary dental activities required by members and is often managed by the exchange of information among participants responsible for the different aspects of care. The State considers interactive communications between the primary dental provider and dental specialists to be an important program objective to ensure that members receive the right care in the right setting.

The Bidder must also coordinate care between primary care provider (PCP) and dental services as needed as well as ensure members have timely access to prescriptions through coordination with other payers and through provider education. The synergy between the PCP and the dentist is essential to ensure that the medical and dental needs of members are met in a coordinated and integrated fashion.

## **3.5 Provider Network**

The Bidder is required to ensure that network providers meet the Provider Network requirements in Section 2.08 of the Model Contract.

The Bidder maintains a robust multi-disciplinary provider network (1) to provide members with the full

range of covered dental services; (2) that maintains providers in sufficient number, mix and geographic area; and (3) makes available all services in a timely manner.

The Bidder agrees to establish and maintain a network that is supported by written agreements and can sufficiently demonstrate to EOHHS' satisfaction the Bidder's ability to provide covered services under this Agreement. Members must have access to services that are at least equal to, or better than community norms.

In establishing and maintaining the network, the Bidder considers the following:

- Anticipated RItE Smiles enrollment
- Expected utilization of services taking into consideration the characteristics and health care needs of specific RItE Smiles populations for which the Bidder will be responsible
- Numbers and types (in terms of training, experience, and specialization) of providers, specifically specialty providers, required to furnish the services contracted for herein
- Numbers of providers who are not accepting new RItE Smiles patients
- Geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities
- "Disability competency" of providers and the physical accessibility of their offices as it relates to the capacity of health professionals and health educators to support the health and wellness of people with disabilities through their knowledge, experience and expertise providing services to children with disabilities.

The provider network consists of a continuum of care required to meet the diverse and often complex needs of RItE Smiles members and will contain, but not be limited to, general dentists and pediatric dentists to meet the service accessibility standards outlined later in this section as well as an adequate specialty network that includes the following specialty dentists: pediatric dentists, periodontists, endodontists, prosthodontists, oral surgeons, and orthodontists.

The Bidder includes in its network traditional providers of dental services to Rhode Island's Medicaid population (i.e., FQHCs/RHCs, hospital-based dental clinics and school-based clinics) as well as private practice dental practitioners and mobile service providers to meet the diverse needs of the RItE Smiles population.

The Bidder provides the State quarterly with a list of all its participating dental providers, including those whose practices are open to additional Rite Smiles members. The Bidder notifies the State monthly of any changes in its network's composition and have procedures to address changes in its network that negatively affect the ability of members to access services.

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

### **3.6 Service Accessibility Standards**

The Bidder is expected to meet the standards as described in Section 2.09 of the Model Contract.

The Bidder shall have written policies and procedures describing how members and providers can contact the Contractor to receive instructions for treatment of an Urgent dental problem. The Bidder makes available dental services within 48 hours for urgent dental conditions.

The Bidder is not responsible for emergency medical or dental conditions.

The Bidder makes available to every member a dental provider, whose office is located within twenty (20) minutes or less driving distance from the member's home. Members may, at their discretion, select a dental provider located farther from their homes.

The Bidder makes services available within 60 days for treatment of a non-emergent, non-urgent dental problem, including preventive dental care. Contractor agrees to make dental services available to new members within 60 days of enrollment.

The Bidder offers members a choice of dental providers accepting new patients.

### **3.7 Member Services**

The Bidder meets the requirements in Section 2.10 of the Model Contract. As part of the Member Services function, the Bidder has an ongoing program of member education that takes into account the multi-lingual, multi-cultural nature of the population and also recognizes that some members have disabilities.

The Bidder staffs a Member Services function that is operated at least during regular business hours (8 AM to 6 PM including lunch, Monday through Friday) and the Bidder's staff conducts the functions identified in the Model Contract. The Bidder maintains a toll-free Member Services telephone number that is staffed during regular business hours as defined above.

Once a year, the Bidder notifies members in writing of their rights to request and obtain information about their benefits, freedom of choice regarding provider restrictions, State's and Dental Plan(s)' grievance and appeals processes, after hour and emergency coverage, requirement for prior authorization of services, referrals for specialty care, and other information as identified in Section 2.10 of the Model Contract.

### **3.8 Provider Services**

The Bidder meets the requirement described in Section 2.11 of the Model Contract. As part of its Provider Services function, the Bidder has an ongoing program of provider education relating to RIte Smiles benefits, program requirements, and the needs of RIte Smile members.

Contractor will make available a Provider Relations Representative who will provide face-to-face, facility-based or practice-based assistance and training when necessary. The Provider Relations Representative will be based in Rhode Island (preferably) or in New England and must be readily accessible to meet the needs of the RIte Smiles providers in a timely manner.

The Bidder maintains a toll-free telephone line and staffs a Provider Services function to be operated at least during regular business hours (8 AM to 6 PM including lunch, Monday through Friday).

The Bidder requires dental providers to report any changes in address or telephone number at least 30 days prior to the change occurring.

### **3.9 Dental Management and Quality Assurance**

The Rhode Island Department of Health regulates the Utilization Review and quality assurance, or quality management (UR/QA) functions of all licensed Health Plans and Dental Plans. The Bidder, therefore, complies with all Department of Health UR/QA standards, in addition to specific standards described in this section.

The requirements for clinical management and quality assurance are described in Section 2.12 of the Model Contract and are highlighted below.

### **3.9.1 Dental Director**

The Bidder designates a Dental Director responsible for the development, implementation, and review of the internal Quality Assurance Program (QAP). The Dental Director has adequate and appropriate experience in successful QA programs and is given sufficient time and support staff to carry out the Dental Plan's QA functions. The Dental Director need not serve full-time nor be a salaried employee of the Bidder, but the Bidder must demonstrate that it is capable of meeting all requirements using a part-time or non-employed Dental Director. The Bidder may use assistant or associate Dental Directors to help carry-out the responsibilities of this office.

The qualifications and responsibilities of the Dental Director include, but need not be limited to, the following:

- Be licensed to practice dentistry in the State of Rhode Island and be board-certified, board-eligible, or trained in his or her field of specialty
- Be responsible for Bidder's UR and QA Committees, direct the development and the implementation of Bidder's internal Quality Assurance Plan, utilization review activities, and monitor the quality of care that members receive
- Be responsible for the development of dental practice standards and protocols for Bidder
- Oversee the investigation of all potential quality of care problems, including , but not limited to member specific occurrences of "never events", potential healthcare acquired infections, and possible health acquired conditions and be responsible for development and implementation of corrective action plans
- Be responsible for the development of Bidder's dental policies
- Be responsible for the Bidder's referral process for specialty and out-of-plan services
- Be involved in the Bidder's recruiting and credentialing activities
- Be involved in the Bidder's process for prior authorizing and denying services
- Be involved in the Bidder's process for ensuring the confidentiality of dental records/client information
- Serve as liaison between the Bidder and its providers and communicate regularly with the Bidder's providers, addressing areas of clinical relevance including but not limited to:
  - Bidder's utilization management functions
  - Health promotion programs offered by the Contractor
  - Any prior authorization (PA) requirements
  - Quality indicators, such as the Bidder's performance on HEDIS® measures
- Participate in the development of strategies to educate members about health promotion, disease prevention and efficient and effective use of oral health care benefits and be available for In-State meetings.
- Be available to the Bidder's dental staff on a daily basis for consultation on referrals,

denials, complaints and problems.

### **3.9.2 Utilization Review**

The Bidder has written policies and procedures to monitor utilization of services by its members and to assure the quality and accessibility of care being provided in its' network. The policies and procedures must: (1) conform to 42 CFR 438.350, (2) assure that the UR and QA Committees meet on a regular schedule, and (3) provide for regular UR/QA reporting to the Dental Plan(s)' management and providers, including profiling of provider utilization patterns.

The policies and procedures include protocols for: denial of services, prior approval, hospital discharge planning, physician profiling, and retrospective review of claims. As part of its utilization review function, the Bidder has processes to identify utilization problems and undertake corrective action. The Bidder has a structured process for the approval or denial of covered services. This includes, in the instance of denials, formal written notification to the member and the requesting or treating provider that includes the basis for the denial, and any applicable appeal rights and procedures including EOHHS level appeal within 14 days of the request for authorization. The Bidder demonstrates to the EOHHS that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically or functionally necessary services to any member. The Bidder may engage in direct discussions and/or patient or patient family interviews, as necessary, in order to consider treatment options or alternatives, and the like for cost-effective, patient-centered medically necessary dental care.

The Bidder shall accept and honor the authorizations that were made prior to the contract commencement date until the authorization period has ended.

### **3.9.3 Quality Assurance**

The Bidder has a written quality assurance or quality management plan that monitors, assures, and improves the quality of care delivered over a wide range of covered services including all subcontractors. The Bidder completes two Quality Improvement Projects, approved by EOHHS, per year. The Bidder reports the status and results of each project to the State, or its designees, in a format to be outlined by the State, at least within 30 days following presentation to Contractor's Quality Improvement Committee or as otherwise requested by the State.

Bidder agrees to cooperate fully with the State or its designees in any efforts to validate performance improvement projects. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

The Bidder supports joint quality improvement projects involving RIte Smiles dental plan(s) and EOHHS.

### **3.9.4 Confidentiality**

The Bidder has written policies and procedures for maintaining the confidentiality of data, including dental records/client information so as to conform to HIPAA requirements.

The Bidder agrees to make available to the State and/or its designees on a periodic basis, medical and other records for review of quality of care and access issues.

### **3.9.5 Practice Guidelines**

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

When developing practice guidelines, the Bidder follows in principle the guidelines promulgated by the American Academy of Pediatric Dentistry (AAPD).

### **3.9.6 Service Provision**

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

### **3.9.7 Provider Credentialing**

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

The Bidder has a uniform credentialing and re-credentialing process and ensures that the process complies consistently with State regulations. For organizational providers, the Bidder must adopt a uniform credentialing and re-credentialing process and that consistently complies with State regulations.

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

The Bidder has written policies and procedures which pertain to disclosures by providers. In accordance with 42 CFR Section 455.104, disclosures must be obtained from any provider or disclosing entity at any of the following times: when submitting a provider application, when executing a provider application, upon request during re-validation or re-credentialing process, within thirty-five (35) day of any change in ownership.

Providers must disclose any individual who has ownership (i.e. five percent or more) or interest in the provider that has been convicted of a criminal offense.

The Bidder may refuse to enter into or renew an agreement with a provider if any person: who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any Federal health care program. The Bidder may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure as required in this section and in the Model Contract. The Bidder promptly notifies EOHHS of any action that it takes to deny a provider's application for enrollment or participation (e.g., a request for initial credentialing or for re-credentialing) when the denial action is based on the Bidder's concern about Medicaid program integrity or quality.

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

### **3.10 Operational Reporting**

The Bidder must comply with Section 2.13 of the Model Contract.

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

The Bidder agrees to provide to the State or its designee, for each member, a person-level record describing the care received by that individual during the previous quarterly period. In addition, Bidder provides aggregate utilization data for all members at such intervals as required by EOHHS. The person-level record includes, at a minimum, those data elements listed in the *Encounter Data Business Design* including updates issued by EOHHS' designated Medicaid Management Information System (MMIS) contractor. The Bidder submits data in an electronic or tape format that conforms to the State's specifications.

The Bidder submits person-level records at intervals specified by the State and in a format determined by the State. The Dental Plan submits aggregate data quarterly and no more than 180 days past the end of the reporting quarter and assists EOHHS in its validation of utilization data by making available medical records and a sample of its claims data.

The Bidder also (1) submits a quarterly grievance and appeals report due no later than 30 days after the end of the reporting quarter, (2) submits internal quality assurance reports as defined by the State, (3) collects member and provider satisfaction data through an annual survey of its members, (4) submits a quarterly fraud and abuse report due no later than thirty days after the end of the reporting period, (5) submits a compliance dashboard report due no later than 30 days after the end of the reporting quarter, and (6) submits an informal complaints report due no later than 30 days after the end of the reporting quarter. These reports should be prepared in conformance with reporting templates established by the State.

The Dental Plan's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the Dental Plan's CEO or CFO must certify the data. The certification must attest, based on best knowledge, information, and belief, as to the accuracy, completeness and truthfulness of the data and the documents submitted to EOHHS. The Bidder complies with standards and operating rules of the Affordable Care Act (ACA) and the Health Insurance Portability and Accountability Act Requirements (HIPAA).

### **3.11 Grievance and Appeals**

The Bidder meets the requirements governing the grievance and appeals process as described in Section 2.14 of the Model Contract.

The State has established a Grievance and Appeals function through which members can seek redress against Dental Plans. The grievance system includes a grievance process, an appeals process, and access to the State's Fair Hearing system. EOHHS requires that the Dental Plan resolve member and provider complaints through internal mechanisms whenever possible.

The Bidder's policies and procedures for processing grievances permit a provider, acting on behalf of a

member and with the member's written consent, to file an appeal of an action within 30 days from the date of the Dental Plan's Notice of Action. An Action means (1) whether or not a service is a covered Service; (2) the denial or limited authorization of a requested service, including the type or level of service; (3) the reduction, suspension, or termination of a previously authorized service; (4) the denial, in whole or in part, of payment of a service; (5) the failure to provide or authorize services within a timely manner, or (6) the failure of the Dental Plan to act within prescribed time frame as indicated in the Model Contract. The information that is required to be in a Notice of Action is also included in the Model Contract. The time frames for mailing a Notice of Action must comply with 42 CFR 438.404. The Dental Plan also notifies the requesting provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

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

For appeals, the process must (a) provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date) and must be confirmed in writing, unless the member or the provider requests expedited resolution; (b) provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing; (c) provide the member and his or her representative opportunity, before and during the appeals process, to examine the case file, including clinical records and other documents and records considered during the appeals process (under certain circumstances certain categories of clinical records and other documents may not be available to the member based on the type of record including but not limited to mental health records); and (d) include, as parties to the appeal, the member and his or her representative, or the legal representative of a deceased member's estate. The Dental Plan(s) provides written notice of the disposition of all appeals within 30 days from the time the Dental Plan(s) receives the appeal. For notice of an expedited appeal, Dental Plan(s) must also make reasonable efforts to provide oral notice. The information that is required to be in the written notice is indicated in the Model Contract. The Dental Plan(s) continues to provide services during the appeals process if the member filed for an appeal within ten days of the Notice of Action.

The Dental Plan(s) establishes and maintains an expedited review process for appeals, when the Dental Plan(s) determines (for a request from a member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function.

If the Dental Plan takes an action to deny, limit or delay services a member may request a State Fair Hearing after the member has exhausted the Dental Plan's Appeal Process. The right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the member by the Dental Plan.

### **3.12 Payments to and from the Dental Plan**

The Bidder accepts the capitation rates as contained in the Model Contract. The State makes capitation payments to the Dental Plan on a monthly basis via electronic funds transfer as described in Section 2.15 of the Model Contract.

Bidder may consider entering into creative or performance based payment arrangements intended to foster and reward effective utilization management and quality of care. The Bidder is expected to conduct procurement practices and to establish provider reimbursement systems that enhance the access, quality and cost-effectiveness of care.

Bidders are required to meet the requirement of the Model Contract related to (1) special reimbursement provisions for FQHCs and RHCs, (2) paying providers within thirty (30) days of receipt of a "clean claim", (3) payment of hospital-based dental clinics, (4) applying Federal and State limitations on provider

incentive plans, (5) Third Party Liability (TPL), (6) reinsurance, (7) maintaining reserves and accounting for incurred but not reported (IBNR) claims, (8) payment adjustments with respect to non-payment of provider preventable conditions, and (9) the State conducting audits of the Dental Plan.

TPL is one of three components of EOHHS Program Integrity efforts (compliance and fraud/abuse are the other two that are subsequently discussed). Dental Plans are expected to make every effort to identify and pursue TPL to the fullest extent possible to assure that other funds are used before Medicaid funds are expended, including but not limited to: (1) identifying potential other TPL when a member initially is enrolled with a Dental Plan and periodically thereafter, (2) identifying other potential TPL when adjudicating member claims (e.g. auto insurers or liability insurers when a claim is related to an accident), (3) notifying the State Fiscal Intermediary when TPL is identified, and (4) making efforts to recover funds related to other TPL coverage

### **3.13 Financial Standards, Record Retention, and Compliance**

#### **3.13.1 Dental Plan(s) Financial Standards**

The Rhode Island Department of Business Regulation regulates the financial stability of all licensed Dental Plans in Rhode Island. The Bidder agrees to comply with all Rhode Island Department of Business Regulation standards in addition to specific requirements described in Section 2.16 of the Model Contract.

The success of the Rhode Island Medicaid Dental managed care program is contingent on the financial stability of participating Dental Plans. As part of its oversight activities, the State has established financial viability criteria, or benchmarks, used in measuring and tracking the fiscal status of the Dental Plans. The areas in which financial benchmarks are established include the following:

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

The Bidder provides the information necessary to calculate benchmark levels and to continually meet the State's financial reporting requirement to monitor the financial conditions of the Bidder once operational. The Bidder complies with corrective actions ordered by the State to address any identified deficiencies with respect to financial benchmarks.

#### **3.13.2 Record Retention**

As required by Section 2.17 of the Model Contract. The Bidder retains the source records for its operational data reports and financial records for a minimum of ten years and must have written policies and procedures for storing this information. The Bidder also preserves and maintains all dental records for a minimum of ten years from expiration of the contract. If records are related to a case in litigation, then these records are retained during litigation and for a period of seven years after the disposition of litigation.

#### **3.13.3 Compliance**

The compliance requirements are discussed in Section 2.18 of the Model Contract. In accordance with 42 CFR 438.608, the Bidder has administrative and management arrangements, including a mandatory written Compliance Plan, which is designed to guard against fraud and abuse. An electronic copy of the Compliance Plan including all relevant operating policies, procedures, workflows, and relevant chart of organization, and the information noted in the Model Contract are submitted to EOHHS for review and approval within 90 days of the execution of the contract and then on an annual basis thereafter.

Compliance is one of three component of the State's Program Integrity efforts (identification and recovery of TPL and detection and control of fraud and abuse are the other two components). Specific requirements related to efforts to identify and recover TPL and to control fraud and abuse are discussed in Section 3.07.03 of the Model Contract.

The Bidder (1) is prohibited to have affiliations with individuals debarred by Federal agencies, (2) must disclose ownership and controlling interest within 35 days of contract execution, (3) must require providers to disclose ownership and controlling interest, (4) must require each to furnish the Federal and State governments full and complete information related to business transactions, within 35 days upon request, (5) must require that providers must disclose any individual who has more than five percent interest in the provider who was convicted of a crime, and (6) must disclose to the State any individual who has more than five percent ownership who has been convicted of a crime. These requirements are more fully discussed in the Model Contract.

### **3.14 Model Contract Terms and Conditions**

The attached Appendix B contains the Model Contract for the forthcoming procurement period. Bidders are urged to read the Model Contract carefully and thoroughly. The Model Contract describes the binding requirements between the State and the Contractor. The successful Bidder(s) will be bound to the requirements and capitation rates contained in this Model Contract. Contractors are expected to have policies, procedures and practices that demonstrate compliance with the requirements contained in this Model Contract.

The Bidder is required to meet the Terms and Conditions described in Article III "Contract Terms and Conditions" of the Model Contract that covers: (1) the general provisions of the contract, (2) interpretations and disputes including compliance with federal and State requirements, (3) contract amendments, (4) payments, (5) guarantees, warranties and certifications including "hold harmless" and insurance requirements as well as requirements related to patents and copy write infringement, non-assignment of the contract, clinical laboratory improvement amendments, (6) personnel and staffing requirements, (7) performance standards and damages including requirements related to fraud and abuse, (8) inspection of the work performed and access to information, (9) confidentiality of information, (10) termination of the contract, and (11) other required terms and conditions. Bidders are urged to review the specific requirements related to the terms and conditions in the Model Contract.

The fraud and abuse requirements merit additional discussion because they are the other component of EOHHS Program Integrity efforts which include: (1) the identification and recovery of third-party liabilities, (2) compliance plan, and (3) fraud and abuse. The first two points were discussed in the previous section; the following highlights requirements related to fraud and abuse.

The Dental Plan(s) must adopt a strategic and robust approach to the prevention, detection, investigation and reporting of potential Medicaid fraud, waste and abuse to assure that Medicaid funds are appropriately expended. Specifically, the Dental Plan(s):

- Operates a comprehensive program for providing targeted feedback to providers and vendors whose coding, documentation, or billing, although not fraudulent, appears problematic.
- Develops mechanisms for educating members and network providers about the impacts of Medicaid fraud, waste and abuse on overall program costs and on clinical outcomes for enrollees.
- Integrates approaches to processing and investigating leads about possible fraud, waste and abuse which may be identified from multiple sources, including the Dental Plan(s)'s toll-free fraud, waste, and abuse reporting hotline, as well as calls or written correspondence directed to the Dental Plan(s)'s customer service, provider relations, utilization management, medical management, and care management departments.

- Employs analytic systems which make use of algorithms to identify: billing for mutually exclusive codes; deviations from time standards; excessive daily billings; excessive diagnostic procedures; outliers in service utilization; provider peer profiling outliers; potential up-coding; potential unbundling; services billed after the date of death of the enrollee or the provider.
- Executes systematic processes for conducting special investigations, provider site inspections, and focused clinical record reviews.
- Engages with the fraud, waste and abuse detection and investigations programs operated by the Bidder's subcontractors.
- Demonstrates interfaces between the Bidder's clinical management, provider credentialing, utilization management, compliance, legal, and special investigations units to analyze patterns of apparent over-utilization on the part of providers, vendors, or members.
- Uses a cohesive approach to synthesizing quantitative and qualitative data to determine whether possible Medicaid fraud, waste and abuse have been discovered.
- Makes referrals to EOHHS in a secure, timely, and thorough manner when the Bidder's initial investigation concludes that a case has reached the level of a suspected case of fraud and abuse on the part of a provider, vendor, or enrollee.

### **3.15 Model Contract Addendums**

The Model Contract contains addendums and critical requirements that the Bidder is expected to meet. These requirements are related to: (1) fiscal assurance, (2) notice to EOHHS providers of their responsibilities under Title VI of the Civil Rights Act of 1964, (3) notice to EOHHS providers of their responsibilities under Section 504 of the Rehabilitation Act of 1973, (4) drug free work place policy, (5) drug free work place provider certificate of compliance, (6) subcontractor compliance, (7) certification regarding environmental tobacco smoke, (8) instructions for certification regarding the debarment , suspension and other responsibility matters primary covered transactions, (9) certification regarding lobbying, (10) supplemental terms and conditions for contracts funded whole or in part by the American Recovery and Reinvestment Act of 2009, and (11) business associate agreement.

The Addendums are signed prior to the commencement date of the contract.

### **3.16 Model Contract Attachments**

The Model Contract contains the following Attachments which are key requisites to achieving the desired procurement results. Bidders are urged to read the Model Contract and are required to meet the requirements contained in these Attachments.

These Attachments contain:

- (1) schedule of in-plan benefits;
- (2) schedule of out-of-plan benefits;
- (3) schedule of non-covered services;
- (4) dental EPSDT periodicity schedule;
- (5) capitation rate;
- (6) actuarial bases for capitation rates;
- (7) special terms and conditions;

- (8) Bidder's insurance certifications; and
- (9) Bidder's locations.

## SECTION 4: TECHNICAL PROPOSAL

Narrative and format: The separate technical proposal should address specifically each of the required elements:

### 1. A LETTER OF TRANSMITTAL

Bidder shall submit a letter of transmittal signed by the owner, officer or authorized agent of the firm or organization, acknowledging and accepting the terms and conditions of this LOI, and tendering an offer to the State. The transmittal letter includes statements regarding the following:

- A) A statement that the Bidder has read, understands and accepts the conditions and limitations of this LOI
- B) A statement that the Technical Proposal is effective for one hundred and 120 days from the date of submission
- C) Identification of any proposed sub-contractor arrangements in the proposal
- D) Identification of the person who will serve as primary contact for the Bidder, including the individual's address, telephone number, fax number and email address
- E) Any other information that the Bidder may want to convey to the State

### 2. ASSURANCES/ATTESTATIONS

Bidder at minimum includes the following statements and assurances in their proposals.

- A) **A statement** that the Bidder is a corporation or other legal entity and is properly licensed to perform the duties of this contract in Rhode Island and will become accredited in Rhode Island as a Dental Plan within 12 months after the State has notified the Contractor of an appropriate accreditation body.
- B) **A statement** of whether the Bidder or any of the Bidder's employees, agents, independent contractors or subcontractors have been convicted of, pled guilty to or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense or have been debarred or suspended by any Federal or State governmental body, and if so, an explanation providing relevant details. Bidder shall include the Bidder's parent organization, affiliates and subsidiaries.
- C) **A statement** that the Bidder has read, understands, and accepts the mandatory requirements, responsibilities, and terms and conditions associated with this procurement, as reflected in the Model Contract.
- D) **A statement** that the Bidder accepts the State's Capitation Rates that will be paid to the successful Bidder(s).
- E) **A statement** of Affirmative Action that the Bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law),

sex, marital status, sexual orientation, political affiliation, national origin, or handicap and complies with the Americans with Disabilities Act.

### **3. BIDDER'S EXPERIENCE AND UNDERSTANDING**

The Bidder includes the following information in this section:

- A) Description of how the Bidder meets the Licensure and Organizational requirement in Section 3.2 of this LOI and Sections 2.01, 2.02 and 2.03 of the Model Contract. Bidder submits copies of its State Licenses with their response to this LOI.
- B) Description of the Bidder, and its subcontractors, regarding the type of organization and ownership; historical perspective of organization; special Federal and State designation businesses (e.g. small businesses, minority/women owned business and disability business enterprises); size of company, national recognitions; and other information that the Bidder would deem appropriate.
- C) A substantial description of the Bidder's ability to provide Medicaid services as a Dental Plan in Rhode Island under a risk-based contract.
- D) A concise description of the Bidder's experience providing Medicaid services as a Dental Plan in other states under a risk-based contract. This description must include information on the Bidder's approaches to serve diverse populations.
- E) A concise description of the Bidder's experience serving as a commercial Dental Plan in Rhode Island under a risk-based contract and the population served. This description must include information on the Bidder's approaches to serve diverse populations.
- F) The Bidder must demonstrate an understanding of the RI environment; the conditions surrounding this procurement and knowledge of and experience with the Medicaid population in other states. The Bidder must describe potential promising approaches to providing Medicaid services in a way that meets the unique needs of the enrolled local population.
- G) The Bidder must describe its capability and capacity to provide the Medicaid services to the eligible populations under a risk sharing arrangement including an appended organization table and description of the units responsible to administering the elements of the RIte Smiles Program.
- H) The Bidder must describe its financial viability (as well as any adverse factors that may affect the Bidder's financial viability including but not limited to bankruptcy proceedings, major lawsuits, fines, etc.).
- I) The Bidder must describe its ability to be ready to serve members by the stated contract commencement date.
- J) The Bidder must describe its relationship and linkages with existing Rhode Island Health Plans.
- K) The Bidder must provide three references where the Bidder provided similar services as requested in this LOI, including the Agency, contact person, e-mail address, address, telephone and fax numbers, and a description of the size and scope of the engagement.
- L) The Bidder may provide other information it believes is essential to provide value-based quality services to the Medicaid populations.

#### **4. TECHNICAL RESPONSES**

The following describes the Technical Responses required from the Bidder. EOHHS is interested in practical cost-effective interventions based on the Bidder's knowledge and experience, when responding to the Plans identified below.

##### **A) Plan for Best Practices**

EOHHS requests that the Bidder provide its proposed plans for designing and implementing "best practices" under this contract. EOHHS requests that the Bidder submit a clear and tangible proposed design plan and an implementation plan.

The Bidder submits a design and implementation plan for "best practices" for the enrolled population. These plans include references to the following:

- (1) a description of how the Bidder will identify specific "best practices" from other jurisdictions that may benefit Rhode Island (e.g., use of Caries Risk Assessment tools and how implementation of those tools leads to better outcomes and reduced expenses),
- (2) a description of a draft outreach protocol directed at parents, schools, physicians, and other community agencies to increase program enrollment,
- (3) a description of how the Bidder will identify and implement caries risk assessment techniques/measures/tools for Rite-Smiles-enrolled children, including those with special needs,
- (4) a description of a draft protocol to educate parents around the benefits of good oral health and to engage parents in intervention activities that may lower a child's risk for more extensive and costly care,
- (5) a draft protocol for ensuring continuity of care between the primary health care physician and the dentist or dental practice,
- (6) a description of how the Bidder will identify and implement specific clinical practices, guidelines and protocols that improve the outcome of care,
- (7) a description of how the Bidder will use of technology to improve the outreach efforts, the delivery of care and the administration of the program, and
- (8) a description of protocols that address other areas that may improve the Rite Smiles program, including methods that may be used to monitor and control the increase in orthodontic expenditures. The Bidder must clearly describe plans for containing these rising costs.

##### **B) Plan for Enrollment**

The Bidder clearly describes its plan for enrolling the Rite Smiles populations and meeting the requirements of Section 3.5 of the LOI and Section 2.05 of the Model Contract.

As part of its response, the Bidder identifies and describes its capability and its policies, procedures and practices, including the following:

- (1) a description of how the Bidder will accept the State supplied monthly list of Dental Plan enrollees,
- (2) a description of how the Bidder will enroll members on the first day of the following month after receiving notification from the State,
- (3) a description of how the Bidder will mail notification of Dental Plan enrollment to members

including effective date and how to access care within ten calendar days after receiving notification from the State,

- (4) a draft orientation protocol and procedure that will be used to engage new members about their benefits, how to utilize services in other circumstances, how to register a complaint or file a grievance and advance directives in accordance with Federal and State legal requirements,
- (5) a description of how the Bidder will make at least four (4) attempts, on different days and on different times, to make a welcome call to all new members within thirty days of enrollment,
- (6) a description of how the Bidder will provide members with a permanent identification card within ten days after receiving notification from the State,
- (7) a description of how the Bidder will mail a Member Handbook to all members within ten days of being notified of their enrollment,
- (8) update the Member Handbook when material changes are needed as determined by EOHHS,
- (9) develop marketing materials with EOHHS approval,
- (10) a description of how the Bidder will identify the diverse population of its members and design member information in a way that is culturally and disability competent appropriate,
- (11) a description of how the Bidder will determine the most recent and accurate telephone numbers and mailing address of its members,
- (12) a description of how the Bidder will identify and implement other member outreach protocols on an as-needed basis.

### **C) Plan for Providing Covered Services and Meeting Accessibility Standards**

The Bidder clearly describes its plan for providing the covered services and meeting accessibility standards contained in Sections 3.6 and 3.9 of this LOI and Sections 2.06 and 2.09 of the Model Contract. This section includes

- (1) a description of how the Bidder will provide the full range of In-Plan dental services to all of its members, including its members with special needs,
- (2) a description of how the Bidder will integrate dental EPSDT, interpreter/translation services, coordination of care, member/provider communications, and second opinions within its continuum of services,
- (3) a description of how the Bidder will ensure that it is meeting and exceeding the service accessibility standards that governs the provision of services,
- (4) a description of how the Bidder will ensure that it is meeting and exceeding additional standards that the Bidder employs above Model Contract requirements,
- (5) a draft design protocol to engage and serve special programs and services that are provided by the Bidder to RIte Smiles members to meet their special needs,
- (6) a description of how the Bidder will design and implement a plan for honoring all existing service authorizations for the designated transition period,
- (7) ideas for active, regular involvement in the Rhode Island oral health community's activities and initiatives (e.g. the RI Oral Health Commission), and

(8) other topics deemed appropriate by the Bidder.

#### **D) Plan for Care Coordination**

The Bidder describes its plan for coordinating benefits that meet the requirements of Section 3.7 of this LOI and Section 2.07 of the Model Contract.

The Bidder describes its plan for coordinating in-plan and out-of-plan dental benefits and coordinating care with member's PCP or other providers, when necessary.

#### **E) Plan for Maintaining a Robust Provider Network**

The Bidder describes its plans to develop and maintain a robust and comprehensive network of providers to meet the diverse and complex needs of RItE Smiles members as described in Section 3.8 of this LOI and in Section 2.08 of the Model Contract. Specifically, the Bidder will include

- (1) a description of how the Bidder will provide its members with the full range of covered dental services for the anticipated members in the service area,
- (2) a description of how the Bidder will increase the number of providers in sufficient number, mix and geographic area to meet the needs of its members. The Bidder will also describe its plans for a continuous recruitment and retention of new providers, plans for ongoing network development, and plans to create goal targets for specific numbers of providers in networks,
- (3) a description of how the Bidder will ensure that all services are available to members in a timely manner,
- (4) a description of how the Bidder will monitor and increase the specific provider network including a geographic access analysis of the network to determine accessibility of services that meet the needs of all members,
- (5) effective description of how the Bidder will design and implement specific measures to improve provider capability to improve the cost-effectiveness of care,
- (6) a description of specific plans for meeting the multi-lingual and multi-cultural needs of RItE Smiles members, as well as
- (7) other topics deemed appropriate by the Bidder.

The Bidder includes as an attachment to its proposal a complete listing of its' provider network including names, addresses, town or city, telephone numbers, provider specialties and foreign language(s) spoken (if any). The Bidder's GeoAccess analysis demonstrates that the network is sufficiently robust and assures timely access to services for RItE Smiles members based on providers who are currently accepting new members.

#### **F) Plan for Providing Member and Provider Services**

The Bidder clearly describes its plan for providing member and provider services as described in Sections 3.10 and 3.11 of the LOI and Sections 2.10 and 2.11 of the Model Contract, respectively.

The Bidder clearly describes its efforts to provide multi-lingual, culturally competent and disability-centric member services and to enhance provider services that promote the integration and coordination of care, and other topics deemed appropriate by the Bidder.

#### **G) Plan for Conducting Dental Management and Quality Assurance Efforts**

The Bidder discusses its plan for conducting dental management and quality assurance activities as described in Section 3.12 of this LOI and Section 2.12 of the Model Contract.

The Bidder includes the following:

- (1) a description of the Dental Director's background and experience as well as his/her role and responsibilities,
- (2) a description of how the Bidder will implement utilization review protocols and criteria that affect the provision, the approval, or the denial of care,
- (3) a description of specific strategies, programs and practices to assure quality of care, including a plan for developing and implementing measurement tools to measure access to care, average wait times for appointments, and access for children with special needs to both primary and specialty dental care,
- (4) a description of how the Bidder will implement practice guidelines,
- (5) a description of how the Bidder will monitor provider credentialing activities including a reasonable timeline to complete the process, and
- (6) other topics deemed appropriate by the Bidder.

The Bidder should attach the Dental Director's resume and his/her job description to its proposal as an attachment.

#### **H) Plan for Meeting the Operational Data Reporting Requirements**

The Bidder clearly describes its plan for meeting the operational data reporting requirements described in Section 3.12 of the LOI and in Section 2.13 of the Model Contract.

Specifically, the Bidder provides the following:

1. a description of how the Bidder will provide EOHHS with uniform utilization, quality assurance, and member satisfaction/complaint data on a regular basis,
2. a description of how the Bidder will provide, in a time-frame determined by the State, a person-level record of all services provided,
3. a description of how the Bidder will provide aggregate utilization data for all members at such intervals as required by EOHHS,
4. a description of how the Bidder will provide quarterly grievance and appeals report due no later than 30 days after the end of the reporting quarter,
5. a description of how the Bidder will submit internal quality assurance reports periodically,
6. a description of how the Bidder collects member satisfaction data through an annual survey of its members,
7. a description of how the Bidder will submit a quarterly fraud and abuse report due no later than thirty days after the end of the reporting period,
8. how the Bidder will submit a compliance dashboard report due no later than 30 days after the end of the reporting quarter,
9. how the Bidder will submit an informal complaints report due no later than 30 days after the end

of the reporting quarter, and

10. other topics deemed appropriate by the Bidder

These reports should be prepared in conformance with reporting templates established by the State.

#### **I) Plan for Meeting Grievance and Appeals Requirements**

The Bidder clearly describes its plan for meeting the grievance and appeals process requirements described in Section 3.14 of the LOI and in Section 2.14 of the Model Contract.

Specifically, the Bidder provides the following:

- (1) a description of the Bidder's policies for processing grievances permits a provider, acting on behalf of a member and with the member's written consent, to file an appeal of an action within 30 days,
- (2) a description of the Bidder's detailed procedures and processes to meet Federal and State requirements,
- (3) a description of how the Bidder will interface with the State Appeals process, and
- (4) other topics deemed appropriate by the Bidder.

#### **J) Plan for Payments to and from the Dental Plan(s)**

The Bidder clearly describes its plans for meeting the requirement for payments to and from the Dental Plan(s) as described in Section 3.15 of the LOI and in Section 2.15 of the Model Contract.

Specifically, the Bidder clearly provides the following:

- (1) a description of its capability to accept the capitation payments from the State,
- (2) a description for a plan for the reimbursement of providers,
- (3) a description of how the Bidder will identify and implement creative or performance based reimbursement arrangements intended to foster and reward effective utilization management and quality assurance,
- (4) an assurance that the Bidder has reinsurance and adequate reserves,
- (5) a description of how the Bidder will implement TPL policies and procedures as well as anticipated results or savings that will be produced as a result of TPL efforts, and
- (6) other topics deemed appropriate by the Bidder.

#### **K) Plan for Meeting Financial Standards, Record Retention and Compliance Requirements**

The Bidder clearly describes its plans for meeting the requirement that the Bidder continue to monitor and maintain its financial viability, record retention and compliance requirements as described in Section 3.16 of the LOI and in Sections 2.16, 2.17 and 2.18 of the Model Contract.

Specifically, the Bidder clearly describes: (1) how it will meet the financial standard requirements; (2) how it will meet the record retention requirements; and (3) how it will meet the compliance requirements.

#### **L) Plan for Meeting Contract Terms and Conditions**

The Bidder clearly describes its plan for meeting the requirement for payments to and from the Dental Plan(s) as described in Section 3.17 of the LOI and in Article III of the Model Contract.

Specifically, the Bidder provides the following:

- (1) a description of how the Bidder will ensure compliance with the general terms and conditions of the Contract,
- (2) a description of how the Bidder will address the fraud and abuse requirements,
- (3) a description of how the Bidder will ensure confidentiality of information,
- (4) an assurance of the Bidder's ability to handle risk-sharing contract provisions, and
- (5) other topics deemed appropriate by the Bidder.

## SECTION 5: EVALUATION AND SELECTION

Proposals will be reviewed by a Technical Review Committee comprised of staff from state agencies. The EOHHS reserves the exclusive right to select the individual(s) or firm (vendor) that it deems to be in its best interest to accomplish the project as specified herein; and conversely, reserves the right not to fund any proposal(s).

Applicants may be required to submit additional written information or be asked to make an oral presentation before the technical review committee to clarify statements made in their proposal.

The State will conduct a comprehensive and impartial evaluation of all bids. The Technical Proposals will be evaluated against a set of minimum standards, to identify any proposals that are incomplete or unresponsive. The State reserves the right to contract with two or more Dental Plans. The State, through its Technical Review Committee, will be the sole judge in reviewing proposals and awarding contracts.

Points will be assigned based on the Bidder's clear demonstration of his/her abilities to complete the work, apply appropriate methods to complete the work, create innovative solutions and quality of past performance in similar projects. The State will evaluate and score all proposals using the following criteria:

- **Provision of Required Information and Assurances/Attestations (Pass/Fail):** Bids will be evaluated to determine whether Bidder provided the necessary information in the Transmittal Letter and that all the Assurances/Attestations have been completed.
- **Experience and Understanding of Bidder (20%):** The Bidder's experience and understanding should address the contractual requirements cited in Section 4.7.3.
- **Technical Response (80%):** The Bidder shall provide responses for each of the proposal sections listed below. Responses for each section will be evaluated based on the specific information requirements noted for each section discussed in Section 4.7.4 of this LOI. See the "Technical Proposal Specifications Summary Checklist".

A scoring instrument will be used to evaluate the Bidder's responses to the specific elements covered in Section 4.7.3 Experience and Understanding and in Section 4.7.4 Technical Response Plans of this LOI.

The following chart provides a Summary Checklist indicating the key elements of the Bidder's proposal as described in Technical Proposal Specifications of this LOI; the points assigned to each section; and a suggested number of pages for the Bidder's response, excluding pertinent attachments. The Bidder is

expected to complete the last column of the check list by providing the page number(s) on which the requirements can be found. The Bidder will attach the completed check list to its proposal. **Technical Proposal Specifications Summary Checklist**

<b>TECHNICAL PROPOSAL ELEMENTS</b>	<b>MAXIMUM POINTS</b>	<b>SUGGESTED NUMBER OF PAGES</b>	<b>PROPOSAL PAGE NUMBER (Completed by Bidder)</b>
<b>Transmittal Letter (4.7.1)</b>	N.A.	N.A.	
<b>Assurances/Attestations (4.7.2)</b>	Pass/Fail.	N.A.	
<b>Experience and Understanding (4.7.3)</b>	<b>20</b>	8	
Licensure/Accreditation Requirements	Pass/Fail	1-2	
Type of Organization/Minority Business Enterprise	Pass/Fail.	1	
Experience	6	2	
Understanding of RI	3	1	
Capability, Capacity, and Financial Viability	5	2	
Relationship with Health Plans	1	1-2	
References	5	1	

<b>Technical Response Plans</b>	<b>80</b>	<b>32</b>	
Best Practices	10	6	
Enrollment	8	3	
Covered Services/Accessibility Standards	12	4	
Care Coordination	5	1	
Provider Network	12	4	
Member & Provider Services	5	4	
Dental Management./Quality Assurance	8	3	
Operational Data Reporting	5	2	
Grievance & Appeals	5	1	
Payments to/from Dental Plan(s)	4	1	
Financial Standards, Record Retention, & Compliance	4	1	
Terms & Conditions	2	1	

## SECTION 6: PROPOSAL SUBMISSION

Questions concerning this solicitation may be e-mailed to the Division of Purchases at [David.Francis@purchasing.ri.gov](mailto:David.Francis@purchasing.ri.gov) no later than the date and time indicated on page one of this solicitation. Please reference **LOI #** on all correspondence. Questions should be submitted in a Microsoft Word attachment. Answers to questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to download this information. If technical assistance is required to download, call the Help Desk at (401) 574-9709.

Bidders are encouraged to submit written questions to the Division of Purchases. **No other contact with State parties will be permitted.** Interested Bidders may submit proposals to provide the services covered by this Request on or before the date and time listed on the cover page of this solicitation. Responses received after this date and time, as registered by the official time clock in the reception area of the Division of Purchases will not be considered.

Responses (an original plus seven (7) copies) and two (2) electronic (Compact Disc or thumb drive) copies should be mailed or hand delivered in a sealed envelope marked “**LOI # 7548558 DENTAL HEALTH PLAN(S) FOR RITE SMILES PROGRAM**” to:

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

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

### RESPONSE CONTENTS

Responses shall include the following:

1. A completed and signed four-page R.I.V.I.P generated bidder certification cover sheet downloaded from the RI Division of Purchases Internet home page at [www.purchasing.ri.gov](http://www.purchasing.ri.gov).
2. A completed and signed W-9 downloaded from the RI Division of Purchases Internet home page at [www.purchasing.ri.gov](http://www.purchasing.ri.gov)
3. **A Technical Proposal** describing the qualifications and background of the applicant and experience with and for similar projects, and all information described earlier in this solicitation. The Technical Proposal is limited to six (6) pages (this excludes any appendices) . As appropriate, resumes of key staff that will provide services covered by this request.
4. In addition to the multiple hard copies of proposals required, Respondents are requested to provide their proposal in **electronic format (CD-Rom, disc, or flash drive)**. Microsoft Word / Excel OR PDF format is preferable. Two electronic copies are requested and should be placed in the proposal marked “original”.

## SECTION 7: CONCLUDING STATEMENTS

Notwithstanding the above, the State reserves the right not to award this contract or to award on the basis of cost alone, to accept or reject any or all proposals, and to award in its best interest.

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

The State may, at its sole option, elect to require presentation(s) by Bidders clearly in consideration for award.

The State's General Conditions of Purchase contain the specific contract terms, stipulations and affirmations to be utilized for the contract awarded to the LOI. The State's General Conditions of Purchases/General Terms and Conditions can be found at the following URL:

<https://www.purchasing.ri.gov/RIVIP/publicdocuments/ATTA.pdf>.

For more detailed information regarding the Rhode Island Medicaid Program in general and Rite Smiles in particular, please see the documents in the Procurement Library at the following URL:

<http://www.eohhs.ri.gov/ReferenceCenter/ImportantLinks.aspx>. The following documents are available in the Procurement Library.

- UnitedHealthcare Dental –RItE Smiles 2013 Annual Report
- RItE Care Marketing Protocols
- Grievance and Appeals Process for RItE Care Applicants/Members
- RItE Care Health Plan Disenrollment Policy and Procedures
- Guidelines for Plan and Consumer-Friendly Materials
- Actuarial Rate Data Book
- RI Annual Expenditure Report-SFY 2012, Executive Office of Health and Human Services, June 2013
- *An Introduction to Practical Oral Care for People with Developmental Disabilities.*
- *EOHHS Approved Encounter 837 Companion Guide* along with associated Companion Guides for data submissions
- Rhode Island Medical Assistance Dental Provider Manual

## Appendix A - Actuarially Sound Rate

### MONTHLY CAPITATION RATES

7/1/2014 – 6/30/2015

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<b>Premium Rate Group</b>	<b>Dental Portion of Capitation Rate</b>	<b>Administrative Portion of Capitation Rate</b>	<b>Federal Issuer Tax If Applicable</b>	<b>Total Capitation Rate</b>
Children born on or after May 1, 2000	<b>\$16.35</b>	<b>\$1.82</b>	<b>\$0.37</b>	<b>\$18.54</b>

**Appendix B –  
Model Contract**

**CONTRACT BETWEEN**

**STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS**

**EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES**

**AND**

**THE DENTAL PLAN CONTRACTOR**

**FOR THE MEDICAID RITE SMILES PROGRAM**

**JULY 1, 2014**

February 24, 2014

# Table of Contents

<b>ARTICLE I: DEFINITIONS</b> .....	8
<b>1.01</b> <b>AGREEMENT/CONTRACT</b> .....	8
<b>1.02</b> <b>CAPITATION PAYMENT</b> .....	8
<b>1.03</b> <b>CARE COORDINATION</b> .....	8
<b>1.04</b> <b>CMS</b> .....	8
<b>1.05</b> <b>COLD CALL MARKETING</b> .....	8
<b>1.06</b> <b>CONTRACTOR</b> .....	9
<b>1.07</b> <b>CONTRACT SERVICES</b> .....	9
<b>1.08</b> <b>COVERED SERVICES</b> .....	9
<b>1.09</b> <b>DAYS</b> .....	9
<b>1.10</b> <b>DENTAL PLAN</b> .....	9
<b>1.11</b> <b>DEPARTMENT</b> .....	9
<b>1.12</b> <b>ENROLLEE</b> .....	9
<b>1.13</b> <b>EXPERIMENTAL OR INVESTIGATIONAL</b> .....	9
<b>1.14</b> <b>FAMILY</b> .....	10
<b>1.15</b> <b>GRIEVANCE</b> .....	10
<b>1.16</b> <b>HEALTH CARE DENTAL PROFESSIONAL</b> .....	10
<b>1.17</b> <b>HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF</b> <b>1996 (HIPAA)</b> 10	
<b>1.18</b> <b>IBNR (Incurred But Not Reported)</b> .....	10
<b>1.19</b> <b>MARKETING</b> .....	10
<b>1.20</b> <b>MARKETING MATERIALS</b> .....	10
<b>1.21</b> <b>MEDICALLY NECESSARY CARE DENTAL</b> .....	11
<b>1.22</b> <b>MEDICAL NECESSITY, MEDICALLY NECESSARY, OR MEDICALLY</b> <b>NECESSARY SERVICE</b> .....	11
<b>1.23</b> <b>MEMBER</b> .....	11
<b>1.24</b> <b>NON-PARTICIPATING DENTIST</b> .....	11
<b>1.25</b> <b>PARTY</b> .....	11
<b>1.26</b> <b>PLAN DENTIST OR PARTICIPATING DENTIST</b> .....	11
<b>1.27</b> <b>PREPAID BENEFIT PACKAGE</b> .....	12
<b>1.28</b> <b>PRIMARY DENTAL CARE</b> .....	12
<b>1.29</b> <b>PROVIDER PREVENTABLE CONDITIONS</b> .....	12
<b>1.30</b> <b>RISK CONTRACT</b> .....	12
<b>1.31</b> <b>RITE CARE</b> .....	12
<b>1.32</b> <b>RITE SMILES</b> .....	12
<b>1.33</b> <b>SIBLING</b> .....	12
<b>1.34</b> <b>SSI</b> .....	13
<b>1.35</b> <b>STATE</b> .....	13
<b>1.36</b> <b>UNINSURED</b> .....	13
<b>1.37</b> <b>URGENT DENTAL CONDITION</b> .....	13
<b>ARTICLE II: HEALTH PLAN PROGRAM STANDARDS</b> .....	14
<b>2.01</b> <b>GENERAL</b> .....	14
<b>2.02</b> <b>LICENSURE/CERTIFICATION</b> .....	14
<b>2.03</b> <b>DENTAL PLAN(S) ADMINISTRATION</b> .....	15
<b>2.03.01</b> <b>Executive Management</b> .....	15
<b>2.03.02</b> <b>Other Administrative Components</b> .....	16
<b>2.03.03</b> <b>RI Works Participants</b> .....	16
<b>2.04</b> <b>ELIGIBILITY AND PROGRAM ENROLLMENT</b> .....	16
<b>2.04.01</b> <b>Eligible Population</b> .....	16
<b>2.04.01.01</b> <b>Children Born on or After May 1, 2000 under 250 Percent of the FPL</b> .....	16
<b>2.04.01.02</b> <b>Children in Substitute Care</b> .....	17
<b>2.04.01.03</b> <b>Children with Special Health Care Needs</b> .....	17
<b>2.04.01.04</b> <b>Excluded Populations</b> .....	17

2.04.02	New Eligibility Groups .....	17
2.04.03	Eligibility Determination .....	17
2.04.04	Guaranteed Eligibility .....	18
2.04.05	Lock-in .....	18
2.04.06	Automatic Re-Assignment Following Resumption of Eligibility .....	18
2.05	<b>MEMBER ENROLLMENT AND DISENROLLMENT .....</b>	<b>18</b>
2.05.01	Dental Plan(s) Marketing .....	18
2.05.02	Dental Plan(s) Enrollment Procedures .....	19
2.05.03	Change in Status .....	19
2.05.04	Enrollment and Disenrollment Updates .....	19
2.05.05	Services For New Members .....	19
2.05.06	New Member Orientation .....	19
2.05.07	Identification Cards .....	20
2.05.08	Member Handbook .....	20
2.05.08.01	Required Information .....	21
2.05.08.02	State Approval .....	23
2.05.08.03	Languages Other Than English .....	23
2.05.09	Member Disenrollment .....	23
2.05.09.01	General Authority .....	23
2.05.09.02	Reasons For Disenrollment .....	23
2.05.09.03	Disenrollment Effective Dates .....	24
2.06	<b>IN-PLAN SERVICES .....</b>	<b>25</b>
2.06.01	Description of Comprehensive Benefit Package .....	25
2.06.01.01	General .....	25
2.06.01.02	Dental EPSDT Services .....	25
2.06.01.03	Interpreter/Translation Services .....	26
2.06.02	Enrollee/Provider Communication .....	27
2.06.03	Second Opinion .....	28
2.06.04	New In-Plan Services and In-Plan Service Coverage Arrangements .....	28
2.07	<b>CARE COORDINATION .....</b>	<b>28</b>
2.08	<b>PROVIDER NETWORKS .....</b>	<b>29</b>
2.08.01	Network Composition .....	29
2.08.02	Transitioning Between Non-Network and Network Providers .....	31
2.08.03	FQHCs/RHCs with Dental Clinics .....	31
2.08.04	Hospital-Based Dental Clinics .....	31
2.08.05	School-Based Clinics .....	31
2.08.06	Mobile Dental Providers .....	31
2.08.06	Mainstreaming .....	31
2.08.07	Provider Network Lists .....	32
2.08.08	Network Changes .....	32
2.08.09	Provider Discrimination .....	32
2.09	<b>SERVICE ACCESSIBILITY STANDARD .....</b>	<b>32</b>
2.09.01	Urgent Dental Condition Standard .....	32
2.09.02	Travel Time .....	32
2.09.03	Days to Appointment for Non-Emergent Conditions .....	33
2.09.04	Compliance with Accessibility Standards .....	33
2.10	<b>MEMBER SERVICES .....</b>	<b>33</b>
2.10.01	General .....	33
2.10.02	Toll-Free Telephone Number .....	33
2.10.03	Annual Notification .....	34
2.10.04	Cultural Competency .....	34
2.11	<b>PROVIDER SERVICES .....</b>	<b>35</b>
2.12	<b>DENTAL MANAGEMENT AND QUALITY ASSURANCE .....</b>	<b>36</b>
2.12.01	General .....	36
2.12.02	Dental Director's Office .....	36
2.12.03	Utilization Review and Quality Assurance (UR/QA) .....	37
2.12.03.01	General .....	37

2.12.03.02	Utilization Review .....	37
2.12.03.03	Quality Assurance .....	38
2.12.03.04	Confidentiality .....	39
2.12.03.05	State and Federal Reviews .....	39
2.12.03.06	Practice Guidelines .....	39
2.12.03.07	Service Provision .....	40
2.12.04	Provider Credentialing .....	40
2.13	<b>OPERATIONAL DATA REPORTING</b> .....	41
2.13.01	General .....	41
2.13.02	Utilization Data .....	42
2.13.02.01	Person-Level Record .....	42
2.13.02.02	Aggregate Data .....	42
2.13.02.03	Data Format .....	42
2.13.02.04	Timing of Data Submittal .....	42
2.13.02.05	Data Validation .....	42
2.13.03	Grievance and Appeals Data .....	42
2.13.04	Quality Assurance Data .....	43
2.13.05	Member and Provider Satisfaction Report .....	43
2.13.06	Fraud and Abuse Reports .....	43
2.13.07	Presentation of Findings .....	43
2.13.08	Health Insurance Portability and Accountability Act Requirements (HIPAA) .....	43
2.13.09	Certification Of Data .....	44
2.13.10	Patient Protection and Affordable Care Act .....	44
2.14	<b>GRIEVANCE AND APPEALS</b> .....	44
2.14.01	General .....	44
2.14.02	Complaint Resolution .....	47
2.14.03	Grievance Process .....	47
2.14.04	Expedited Resolution Of Appeals .....	47
2.15	<b>PAYMENTS TO AND FROM PLANS</b> .....	48
2.15.01	Acceptance of State Capitation Payments .....	48
2.15.02	Payments to Providers .....	49
2.15.02.01	General .....	49
2.15.02.02	Retroactive Eligibility Period .....	49
2.15.02.03	In-Network (Contracted) Services .....	49
2.15.02.04.1	Out-of-Network and Out-of-State Providers .....	49
2.15.02.05	FQHCs/RHCs .....	50
2.15.02.06	Hospital-Based Dental Clinics .....	50
2.15.02.07	Liability during an Active Grievance or Appeal .....	50
2.15.02.08	Limit On Payment to Other Providers .....	50
2.15.02.09	Dental Provider Incentive Plans .....	51
2.15.02.10	Actuarial Basis .....	51
2.15.02.11	Payment Adjustment for Provider Preventable Conditions .....	51
2.15.03	Cost Sharing .....	51
2.15.03	Third-Party Liability .....	51
2.15.05	Reinsurance .....	52
2.15.06	Reserving .....	52
2.15.07	Claims Processing and MIS .....	52
2.15.08	Audits .....	52
2.16	<b>FINANCIAL STANDARDS</b> .....	53
2.16.01	General .....	53
2.16.02	Financial Benchmarks .....	53
2.16.03	Financial Data Reporting .....	53
2.16.04	Audit .....	53
2.17	<b>RECORD RETENTION</b> .....	54
2.17.01	General .....	54
2.17.02	Operational Data Reports .....	54
2.17.03	Medical Records .....	54

2.18	COMPLIANCE.....	54
2.18.01	General Requirements.....	54
2.18.02	Prohibited Affiliations with Individuals Debarred by Federal Agencies.....	55
2.18.03	Disclosure of the Contractor’s Ownership and Control Interest.....	55
2.18.04	Disclosure by Providers: Information on Ownership and Control.....	56
2.18.05	Disclosure by Providers: Information Related to Business Transactions.....	57
2.18.06	Disclosure by Providers: Information on Persons Convicted of Crimes.....	58
2.18.07	Disclosures Made by Providers to the Contractor.....	58
<b>ARTICLE III: CONTRACT TERMS AND CONDITIONS .....</b>		<b>61</b>
3.01	<b>GENERAL PROVISIONS.....</b>	<b>61</b>
3.01.01	Contract Composition and Order of Precedence.....	61
3.01.02	Integration Clause.....	61
3.01.03	Subsequent Conditions.....	61
3.01.04	Effective Date and Term.....	61
3.01.05	Contract Administration.....	61
3.01.06	Contract Officers.....	62
3.01.07	Liaisons.....	62
3.01.08	Notification of Administrative Changes.....	62
3.01.09	Notices.....	62
3.01.10	Authority.....	63
3.01.11	Federal Approval of Contract.....	63
3.01.12	Special Terms and Conditions.....	63
3.02	<b>INTERPRETATIONS AND DISPUTES.....</b>	<b>63</b>
3.02.01	Conformance with State and Federal Regulations.....	63
3.02.02	Waivers.....	63
3.02.03	Severability.....	64
3.02.04	Jurisdiction.....	64
3.02.05	Disputes.....	64
3.03	<b>CONTRACT AMENDMENTS.....</b>	<b>65</b>
3.04	<b>PAYMENT.....</b>	<b>66</b>
3.04.01	Capitation Payments.....	66
3.04.02	Payments to Subcontractors and Providers.....	66
3.04.03	Liability For Payment.....	66
3.05	<b>GUARANTEES, WARRANTIES, AND CERTIFICATIONS.....</b>	<b>67</b>
3.05.01	Contractor Certification of Truthfulness.....	67
3.05.02	Contractor Certification of Legality.....	67
3.05.03	Contractor Certification of HMO Licensure.....	67
3.05.04	Performance Bond or Substitutes.....	67
3.05.05	Subcontracts and Delegation of Duty.....	68
3.05.06	Assignment of the Contract.....	69
3.05.07	Hold Harmless.....	69
3.05.08	Insurance.....	70
3.05.08.01	Professional Liability Insurance.....	70
3.05.08.02	Workers' Compensation.....	70
3.05.08.03	Minimum Liability and Property Damage Insurance.....	70
3.05.08.04	Errors and Omissions Insurance.....	71
3.05.08.05	Reinsurance.....	71
3.05.08.06	Evidence of Coverage.....	71
3.05.09	Force Majeure.....	71
3.05.10	Patent or Copyright Infringement.....	72
3.05.11	Clinical Laboratory Improvement Amendments (CLIA) of 1988.....	72
3.06	<b>PERSONNEL.....</b>	<b>72</b>
3.06.01	Employment Practices.....	72
3.06.02	Employment of State Personnel.....	73
3.06.03	Prohibited Affiliations with Individuals Debarred by Federal Agencies.....	73
3.07	<b>PERFORMANCE STANDARDS AND DAMAGES.....</b>	<b>74</b>

3.07.01	Performance Standards for Medicaid Managed Care .....	74
3.07.02	Suspension of New Enrollment .....	74
3.07.03	Fraud and Abuse.....	74
3.07.03.01	General Requirements.....	74
3.07.03.02	Mandatory Components of Employee Education about False Claims Recovery .....	75
3.07.03.03	Member Education about Medicaid Fraud and Abuse .....	76
3.07.03.04	Recipient Verification Procedures.....	76
3.07.03.05	Explanation of Member Benefits .....	77
3.07.03.06	Investigating and Reporting Suspected Fraud and Abuse .....	77
3.07.04	Damages.....	78
3.07.04.01	Non-Compliance with Program Standards.....	78
3.07.04.02	Non-Compliance with Monthly Reconciliation Tasks .....	79
3.07.04.03	Non-Compliance with Data Reporting Standards .....	79
3.07.04.04	Compliance with Other Material Contract Provisions.....	79
3.07.05	Deduction of Damages from Payments .....	80
3.08	<b>INSPECTION OF WORK PERFORMED .....</b>	<b>80</b>
3.08.01	Access To Information.....	80
3.08.02	Inspection of Premises .....	80
3.08.03	Approval of Written Materials.....	80
3.09	<b>CONFIDENTIALITY OF INFORMATION .....</b>	<b>81</b>
3.09.01	Maintain Confidentiality of Information.....	81
3.09.02	Confidentiality of Information.....	83
3.09.03	Assurance of Security and Confidentiality .....	85
3.09.04	Return Of Confidential Data .....	85
3.09.05	Hold Harmless.....	85
3.09.06	State Assurance of Confidentiality .....	85
3.09.07	Publicizing Safeguarding Requirements.....	85
3.09.08	Types Of Information to Be Safeguarded.....	85
3.09.09	Confidentiality and Protection of Public Health Information and Related Data.....	86
3.10	<b>TERMINATION OF THE CONTRACT .....</b>	<b>87</b>
3.10.01	Termination for Default .....	87
3.10.02	Termination for Unavailability of Funds.....	88
3.10.03	Termination for Financial Instability.....	89
3.10.04	Procedures on Termination.....	89
3.10.05	Refunds of Advance Payments.....	89
3.10.06	Liability for Medical Claims .....	90
3.10.07	Termination Claims .....	90
3.10.08	Notification of Members.....	90
3.10.09	Non-Compete Covenant .....	90
3.11	<b>OTHER CONTRACT TERMS AND CONDITIONS .....</b>	<b>91</b>
3.11.01	Environmental Protection .....	91
3.11.02	Ownership of Data and Reports .....	91
3.11.03	Publicity .....	91
3.11.04	Award of Related Contracts .....	91
3.11.05	Conflict of Interest.....	91
3.11.06	Reporting of Political Contributions.....	92
3.11.07	Environmental Tobacco Smoke .....	92
3.11.08	Titles Not Controlling.....	92
3.11.09	Other Contracts .....	92
3.11.10	Counterparts .....	92
3.11.11	Administrative Procedures Not Covered .....	93
<b>ADDENDUM I: FISCAL ASSURANCES .....</b>		<b>95</b>
<b>ADDENDUM II: NOTICE TO EOHHS CONTRACTORS OF THEIR RESPONSIBILITIES UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 .....</b>		<b>97</b>

<b>ADDENDUM III: NOTICE TO EOHHS' CONTRACTORS OF THEIR RESPONSIBILITIES UNDER SECTION USC 504 OF THE REHABILITATION ACT OF 1973 .....</b>	<b>99</b>
<b>ADDENDUM IV: DRUG-FREE WORKPLACE POLICY.....</b>	<b>102</b>
<b>ADDENDUM V: DRUG-FREE WORKPLACE POLICY PROVIDER CERTIFICATE OF COMPLIANCE .....</b>	<b>104</b>
<b>ADDENDUM VI: SUBCONTRACTOR COMPLIANCE .....</b>	<b>105</b>
<b>ADDENDUM VII: CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE.....</b>	<b>106</b>
<b>ADDENDUM VIII: INSTRUCTIONS FOR CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS PRIMARY COVERED TRANSACTIONS .....</b>	<b>107</b>
<b>ADDENDUM IX: CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS - PRIMARY COVERED TRANSACTIONS.....</b>	<b>109</b>
<b>ADDENDUM X: LIQUIDATED DAMAGES.....</b>	<b>111</b>
<b>ADDENDUM XI: EQUAL EMPLOYMENT OPPORTUNITY.....</b>	<b>113</b>
<b>ADDENDUM XII: BYRD ANTI-LOBBYING AMENDMENT.....</b>	<b>115</b>
<b>ADDENDUM XIII: BID PROPOSAL.....</b>	<b>116</b>
<b>ADDENDUM XIV: CORE STAFF POSTIONS .....</b>	<b>117</b>
<b>ADDENDUM XV: FEDERAL SUBAWARD REPORTING.....</b>	<b>118</b>
<b>ADDENDUM XVI: BUSINESS ASSOCIATE AGREEMENT .....</b>	<b>121</b>
<b>ATTACHMENT A: SCHEDULE OF IN-PLAN BENEFITS.....</b>	<b>132</b>
<b>ATTACHMENT B: SCHEDULE OF OUT-OF-PLAN BENEFITS .....</b>	<b>134</b>
<b>ATTACHMENT C: SCHEDULE OF NON-COVERED BENEFITS.....</b>	<b>142</b>
<b>ATTACHMENT D: EPSDT PERIODICITY SCHEDULE .....</b>	<b>144</b>
<b>ATTACHMENT E: CONTRACTOR'S CAPITATION RATES.....</b>	<b>147</b>
<b>ATTACHMENT F: ACTUARIAL BASIS FOR CAPITATION RATES .....</b>	<b>149</b>
<b>ATTACHMENT G: SPECIAL TERMS AND CONDITIONS.....</b>	<b>151</b>
<b>ATTACHMENT H: CONTRACTOR'S INSURANCE CERTIFICATION.....</b>	<b>156</b>
<b>ATTACHMENT I: CONTRACTOR'S LOCATIONS .....</b>	<b>158</b>

## **GENERAL PROVISIONS**

This Agreement, including the attachments hereto, is made and entered into effective the 1st day of July 2014, between the Rhode Island Executive Office of Health and Human Services (referred to as "EOHHS", or "Executive Office" in this Agreement) and \_\_\_\_\_ (the "Contractor"). This Agreement ("Agreement") is entered into in conformity with EOHHS procedures.

### **ARTICLE I: DEFINITIONS**

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

#### **1.01 AGREEMENT/CONTRACT**

This document is referred to as an Agreement or Contract between the State and the Contractor.

#### **1.02 CAPITATION PAYMENT**

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

#### **1.03 CARE COORDINATION**

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

#### **1.04 CMS**

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

#### **1.05 COLD CALL MARKETING**

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

## **1.06 CONTRACTOR**

Contractor(s) means the Dental Plan(s) (i.e. Name of Dental Plan(s)) that has executed this Agreement with the State to enroll and serve members under the conditions specified in this Agreement

## **1.07 CONTRACT SERVICES**

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

## **1.08 COVERED SERVICES**

Covered Services mean the oral services described in Article III of this Agreement and set forth in Attachment A.

## **1.09 DAYS**

Days mean calendar days unless otherwise specified.

## **1.10 DENTAL PLAN**

Dental Plan or Plan means any organization that is properly licensed by the State of Rhode Island and meets the requirements of Article II-Section 2.02 of this Agreement, and contracts with the State to provide dental services as describe in Section 2.06 of this Agreement and pursuant to Title XIX of the Social Security Act to members. A Dental Plan is considered a Prepaid Ambulatory Health Plan (PAHP) based on CMS guidance.

## **1.11 DEPARTMENT**

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

## **1.12 ENROLLEE**

A Medicaid beneficiary/recipient currently enrolled in a Dental Plan. Potential enrollee is Medicaid recipient not yet enrolled in a Dental Plan. The term enrollee is used synonymously with the term member.

## **1.13 EXPERIMENTAL OR INVESTIGATIONAL**

Reliable evidence shows that the consensus of opinion among experts regarding the dental service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or

Reliable evidence shows that the dental service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) does not improve net health outcome, is not as beneficial as any established alternatives, or does not produce improvement outside of the research setting.

#### **1.14 FAMILY**

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

#### **1.15 GRIEVANCE**

An expression of dissatisfaction about any matter other than the appeal of actions, a formal complaint (refer to section 2.14.01).

#### **1.16 HEALTH CARE DENTAL PROFESSIONAL**

Health Care Dental Professional means any licensed general dentists, pediatric dentists and specialty dentists including periodontists, endodontists, prosthodontist, oral surgeons, and orthodontists as well as other members of the dental team including dental hygienists, dental laboratory technicians and dental assistants.

#### **1.17 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.

#### **1.18 IBNR (Incurred But Not Reported)**

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

#### **1.19 MARKETING**

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

#### **1.20 MARKETING MATERIALS**

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

## **1.21 MEDICALLY NECESSARY CARE DENTAL**

Medically Necessary Care (MNC) as defined by the American Academy of Pediatric Dentistry is “ *the reasonable and essential diagnostic, preventive and treatment services (including supplies, appliances and devices) and follow-up care as determined by qualified health care providers in treating any condition, disease, injury or congenital or development malformation. MNC includes all supportive health care services that, in the judgment of the attending dentist, is necessary for the provision of optimal quality therapeutic and preventive oral care. These services include, but not limited to,, sedation, general anesthesia, and utilization of surgical facilities. MNC must take into account the patient’s age, developmental status and psychosocial well-being, in addition to the setting appropriate to meet the needs of the patient and family. Dental care is medically necessary to prevent and eliminate orofacial disease, infection, and pain, to restore the form and function of the dentition, and to correct facial disfiguration or dysfunction*”. Medically necessary care must be provided in the most cost effective and appropriate setting and shall not be provided solely for the convenience of the member or service provider.

## **1.22 MEDICAL NECESSITY, MEDICALLY NECESSARY, OR MEDICALLY NECESSARY SERVICE**

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

## **1.23 MEMBER**

Member means a Medicaid recipient enrolled in a Health Plan. The term member is used synonymously with the term enrollee.

## **1.24 NON-PARTICIPATING DENTIST**

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

## **1.25 PARTY**

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

## **1.26 PLAN DENTIST OR PARTICIPATING DENTIST**

Plan dentist or participating dentist means a dentist licensed to practice in Rhode Island or licensed in a neighboring State and practicing in a community that borders Rhode Island who has contracted with or is employed by the Contractor to furnish services covered in this Agreement.

## **1.27 PREPAID BENEFIT PACKAGE**

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

## **1.28 PRIMARY DENTAL CARE**

Primary dental care means all dental care services and laboratory services customarily furnished by or through a general or pediatric dental practitioner to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

## **1.29 PROVIDER PREVENTABLE CONDITIONS**

*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.

## **1.30 RISK CONTRACT**

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

## **1.31 RITE CARE**

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

## **1.32 RITE SMILES**

This Agreement covers the Rhode Island Rite Smiles program. The Rite Smiles program is Rhode Island's managed care program designed to increase access to and the outcomes of dental services provided to Medicaid children born on or after May 1, 2000. The Rite Smiles program was implemented in September 1, 2006.

## **1.33 SIBLING**

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

### **1.34 SSI**

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

### **1.35 STATE**

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

### **1.36 UNINSURED**

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

### **1.37 URGENT DENTAL CONDITION**

Urgent Dental Condition means a dental condition manifesting itself by acute symptoms of sufficient severity (including infection and pain) such that the absence of dental attention within forty-eight (48) hours that could reasonably be expected to result in: placing the patient's health in serious jeopardy; serious impairment to bodily function; or serious dysfunction of any bodily organ or part.

## **ARTICLE II: HEALTH PLAN PROGRAM STANDARDS**

### **2.01 GENERAL**

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

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

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

Contractor shall furnish or arrange for the personnel, facilities, equipment, supplies, pharmaceuticals, and other items and expertise necessary for, or incidental to, the provision of dental care services specified below, at locations including, but not limited to, the entire State of Rhode Island, to Members covered by this agreement and enrolled with Contractor.

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

### **2.02 LICENSURE/CERTIFICATION**

The Contractor certifies that it is licensed in Rhode Island as an HMO under the provisions of Chapter 2741, "the HMO Act" or that it shall become licensed as a Health Maintenance Organization (HMO) or Health Plan (HP) in the State of Rhode Island by the Rhode Island Department of Health and the Rhode Island Department of Business Regulation prior to signing an Agreement with State. If Contractor is not a licensed HMO in Rhode Island, Contractor certifies that it is either a nonprofit hospital service corporation that is licensed by the Rhode Island Department of Business Regulation ("DBR") under Chapter 27-19 of the Rhode Island General Laws, a nonprofit medical service corporation that is licensed by DBR under Chapter 27-20 of the Rhode Island General Laws, a nonprofit dental service corporation subject to R.I.G.L. 27-20.1.1 et seq. or another health insurance entity licensed by DBR, and that it meets the following requirements:

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

- Meets the requirements of Sections 3.4, 5.2, 6.1.4, and 6.4.7 under R23-17.13-CHP; and
- Meets the requirements under R23-17.12: *Rules and Regulations for the Utilization Review of Health Care Services*

If the entity providing the dental benefits is a separate corporation (e.g., a subsidiary of Contractor or a subcontractor to which delegation is to be made), then Contractor assures that the entity meets the foregoing requirements.

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

Contractor agrees to provide to the State, or its designees, any information requested pertaining to its licensure, certification, and/or accreditation including communication to and from DBR and the Department of Health. This provision shall apply to any subsidiary of Contractor or any subcontractor with delegated authority for administration or oversight of dental benefits or adjudication of dental benefit claims under this Agreement.

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

The Contractor will become accredited in Rhode Island as a Dental Plan within 12 months after the State has notified the Contractor of an appropriate accreditation body(ies).

## **2.03 DENTAL PLAN(S) ADMINISTRATION**

Contractor agrees to maintain sufficient administrative staff and organizational components to comply with all program standards described within this Agreement. At a minimum, Contractor agrees to include each of the functions noted in Sections 2.03.01 and 2.03.02 below. Contractor agrees to staff qualified persons in numbers appropriate to its size of enrollment. Contractor shall be required to have In-State presence to conduct outreach, approved marketing efforts, and attend or preside at meetings with stakeholders at community agencies throughout the State at health fairs and in other health related events.

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

### **2.03.01 Executive Management**

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

### **2.03.02 Other Administrative Components**

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

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

### **2.03.03 RI Works Participants**

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

## **2.04 ELIGIBILITY AND PROGRAM ENROLLMENT**

### **2.04.01 Eligible Population**

Rite Smiles eligible population is defined to consist of three (Sections 2.4.01 through and including 2.4.03) different eligible groups. Qualification for the program is based on a combination of factors, including family composition, income level, insurance status, and/or pregnancy status. The scope of benefits, program cost sharing options/requirements and enrollment procedures vary by eligibility group and are described herein.

#### **2.04.01.01 Children Born on or After May 1, 2000 under 250 Percent of the FPL**

This aid category consists of children born on or after May 1, 2000 living in families whose income is under 250 percent of the FPL.

#### **2.04.01.02 Children in Substitute Care**

This aid category includes children in foster care born on or after May 1, 2000, who are currently enrolled in RItE Care on a voluntary basis or are in Medicaid fee-for-service (FFS). These children receive the same benefits as any other children (e.g., FIP and FIP-related).

#### **2.04.01.03 Children with Special Health Care Needs**

This group includes children on SSI born on or after May 1, 2000, "Katie Beckett" children born on or after May 1, 2000, and children in adoption subsidy born on or after May 1, 2000, who are enrolled in RItE Care currently or are in Medicaid FFS. These children also receive the same benefits as other children.

#### **2.04.01.04 Excluded Populations**

The following children are excluded from participation in RItE Smiles:

- Children residing in a nursing home or an intermediate care facility for the mentally retarded (ICF/MR)
- Children with third-party coverage for dental benefits
- Children residing outside of Rhode Island

These children will continue to access their benefits through the State's Medicaid fee-for-service system.

#### **2.04.02 New Eligibility Groups**

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

#### **2.04.03 Eligibility Determination**

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

#### **2.04.04 Guaranteed Eligibility**

There are no eligibility guarantees for members covered under this Agreement.

#### **2.04.05 Lock-in**

Following their initial enrollment into a dental plan, RItE Smiles eligible children will be restricted to that RItE Smiles dental plan after the first ninety (90) days of enrollment until the next open enrollment period, unless disenrolled under one of the conditions described in Section 2.05.10.

#### **2.04.06 Automatic Re-Assignment Following Resumption of Eligibility**

Members who are disenrolled from a Dental Plan due to loss of eligibility shall automatically be re-enrolled, or assigned, into the same Dental Plan should they regain eligibility within sixty (60) calendar days. If more than sixty (60) days have elapsed, the member shall be permitted to select a Health Plan or automatically assigned to a Dental Plan.

### **2.05 MEMBER ENROLLMENT AND DISENROLLMENT**

#### **2.05.01 Dental Plan(s) Marketing**

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

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

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

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

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

## **2.05.02 Dental Plan(s) Enrollment Procedures**

The State shall conduct enrollment activities for eligible individuals under this agreement. All eligible children will be enrolled in the RIte Smiles program by the State.

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

Contractor agrees to have written policies and procedures for enrolling these members effective on the first day of the following month after receiving notification from the State. Members must be mailed notification of enrollment including effective date and how to access care within ten (10) calendar days after receiving notification from the State of their enrollment.

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

Contractor agrees to have written policies and procedures for enrolling members, which specifically address the requirements for these members as set forth in this Agreement.

## **2.05.03 Change in Status**

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

Contractor shall have a process for performing outreach calls and an approach for determining a member's most recent address and accurate address and telephone number.

## **2.05.04 Enrollment and Disenrollment Updates**

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

## **2.05.05 Services For New Members**

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

## **2.05.06 New Member Orientation**

Contractor shall have written policies and procedures for orienting new members to their benefits, how to utilize services in other circumstances, how to register a complaint or file a grievance. These policies and procedures shall take into account the multi-lingual, multi-cultural nature of the population. All enrollment notices, informational materials and instructional materials relating to members should be written at no higher than a sixth-grade level, presented in a manner and format that may be easily understood. All written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who are visually limited or have limited reading proficiency. All members must be informed that information is available in alternative formats and how to access those formats.

Contractor shall make at least four attempts, on different days, and at different times of the day, to make a welcome call to all new members within thirty (30) days of enrollment to provide the same information as in the paragraph above. Welcome call scripts shall also solicit whether members have a regular dentist within the network, and whether they have new or existing dental care needs. In the event that a welcome call identifies any new members who have existing health care needs immediate steps will be taken to ensure the member's needs are met. Any scripts developed or used by the Contractor for these purposes shall be subject to review and prior approval by EOHHS.

Orientation Process for members shall include a contact to acquaint the member to the Contractor. Any script or other materials developed by the Contractor for this purpose is subject to review and prior approval by EOHHS.

#### **2.05.07 Identification Cards**

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

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

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

- Dental Plan name
- Twenty-four hour Dental Plan telephone number for use in urgent or emergent medical situations
- Telephone number for Member Services function (if different)

#### **2.05.08 Member Handbook**

Contractor must mail a Member Handbook to all members within ten (10) days of being notified of their enrollment and to update the handbook when material changes are needed as determined

by EOHHS. Contractor must use the *Guidelines for Plan Consumer-Friendly Materials* in preparing this handbook.

Written material must use easily understood language and format. All written material must be written at no higher than a sixth-grade level. Written material must be available in alternative formats (e.g. tape or compact disc) and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

All enrollees must be informed that information is available in alternative formats and how to access those formats. However, such alternative media shall not substitute for the above requirement to provide all members with a written Member Handbook except for those members with special needs that warrant an alternative format.

### **2.05.08.01 Required Information**

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

- Information on Member Services.
- Appointment procedures and what to do in a dental emergency
- Information on what to do when family size changes.
- Provider network listing (may be included as an insert). The information must include their names, locations, telephone numbers, and non-English languages spoken by current providers in the member's service area, including identification of providers that are not accepting new patients.
- Any restrictions on the member's freedom of choice among network providers.
- Information on amount, duration, and scope of Covered Services. This information must include sufficient detail to ensure that the Member understands the benefits to which they are entitled.
- Procedures for obtaining benefits, including authorization requirements.
- Right to a second surgical opinion.
- How members may obtain benefits from an out-of network provider.
- Information on out-of-plan, out-of-network benefits and information on non-covered services. How and where to access any benefits that are available under the State plan but are not covered under this Agreement, including any cost sharing.
- How transportation is provided.
- Information on member's rights and protections, as specified in 42 CFR 438.100.
- Information on formal grievance, appeal and fair hearing procedures, and the information specified in 42 CFR 438.10(g) (1) and described in Section 2.15 of this Agreement.
- Information that a member may request disenrollment at any time from the Dental Plan

- Fraud and abuse
  - Provide examples of possible Medicaid fraud and abuse which might be undertaken by providers, vendors and enrollees
  - Inform enrollees about how to report suspected Medicaid fraud and abuse, including any dedicated toll-free number established by the Contractor for reporting possible fraud and abuse
  - Instruct enrollees about how to contact EOHHS's Fraud Unit
- Information on grievance, appeal and fair hearing procedures and timeframes, as provided in 42 CFR 438.400 through 438.424, in a State-developed or State approved description that must include the following:
  - The member's right to a State Fair Hearing, how to obtain a hearing, and the right to representation at a hearing
  - The member's right to file grievances and appeals and their requirements and timeframes for filing
  - The availability of assistance in the filing process
  - The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone
  - The member's right to request continuation of Covered Benefits during an appeal or State Fair Hearing; and the member may be liable for the cost of any continued benefits while the appeal is pending, if the final decision is adverse to the enrollee (as defined in 42 CFR 438.420).
- Additional information that is available upon request, including the following:
  - Information on the structure and operation of the Contractor
  - Information on any provider incentive plans as set forth in 42 CFR 438.6(h)

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

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

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

- Each member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
- Each member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
- Each member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
- Each member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Each member is guaranteed the right to request and receive a copy of his or her dental records, and to request that they be amended or corrected, as specified in 45 CFR Part 164.

### **2.05.08.02 State Approval**

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

### **2.05.08.03 Languages Other Than English**

Contractor agrees to make available Member Handbooks in languages other than English consistent with interpreter service requirements described in 2.06.01.03 for members, and to distribute them to members needing them, whether new or established members. Contractor agrees to publish a revised Member Handbook within six (6) months of the effective date of this Agreement in all required languages, according to the non-English language enrollment profile of the Contractor on the effective date of this Agreement. Contractor agrees to designate non-English language capability in its provider listings distributed to members.

## **2.05.09 Member Disenrollment**

### **2.05.09.01 General Authority**

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

### **2.05.09.02 Reasons For Disenrollment**

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

- Loss of Medicaid eligibility or medically needy
- Loss of program eligibility

- For members who opt for another Medical Assistance managed care option
- Death
- Relocation out-of-State
- Adjudicative actions
- Change of eligibility status
- Placement in Eleanor Slater Hospital, Cranston RI or placement in Tavares Pediatric Center, Providence RI or placement in an out-of- state hospital
- Eligibility determination error
- Just cause (as determined by the State on an individual basis)
- Other reasons for disenrollment include but are not limited to: poor quality of care, lack of access to providers experienced in dealing with the member's health needs.

A member may request disenrollment without cause during the 90 days following the date of the recipient's initial enrollment with the Dental Plan.

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

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

In accordance with 42 CFR 438.56(b)(2), Contractor may not request disenrollment of a member because of an adverse change in the member's health status, or because of the member's utilization of dental services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the member's special needs (except when the member's continued enrollment in the Dental Plan seriously impairs the Dental Plan's ability to furnish services to either the particular member or other members). The Contractor may request in writing that a member be disenrolled for the foregoing exception. All disenrollments are subject to approval by the State, and Contractor shall submit written disenrollment policies and procedures to the State for approval.

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

### **2.05.09.03 Disenrollment Effective Dates**

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

considered approved, if the State fails to make a disenrollment determination within the described timeframe.

## **2.06 IN-PLAN SERVICES**

### **2.06.01 Description of Comprehensive Benefit Package**

#### **2.06.01.01 General**

The Contractor must agree to make available the comprehensive benefit package to members covered under this agreement. The comprehensive benefit package includes preventive and restorative services. The comprehensive benefit package does not include all services to which this group is entitled. The State will continue to offer a schedule of out-of-plan benefits that Contractor agrees to be required to coordinate but will not be responsible to deliver and which will be reimbursed fee-for-service.

Attachment A of this Agreement presents the Schedule of In-Plan Benefits contained in the comprehensive benefit package. Attachment B of this Agreement presents the Schedule of Out-of-Plan Benefits. Attachment C of this Agreement presents the Schedule of Non-Covered Benefits.

#### **2.06.01.02 Dental EPSDT Services**

Contractor agrees to provide the full early and periodic screening, diagnosis, and treatment related to dental services to all eligible children and young adults up to age 21 in accordance with the Rhode Island EPSDT Periodicity Schedule as included in Attachment D or modified by the State during the period of this Agreement.

In addition, Contractor agrees to have written policies and procedures for conducting tracking, follow-up, and outreach to ensure compliance with Rhode Island EPSDT Periodicity Schedule. These policies and procedures shall emphasize outreach and compliance monitoring for children and adolescents, taking into account the multi-lingual, multi-cultural nature of the population as well as other unique characteristics of this population.

The full scope of Contractor's EPSDT requirements is described below.

#### **Screening**

The Contractor must conduct inter-periodic EPSDT screens on members to identify dental problems in conformance with Attachment D to this Agreement. Additional screens should be provided as Medically Necessary.

#### **Diagnosis and Treatment**

If a suspected problem is detected by a screening examination as described above, the child shall be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs.

EPSDT requires coverage for all follow-up diagnostic and treatment services deemed Medically Necessary to ameliorate or correct a problem discovered during an EPSDT screen. Such Medically Necessary diagnosis and treatment services must be provided regardless of whether such services are covered by the State Medicaid Plan, as long as they are Medicaid-covered services as defined in the Social Security Act.

Contractor shall assure that all Medically Necessary, Medicaid-covered diagnosis and treatment services are provided, either directly or by referral. However, if the services are neither covered by the State Medicaid Plan nor included in the comprehensive benefit package, Contractor may bill the State fee-for-service for these services if provided by Contractor. Such services are outlined in Attachment B of this Agreement.

### **Tracking**

Contractor shall establish a tracking system that provides up-to-date information on compliance with EPSDT service provision requirements in the following areas:

- A clinical dental examination at the eruption of the first tooth and no later than twelve (12) month and
- Every six months thereafter, or as indicated by the child's risk status/susceptibility to disease.
- Diagnosis and/or treatment, or other referrals in accordance with EPSDT screen results.

### **Follow-up and Outreach**

Contractor shall have an established process for reminders, follow-ups, and outreach to members that includes:

- Written notification of upcoming or missed key points of contact within a set time period, taking into consideration language and literacy capabilities of members.
- Telephone protocols to remind members of upcoming visits and follow-up on missed appointments within a set time period.
- Protocols for conducting regularly scheduled outreach with noncompliant members and addressing access barriers such as arranging transportation, interpreters, connections with multi-lingual/multi-cultural service providers, etc.

This process must take into account the multi-lingual, multi-cultural nature of the population as well as other unique characteristics of this population such as a greater frequency of changes of address and absence of telephones.

#### **2.06.01.03 Interpreter/Translation Services**

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

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

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

In addition, Contractor agrees to conform with standards outlined in the Americans with Disabilities Act (ADA) for purposes with its members who are visually or hearing impaired and who may have physical disabilities.

#### **2.06.02 Enrollee/Provider Communication**

Contractor may not prohibit, or otherwise restrict, a health care professional, acting within the lawful scope of practice, from advising or advocating on behalf of a member about: (1) the member's health status, medical care, or treatment options including any alternative treatment that may be self-administered; (2) any information the member needs in order to decide among all relevant treatment options; (3) the risks, benefits, and consequences of treatment or non-treatment; or (4) the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

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

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

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

### **2.06.03 Second Opinion**

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

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

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

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

## **2.07 CARE COORDINATION**

Contractor shall ensure coordination of care of all covered dental benefits under this Agreement. Coordination of care involves the organizing and marshalling of personnel and other resources needed to carry out all medically necessary dental activities required by members and is often managed by the exchange of information among participants responsible for the different aspects of care.

The coordination of care may include, but not limited to:

- Member and parental education and outreach,
- Actively encouraging routine preventive and screening visits that comply with the EPSDT periodicity schedule,
- Use of dental sealants,
- Referral to dental specialists to treat medically necessary dental conditions,
- Referral to other necessary related services required by the member (e.g. medical care, transportation, interpreter services, etc),
- Follow-up with dental specialists and other provider's to whom the member was referred.

The State considers interactive communications between the primary dental provider and dental specialists to be an important program objective to ensure that members receive the right care in

the right setting. The Contractor is encouraged to promote interactive communication methods or systems that enable timely exchange of member information between collaborating providers.

Contractor will ensure that members have timely access to prescriptions through coordination with other payers and through provider education. Prescription drugs ordered by a dental provider will be paid for by the Medicaid fee-for-service system, RIte Care, or RIte Share, depending on the member's eligibility.

Contractor shall ensure coordination of care of all covered benefits under this Agreement. Contractor shall coordinate care with the dental practitioners providing Out-of-Plan benefits described in Attachment B of this Agreement. Coordination of care includes identification and follow-up of high risk members, ensuring coordination of services and appropriate referral and follow-up.

In particular, Contractor shall encourage and ensure the coordination of care between the member's primary provider of medical care (PCP) and the Contractor's Dental Care Providers, as needed. The synergy between the PCP and the dentist is essential to ensure that the medical and dental needs of the member are met in a coordinated and integrated fashion.

## **2.08 PROVIDER NETWORKS**

### **2.08.01 Network Composition**

The Contractor will be responsible for establishing and maintaining a geographically accessible statewide provider network comprised of general and specialty dentists in adequate numbers to meet accessibility standards and make services available in a timely manner. The RIte Smiles Contractor will develop and maintain a sufficient provider network to provide dental services to RIte Smiles eligible children. The network will include a sufficient number of general and pediatric dentists to meet the service accessibility standards outlined later in this section as well as an adequate specialty network that includes the following specialty dentists: endodontist, periodontist, prosthodontist, oral surgeons, and orthodontist.

The RIte Smiles Contractor must include in its network traditional providers of dental services to Rhode Island's Medicaid population. The RIte Smiles Contractor must have a sufficient network of primary and specialty dental services to meet the diverse needs of the Medicaid population, including dentists with the experience and capacity to serve children with special health care needs according to guidelines set forth by the U.S. Department of Health and Human Services in *An Introduction to Practical Oral Care for People with Developmental Disabilities*.

The Contractor agrees to establish and maintain a network that is supported by written agreements and can sufficiently demonstrate to EOHHS' satisfaction the Contractor's ability to provide covered services under this Agreement. Members must have access to services that are at least equal to, or better than community practice standards. In establishing and maintaining the network, the Contractor must consider the following:

- Anticipated member enrollment,
- Expected utilization of services taking into consideration the characteristics and

needs of specific RItE Smiles eligible populations for which the RItE Smiles Contractor will be responsible,

- Numbers and types (in terms of training, experience, and specialization) of providers required to furnish the services to be contracted,
- Numbers of providers who are not accepting new Medicaid patients,
- Geographic location of providers and members, considering the distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities, and
- “Disability competency” of providers and the physical accessibility of their offices as it relates to the capacity of health professionals and health educators to support the health and wellness of people with disabilities through their knowledge, experience and expertise providing services to children with disabilities.

If Contractor declines to include individual(s) or groups of providers in its network, Contractor agrees to give the affected providers written notice of the reason for its decision.

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

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

Contractor agrees to ensure that all in-plan services covered under the Medicaid State Plan and provided for in Attachment A are available and accessible to members, according to 42 CFR 438.206. Refer to Section 2.09 of this Agreement for service accessibility standards.

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

Nothing in this section may be construed to:

- Require Contractor to contract with providers beyond the number necessary to meet the needs of members;
- Preclude Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty;
- Preclude Contractor from establishing measures that are designed to maintain quality of services to control costs and that are consistent with its responsibilities to members; or

For members, this may require the Contractor’s inclusion of providers who practice or are located outside of the State and/or allowing such members to retain established relationships to preserve continuity of care with non-network providers, including traditional Medical Assistance

providers. Contractor shall be obligated to offer a provider agreement to become a Participating Provider to any such providers. Contractor may inquire as to member's interest in switching to a closer in-State, in-network provider.

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

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

#### **2.08.02 Transitioning Between Non-Network and Network Providers**

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

#### **2.08.03 FQHCs/RHCs with Dental Clinics**

Contractor shall include FQHCs and RHCs that offer dental services in its network.

#### **2.08.04 Hospital-Based Dental Clinics**

Contractor shall include all hospital-based dental clinics in its network.

#### **2.08.05 School-Based Clinics**

The State considers school-based services to be an important part of the dental care delivery system for Rhode Island's children. Contractor is required to include all State-approved school-based dental services in its network for delivery of covered dental services available at the school-based settings by the effective date of this Agreement.

#### **2.08.06 Mobile Dental Providers**

The State considers mobile dental providers to be an important part of the dental delivery system for children enrolled in RIte Smiles. Although mobile dental providers are not equipped to provide a child's primary dental care, they do provide valuable dental care in underserved communities. Contractor is required to include State-approved mobile dental providers in its network for delivery of covered dental services by the effective date of this agreement.

#### **2.08.06 Mainstreaming**

The State considers mainstreaming of members into the broader health delivery system to be an important program objective. Contractor agrees that all of its network providers will accept members for treatment. Contractor agrees to have policies and procedures in place such that any provider in its network who refuses to accept a member for treatment cannot accept non-members for treatment and remain in the network. Contractor also agrees to accept responsibility

for ensuring that network providers do not intentionally segregate members in any way from other persons receiving services. A violation of these terms may be considered a material breach and any such material breach may be grounds for termination of this Agreement under the provisions of Section 3.10.

#### **2.08.07 Provider Network Lists**

Contractor agrees to provide the State quarterly with a list of all its participating dental providers, including those whose practices are open to additional RItE Smiles members. The list shall be provided quarterly and includes designation of language capability of the provider and physical accessibility of the provider's location, as well as applicable addresses and telephone numbers. The format of data submission will be determined by the State.

#### **2.08.08 Network Changes**

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

Contractor will require network providers to give written notice of his/her termination from the RItE Smiles network, within fifteen (15) business days after receipt or issuance of the termination notice, to each RItE Smiles member who received his or her preventive dental care from the terminated provider.

#### **2.08.09 Provider Discrimination**

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

### **2.09 SERVICE ACCESSIBILITY STANDARD**

#### **2.09.01 Urgent Dental Condition Standard**

Contractor agrees to have written policies and procedures describing how members and providers can contact the Contractor to receive instructions for treatment of an Urgent dental problem.

Contractor shall make available dental services within forty-eight (48) hours for urgent dental conditions.

The Contractor is not responsible for emergency medical or dental conditions.

#### **2.09.02 Travel Time**

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

### **2.09.03 Days to Appointment for Non-Emergent Conditions**

Contractor agrees to make services available within forty-eight (48) for treatment of an Urgent Dental Conditions. Contractor agrees to make services available within sixty (60) days for treatment of a non-emergent, non-urgent dental problem, including preventive dental care. Contractor agrees to make dental services available to new members within sixty (60) days of enrollment.

Contractor shall offer members a choice of dental providers accepting new patients.

### **2.09.04 Compliance with Accessibility Standards**

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

## **2.10 MEMBER SERVICES**

### **2.10.01 General**

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

- Explaining to members the operation of the Dental Plan including dental benefits and what to do in an Emergency or Urgent medical situation
- Assisting members to find a dentist
- Assisting members to make appointments and obtain services
- Arranging medically necessary transportation for members
- Handling member complaints
- Assisting members with coordination of out-of-plan services

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

### **2.10.02 Toll-Free Telephone Number**

Contractor agrees to maintain a toll-free Member Services telephone number during regular business hours (between 8 AM and 6 PM).

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

### **2.10.03 Annual Notification**

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

- Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the member's services area, including those not accepting new patients.
- Any restriction on the member's freedom of choice of network providers
- Member rights and protections, including those specified in 42 CFR 438.100
- Notify all members of their disenrollment rights
- Information on grievance, appeal, and State Fair Hearing procedures, including applicable time frames and the information specified in 42 CFR 438.10(g)(1)
- The amount, duration, and scope of benefits available under this Agreement in sufficient detail to ensure that members understand the benefits to which they are entitled
- Procedures for obtaining benefits, including authorization requirements
- The extent to which, and how, members may obtain benefits from out-of-network providers
- The extent to which, and how, after-hours and emergency coverage are provided, including:
  - The fact that prior authorization is not required for emergency services.
  - The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent.
  - The member has a right to use any hospital or other setting for emergency care.
- Policy on referrals for specialty care
- Cost-sharing, if applicable
- Additional information that is available on request, including information on the structure and operation of the Dental Plan and provider incentive plans as set forth in 42CFR 438.6(h).

Contractor must use Guidelines for Plan and Consumer Friendly Materials in preparing the Hand Book.

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

### **2.10.04 Cultural Competency**

Contractor must ensure that services are provided in a culturally competent manner to all members. Specifically, Contractor: (1) must give the concerns of members related to their racial

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

## **2.11 PROVIDER SERVICES**

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

- Assisting providers with questions concerning member eligibility status
- Assisting providers with prior authorization and referral procedures
- Assisting providers with claims payment procedures
- Handling provider complaints
- Assisting with care management
- Education around cultural competency

As part of its Provider Services function, Contractor shall have an ongoing program of provider education concerning the benefits and the needs of the member population covered under this Agreement. The provider education program shall include a quarterly provider newsletter and shall communicate at least twice per year, about the RItE Smiles program, its benefits, and about the needs of the covered population.

Contractor will have a Provider Services a toll-free telephone line that operates at least during normal business hours to provide assistance to providers concerning:

- RItE Smiles member eligibility status,
- Covered benefits,
- Claims submission and payment procedures,
- Prior authorization and referral, where allowable under State Medicaid policy,
- Provider complaints,
- Care management and
- Cultural Competency

Contractor will make available a Provider Relations Representative who will provide face-to-face, facility-based assistance and training when necessary. The Provider Relations Representative will be based either in Rhode Island or in New England and must be readily accessible to meet the needs of the RItE Smiles providers in a timely manner.

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

## **2.12 DENTAL MANAGEMENT AND QUALITY ASSURANCE**

### **2.12.01 General**

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

### **2.12.02 Dental Director's Office**

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

The qualifications and responsibilities shall include, but need not be limited to, the following:

- Be licensed to practice dentistry in the State of Rhode Island and be board-certified, board eligible, or board trained in his or her field of specialty
- Be responsible for Contractor's UR and QA Committees, direct the development and implementation of Contractor's internal Quality Assurance Plan, utilization review activities, and monitor the quality of care that members receive
- Be responsible for the development of dental practice standards and protocols for Contractor
- Oversee the investigation of all potential quality of care problems, including , but not limited to member specific occurrences of "never events", potential healthcare acquired infections, and possible hospital acquired conditions and be responsible for development and implementation of corrective action plans
- Be responsible for the development of Contractor's dental policies
- Be responsible for the Contractor's referral process for specialty and out-of-plan services
- Be involved in the Contractor's recruiting and credentialing activities
- Be involved in the Contractor's process for prior authorizing and denying services
- Be involved in the development and oversight of the Contractor's disease management programs
- Be involved in the Contractor's process for ensuring the confidentiality of dental records/client information

- Serve as liaison between the Contractor and its providers and communicate regularly with the Contractor's providers, addressing areas of clinical relevance including but not limited to:
  - Contractor's utilization management functions
  - Any prior authorization (PA) requirements
  - Quality indicators, such as the Contractor's performance on HEDIS-like measures
- Participate in the development of strategies to educate members about health promotion, disease prevention and efficient and effective use of oral health care benefits
- Be available to the Contractor's dental staff on a daily basis for consultation on referrals, denials, complaints and problems.

### **2.12.03 Utilization Review and Quality Assurance (UR/QA)**

#### **2.12.03.01 General**

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

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

#### **2.12.03.02 Utilization Review**

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

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

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

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

### **2.12.03.03 Quality Assurance**

Contractor agrees to have a written quality assurance or quality management plan that monitors, assures, and improves the quality of care delivered over a wide range of clinical and health service delivery areas including all subcontractors. Emphasis shall be placed on, but need not be limited to, clinical areas relating to management of members with special needs, and access to services for members.

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

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

Contractor shall complete two (2) Quality Improvement Projects, approved by EOHHS, within a calendar year. Contractor agrees to report the status and results of each project to the State, or its designees, as requested, but at least within thirty (30) days following presentation to Contractor's Quality Improvement Committee. Contractor agrees to cooperate fully with the State or its designees in any efforts to validate performance improvement projects. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

Contractor agrees to support joint quality improvement projects involving Health Plans and EOHHS. Contractor agrees to use the Quality Improvement Activity Form developed by NCQA for reporting all quality improvement activities to the state.

Contractor agrees to provide the results of Medicaid HEDIS<sup>®</sup> and Medicaid HEDIS<sup>®</sup>-like measures or oral health quality measures set forth by CMS to the State, or its designees, within thirty (30) days, following presentation to Contractor's Quality Improvement Committee.

For members under this Agreement, Contractor shall have defined protocols that require routine reporting on the quality of care and access to services (e.g., access barrier analysis).

The Quality Assurance Plan also shall:

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

#### **2.12.03.04 Confidentiality**

Contractor must have written policies and procedures for maintaining the confidentiality of data; including medical records/client information that conforms to HIPAA requirements (also see Section 3.09 Confidentiality of Information).

#### **2.12.03.05 State and Federal Reviews**

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

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

#### **2.12.03.06 Practice Guidelines**

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

When developing these guidelines, Contractor agrees to follow in principle the guidelines

promulgated by the American Academy of Pediatric Dentistry.

### **2.12.03.07 Service Provision**

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

### **2.12.04 Provider Credentialing**

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

Contractor's credentialing process must be efficient and timely so as not to adversely affect the necessary treatment of children and the billing of dental services.

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

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

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

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

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

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

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

The Contractor should refer to the Compliance Section of the Model Contract for further requirements pertaining to disclosures.

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

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

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

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

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

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

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

## **2.13 OPERATIONAL DATA REPORTING**

### **2.13.01 General**

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

utilization review activities. Contractor also agrees to cooperate with the State in carrying out data validation activities.

## **2.13.02 Utilization Data**

Contractor agrees to provide, for each member, person level records that describe the care received by that individual during his or her enrollment period with the Contractor, such as records shall be provided at intervals specified by EOHHS. Currently the State requests these data files be sent at the completion of each of the Contractor's financial cycles. In addition, Contractor agrees to provide aggregate utilization data for all members at such intervals as required by the State.

### **2.13.02.01 Person-Level Record**

The person-level record shall include, at a minimum, those data elements listed in the *EOHHS Approved Encounter 837 Companion Guide* and other associated HIPAA companion guides including updates issued by the State's designated Medicaid management information system ("MMIS") contractor.

### **2.13.02.02 Aggregate Data**

The aggregate data submittal shall include, at a minimum, those data elements listed in the appropriate *EOHHS Approved Companion Guide*, including updates.

### **2.13.02.03 Data Format**

Contractor agrees to submit data in an electronic or tape format that conforms to the State's specifications. The precise nature of these specifications is included in the appropriate *EOHHS Approved Companion Guide* including updates and associated HIPAA companion guides.

### **2.13.02.04 Timing of Data Submittal**

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

### **2.13.02.05 Data Validation**

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

## **2.13.03 Grievance and Appeals Data**

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

#### **2.13.04 Quality Assurance Data**

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

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

#### **2.13.05 Member and Provider Satisfaction Report**

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

#### **2.13.06 Fraud and Abuse Reports**

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

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

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

#### **2.13.07 Presentation of Findings**

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

#### **2.13.08 Health Insurance Portability and Accountability Act Requirements (HIPAA)**

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

### **2.13.09 Certification Of Data**

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

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

Contractor must submit the certification concurrently with the certified data.

### **2.13.10 Patient Protection and Affordable Care Act**

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

## **2.14 GRIEVANCE AND APPEALS**

### **2.14.01 General**

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

Contractor's policies and procedures for processing grievances must permit a provider, acting on behalf of the member and with the member's written consent, to file an appeal of an action within 30 days from the date on the Contractor's notice of action. An action means: (1) whether or not a service is a Covered Service; (2) the denial or limited authorization of a requested

service, including the type or level of service; (3) the reduction, suspension, or termination of a previously authorized service; (4) the denial, in whole or in part, of payment of a service; (5) the failure to provide or authorize services within a timely manner, as defined Section 2.10 of this Agreement or (6) the failure of the Contractor to act within the timeframes required by the *Rhode Island Medicaid Managed Care Grievance and Appeals Process* and in Section 2.15.03 of this Agreement.

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

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

The Contractor must meet the requirements specified in 42 CFR 438.210. Contractor must mail the notice of action to the member within the timeframes specified in 42 CFR 438.404. The Contractor shall also meet the requirements in 42. CFR 438.10 regarding information provided to enrollees. Written materials must use easily understood language and members must be informed that alternative formats available for those with special needs who may be visually limited or have limited reading proficiency. Written notices must be translated for members who speak non-English languages and oral interpretations must be available in all languages, as needed.

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

In handling grievances and appeals, Contractor must:

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

a grievance or appeal that involves clinical issues.

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

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

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

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

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

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

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

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

request it

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

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

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

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

#### **2.14.02 Complaint Resolution**

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

#### **2.14.03 Grievance Process**

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

#### **2.14.04 Expedited Resolution Of Appeals**

Contractor must establish and maintain an expedited review process for appeals, when Contractor determines (for a request from a member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. The contractor must inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of an expedited resolution.

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

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

If Contractor denies a request for expedited resolution of an appeal, it must transfer the appeal to the timeframe for standard resolution in accordance with *Rhode Island Medicaid Managed Care Grievance and Appeals Process* and make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with written notice.

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

## **2.15 PAYMENTS TO AND FROM PLANS**

### **2.15.01 Acceptance of State Capitation Payments**

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

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

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

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

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

## **2.15.02 Payments to Providers**

### **2.15.02.01 General**

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

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

### **2.15.02.02 Retroactive Eligibility Period**

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

### **2.15.02.03 In-Network (Contracted) Services**

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

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

A claim means (1) a bill for services, (2) a line item of service, or (3) all services for one enrollee within a bill. A clean claim means one that can be processed without additional information from the provider of service or from a third party. It includes a claim with errors originating in the State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. Timely payment means within thirty (30) days of receipt of a "clean claim" for reimbursement. Timely payment is judged by the date that the contractor receives the claim as indicated by its date stamped on the claim and the date of payment is the date of the check or other form of payment.

### **2.15.02.04.1 Out-of-Network and Out-of-State Providers**

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

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

Under these terms, Contractor shall not be financially liable for services rendered to treat a non-emergent condition in a hospital emergency room (except to assess whether a condition warrants treatment as Emergency Services, or as required elsewhere in law), unless the services were prior authorized or otherwise conformed to the terms of Contractor's contract with the provider. The Contractor shall meet the requirements of the *Rhode Island Medicaid Managed Care Protocol*.

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

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

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

#### **2.15.02.05 FQHCs/RHCs**

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

#### **2.15.02.06 Hospital-Based Dental Clinics**

The Contractor shall be required, to implement reforms required by Rhode Island State Legislation (i.e. R.I. General Law Chapter 40-8, Section 40-8-13.4) which stipulates certain requirements for payments to hospitals.

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

#### **2.15.02.07 Liability during an Active Grievance or Appeal**

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

#### **2.15.02.08 Limit On Payment to Other Providers**

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

### **2.15.02.09 Dental Provider Incentive Plans**

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

### **2.15.02.10 Actuarial Basis**

The actuarial basis in the rate setting process for the computation of capitated rates is provided in Attachment F of this Agreement.

### **2.15.02.11 Payment Adjustment for Provider Preventable Conditions**

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

### **2.15.03 Cost Sharing**

Currently, the State of Rhode Island does not impose cost sharing requirements on RIte Smiles members. However, it retains the right to impose cost sharing requirements at any point in the future. Any cost sharing imposed on Medicaid members shall be in accordance with 42 CFR 447.50 through 42 CFR 447.60. The State shall notify members of their cost-sharing responsibilities including the amounts of cost-sharing. The State shall notify the Contractor of a member's cost-sharing responsibilities.

Should the State impose cost sharing requirements, the Contractor shall have policies, practices and procedures to ensure that cost-sharing responsibilities are met.

### **2.15.03 Third-Party Liability**

Third-Party Liability ("TPL") refers to any individual entity (e.g., insurance company) or program (e.g., Medicare) that may be liable for all or part of Member's health coverage including subrogation. Under Section 1902(a) (25) of the Social Security Act, the State is required to take all reasonable measures to identify legally liable third parties and treat verified TPL as a resource of the Medicaid recipient.

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

Contractor agrees to cooperate with the State in the implementation of RI General Laws 40-6-9.1

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

#### **2.15.05 Reinsurance**

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

#### **2.15.06 Reserving**

As part of its accounting and budgeting function, Contractor shall establish an actuarially sound process for estimating and tracking incurred but not reported claims (IBNRs). As part of its reserving methodology, the Contractor shall conduct "look backs" at least annually to assess its reserving methodology and make adjustments as necessary.

#### **2.15.07 Claims Processing and MIS**

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

#### **2.15.08 Audits**

Pursuant to Section 3.08 of the Agreement, the State, or its designees, maintains the right to conduct with reasonable notice whatever audit functions are necessary to verify proper invoicing by Contractor for provision of services, proper payments by the State to Contractor, and proper identification of TPL in accordance with Section 2.15.04 of this Agreement.

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

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

8.2-22.

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

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

## **2.16 FINANCIAL STANDARDS**

### **2.16.01 General**

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

### **2.16.02 Financial Benchmarks**

The success of the Rhode Island Medicaid managed care program is contingent on the financial stability of participating Dental Plan(s). 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 Dental Plan(s). The areas in which financial benchmarks have been established include the following:

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

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

### **2.16.03 Financial Data Reporting**

Contractor agrees to comply with the *Rhode Island Medicaid Managed Care Health Plan Financial Reporting Program and Procedures*.

### **2.16.04 Audit**

In the case where the Agreement amount identified in Section 2.15.08 is at least twenty-five thousand dollars (\$25,000) in any year, Contractor must submit an acceptable audited financial statement prepared by an independent auditor within nine (9) months of the end of the Contractor's fiscal year. The audit must provide full and frank disclosure of all assets, liabilities,

changes in fund balances, and all revenues and expenditures.

## **2.17 RECORD RETENTION**

### **2.17.01 General**

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

Contractor also agrees to comply with all standards for record keeping specified by the State. Operational data and medical record standards are described below. In addition, the Contractor must agree to permit inspection of its records under the terms specified in Section 2.13? and in Article III of the Agreement.

### **2.17.02 Operational Data Reports**

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

### **2.17.03 Medical Records**

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

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

## **2.18 COMPLIANCE**

### **2.18.01 General Requirements**

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

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

- Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards
- The designation of a compliance officer and a compliance committee that are accountable to senior management

- Effective training and education for the compliance officer and the organization's employees
- Effective lines of communication between the compliance officer and the organization's employees
- Enforcement of standards through well-publicized guidelines
- Provision for internal monitoring and auditing
- Provision for prompt response to detected offenses, and for development of corrective action initiatives

### **2.18.02 Prohibited Affiliations with Individuals Debarred by Federal Agencies**

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

- (1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- (2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (1) of this section.

The relationships described are as follows:

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

### **2.18.03 Disclosure of the Contractor's Ownership and Control Interest**

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

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

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

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

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

#### **2.18.04 Disclosure by Providers: Information on Ownership and Control**

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

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

the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a five (5) percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

- (3) The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.
- (4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity.

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

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

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

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

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

#### **2.18.05 Disclosure by Providers: Information Related to Business Transactions**

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

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

period ending on the date of request; and any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor during the five year period ending on the date of the request.

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

#### **2.18.06 Disclosure by Providers: Information on Persons Convicted of Crimes**

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

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

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

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

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

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

#### **2.18.07 Disclosures Made by Providers to the Contractor**

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

- (A) Has been convicted of a criminal offense as described in Sections 1128(a) and 1182(b) (1), (2), or (3) of the Social Security Act
- (B) Has had civil money penalties or assessments imposed under Section 1129A of

the Social Security Act; or

(C) Has been excluded from participation in Medicare, Medicaid, or any Federal or State health care programs and such a person has:

- (1) A direct or indirect ownership interest of five (5) percent or more in the entity;
- (2) Is the owner of a whole or part interest in any mortgage, deed of trust, note for other obligation secured (in whole or in part) by the entity or any of the property assets thereof, in which whole or part interest is equal to or exceed five (5) percent of the total property and assets of the entity;
- (3) Is an officer or director of the entity, if the entity is organized as a corporation;
- (4) Is partner in the entity, if the entity is organized as a partnership;
- (5) Is an agent of the entity; or
- (6) Is a managing employee, that is (including a general manager, business manager, administrator or director) who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity or part thereof, or directly or indirectly conducts the day-to-day operations of the entity or part thereof, or
- (7) Was formerly described in paragraph (a)(1)(ii)(A) of this section, but is no longer so described because of a transfer of ownership or control interest to an immediate family member or a member of the person's household as defined in paragraph (a) (2) of this section, in anticipation of or following a conviction, assessment of a CMP, or imposition of an exclusion.

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

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

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

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

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

Ownership interest means an interest in:

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

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

The Contractor must promptly notify EOHHS in writing within ten (10) business days of any action that it takes to deny a provider's application for enrollment or participation (e.g., a request for initial credentialing or for re-credentialing) when the denial action is based on the Contractor's concern about Medicaid program integrity or quality. Provider credentialing requirements are addressed further in Section 2.12.04.

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

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

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

## **ARTICLE III: CONTRACT TERMS AND CONDITIONS**

### **3.01 GENERAL PROVISIONS**

#### **3.01.01 Contract Composition and Order of Precedence**

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

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

- Attachment A:** Schedule of In-Plan Benefits
- Attachment B:** Schedule of Out-of-Plan Benefits
- Attachment C:** Schedule of Non-Covered benefits
- Attachment D:** EPSDT Periodicity Schedule
- Attachment E:** Contractor's Capitation Rates
- Attachment F:** Actuarial Basis for Capitation Rates
- Attachment G:** Special Terms and Conditions
- Attachment H:** Contractor's Insurance Certificates
- Attachment I:** Contractor's Locations

#### **3.01.02 Integration Clause**

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

#### **3.01.03 Subsequent Conditions**

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

#### **3.01.04 Effective Date and Term**

Contractor assumes responsibility for the work described in this Agreement on July 1, 2014. The Contract shall continue in force until June 30, 2016, with three (3) one-year option periods.

#### **3.01.05 Contract Administration**

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

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

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

### **3.01.06 Contract Officers**

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

### **3.01.07 Liaisons**

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

### **3.01.08 Notification of Administrative Changes**

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

### **3.01.09 Notices**

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

Notices shall be addressed as follows:

In case of notice to Contractor: Chief Executive Officer,

Contractor's Address

In case of notice to EOHHS: EOHHS Administrator, Hazard Building 74, West Road, Cranston, RI 02920

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

### **3.01.10 Authority**

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

### **3.01.11 Federal Approval of Contract**

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

### **3.01.12 Special Terms and Conditions**

The Contractors shall comply with the requirements specified in Attachment G of this Agreement.

## **3.02 INTERPRETATIONS AND DISPUTES**

### **3.02.01 Conformance with State and Federal Regulations**

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

### **3.02.02 Waivers**

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

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

### **3.02.03 Severability**

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

### **3.02.04 Jurisdiction**

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

### **3.02.05 Disputes**

Prior to the institution of arbitration or litigation concerning any dispute arising under this Agreement, the Chief Purchasing Officer of the State of Rhode Island is authorized, subject to any limitations or conditions imposed by regulations, to settle, compromise, pay, or otherwise adjust the dispute by or against or in controversy with, a Contractor relating to a contract entered into by the Department of Administration on behalf of the State or any State agency, including a claim or controversy based on contract, mistake, misrepresentation, or other cause for contract modification or rescission, but excluding any claim or controversy involving penalties or forfeitures prescribed by statute or regulation where an official other than the Chief Purchasing Officer is specifically authorized to settle or determine such controversy.

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

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

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

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

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

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

Any fraudulent activity may result in criminal prosecution.

### **3.03 CONTRACT AMENDMENTS**

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

Special Projects are defined as additional services available to the Executive Office on a time and materials basis with the amounts not to exceed the amounts referenced on the Contractor's RFP cost proposal or as negotiated by project or activity. The change order will specify the scope of the change and the expected completion date. Any change order shall be subject to the same

terms and conditions of this Agreement unless otherwise specified in the change order and agreed upon by the parties. The parties will negotiate in good faith and in a timely manner all aspects of the proposed change order.

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

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

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

### **3.04 PAYMENT**

#### **3.04.01 Capitation Payments**

Contractor shall receive Capitation Payments in the manner described in Section 2.15 of this Agreement. All payments will be subject to the availability of funds. Adjustments to Capitation Payments due to member reconciliations will be made in the month following their discovery.

#### **3.04.02 Payments to Subcontractors and Providers**

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

#### **3.04.03 Liability For Payment**

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

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

Member would owe if Contractor provided the services directly

### **3.05 GUARANTEES, WARRANTIES, AND CERTIFICATIONS**

#### **3.05.01 Contractor Certification of Truthfulness**

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

#### **3.05.02 Contractor Certification of Legality**

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

#### **3.05.03 Contractor Certification of HMO Licensure**

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

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

#### **3.05.04 Performance Bond or Substitutes**

Contractor shall furnish a performance bond, a cash deposit, or an irrevocable letter of credit. The performance bond shall be in a form acceptable to the State. If a cash deposit is used, it should be placed in different financial institutions to a maximum of one hundred thousand dollars (\$100,000.00) per deposit. If a letter of credit is used, the letter should be issued by a bank doing business in the State of Rhode Island and insured by the Federal Deposit Insurance Corporation; a savings and loan institution doing business in the State of Rhode Island and insured by the Federal Savings and Loan Insurance Corporation; or a credit union doing business in the State of Rhode Island and insured by the National Credit Union Administration.

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

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

### **3.05.05 Subcontracts and Delegation of Duty**

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

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

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

Executive Order 92-4 encourages each State agency to meet a goal of ten percent (10%) of the dollar value of all procurement be awarded to small and small disadvantaged and minority and woman-owned businesses as subcontractors, pursuant to the provisions of Part 19 of Title 48, Federal Acquisition Regulations; 45 CFR 74.161, Attachment E: Capitation Rates; and Chapter 37-2.5.5.2.

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

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

### **3.05.06 Assignment of the Contract**

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

### **3.05.07 Hold Harmless**

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

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

Nothing in the language contained in this Agreement shall be construed to waive or limit the State or federal sovereign immunity or any other immunity from suit provided by law including, but not limited to Rhode Island General Law, Title 9, Chapter 31 et al., entitled “Governmental Tort Liability.”

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

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

### **3.05.08 Insurance**

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

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

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

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

#### **3.05.08.01 Professional Liability Insurance**

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

#### **3.05.08.02 Workers' Compensation**

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

#### **3.05.08.03 Minimum Liability and Property Damage Insurance**

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

#### **3.05.08.04 Errors and Omissions Insurance**

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

#### **3.05.08.05 Reinsurance**

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

#### **3.05.08.06 Evidence of Coverage**

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

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

#### **3.05.09 Force Majeure**

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

employees; and freight embargoes. In all cases, the failure to perform must be beyond reasonable control of, and without fault or negligence of, either party.

### **3.05.10 Patent or Copyright Infringement**

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

### **3.05.11 Clinical Laboratory Improvement Amendments (CLIA) of 1988**

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

## **3.06 PERSONNEL**

### **3.06.01 Employment Practices**

By signing this Agreement, the Contractor agrees to comply with the requirements of Title VI of the Civil Rights Act of 1964 (42 USC 2000d et seq.); Section 504 of the Rehabilitation Act of 1973, as amended (29 USC 794); Americans with Disabilities Act of 1990 (42 USC 12101 et. seq.); Title IX of the Education Amendments of 1972 (20 USC 1681 et. seq.); The Food Stamp Act, and the Age Discrimination Act of 1975, The United States Department of Health and Human Services Regulations found in 45 CFR, Parts 80 and 84; the United States Department of Education Implementing regulations (34 CFR, Parts 104 and 106; and the United States Department of Agriculture, Food and Nutrition Services (7 CFR 272.6), which prohibit discrimination on the basis of race, color, national origin (limited English proficiency persons), age, sex, disability, religion, political beliefs, in acceptance for or provision of services, employment, or treatment in educational or other programs or activities, or as any of the Acts are amended from time to time.

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

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

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

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

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

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

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

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

### **3.06.02 Employment of State Personnel**

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

The penalty for violation of the above conditions shall result in a two thousand five hundred dollar (\$2,500.00) penalty per employee, plus an added two thousand five hundred (\$2,500.00) penalty per month, per employee if Contractor or subcontractor fails to terminate the employee after they have been notified in writing of the violation by the State's designated contract administrator.

### **3.06.03 Prohibited Affiliations with Individuals Debarred by Federal Agencies**

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

### **3.07 PERFORMANCE STANDARDS AND DAMAGES**

#### **3.07.01 Performance Standards for Medicaid Managed Care**

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

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

#### **3.07.02 Suspension of New Enrollment**

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

#### **3.07.03 Fraud and Abuse**

##### **3.07.03.01 General Requirements**

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

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

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

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

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

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

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

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

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

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

### **3.07.03.02 Mandatory Components of Employee Education about False Claims Recovery**

In accordance with Section 6032 of the Deficit Reduction Act of 2005, if the Contractor receives more than five million dollars (\$5,000,000) in Medicaid payments on an annual basis, then it must establish and disseminate written policies for all employees, including management and any subcontractor or agent of the Contractor, that include detailed information about the False Claims Act, established under sections 3279 through 3733 of Title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of Title 31,

United States Code, any State laws pertaining to civil and criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f) of the Social Security Act.

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

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

### **3.07.03.03 Member Education about Medicaid Fraud and Abuse**

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

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

These Member Handbook requirements are addressed further in Section 2.05.10.

### **3.07.03.04 Recipient Verification Procedures**

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

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

- Informing enrollees in writing when goods or services have been prior authorized by the Contractor

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

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

### **3.07.03.05 Explanation of Member Benefits**

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

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

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

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

### **3.07.03.06 Investigating and Reporting Suspected Fraud and Abuse**

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

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

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

In addition to reporting any suspected cases of provider or vendor fraud and/or abuse to the Medicaid Fraud Control Unit (MFCU) within five (5) business days following the close of an initial investigation, the Contractor shall also submit quarterly reports to EOHHS and to the State's Medicaid Fraud Control Unit documenting the Contractor's open and closed cases. The quarterly reports shall be formatted in conformance with requirements established by the *Rhode Island Medicaid Managed Care Fraud and Abuse Prevention, Detection and Reporting Requirements* for members and shall document all open and closed cases of suspected provider and vendor fraud and/or abuse. These quarterly reporting requirements are addressed further in Section 2.13.06 (Fraud and Abuse Reports).

### **3.07.04 Damages**

Contractor shall use ordinary care and reasonable diligence in the exercise of its powers and the performance of its duties under this Agreement. Contractor shall be liable for any loss resulting from its exercise (or failure to exercise) its powers and performance (or failure to perform) of its duties under this Agreement, up to a maximum cap of One Hundred Thousand Dollars (\$100,000); provided, however, that Contractor agrees to indemnify and hold harmless EOHHS from and against any and all claims, lawsuits, settlements, judgments, costs, penalties, and expenses, including attorneys' fees, with respect to this Agreement, resulting or arising out of the dishonest, fraudulent, or criminal acts of Contractor or its employees, acting alone or in collusion with others; and provided, further, that this maximum cap on damages shall not apply in the event that the loss arises in a situation in which Contractor failed to follow its own policies and procedures.

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

#### **3.07.04.01 Non-Compliance with Program Standards**

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

#### **3.07.04.02 Non-Compliance with Monthly Reconciliation Tasks**

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

#### **3.07.04.03 Non-Compliance with Data Reporting Standards**

Contractor shall comply with the operational and financial data reporting requirements described respectively in Sections, 2.13, 2.15, and 2.16 of Article II. Contractor shall be liable for up to two thousand five hundred dollars (\$2,500.00) for each business day that any report is delivered after the date when it is due, or includes less than the required information, or is not in the approved media or format. Damages shall not be imposed until such time that the State has notified Contractor in writing of a deficiency and has allowed a reasonable period of time for resolution.

#### **3.07.04.04 Compliance with Other Material Contract Provisions**

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

The State may identify contractual compliance issues resulting from Contractor's performance of its responsibilities through routine contract monitoring activities. If this occurs, the EOHHS Administrator or designee will notify Contractor in writing of the nature of the performance issue. The State will also designate a period of time, not to be less than thirty (30) calendar days, in which Contractor must provide a written response to the notification and will recommend, when appropriate, a reasonable period of time in which Contractor should remedy the non-compliance, but not less than thirty (30) days.

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

### **3.07.05 Deduction of Damages from Payments**

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

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

## **3.08 INSPECTION OF WORK PERFORMED**

### **3.08.01 Access To Information**

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

### **3.08.02 Inspection of Premises**

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

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

### **3.08.03 Approval of Written Materials**

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

Contractor's policies and procedures pertaining to the program covered under this Agreement produced for dissemination to actual and potential members, including but not limited to procedures for determining eligibility for coverage as a related group, also shall be subject to inspection and approval by the State.

### **3.09 CONFIDENTIALITY OF INFORMATION**

#### **3.09.01 Maintain Confidentiality of Information**

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

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

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

The Contractor agrees to abide by all applicable, current and as amended Federal and State laws and regulations governing the confidentiality of information, including to but not limited to the Business Associate requirements of HIPAA ([WWW.HHS.GOV/OCR/HIPAA](http://WWW.HHS.GOV/OCR/HIPAA)), to which it may

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

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

Personally Identifiable Information (PII) is defined as any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, social security number, date and place of birth, mother's maiden name, biometric records, etc., including any other personal information which is linked or linkable to an individual. (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").

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

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

The Contractor shall notify the Covered Entity within one (1) hour by telephone call plus e-mail, web form or fax upon the discovery of any breach of security of PHI, PII or SI or suspected

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

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

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

### **3.09.02 Confidentiality of Information**

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

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

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

The Contractor's obligations and responsibilities:

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

Act, Rhode Island General Laws, Section 5-37.3 seq.

### **3.09.03 Assurance of Security and Confidentiality**

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

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

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

### **3.09.04 Return Of Confidential Data**

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

### **3.09.05 Hold Harmless**

Contractor agrees to defend (subject to the approval of the Attorney General), indemnify, and hold harmless EOHHS and the State against any claim, loss, damage, or liability incurred as a result of any breach of the obligations of Section 3.09.05 by Contractor or any subcontractor.

### **3.09.06 State Assurance of Confidentiality**

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

### **3.09.07 Publicizing Safeguarding Requirements**

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

### **3.09.08 Types Of Information to Be Safeguarded**

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

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

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

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

### **3.09.09 Confidentiality and Protection of Public Health Information and Related Data**

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

Notwithstanding any other requirement set out in this contract, the Contractor acknowledges and agrees that the Health Information Technology for Economic and Clinical Health Act and its implementing regulations (collectively, “HITECH”) impose new requirements with respect to privacy, security and breach notification and contemplates that such requirements shall be implemented by regulations to be adopted by the Department of Health and Human Services. The HITECH requirements, regulations and provisions are hereby incorporated by reference into this contract as if set forth in this contract in their entirety. Notwithstanding anything to the contrary or any provision that may be more restrictive within this contract, all requirements and provisions of HITECH, and implementing regulations currently in effect and promulgated and/or

implemented after the date of this Contract, are automatically effective and incorporated herein. Where this contract requires stricter guidelines, the stricter guidelines must be adhered to.

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

### **3.10 TERMINATION OF THE CONTRACT**

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

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

#### **3.10.01 Termination for Default**

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

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

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

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

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

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

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

Any fraudulent activities may result in criminal prosecution.

### **3.10.02 Termination for Unavailability of Funds**

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

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

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

### **3.10.03 Termination for Financial Instability**

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

### **3.10.04 Procedures on Termination**

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

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

### **3.10.05 Refunds of Advance Payments**

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

### **3.10.06 Liability for Medical Claims**

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

### **3.10.07 Termination Claims**

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

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

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

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

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

### **3.10.08 Notification of Members**

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

### **3.10.09 Non-Compete Covenant**

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

## **3.11 OTHER CONTRACT TERMS AND CONDITIONS**

### **3.11.01 Environmental Protection**

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

### **3.11.02 Ownership of Data and Reports**

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

### **3.11.03 Publicity**

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

### **3.11.04 Award of Related Contracts**

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

### **3.11.05 Conflict of Interest**

No official or employee of the State of Rhode Island or the Federal government who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of

this Agreement shall, prior to the completion of the project, voluntarily acquire any personal interest, direct or indirect, in the contract or proposed contract. All State employees shall be subject to the provisions of Chapter 36-14 of the General Laws of Rhode Island.

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

### **3.11.06 Reporting of Political Contributions**

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

### **3.11.07 Environmental Tobacco Smoke**

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

### **3.11.08 Titles Not Controlling**

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

### **3.11.09 Other Contracts**

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

### **3.11.10 Counterparts**

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

### **3.11.11 Administrative Procedures Not Covered**

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

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

**STATE OF RHODE ISLAND:      DENTAL PLAN:**

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

\_\_\_\_\_  
AUTHORIZED AGENT  
TITLE: CHIEF EXECUTIVE OFFICER

PRINT NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DATE

## ADDENDUM I: FISCAL ASSURANCES

THE CONTRACTOR AGREES TO SEGREGATE ALL RECEIPTS AND DISBURSEMENTS PERTAINING TO THIS AGREEMENT FROM RECEIPTS AND DISBURSEMENTS FROM ALL OTHER SOURCES, WHETHER BY SEPARATE ACCOUNTS OR BY UTILIZING A FISCAL CODE SYSTEM.

THE CONTRACTOR ASSURES A SYSTEM OF ADEQUATE INTERNAL CONTROL WILL BE IMPLEMENTED TO ENSURE A SEPARATION OF DUTIES IN ALL CASH TRANSACTIONS.

THE CONTRACTOR ASSURES THE EXISTENCE OF AN AUDIT TRAIL WHICH INCLUDES: CANCELLED CHECKS, VOUCHER AUTHORIZATION, INVOICES, RECEIVING REPORTS, AND TIME DISTRIBUTION REPORTS.

THE CONTRACTOR ASSURES A SEPARATE SUBSIDIARY LEDGER OF EQUIPMENT AND PROPERTY WILL BE MAINTAINED.

THE CONTRACTOR AGREES ANY UNEXPENDED FUNDS FROM THIS AGREEMENT ARE TO BE RETURNED TO THE DEPARTMENT AT THE END OF THE TIME OF PERFORMANCE UNLESS THE DEPARTMENT GIVES WRITTEN CONSENT FOR THEIR RETENTION.

THE CONTRACTOR ASSURES INSURANCE COVERAGE IS IN EFFECT IN THE FOLLOWING CATEGORIES: BONDING, VEHICLES, FIRE AND THEFT, LIABILITY AND WORKER'S COMPENSATION.

THE FOLLOWING FEDERAL REQUIREMENTS SHALL APPLY AS INDICATED:

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

IF THE CONTRACTOR EXPENDS FEDERAL AWARDS DURING THE PROVIDER'S PARTICULAR FISCAL YEAR OF \$500,000 OR MORE, THEN OMB CIRCULAR A-133, AUDITS OF STATES, LOCAL GOVERNMENTS AND NON-PROFIT ORGANIZATIONS SHALL ALSO APPLY.

THIS AGREEMENT MAY BE FUNDED IN WHOLE OR IN PART WITH FEDERAL FUNDS. IF SO, THE CFDA REFERENCE NUMBER IS 93.778.

## **ADDENDUM II: NOTICE TO EOHHS CONTRACTORS OF THEIR RESPONSIBILITIES UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964**

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

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

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

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

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

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

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

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

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

**THE REGULATIONS ADDRESS THE FOLLOWING TOPICS:**

**SECTION:**

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

**ADDENDUM III: NOTICE TO EOHHS' CONTRACTORS OF THEIR  
RESPONSIBILITIES UNDER SECTION USC 504 OF THE  
REHABILITATION ACT OF 1973**

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

THE CONTRACTOR SHALL HAVE POLICIES AND PROCEDURES IN EFFECT, INCLUDING, A MANDATORY WRITTEN COMPLIANCE PLAN, WHICH ARE DESIGNED TO ASSURE COMPLIANCE WITH SECTION 504. AN ELECTRONIC COPY OF THE CONTRACTOR'S WRITTEN COMPLIANCE PLAN AND ALL RELEVANT POLICIES, PROCEDURES, WORKFLOWS AND RELEVANT CHART OF RESPONSIBLE PERSONNEL MUST BE SUBMITTED TO RHODE ISLAND EOHHS UPON REQUEST.

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

- ❑ WRITTEN POLICIES, PROCEDURES AND STANDARDS OF CONDUCT THAT ARTICULATE THE ORGANIZATION'S COMMITMENT TO COMPLY WITH ALL SECTION 504 STANDARDS.
- ❑ DESIGNATION OF A COMPLIANCE OFFICER WHO IS ACCOUNTABLE TO THE CONTRACTOR'S SENIOR MANAGEMENT.
- ❑ EFFECTIVE TRAINING AND EDUCATION FOR THE COMPLIANCE OFFICER AND THE ORGANIZATION'S EMPLOYEES.
- ❑ ENFORCEMENT OF STANDARDS THROUGH WELL-PUBLICIZED GUIDELINES.
- ❑ PROVISION FOR INTERNAL MONITORING AND AUDITING.
- ❑ WRITTEN COMPLAINT PROCEDURES

- ❑ PROVISION FOR PROMPT RESPONSE TO ALL COMPLAINTS, DETECTED OFFENSES OR LAPSES, AND FOR DEVELOPMENT AND IMPLEMENTATION OF CORRECTIVE ACTION INITIATIVES.
- ❑ PROVISION THAT ALL CONTRACTORS, SUB-CONTRACTORS AND VENDORS OF THE SERVICE PROVIDER EXECUTE ASSURANCES THAT SAID CONTRACTORS, SUB-CONTRACTORS AND VENDORS ARE IN COMPLIANCE WITH SECTION 504.

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

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

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

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

**SUBPART A - GENERAL PROVISIONS**

**SECTION:**

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

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

**SUBPART B - EMPLOYMENT PRACTICES**

**SECTION:**

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

**SUBPART C - PROGRAM ACCESSIBILITY**

**SECTION:**

- 84.21 DISCRIMINATION PROHIBITED
- 84.22 EXISTING FACILITIES
- 84.23 NEW CONSTRUCTION
- 84.24 - 84.30 (RESERVED)

**SUBPART F - HEALTH, WELFARE, AND SOCIAL SERVICES**

**SECTION:**

- 84.51 APPLICATION OF THIS SUBPART
- 84.52 HEALTH, WELFARE, AND OTHER SOCIAL SERVICES
- 84.53 DRUG AND ALCOHOL ADDICTS
- 84.54 EDUCATION AND INSTITUTIONALIZED PERSONS

## **ADDENDUM IV: DRUG-FREE WORKPLACE POLICY**

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

1. ANY UNAUTHORIZED EMPLOYEE WHO GIVES OR IN ANY WAY TRANSFERS A CONTROLLED SUBSTANCE TO ANOTHER PERSON OR SELLS OR MANUFACTURES A CONTROLLED SUBSTANCE WHILE ON DUTY, REGARDLESS OF WHETHER THE EMPLOYEE IS ON OR OFF THE PREMISES OF THE EMPLOYER WILL BE SUBJECT TO DISCIPLINE UP TO AND INCLUDING TERMINATION.

THE TERM "CONTROLLED SUBSTANCE" MEANS ANY DRUGS LISTED IN 21 USC, SECTION 812 AND OTHER FEDERAL REGULATIONS. GENERALLY, ALL ILLEGAL DRUGS AND SUBSTANCES ARE INCLUDED, SUCH AS MARIJUANA, HEROIN, MORPHINE, COCAINE, CODEINE OR OPIUM ADDITIVES, LSD, DMT, STP, AMPHETAMINES, METHAMPHETAMINES, AND BARBITURATES.

EACH EMPLOYEE IS REQUIRED BY LAW TO INFORM THE AGENCY WITHIN FIVE (5) DAYS AFTER HE/SHE IS CONVICTED FOR VIOLATION OF ANY FEDERAL OR STATE CRIMINAL DRUG STATUTE. A CONVICTION MEANS A FINDING OF GUILT (INCLUDING A PLEA OF NOLO CONTENDERE) OR THE IMPOSITION OF A SENTENCE BY A JUDGE OR JURY IN ANY FEDERAL OR STATE COURT.

THE EMPLOYER (THE HIRING AUTHORITY) WILL BE RESPONSIBLE FOR REPORTING CONVICTION(S) TO THE APPROPRIATE FEDERAL GRANTING SOURCE WITHIN TEN (10) DAYS AFTER RECEIVING NOTICE FROM THE EMPLOYEE OR OTHERWISE RECEIVES ACTUAL NOTICE OF SUCH CONVICTION(S). ALL CONVICTION(S) MUST BE REPORTED IN WRITING TO

THE OFFICE OF PERSONNEL ADMINISTRATION (OPA) WITHIN THE SAME TIME FRAME.

IF AN EMPLOYEE IS CONVICTED OF VIOLATING ANY CRIMINAL DRUG STATUTE WHILE ON DUTY, HE/SHE WILL BE SUBJECT TO DISCIPLINE UP TO AND INCLUDING TERMINATION. CONVICTION(S) WHILE OFF DUTY MAY RESULT IN DISCIPLINE OR DISCHARGE.

THE STATE ENCOURAGES ANY EMPLOYEE WITH A DRUG ABUSE PROBLEM TO SEEK ASSISTANCE FROM THE RHODE ISLAND EMPLOYEE ASSISTANCE PROGRAM (RIEAP). YOUR DEPARTMENT PERSONNEL OFFICER HAS MORE INFORMATION ON RIEAP.

THE LAW REQUIRES ALL EMPLOYEES TO ABIDE BY THIS POLICY.

***EMPLOYEE RETAIN THIS COPY***

**ADDENDUM V: DRUG-FREE WORKPLACE POLICY PROVIDER  
CERTIFICATE OF COMPLIANCE**

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

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

**SIGNATURE:**

\_\_\_\_\_

**TITLE:**

\_\_\_\_\_

**DATE:**

\_\_\_\_\_

**ADDENDUM VI: SUBCONTRACTOR COMPLIANCE**

I, (NAME), (TITLE),  
(CONTRACTOR NAME), A PROVIDER DOING BUSINESS WITH  
THE STATE OF RHODE ISLAND, HEREBY CERTIFY THAT ALL APPROVED  
SUBCONTRACTORS PERFORMING SERVICES UNDER THE TERMS OF THIS  
AGREEMENT WILL HAVE EXECUTED WRITTEN CONTRACTS WITH THIS  
(CONTRACTOR NAME), AND ALL CONTRACTS WILL BE MAINTAINED ON FILE AND  
PRODUCED UPON REQUEST. ALL CONTRACTS MUST CONTAIN LANGUAGE  
IDENTICAL TO THE PROVISIONS OF THIS AGREEMENT AS FOLLOWS:

**SECTION 3.05.07            HOLD HARMLESS**

**SECTION 3.06.01    EMPLOYMENT PRACTICES**

**SIGNATURE:**

\_\_\_\_\_

**TITLE:**

\_\_\_\_\_

**DATE:**

\_\_\_\_\_

**ADDENDUM VII: CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE**

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

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

**SIGNATURE:**

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**TITLE:**

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**DATE:**

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

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

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

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

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

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

THE PROSPECTIVE PRIMARY PARTICIPANT AGREES BY SUBMITTING THIS CONTRACT THAT, SHOULD THE PROPOSED COVERED TRANSACTION BE ENTERED INTO, IT SHALL NOT KNOWINGLY ENTER INTO ANY LOWER TIER COVERED TRANSACTION WITH A PERSON WHO IS DEBARRED, SUSPENDED,

DECLARED INELIGIBLE, OR VOLUNTARILY EXCLUDED FROM PARTICIPATION IN THIS COVERED TRANSACTION, UNLESS AUTHORIZED BY THE EXECUTIVE OFFICE.

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

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

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

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

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

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

ARE NOT PRESENTLY DEBARRED, SUSPENDED, PROPOSED FOR DEBARMENT, DECLARED INELIGIBLE, OR VOLUNTARILY EXCLUDED FROM COVERED TRANSACTIONS BY ANY FEDERAL DEPARTMENT OR AGENCY;

HAVE NOT WITHIN A THREE (3) YEAR PERIOD PRECEDING THIS CONTRACT BEEN CONVICTED OF OR HAD A CIVIL JUDGMENT RENDERED AGAINST THEM FOR COMMISSION OF FRAUD OR A CRIMINAL OFFENSE IN CONNECTION WITH OBTAINING, ATTEMPTING TO OBTAIN, OR PERFORMING A PUBLIC (FEDERAL, STATE OR LOCAL) TRANSACTION OR CONTRACT UNDER PUBLIC TRANSACTION; VIOLATION OF FEDERAL OR STATE ANTITRUST STATUES OR COMMISSION OF EMBEZZLEMENT, THEFT, FORGERY, BRIBERY, FALSIFICATION OR DESTRUCTION OF RECORDS, MAKING FALSE STATEMENTS, OR RECEIVING STOLEN PROPERTY;

3. ARE NOT PRESENTLY INDICTED OR OTHERWISE CRIMINALLY OR CIVILLY CHARGED BY A GOVERNMENTAL ENTITY (FEDERAL, STATE OR LOCAL) WITH COMMISSION OF ANY OF THE OFFENSES ENUMERATED IN PARAGRAPH (1) AND (2) OF THIS ADDENDUM; AND
4. HAVE NOT WITHIN A THREE-YEAR PERIOD PRECEDING THIS CONTRACT HAD ONE OR MORE PUBLIC TRANSACTIONS (FEDERAL, STATE OR LOCAL) TERMINATED FOR CAUSE OR DEFAULT.

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

**SIGNATURE:**

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**TITLE:**

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**DATE:**

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## **ADDENDUM X: LIQUIDATED DAMAGES**

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

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

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

IN THE EVENT THAT LIQUIDATED DAMAGES HAVE BEEN IMPOSED AND RETAINED

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

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

## **ADDENDUM XI: EQUAL EMPLOYMENT OPPORTUNITY**

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

1. THE CONTRACTOR SHALL NOT DISCRIMINATE AGAINST ANY EMPLOYEE OR APPLICANT FOR EMPLOYMENT RELATING TO THIS AGREEMENT BECAUSE OF RACE, COLOR, RELIGIOUS CREED, SEX, NATIONAL ORIGIN, ANCESTRY, AGE, PHYSICAL OR MENTAL DISABILITY, UNLESS RELATED TO A BONA FIDE OCCUPATIONAL QUALIFICATION. THE CONTRACTOR SHALL TAKE AFFIRMATIVE ACTION TO ENSURE THAT APPLICANTS ARE EMPLOYED AND EMPLOYEES ARE TREATED EQUALLY DURING EMPLOYMENT, WITHOUT REGARD TO THEIR RACE, COLOR, RELIGION, SEX, AGE, NATIONAL ORIGIN, OR PHYSICAL OR MENTAL DISABILITY. SUCH ACTION SHALL INCLUDE BUT NOT BE LIMITED TO THE FOLLOWING: EMPLOYMENT, UPGRADING, DEMOTIONS, OR TRANSFERS; RECRUITMENT OR RECRUITMENT ADVERTISING; LAYOFFS OR TERMINATIONS; RATES OF PAY OR OTHER FORMS OF COMPENSATION; AND SELECTION FOR TRAINING INCLUDING APPRENTICESHIP. THE CONTRACTOR AGREES TO POST IN CONSPICUOUS PLACES AVAILABLE TO EMPLOYEES AND APPLICANTS FOR EMPLOYMENT NOTICES SETTING FORTH THE PROVISIONS OF THIS NONDISCRIMINATION CLAUSE.
2. THE CONTRACTOR SHALL, IN ALL SOLICITATIONS OR ADVERTISING FOR EMPLOYEES PLACED BY OR ON BEHALF OF THE CONTRACTOR RELATING TO THIS AGREEMENT, STATE THAT ALL QUALIFIED APPLICANTS SHALL RECEIVE CONSIDERATION FOR EMPLOYMENT WITHOUT REGARD TO RACE, COLOR, RELIGIOUS CREED, SEX, NATIONAL ORIGIN, ANCESTRY, AGE, PHYSICAL OR MENTAL DISABILITY.
3. THE CONTRACTOR SHALL INFORM THE CONTRACTING EXECUTIVE OFFICE'S EQUAL EMPLOYMENT OPPORTUNITY COORDINATOR OF ANY DISCRIMINATION COMPLAINTS BROUGHT TO AN EXTERNAL REGULATORY BODY (RI ETHICS COMMISSION, RI DEPARTMENT OF ADMINISTRATION, US DHHS OFFICE OF CIVIL RIGHTS) AGAINST THEIR AGENCY BY ANY INDIVIDUAL AS WELL AS ANY LAWSUIT REGARDING ALLEGED DISCRIMINATORY PRACTICE.
4. THE CONTRACTOR SHALL COMPLY WITH ALL ASPECTS OF THE

AMERICANS WITH DISABILITIES ACT (ADA) IN EMPLOYMENT AND IN THE PROVISION OF SERVICE TO INCLUDE ACCESSIBILITY AND REASONABLE ACCOMMODATIONS FOR EMPLOYEES AND CLIENTS.

5. CONTRACTORS AND SUBCONTRACTORS WITH AGREEMENTS IN EXCESS OF \$50,000 SHALL ALSO PURSUE IN GOOD FAITH AFFIRMATIVE ACTION PROGRAMS.
6. THE CONTRACTOR SHALL CAUSE THE FOREGOING PROVISIONS TO BE INSERTED IN ANY SUBCONTRACT FOR ANY WORK COVERED BY THIS AGREEMENT SO THAT SUCH PROVISIONS SHALL BE BINDING UPON EACH SUBCONTRACTOR, PROVIDED THAT THE FOREGOING PROVISIONS SHALL NOT APPLY TO CONTRACTS OR SUBCONTRACTS FOR STANDARD COMMERCIAL SUPPLIES OR RAW MATERIALS.

**ADDENDUM XII: BYRD ANTI-LOBBYING AMENDMENT**

NO FEDERAL OR STATE APPROPRIATED FUNDS SHALL BE EXPENDED BY THE CONTRACTOR FOR INFLUENCING OR ATTEMPTING TO INFLUENCE AN OFFICER OR EMPLOYEE OF ANY AGENCY, A MEMBER OF CONGRESS OR STATE LEGISLATURE, AN OFFICER OR EMPLOYEE OF CONGRESS OR STATE LEGISLATURE, OR AN EMPLOYEE OF A MEMBER OF CONGRESS OR STATE LEGISLATURE IN CONNECTION WITH ANY OF THE FOLLOWING COVERED ACTIONS: THE AWARDING OF ANY AGREEMENT; THE MAKING OF ANY GRANT; THE ENTERING INTO OF ANY COOPERATIVE AGREEMENT; AND THE EXTENSION, CONTINUATION, RENEWAL, AMENDMENT, OR MODIFICATION OF ANY AGREEMENT, GRANT, OR COOPERATIVE AGREEMENT. SIGNING THIS AGREEMENT FULFILLS THE REQUIREMENT THAT CONTRACTORS RECEIVING OVER \$100,000 IN FEDERAL OR STATE FUNDS FILE WITH THE EXECUTIVE OFFICE ON THIS PROVISION.

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

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

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

FINAL RULE REQUIREMENTS CAN BE FOUND AT:

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

[https://www.socialsecurity.gov/OP\\_Home/cfr20/435/435-ap01.htm](https://www.socialsecurity.gov/OP_Home/cfr20/435/435-ap01.htm)

**SIGNATURE:** \_\_\_\_\_

**TITLE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

## **ADDENDUM XIII: BID PROPOSAL**

**Please see attached technical proposal for LOI #                      related to the Medicaid Rite Smiles Program.**

## **ADDENDUM XIV: CORE STAFF POSTIONS**

## ADDENDUM XV: FEDERAL SUBAWARD REPORTING

### Executive Office of Health and Human Services

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

- 
1. Name and address of entity receiving the grant: \_\_\_\_\_  
\_\_\_\_\_
  2. DBA name: \_\_\_\_\_
  3. Does the entity receive equal to or greater than \$25,000 each fiscal year on or after October 1, 2010 (mandatory & discretionary grants) Yes \_\_\_\_\_ No \_\_\_\_\_ (does not include ARRA funds)
  1. Amount of this Award: \_\_\_\_\_
  2. Federal Funding Agency: \_\_\_\_\_
  3. CFDA Number: \_\_\_\_\_
  4. Award title (descriptive of the purpose of the funding action): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  5. Location of the entity (including congressional district): \_\_\_\_\_
  6. Place of performance (including congressional district): \_\_\_\_\_  
\_\_\_\_\_
  7. Unique identifier (DUNS) of the entity and its parent and DUNS +4: \_\_\_\_\_
  8. If the entity received 80 percent of its annual gross revenues in Federal funding awards and \$25 million or more in annual gross revenues from Federal awards in the preceding fiscal year, they must disclose the total compensation and names of top five (5) executives:

Name	Compensation
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

\_\_\_\_\_  
Authorized Agent/Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

## **IMPORTANT ITEMS TO NOTE ABOUT NEW REQUIREMENT**

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

--Includes both mandatory and discretionary grants

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

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

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

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

## **ADDENDUM XVI: BUSINESS ASSOCIATE AGREEMENT**

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

### **1. Definitions:**

#### **A. Generally:**

- (1) Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in 45 C.F.R. §§ 160.103, 164.103, and 164.304, 164.501 and 164.502.
- (2) The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA, the Privacy and Security Rules and the HITECH Act: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

#### **B. Specific:**

- (1) "Addendum" means this Business Associate Agreement Addendum.
- (2) "Agreement" means the contractual Agreement by and between the State

of Rhode Island, EOHHS and Business Associate, awarded pursuant to State of Rhode Island's Purchasing Law (Chapter 37-2 of the Rhode Island General Laws) and Rhode Island Department of Administration, Division of Purchases, Purchasing Rules, Regulations, and General Conditions of Purchasing.

- C. "Business Associate" generally has the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean [Insert Name of Business Associate].
- D. "Client/Patient" means Covered Entity funded person who is a recipient and/or the client or patient of the Business Associate.
- E. "Covered Entity" generally has the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean [Insert Name of Covered Entity].
- F. "Electronic Health Record" means an electronic record of health-related information on an individual that is created, gathered, managed or consulted by authorized health care clinicians and staff.
- G. "Electronic Protected Health Information" or "Electronic PHI" means PHI that is transmitted by or maintained in electronic media as defined in the HIPA Security Regulations.
- H. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.
- I. "HIPAA Privacy Rule" means the regulations promulgated under HIPAA by the United States Department of Health and Human Services to protect the privacy of Protected Health Information including, the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.
- J. "HITECH Act" means the privacy, security and security Breach notification provisions applicable to Business Associate under Subtitle D of the Health Information Technology for Economic and Clinical Health Act, which is Title XII of the American Recovery and Reinvestment Act of 2009, Public Law 111-5, and any regulations promulgated thereunder and as amended from time to time.
- K. "Secured PHI" means PHI that was rendered unusable, unreadable or indecipherable to unauthorized individuals through the use of technologies or methodologies specified under or pursuant to Section 13402 (h)(2) of the HITECH Act under ARRA.
- L. "Security Incident" means any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information.
- M. "Security Rule" means the Standards for the security of Electronic Protected Health Information found at 45 CFR Parts 160 and 162, and Part 164,

Subparts A and C. The application of Security provisions Sections 164.308, 164.310, 164.312, and 164.316 of title 45, Code of Federal Regulations shall apply to Business Associate of Covered Entity in the same manner that such sections apply to the Covered Entity.

- N. "Suspected breach" is a suspected acquisition, access, use or disclosure of protected health information ("PHI") in violation of HIPPA privacy rules, as referenced above, that compromises the security or privacy of PHI.
- O. "Unsecured PHI" means PHI that is not secured, as defined in this section, through the use of a technology or methodology specified by the Secretary of the U.S. Department of Health and Human Services.

2. Obligations and Activities of Business Associate.

- A. Business Associate agrees to not use or further disclose PHI other than as permitted or required by this Agreement or as required by Law, provided such use or disclosure would also be permissible by law by Covered Entity.
- B. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement. Business Associate agrees to implement Administrative Safeguards, Physical Safeguards and Technical Safeguards ("Safeguards") that reasonably and appropriately protect the confidentiality, integrity and availability of PHI as required by the "Security Rule."
- C. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.
- D. Business Associate agrees to report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement, including breaches of unsecured PHI as required by 45 C.F.R. § 164.410, and any Security Incident of which it becomes aware, within five (5) days of the incident.
- E. Business Associate agrees to ensure that any agent, including a subcontractor or vendor, to whom it provides PHI received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information through a contractual arrangement that complies with 45 C.F.R. § 164.314.
- F. Business Associate agrees to provide paper or electronic access, at the request of Covered Entity and in the time and manner designated by Covered Entity, to PHI in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. § 164.524. If the Individual requests an electronic copy of the information, Business Associate must provide Covered Entity with the information requested in the electronic form and format requested by the Individual and/or Covered Entity if it is readily producible in such form and

format; or, if not, in a readable electronic form and format as requested by Covered Entity.

- G. Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 C.F.R. §164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity. If Business Associate receives a request for amendment to PHI directly from an Individual, Business Associate shall notify Covered Entity upon receipt of such request.
- H. Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from, created or received by Business Associate on behalf of Covered Entity available to Covered Entity, or at the request of Covered Entity to the Secretary, in a time and manner designated by Covered Entity or the Secretary, for the purposes of the Secretary determining compliance with the Privacy Rule and Security Rule.
- I. Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. §164.528.
- J. Business Associate agrees to provide to Covered Entity or an Individual, in a time and manner designated by Covered Entity, information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an individual for an accounting of disclosures for PHI in accordance with 45 §C.F.R. 164.528.
- K. If Business Associate accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses Unsecured Protected Health Information (as defined in 45 C.F.R. § 164.402) for Covered Entity, it shall, following the discovery of a breach of such information, notify Covered Entity of such breach within a period of five (5) days after discovery of the breach. Such notice shall include: a) the identification of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by Business Associate to have been accessed, acquired or disclosed during such breach; b) a brief description of what happened, including the date of the breach and discovery of the breach; c) a description of the type of Unsecured PHI that was involved in the breach; d) a description of the investigation into the breach, mitigation of harm to the individuals and protection against further breaches; e) the results of any and all investigation performed by Business Associate related to the breach; and f) contact information of the most knowledgeable individual for Covered Entity to contact relating to the breach and its investigation into the breach.
- L. To the extent the Business Associate is carrying out an obligation of the Covered Entity's under the Privacy Rule, the Business Associate must comply with the requirements of the Privacy Rule that apply to the Covered Entity in the performance of such obligation.

- M. Business Associate agrees that it will not receive remuneration directly or indirectly in exchange for PHI without authorization unless an exception under 45 C.F.R. § 164.502(a)(5)(ii)(B)(2) applies.
- N. Business Associate agrees that it will not receive remuneration for certain communications that fall within the exceptions to the definition of Marketing under 45 C.F.R. § 164.501, unless permitted by 45 C.F.R. § 164.508(a)(3)(A)-(B).
- O. If applicable, Business Associate agrees that it will not use or disclose genetic information for underwriting purposes, as that term is defined in 45 C.F.R. § 164.502.
- P. Business Associate hereby agrees to comply with state laws and rules and regulations applicable to PHI and personal information of individuals' information it receives from Covered Entity during the term of the Agreement.
  - i. Business Associate agrees to: (a) implement and maintain appropriate physical, technical and administrative security measures for the protection of personal information as required by any state law and rules and regulations; including, but not limited to: (i) encrypting all transmitted records and files containing personal information that will travel across public networks, and encryption of all data containing personal information to be transmitted wirelessly; (ii) prohibiting the transfer of personal information to any portable device unless such transfer has been approved in advance; and (iii) encrypting any personal information to be transferred to a portable device; and (b) implement and maintain a Written Information Security Program as required by any state law as applicable.
  - ii. The safeguards set forth in this Agreement shall apply equally to PHI, confidential and "personal information." Personal information means an individual's first name and last name or first initial and last name in combination with any one or more of the following data elements that relate to such resident: (a) Social Security number; (b) driver's license number or state-issued identification card number; or (c) financial account number, or credit or debit card number, with or without any required security code, access code, personal identification number or password, that would permit access to a resident's financial account; provided, however, that "personal information" shall not include information that is lawfully obtained from publicly available information, or from federal, state or local government records lawfully made available to the general public.

3. Permitted Uses and Disclosures by Business Associate.

- a. Except as otherwise limited to this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services

for, or on behalf of, Covered Entity as specified in the Service Arrangement, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of Covered Entity required by 45 C.F.R. §164.514(d).

- b. Except as otherwise limited in this Agreement, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
- c. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
- d. Except as otherwise limited in this Agreement, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. §164.504 (e)(2)(i)(B).
- e. Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. §164.502(j)(1).

#### 4. Obligations of Covered Entity

- a. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 C.F.R. § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.
- b. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI to the extent that such changes may affect Business Associate's use or disclosure of PHI.
- c. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. §164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

#### 5. Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose PHI in

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

6. Term and Termination.

- a. The term of this Agreement shall begin as of the effective date of the Service Arrangement and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions of this Section.
- b. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:
  - i. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement and the Service Arrangement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity.
  - ii. Immediately terminate this Agreement and the Service arrangement if Business Associate has breached a material term of this Agreement and cure is not possible.
- c. Except as provided in paragraph (d) of this Section, upon any termination or expiration of this Agreement, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI. Business Associate shall ensure that its subcontractors or vendors return or destroy any of Covered Entity's PHI received from Business Associate.
- d. In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon Covered Entity's written agreement that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

7. Miscellaneous.

- a. A reference in this Agreement to a section in the Privacy Rule or Security Rule means the section as in effect or as amended.
- b. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of HIPAA, the Privacy and Security Rules and HITECH.
- c. The respective rights and obligations of Business Associate under Section 6 (c) and (d) of this Agreement shall survive the termination of this Agreement.
- d. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with HIPAA and HITECH.
- e. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.
- f. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer upon any person other than Covered Entity, Business Associate and their respective successors and assigns, any rights, remedies, obligations or liabilities whatsoever.
- g. Modification of the terms of this Agreement shall not be effective or binding upon the parties unless and until such modification is committed to writing and executed by the parties hereto.
- h. This Agreement shall be binding upon the parties hereto, and their respective legal representatives, trustees, receivers, successors and permitted assigns.
- i. Should any provision of this Agreement be found unenforceable, it shall be deemed severable and the balance of the Agreement shall continue in full force and effect as if the unenforceable provision had never been made a part hereof.
- j. This Agreement and the rights and obligations of the parties hereunder shall in all respects be governed by, and construed in accordance with, the laws of the State of Rhode Island, including all matters of construction, validity and performance.
- k. All notices and communications required or permitted to be given hereunder shall be sent by certified or regular mail, addressed to the other party as its respective address as shown on the signature page, or at such other address as such party shall from time to time designate in writing to the other party, and shall be effective from the date of mailing.
- l. This Agreement, including such portions as are incorporated by reference herein, constitutes the entire agreement by, between and among the parties, and such parties acknowledge by their signature

hereto that they do not rely upon any representations or undertakings by any person or party, past or future, not expressly set forth in writing herein.

- m. Business Associate shall maintain or cause to be maintained sufficient insurance coverage as shall be necessary to insure Business Associate and its employees, agents, representatives or subcontractors against any and all claims or claims for damages arising under this Business Associate Agreement and such insurance coverage shall apply to all services provided by Business Associate or its agents or subcontractors pursuant to this Business Associate Agreement. Business Associate shall indemnify, hold harmless and defend Covered Entity from and against any and all claims, losses, liabilities, costs and other expenses (including but not limited to, reasonable attorneys' fees and costs, administrative penalties and fines, costs expended to notify individuals and/or to prevent or remedy possible identity theft, financial harm, reputational harm, or any other claims of harm related to a breach) incurred as a result of, or arising directly or indirectly out of or in connection with any acts or omissions of Business Associate, its employees, agents, representatives or subcontractors, under this Business Associate Agreement, including, but not limited to, negligent or intentional acts or omissions. This provision shall survive termination of this Agreement.

8. Acknowledgment.

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

Acknowledged and agreed to by:

**STATE OF RHODE ISLAND:**

**DENTAL PLAN:**

\_\_\_\_\_  
 ALDA REGO  
 CHIEF FINANCIAL OFFICER  
 EXECUTIVE OFFICE OF HEALTH  
 AND HUMAN SERVICES

\_\_\_\_\_  
 AUTHORIZED AGENT  
 TITLE: \_\_\_\_\_

PRINT NAME

PRINT NAME

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DATE

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DATE

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**ATTACHMENT A**

**SCHEDULE OF IN-PLAN BENEFITS**

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## ATTACHMENT A: SCHEDULE OF IN-PLAN BENEFITS

The covered dental benefit package for which the Contractor will be responsible is shown below.

DENTAL BENEFITS/RITE SMILES	
Dental Service	Benefit Package Provided When Medically Necessary
Preventive Services	Periodic screening examination, prophylaxis, sealants, topical fluoride, space maintainers
Diagnostic and Radiology Services	Oral exam, Bitewing X-rays, Full Series X-rays, biopsies of oral tissue, all medically necessary diagnostic evaluation and radiographs/diagnostic images
Endodontic Services	Complete root canal therapy, including pulpectomy, intra-operative radiographs, apexification/recalcification procedures, other reinforcements, crowns, other medically necessary endodontic services
Restorative Services	All restorative services, including amalgams, resins, cast cores, stainless steel crowns, pin and/or post reinforcements, temporary and permanent, crowns, and other medically necessary restorative services
Periodontic Services	Scaling, root planning, gingival curettage, gingivectomy, other medically necessary periodontal procedures
Orthodontic Services	Covered when medically necessary subject to prior approval
Prosthodontic Services	Relines and adjustments, acrylic crowns, stainless steel crowns, partial or full dentures, other medically necessary prosthodontic procedures
Emergency and Palliative Services	Medically necessary emergency dental services all palliative services, including routine and surgical extractions, incisions and drainage of abscesses not provided in an inpatient hospital or hospital emergency department setting
Oral Surgery	Covered when medically necessary
General Anesthesia Services	Covered when medically necessary
Behavior Management	Covered for patients whose medical status and/or behavior requires special management

Specific dental services and procedures covered and any prior authorization requirements must be in conformance with Rhode Island Medical Assistance

Program policy (i.e., *Dental Services Coverage Policy, 300-45*)

(<http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/dental.pdf>).

Contractor may not require prior authorization of or apply any other limitations on any pediatric dental service not provided for in Rhode Island Medical Assistance Program policy.

Contractor may not pay for cancelled or missed office visits.

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**ATTACHMENT B**

**SCHEDULE OF OUT-OF-PLAN BENEFITS**

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## **ATTACHMENT B: SCHEDULE OF OUT-OF-PLAN BENEFITS**

These benefits are not included in the capitated benefits and are not the responsibility of the Contractor to provide or arrange. The Contractor is expected to refer to and coordinate with these services as appropriate. The following services will be paid for by existing Medicaid fee-for-service system, or on a contractual basis by the Department: (1) Services to diagnose and treat an Emergency Dental Condition in an inpatient hospital setting, or (2) Services to diagnose and treat an Emergency Dental Condition in a hospital emergency department.

In addition, the following oral surgery services are considered "medical" and will be paid for under the existing Medicaid fee-for-service system or on a contractual basis by the Department:

### **OTHER SURGICAL PROCEDURES**

- D7260**            **Oroantral fistula closure**  
**Excision of fistulous tract between maxillary sinus and oral cavity and closure by advancement flap.**
- D7270**            **Tooth reimplantation and/or stabilization of accidentally or evulsed displaced tooth and/or alveolus Includes splinting and/or stabilization.**
- D7285**            **Biopsy of oral tissue — hard (bone, tooth)**  
**For surgical removal of specimen only. This code involves biopsy of osseous lesions and is not used for apicoectomy/periradicular curettage.**
- D7286**            **Biopsy of oral tissue - soft (all others)**  
**For surgical removal of specimen only. This code is not used at the same time as codes for apicoectomy/periradicular curettage. For surgical oral pathology procedures, See D0502.**
- D7260**            **Oroantral fistula closure**  
**Excision of fistulous tract between maxillary sinus and oral cavity and closure by advancement flap.**
- D7270**            **Tooth reimplantation and/or stabilization of accidentally or evulsed displaced tooth and/or alveolus Includes splinting and/or stabilization.**
- D7285**            **Biopsy of oral tissue — hard (bone, tooth)**  
**For surgical removal of specimen only. This code involves biopsy of osseous lesions and is not used for apicoectomy/periradicular curettage.**
- D7286**            **Biopsy of oral tissue - soft (all others)**  
**For surgical removal of specimen only. This code is not used at the same time as codes for apicoectomy/periradicular curettage. For surgical oral**

pathology procedures, See D0502.

#### **SURGICAL EXCISION OF SOFT TISSUE LESIONS**

- D7410**            **Excision of benign lesion diameter up to 1.25 cm**
- D7411**            **Excision of benign lesion diameter greater than 1,25 cm**

#### **SURGICAL EXCISION OF INTRA-OSSEOUS LESION**

- D7440**            **Excision of malignant tumor - lesion diameter up to 1.25 cm**
- D7441**            **Excision of malignant tumor - lesion diameter greater than 1.25 cm**
- D7450**            **Removal of benign odontogenic cyst or tumor-lesion diameter up to 1.25 cm**
- D7451**            **Removal of benign odontogenic cyst or tumor-lesion diameter greater than 1.25 cm**
- D7460**            **Removal of nonodontogenic cyst or tumor-lesion diameter up to 1.25 cm**
- D7461**            **Removal of nonodontogenic cyst or tumor-lesion diameter greater than 1.25 cm**

#### **EXCISION OF BONE TISSUE**

- D7471**            **Removal of lateral exostosis —(maxilla or mandible)**
- D7490**            **Radical resection of mandible with bone graft**  
**Partial resection of mandible; removal of lesion and defect with**  
**margin of normal appearing bone. Reconstruction and bone**  
**grafts should be reported separately.**

#### **SURGICAL INCISION**

- D7510**            **Incision and drainage of abscess - intraoral soft tissue**  
**Involves incision through mucosa, including periodontal origins.**
- D7520**            **Incision and drainage of abscess - extraoral soft tissue**  
**Involves incision through skin.**
- D7530**            **Removal of foreign body from mucosa , skin, or**  
**subcutaneous alveolar tissue**
- D7540**            **Removal of reaction-producing foreign bodies-musculoskeletal system**  
**May include, but is not limited to, removal of splinters, pieces of**  
**wire, etc., from muscle and/or bone.**
- D7550**            **Partial ostectomy/sequestrectomy for removal of non-vital bone**  
**Removal of loose or sloughed-off dead bone caused by infection**  
**or reduced blood supply.**
- D7560**            **Maxillary sinusotomy for removal of tooth fragment or foreign body**

**TREATMENT OF FRACTURES — SIMPLE**

**D7610**            **Maxilla - open reduction (teeth immobilized, if present)**

Teeth may be wired, banded or splinted together to prevent movement. Surgical incision required for interosseous fixation.

- D7620** Maxilla - closed reduction (teeth immobilized, if present)  
No incision required to reduce fracture. See D7610 if interosseous fixation is applied.
- D7630** Mandible - open reduction (teeth immobilized, if present)  
Teeth may be wired, banded or splinted together to prevent movement. Surgical incision required to reduce fracture.
- D7640** Mandible - closed reduction (teeth immobilized, if present)  
No incision required to reduce fracture. See D7630 if interosseous fixation is applied.
- D7650** Malar and/or zygomatic arch - open reduction
- D7660** Malar and/or zygomatic arch - closed reduction
- D7670** Alveolus —closed reduction, may include stabilization of teeth  
Teeth may be wired, banded or splinted together to prevent movement.
- D7680** Facial bones - complicated reduction with fixation and multiple surgical approaches  
Facial bones include upper and lower jaw, cheek, and bones around eyes, nose and ears.

#### **TREATMENT OF FRACTURES - COMPOUND**

- D7710** Maxilla - open reduction  
Surgical incision required to reduce fracture
- D7720** Maxilla - closed
- D7730** Mandible - open reduction  
Surgical incision required to reduce fracture
- D7740** Mandible - closed reduction
- D7750** Malar and/or zygomatic arch - open reduction  
Surgical incision required to reduce fracture
- D7760** Malar and/or zygomatic arch - closed reduction
- D7770** Alveolus - open reduction stabilization of teeth  
Fractured bone(s) are exposed to mouth or outside the face; see D7670. Surgical incision required to reduce fracture
- D7780** Facial bones - complicated reduction with fixation and multiple surgical approaches  
Surgical incision required to reduce fracture. Facial bones include upper and lower jaw, cheek, and bones around eyes, nose, and ears.

#### **REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS**

Procedures which are an integral part of a primary procedure should not be reported separately.

- D7810** Open reduction of dislocation

- Access to TMJ via surgical opening.
- D7820**      **Closed reduction of dislocation**  
**Joint manipulated into place; no surgical exposure**
- D7830**      **Manipulation under anesthesia**  
**Usually done via general anesthesia or intravenous sedation.**
- D7840**      **Condylectomy**  
**Surgical removal of all or portion of the mandibular condyle (separate procedure).**
- D7850**      **Surgical discectomy, with/without implant**  
**Excision of the intra-articular disc of a joint**
- D7852**      **Disc repair**  
**Repositioning and/or sculpting of disc; repair of perforated posterior attachment**
- D7854**      **Synovectomy**  
**Excision of a portion or all of the synovial membrane of a joint**
- D7856**      **Myotomy**  
**Cutting of muscle for therapeutic purposes (separate procedure).**
- D7858**      **Joint reconstruction**  
**Reconstruction of osseous components including or excluding soft tissues of the joint with autogenous, homologous, or alloplastic materials.**
- D7860**      **Arthrotomy**  
**Cutting into joint (separate procedure).**
- D7865**      **Arthroplasty**  
**Reduction of osseous components of the joint to create a pseudoarthrosis or eliminate an irregular remodeling pattern (osteophytes).**
- D7870**      **Arthrocentesis**  
**Withdrawal of fluid from a joint space by aspiration.**
- D7872**      **Arthroscopy - diagnosis, with or without biopsy**
- D7873**      **Arthroscopy — surgical: lavage and lysis of adhesions**  
**Removal of adhesions using the arthroscope and lavage of the joint cavities.**
- D7874**      **Arthroscopy — surgical: disc repositioning and stabilization**  
**Repositioning and stabilization of disc using arthroscopic techniques.**
- D7875**      **Arthroscopy — surgical: synovectomy**  
**Removal of inflamed and hyperplastic synovium (partial/complete) via an arthroscopic technique.**
- D7876**      **Arthroscopy — surgical: discectomy**  
**Removal of disc and remodeled posterior attachment via the arthroscope.**
- D7877**      **Arthroscopy — surgical: debridement**  
**Removal of pathologic hard and/or soft tissue using the arthroscope.**
- D7880**      **Occlusal orthotic device, by report**

Presently includes splints provided for treatment of temporomandibular joint dysfunction

**D7899** Unspecified TMD therapy, by report  
Used for procedure which is not adequately described by a code. Describe procedure

#### **REPAIR OF TRAUMATIC WOUNDS**

Excludes closure of surgical incisions.

**D7910** Suture of recent small wounds up to 5 cm

#### **COMPLICATED SUTURING (RECONSTRUCTION REQUIRING DELICATE HANDLING OF TISSUES AND WIDE UNDERMINING FOR METICULOUS CLOSURE)**

Excludes closure of surgical incisions.

**D7911** Complicated suture - up to 5 cm

**D7912** Complicated suture - greater than 5 cm

#### **OTHER REPAIR PROCEDURES**

**D7920** Skin graft (identify defect covered, location and type of graft)

**D7940** Osteoplasty - for orthognathic deformities  
Reconstruction of jaws for correction of congenital, developmental or acquired traumatic or surgical deformity.

**D7941** Osteotomy —mandibular rami

**D7943** Osteotomy — mandibular rami with bone graft; includes obtaining the graft

**D7944** Osteotomy - segmented or subapical - per sextant or quadrant

**D7945** Osteotomy - body of mandible  
Surgical section of the lower jaw. This includes the surgical exposure, bone cut, fixation, routine wound closure and normal post-operative follow-up care.

**D7946** LeFort I (maxilla - total)  
Surgical section of the upper jaw. This includes the surgical exposure, bone cuts, downfracture, repositioning, fixation, routine wound closure and normal post-operative follow-up care.

**D7947** LeFort I (maxilla - segmented)  
When reporting a surgically assisted palatal expansion without downfracture, this code would entail a reduced service and should be "by report."

**D7948** LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion)-without bone graft

**Surgical section of upper jaw. This includes the surgical exposure, bone cuts, downfracture, segmentation of maxilla, repositioning, fixation, routine wound closure and normal post-operative follow-up care,**

- D7949**      **LeFort II or LeFort III - with bone graft**  
**Includes obtaining autografts.**
- D7950**      **Osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones - autogenous or nonautogenous, by report**
- D7953**      **Bone replacement graft for ridge preservation – per site**
- D7955**      **Repair of maxillofacial soft and hard tissue defect**
- D7960**      **Frenulectomy (frenectomy or frenotomy) - separate procedure**  
**The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.**
- D7970**      **Excision of hyperplastic tissue - per arch**
- D7980**      **Sialolithotomy**  
**Surgical procedure by which a stone within a salivary gland or its duct is removed, either intraorally or extraorally.**
- D7981**      **Excision of salivary gland, by report**
- D7982**      **Sialodochoplasty**  
**Surgical procedure for the repair of a defect and/or restoration of a portion of a salivary gland duct.**
- D7983**      **Closure of salivary fistula**  
**Surgical closure of an opening between a salivary duct and/or gland and the cutaneous surface, or an opening into the oral cavity through other than the normal anatomic pathway.**
- D7990**      **Emergency tracheotomy**  
**Surgical formation of a tracheal opening usually below the cricoid cartilage to allow for respiratory exchange.**

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**ATTACHMENT C**

**SCHEDULE OF NON-COVERED BENEFITS**

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## **ATTACHMENT C: SCHEDULE OF NON-COVERED BENEFITS**

- **Cosmetic Procedures (e.g., Tooth Whitening)**
- **Dental Implants**
- **Procedures considered Experimental or Investigational**

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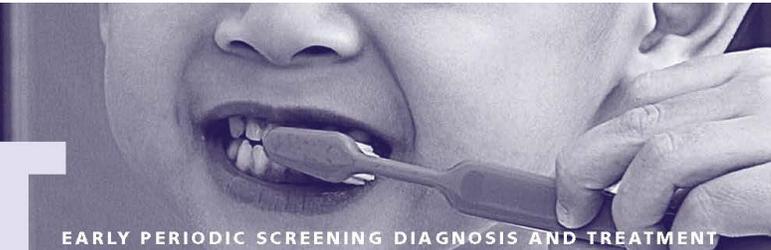
**Note- This is a list of some common non-covered dental services. As a general rule, the dental service is not covered if the CDT Code is not among those in the RI Medical Assistance Provider Manual ([link](#)).**

**ATTACHMENT D**

**EPSDT PERIODICITY SCHEDULE**

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# ATTACHMENT D: EPSDT PERIODICITY SCHEDULE



## EPSDT

EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT  
RHODE ISLAND MEDICAID PEDIATRIC ORAL HEALTH SCHEDULE

◆ TO BE PERFORMED

■ PERFORM WHEN CLINICALLY NECESSARY

←→ PERFORM WITHIN INDICATED TIME FRAME

	INFANCY						EARLY CHILDHOOD						MIDDLE CHILDHOOD						ADOLESCENCE										
	NEWBORN	3-5 DAYS	BY 1 MO	2 MO	4 MO	6 MO	9 MO	12 MO	18 MO	24 MO	30 MO	3 YRS	4 YRS	5 YRS	6 YRS	7 YRS	8 YRS	9 YRS	10 YRS	11 YRS	12 YRS	13 YRS	14 YRS	15 YRS	16 YRS	17 YRS	18 YRS	19 YRS	20 YRS
Clinical oral examination <sup>1,2</sup>							←→	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Assess oral growth and development <sup>3</sup>							←→	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Caries-risk assessment <sup>4</sup>							←→	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Radiographic assessment <sup>5</sup>							←→	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Prophylaxis and topical fluoride treatment <sup>4,5</sup>							←→	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Fluoride supplementation <sup>6,7</sup>							←→	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Anticipatory guidance/counseling <sup>8</sup>							←→	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Oral hygiene counseling <sup>9</sup>							←→	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Dietary counseling <sup>10</sup>							←→	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Injury prevention counseling <sup>11</sup>							←→	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Counseling for nonnutritive habits <sup>12</sup>							←→	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Counseling for speech/language development <sup>13</sup>							←→	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Alcohol and drug use assessment <sup>13</sup>															◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Counseling for intraoral/perioral piercing															◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Assessment and treatment of developing malocclusion							←→	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Assessment for pit and fissure sealants <sup>14</sup>								◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Assessment and /or removal of third molars																													
Transition to adult dental care																													

NOTE: Rite Smiles is a Rhode Island Medicaid dental program for children that's designed to improve access to dental care. Children who have Medicaid coverage who were born on or after May 1, 2000 are eligible. For more information on Rite Smiles, go to [www.dhs.ri.gov](http://www.dhs.ri.gov).

Rhode Island Department of Human Services, [www.dhs.ri.gov](http://www.dhs.ri.gov) • Rhode Island Department of Health, [www.health.ri.gov](http://www.health.ri.gov)




2008

## FOOTNOTES

1. First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease.
2. Includes assessment of pathology and injuries.
3. By clinical examination.
4. Must be repeated regularly and frequently to maximize effectiveness.
5. Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.
6. Consider when systemic fluoride exposure is suboptimal.
7. Up to at least 16 years of age.
8. Appropriate discussion and counseling should be an integral part of each visit.
9. Initially, responsibility of parent; as child develops, jointly with parent; then, when indicated, only child.
10. At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
11. Initially play objects, pacifiers, car seats; then learning to walk, sports, and routine playing.
12. At first discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
13. Referral to a Pediatrician, if necessary.
14. For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

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**ATTACHMENT E**

**CONTRACTOR'S CAPITATION RATES**

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## ATTACHMENT E: CONTRACTOR'S CAPITATION RATES

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### MONTHLY CAPITATION RATES

<b>Premium Rate Group</b>	<b>Dental Portion of Capitation Rate</b>	<b>Administrative Portion of Capitation Rate</b>	<b>Federal Issuer Tax If Applicable</b>	<b>Total Capitation Rate</b>
Children born on or after May 1, 2000	<b>\$16.35</b>	<b>\$1.82</b>	<b>\$0.37</b>	<b>\$18.54</b>

7/1/2014 – 6/30/2015

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**ATTACHMENT F**

**ACTUARIAL BASIS FOR CAPITATION RATES**

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**ATTACHMENT F: ACTUARIAL BASIS FOR CAPITATION RATES**

**INSERT NEW VERSION HERE**

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**ATTACHMENT G**

**SPECIAL TERMS AND CONDITIONS**

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## ATTACHMENT G: SPECIAL TERMS AND CONDITIONS

### I. Risk-Sharing 1.

#### Definitions

- (A) **Baseline:** For the first Contract Period, Baseline means the dental portion of the capitation rate as shown in Attachment I.
- (B) **Contract Period:** Contract Period means the applicable period for risk-sharing calculations and related provisions. The first Contract Period is the 12-month period beginning July 1, 2014 and ending June 30, 2015 during the term of this Agreement..
- (C) **Dental Expenses:** Dental Expenses means those benefits and services that Contractor is obligated to provide or pay for pursuant to Section 2.06 and Attachment A to the Agreement, including but not limited to preventive services, diagnostic and radiology services, endodontic services, restorative services, periodontal services, orthodontic services, prosthodontic services, emergency and palliative services, oral surgery, general anesthesia, and behavior management. Dental Expenses must be reduced by any payment from the State of Rhode Island for any recoveries from other payers pursuant to coordination of benefits, third-party liability (TPL), reinsurance, or adjustments in claims paid.
- (D) **Dental Expense Threshold:** For the purposes of Risk Share, Dental Expense Threshold means Baseline plus one percent (1%) of Baseline (or 101% of Baseline). For purposes of Gain Share, Dental Expense Threshold means Baseline minus one percent (1%) of Baseline (or 99% of Baseline)
- (E) **Dental Loss Ratio:** Means Dental Expenses divided by Premium.
- (F) **Dental Portion of the Rate:** The Dental Portion of the Rate is as shown in Attachment I.
- (G) **Gain Share:** Gain Share means the terms by which DHS and the Plan share in the gain realized from participating in the program for a Contract Period
- (H) **PMPM:** Means per member per month

- (I) **Premium:** For any given period, Premium means the capitation payments made PMPM by the State to Contractor for Medicaid members enrolled during that period. Premium includes a dental and administrative portion.
- (J) **Quarter:** Quarter means a calendar quarter (i.e., January 1 through March 31, April 1 through June 30, July 1 through September 30, and October 1 through December 31).
- (K) **Reinsurance:** Contractor will reinsure Dental Expenses for Medicaid enrollees. Such costs will be a component of Dental Expense that will be reduced by any claims against Reinsurance.
- (L) **Risk Share:** Risk Share means the terms by which DHS and the Plans share in the loss realized from participating in the program for the duration of a Contract Period.

## 2. Risk-Sharing/Gain Share Methodology

The terms of the risk/gain sharing agreement exclude certain expenses when the State directly reimburses dental providers for those services. Risk/gain-sharing is based on the Contract Period. For risk share, Contractor must agree to retain forty percent (40%) of the risk for Dental Expenses for the first three (3) percentage points in excess of the Dental Expenses Threshold. The Dental Expenses Threshold is the Baseline plus one percent (1%). Contractor will retain ten percent (10%) of the risk for dental expenses greater than three percent (3%) above the Dental Expenses Threshold. Contractor agrees to similarly share gains with the Department as outlined below.

All contracts for dental services and the terms of those contracts, including payment arrangements with all dental providers that serve Medicaid enrollees must be available for review by the State or its agents. Contracts with dental providers that are not made available will be subject to exclusion from the risk-share/gain-share arrangement.

### Risk-Share/Gain Share Method

(A) Exclusions for purposes of the risk/gain-share calculations include:

- The Dental Expenses incurred for any dental providers for whom their contracts are not made available for review by the State or its agents.

(B) Offsets for the purposes of the risk/gain-share calculations include:

- Coordination of Benefits with other payers
- All TPL collections by Contractor
- Reinsurance
- Adjustments in claims paid

(C) The actual cumulative Dental Expenses for the Contract Period will be reported to the Department each month based on Dental Expenses for claims paid for services provided on dates of service during the Contract Period.

(D)For the first Contract Period, Dental Expense Threshold is set at the Baseline plus one percent (1%) of the Baseline or 101% of the dental portion of the capitation rate.

When actual Dental Expenses exceed the Dental Expense Threshold, the excess of the aggregate Dental Expenses over the Dental Expense Threshold will be shared by the Contractor and the Department as follows:

- When the Dental Expense is between one hundred one percent (101%) and one hundred four percent (104%) of the Baseline, the Department will assume the risk of sixty percent (60%) of the excess and the Contractor will assume the risk of forty percent (40%) of the excess for that portion.
- When the Dental Expense exceeds 104% of the Baseline, the Department will assume the risk of ninety percent (90%) of the excess and the Contractor will assume the risk of ten percent (10%) of the excess for that portion.

When actual Dental Expenses are less than the Dental Expense Threshold, the gains resulting from the aggregate Dental Expenses being lower than the Dental Expense Threshold will be shared by the Contractor and the Department as follows:

- When the Dental Expense is between ninety-six percent (96%) and ninety-nine percent (99%) of the Baseline, the gains will be shared sixty percent (60%) to the Department and forty percent (40%) to the Contractor for that portion.
- When the Dental Expense is less than ninety-six percent (96%) of the Baseline, the gains will be shared ninety percent (90%) to the Department and ten percent (10%) to the Contractor for that portion.

### **3. Reconciliation and Payment**

The cumulative Dental Expense Report for the Contract Period shall be submitted each month on a form set forth by EOHHS, including attestation as to the accuracy and completeness of the report. In the event that reported Dental expenses exceed the Dental Expenses Threshold, the signed Dental Expenses Report shall serve as the risk-sharing request for payment to the Plan.

Final settlement is based on review of the complete experience for the contract period following the full twelve-month run out as set forth below. When DHS requests Contractor to perform a reconciliation of encounter data, Contractor agrees to submit the reconciliation to DHS within fifteen (15) business days. In the event Contractor’s response takes longer to be submitted, DHS may at its discretion move forward to final settlement without regard to any additional dental expenses that might have been identified.

- The cumulative Dental Expense Report will include no allowance for incurred but not reported (IBNR) claims. Risk-sharing will be paid only on claims paid experience. To assure fairness in resolving outstanding claims, the Department will allow inclusion of claims for services provided to eligible and enrolled Members for a period not to exceed three hundred sixty-five (365) days from the date of a Covered Service. In its request for payment to the Department, Contractor will separately identify claims from prior periods to assure accurate calculation of the risk-share payment. This procedure will assure that no risk/gain-share period goes back to a date earlier than three hundred sixty-five (365) days from the date of request for payment of service.
- This Agreement provides risk/gain-share for claims paid for Covered Services for eligible and enrolled members with dates of service during each Contract Period.

Total Dental Expenses reported in the Dental Expense Report will be evaluated in relation to the total Dental Expenses reported through encounter data submissions.

**II. SPECIAL TERMS AND CONDITIONS**

1. Contractor agrees that at a minimum, fees paid to dentists for the codes identified below will be set at ninety percent (90%) of prevailing commercial rates in Rhode Island:

- HCPCS**
- D1120
- D0120
  
- D1206
  
- D1208

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**ATTACHMENT H**

**CONTRACTOR'S INSURANCE CERTIFICATION**

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## **ATTACHMENT H: CONTRACTOR'S INSURANCE CERTIFICATION**

Note: Documents to be submitted to the Department of Administration, Division of Purchasing, as indicated in tentative award letter

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**ATTACHMENT I**

**CONTRACTOR'S LOCATIONS**

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**ATTACHMENT I: CONTRACTOR'S LOCATIONS**

**Insert Locations Here**