State of Rhode Island
Department of Administration / Division of Purchases
One Capitol Hill, Providence, Rhode Island 02908-5855
Tel: (401) 574-8100 Fax: (401) 574-8387

Solicitation Information
1/6/2020

ADDENDUM# 1

RFP #7599917

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

Bid Closing Date & Time: February 2, 2020 @ 10:00 AM Eastern Time (ET)

Notice to Vendors

Original version did not include the Model Contract sample.

Dawn Vittorioso
Buyer II

Interested parties should monitor this website, on a regular basis, for any additional information that may be posted.

Solicitation Information
January 6, 2020

LOI #7599917

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

Submission Deadline: Monday, February 3, 2020 @ 10:00 AM Eastern Standard Time (EST)

Questions concerning this solicitation must be received by the Division of Purchases at DOA.PurQuestions10@purchasing.ri.gov no later than January 15, 2020 @ 10:00 AM (EST). Questions should be submitted in a *Microsoft Word attachment*. Please reference the LOI #7599917 on all correspondence. Questions received, if any, will be posted on the Division of Purchases' website as an addendum to this solicitation. It is the responsibility of all interested parties to download this information.

Dawn Vittorioso, Buyer II

Note to Applicants:

(1) Applicants must register on-line at the State Purchasing Website at www.ridop.ri.gov
(2) Proposals received without a completed RIVIP Bidder Certification Cover Form attached may result in disqualification.

THIS PAGE IS NOT A BIDDER CERTIFICATION COVER FORM

Table of Contents

SECTION 1: INTRODUCTION 3

Instructions and Notifications to Offerors 3

SECTION 2: BACKGROUND 6

2.1 Overview of Rhode Island Executive Office of Health and Human Services 6

2.2 Overview of the Rhode Island Medicaid Managed Care Program 6

2.3 Evolution of Managed Care in Rhode Island 7

2.4 Rhode Island Managed Care in 2019 9

2.5 Overview of the RIte Smiles Program 9

SECTION 3: SCOPE OF WORK AND REQUIREMENTS 11

General Scope of Work 11

3.1 Core Requirements 12

3.1.1 Dental Plan(s) Licensure and Organizational Requirements 12

3.1.2 Dental Plan(s) Administration 12

3.1.3 Eligibility and Program Enrollment 13

3.1.4 Member Enrollment and Disenrollment 14

3.1.5 In-Plan Services/Benefits 17

3.1.6 Care Coordination 18

3.1.7 Provider Networks 18

3.1.8 Service Accessibility Standard 21

3.1.9 Member Services 21

3.1.10 Provider Services 22

3.1.11 Dental Management and Quality Assurance 22

3.1.12 Operational Data Reporting 24

3.1.13 Grievance and Appeals 25

3.1.14 Payments to and from Plans 26

3.1.15 Financial Standards 27

3.1.16 Record Retention 27

3.1.17 Compliance 27

3.2 Model Contract Terms and Conditions 28

3.3 Model Contract Addendums 29

3.4 Model Contract Attachments 30

SECTION 4: PROPOSAL 30

A. Technical Proposal 30

SECTION 5: EVALUATION AND SELECTION 42

SECTION 6: QUESTIONS 43

SECTION 7: PROPOSAL CONTENTS 43

SECTION 8: PROPOSAL SUBMISSION 44

SECTION 9: CONCLUDING STATEMENTS 45

APPENDIX A: SAMPLE MODEL CONTRACT……..46

SECTION 1: INTRODUCTION

The Rhode Island Department of Administration/Division of Purchases, on behalf of the Rhode Island Executive Office of Health & Human Services (EOHHS) is soliciting proposals from qualified firms to provide Dental Plan(s) (DP) services under a managed care capitated contract that will serve the RIte Smiles-eligible population. RIte Smiles beneficiaries are the Rhode Island Medicaid population born on or after May 1, 2000 and who are living in households with income less than 250 percent of the Federal Poverty Level (FPL) until their twenty-first (21st) birthday in accordance with the terms of this Letter of Interest ("LOI") and the State's General Conditions of Purchase, which may be obtained at the Division of Purchases' website at www.ridop.ri.gov.

The initial contract period will begin July 1, 2020 for three (3) years. Contracts may be renewed for up to three (3) additional twelve (12) month periods based on Bidder performance and the availability of funds.

This is a Letter of Interest (LOI), not a Request for Proposal (RFP) or an Invitation to Bid (ITB). Responses will be evaluated on the basis of the relative merits of the technical proposal; there will be no public opening and reading of responses received by the Division of Purchases pursuant to this solicitation, other than to name those offerors who have submitted proposals.

Instructions and Notifications to Offerors

(1) Potential vendors 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 LOI are solicited. However, proposals which depart from or materially alter the terms, requirements, or scope of work defined by this LOI may be rejected as being non-responsive.

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

(4) Proposals are considered to be irrevocable for a period of not less than 180 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 in the proposal.

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

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

(8) Vendors are advised that all materials submitted to the Division of Purchases for consideration in response to this LOI may be considered to be public records as defined in

R. I. Gen. Laws § 38-2-1, *et seq*. and may be released for inspection upon request once an award has been made.

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

(9) 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.

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

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

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

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

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

b. Vendors further agree, where applicable, to complete the "Contract Compliance Report" (http://odeo.ri.gov/documents/odeo-eeo-contract-compliance-report.pdf), as well as the "Certificate of Compliance**"** (http://odeo.ri.gov/documents/odeo-eeo-certificate-of-compliance.pdf)**,** and submit both documents, along with their Affirmative Action Plan or an Affirmative Action Policy Statement, prior to issuance of a purchase order. For public works projects vendors and all subcontractors must submit a "Monthly Utilization Report" (http://odeo.ri.gov/documents/monthly-employment-utilization-report-form.xlsx) to the ODEO/State Equal Opportunity Office, which identifies the workforce actually utilized on the project.

For further information, contact Vilma Peguero at the Rhode Island Equal Employment Opportunity Office, at 222-3090 or via e-mail at ODEO.EOO@doa.ri.gov .

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

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

For further information, visit the Office of Diversity, Equity & Opportunity's website, at http://odeo.ri.gov/ and *see* R.I. Gen. Laws Ch. 37-14.1, R.I. Gen. Laws Ch. 37-2.2, and 150-RICR-90-10-1. The Office of Diversity, Equity & Opportunity may be contacted at, (401) 574-8670 or via email Dorinda.Keene@doa.ri.gov

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

(14) Eligible Entity - In order to perform the contemplated services related to the Rhode Island Health Benefits Exchange (HealthSource RI), the contractor 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 contractor agrees to indemnify and hold the State of Rhode Island harmless for all expenses that are deemed to be unallowable by the Federal government because it is determined that the vendor is not an "eligible entity," as defined by 45 C.F.R. § 155.110.

SECTION 2: BACKGROUND

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

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

This procurement is to secure the services of qualified Bidders to serve as the Dental Plan(s) ("DP") for the entire Rhode Island Medicaid RIte Smiles program through a managed care capitated contract. This LOI and any subsequent award(s) are governed by the State's General Conditions of Purchase (available via internet at www.ridop.ri.gov). Currently, the RIte Smiles managed care program is served by one (1) contracted managed care organization. RI EOHHS welcomes qualified Bidders with the capacity and capability to provide high-quality and cost-effective services to Medicaid eligible populations. The State reserves the right to contract with one (1) or more DPs at its discretion.

The below Sections provide potential Bidders with background information about the Rhode Island Medicaid program and the reasons for this procurement.

2.2 Overview of the Rhode Island Medicaid Managed Care 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. 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.

Medicaid is a main source of health care coverage and services in Rhode Island, serving approximately one-fourth of the State's population. Medicaid served approximately 316,000 Rhode Islanders in State Fiscal Year (SFY) 2018 at a cost of $2.6 billion dollars which is approximately one-quarter of the State's budget. Between SFY 2015 and 2018, the average total Medicaid medical expenditures based on the date of service has increased annually by 3.3 percent. This overall expenditure increase is associated with a 5.3 percent average annual increase in enrollment during the same time period, combined with a 1.8 percent overall average decrease in per member per month (PMPM) cost. These expenditure trends compare favorably to both national Medicaid expenditures and state commercial PMPM cost trends.

The expenditures for each major population group for SFY 2018 are noted below:

- **Adults with disabilities:** Represents eleven percent (11%) of the Medicaid population (33,177 individuals) and account for the largest share (29%) of Medicaid expenditures ($770 million) at an average PMPM of $1,934. The major source of expenditures for this population is residential and rehabilitation services for persons with intellectual and developmental disabilities and hospital care.

- **Elders:** Represents seven percent (7%) of the Medicaid population (22,235 individuals) and accounts for $609 million or twenty-three percent (23%) of Medicaid expenditures. Compared to all other Medicaid populations, elders have the highest average PMPM cost at $2,284. Nursing facilities account for slightly more than half (53%) of expenditures.
- **Children and Families:** Represents fifty-three percent (53%) of the total Medicaid enrollment (168,489 individuals), including low-income children, parents and pregnant women who meet specific income requirements. This category accounts for twenty-three percent (23%) of the total expenditures ($592 million) and have the lowest PMPM cost of less than $300.
- **Children with Special Health Care Needs (CSHCN):** CSHCN is relatively small population, as it encompasses four percent (4%) of Medicaid recipients and accounts for seven percent (7%) of expenditures ($176 million).
- **Expansion:** Represents twenty-five percent (25%) of the Medicaid population and accounts for eighteen percent (18%) of total expenditures ($473 million). Most of these expenditures are attributed to hospital and professional services.

Hospitals and nursing homes account for 40 percent (40%) of all program expenditures. (Hospitals account for 24 percent (24%) and nursing facilities, including hospice, and nursing facilities account for 16 percent (16%) of expenditures.)

Medicaid expenditures are highly concentrated. The top five percent (5%) of Medicaid users, those with more than $25,000 in annual claims expenditures, account for nearly two thirds (63%) of claims expenditures. High cost users, defined as recipients that incur more than $15,000 annually, account for seventy-one percent (71%) of Medicaid claims expenditures. These users include those residing in institutions or residential facilities, those receiving maternity/delivery services, and others residing in the community, more than half (60%) of which represented by adults with disabilities and the Medicaid Expansion population.

RIte Smiles beneficiaries are the Rhode Island Medicaid population born on or after May 1, 2000, who reside in households with income less than 250 percent of the Federal Poverty Level ("FPL"), until their twenty-first ("21st") birthday. The RIte Smiles program consists mainly of the children and families, CHSCN and Medicaid Expansion major population groups.

2.3 Evolution of Managed Care in Rhode Island

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 progression has been a focus upon improved access and quality, along with cost management. Contracting with managed care organizations ("Health Plans") provides a structure for measuring and enforcing performance standards. Both of Rhode Island's medical Medicaid managed care organizations were rated 4.5 out of 5 by the National Committee for Quality Assurance ("NCQA").[1]

The State's first 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 Health Plans to 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 in managed care for CSHCN became mandatory in 2008.

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 15,000 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 State has expanded the program requirements and covered benefits contained in the Health Plans contracts, while also increasing the Health Plan performance requirements for managing the health care needs of complex populations. Health Plans were not required, however, to pay for home and community-based services but are required to pay for up to thirty (30) days of nursing home stays.

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 sixty-five (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. The program was sunset in October 2019.

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. 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.

In SFY 2018, ninety-one percent (91%) of the Medicaid population were enrolled in a Health Plan and accounted for seventy-eight percent (78%) of Medicaid expenditures. The Rhode Island Medicaid Managed Care Plan have consistently been ranked among the best in the nation. Please reference the *Rhode Island Annual Medicaid Expenditure Report* for further details regarding Medicaid managed care expenditures.

Currently, there are four (4) health plans participating in the Medicaid managed care program. Three (3) medical Medicaid managed care programs: (1) Neighborhood Health Plan of Rhode Island ("NHPRI"); (2) UnitedHealthcare Community Plan of Rhode Island ("UHCCP-RI"); and, (3) Tufts Health Public Plans, Inc. The total enrollment in all medical health plans was 269,902 as of November 2019: NHPRI has 170,580 members; UHCCP-RI has 89,992 members; and, THP has 9,330 members. The fourth participating health plan and only Medicaid dental managed care provider for the RIte Smiles program, (4) UnitedHealthcare Dental, has 110,389 members as of November 2019.

2.4 Rhode Island Managed Care in 2019

The Rhode Island Medicaid Managed Care Program's mission is to provide for the holistic delivery of Medicaid health benefits to meet individual Rhode Islander's needs and foster improvements in health and well-being, while simultaneously demonstrating improvement across population health outcomes and health care system financial sustainability.

EOHHS envisions a Managed Care Program which rapidly evolves into the next generation of managed care as articulated in the 2015 *Report of the Working Group to Reinvent Medicaid* . EOHHS is focused upon the continued development of a Managed Care Program through payment and delivery system reform that achieves and promotes the following strategic goals:

- **Sustainably achieve better health outcomes and lower costs** for all Rhode Islanders eligible for Medicaid by aligning incentives across delivery system actors to ensure that improved population health and operational efficiency are reflected in all actors' financial interests;
- **Integrate care to support whole-person health by leveraging a strong primary care infrastructure** with an orientation toward prevention and wellness, that is able to respond holistically to a member's medical, behavioral health, socio-economic, or long-term care needs;
- **Foster choice and engagement** among Rhode Islanders eligible for Medicaid, such that members are active participants in the selection of a health plan and providers, as well as the care they receive; and,
- **Build upon the respective strengths of payers and providers** to prioritize high-quality care, minimize unnecessary duplication, and improve efficiency.

This next generation of Managed Care programs will have as their foundation Managed Care Organizations ("MCOs") that will serve as the critical vehicle in the transition to accountable care in Medicaid. MCOs will contract with Accountable Entities ("AEs") to provide person centered health care delivery, increase access and efficiencies. AEs are integrated provider organizations responsible for the total cost of care and quality outcomes of an attributed population. The transition to MCOs contracting with AEs is consistent with initiatives taking hold across the country and represents a strategic movement toward increased integrated care coordination and value-based payment methodologies to support delivery system reform.

2.5 Overview of the RIte Smiles Program

In the fall of 1998, DHS (which was then the Medicaid SSA) 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 Association, Samuels Dental Center at Rhode Island Hospital, St. Joseph Hospital Dental Program, the Rhode Island Health Center Association, Rhode Island KIDS COUNT, the Rhode Island Foundation, the Rhode Island Dental Hygienist Association, Crossroads RI, the Rhode Island HMO Association, two (2) 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. Later that year, DHS developed a Request

for Proposals ("RFP") soliciting a qualified organization to serve as DBM for Rhode Island Medicaid recipients through a program called RIte Smiles. 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 as a children's Medicaid managed care dental program. 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 for children.

As of November 30, 2019, there were 110,389 members enrolled in RIte Smiles.

RIte Smiles dental providers practice in three (3) types of dental settings: (1) Federally Qualified Health Centers (FQHCs); (2) Hospital-based clinics; and, (3) Private practice settings.

The RIte Smiles program continues to receive national attention. In FFY 2017, RI had forty-nine percent (49%) utilization among those under twenty-one (21), which ranks twenty-seventh (27^{th}) among the states. EOHHS anticipates to further increase utilization to ensure preventive dental care services for the RIte Smiles population.

The RIte Smiles eligibility groups consist of the following:

- *Uninsured Children and/or Young Adults Born on or After May 1, 2000, until their 21^{st} birthday, 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). The medical benefit of Children in Substitute care is only administered by NHPRI.
- *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 persons with intellectual/developmental disabilities ("ICF-I/DD");
- Children with third-party coverage for dental benefits; and,
- 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 and/or young adults will need to be re-certified for Medicaid eligibility as required by State Medical Assistance policy or as individual case circumstances may warrant.

The purpose of this procurement is to seek qualified vendors to serve as a Dental Plan for the RIte Smiles program in Rhode Island as indicated in the following section. The successful Bidder(s) must consider how to most effectively manage the contract, in terms of cost, quality of care and member satisfaction of dental services.

SECTION 3: SCOPE OF WORK AND REQUIREMENTS

General Scope of Work

The goal of the RIte Smiles Program is to improve access to dental care for eligible enrollees, to increase the percentage of young Medicaid members who receive dental services, to increase the use of medically-necessary dental services, to increase use of dental preventive services, and to provide dental services in hospital, community and private practice settings and other innovative settings designed to reach vulnerable populations.

Specific Activities / Tasks

The Executive Office of Health and Human Services, through issuance of this Letter of Intent ("LOI"), invites qualified Bidder(s) to submit proposals to manage the RIte Smiles Medicaid Dental Benefit Program statewide for eligible beneficiaries for a monthly capitation payment made in accordance with the specifications and conditions set forth herein. In response to this LOI, as outlined in Section 4, Technical Response, qualified Bidder(s) must certify that they will meet all elements outlined in this section 3, Scope of Work, which is further outlined in **Appendix B, Model Contract,** referred to as "Model Contract" throughout sections 3 (Scope of Work) 4 (Proposal). Bidders must provide evidence that further validates their capacity to meet all requirements.

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 meet financial standards;
- Maintain a viable information technology capacity and meet Federal and State reporting requirements;
- Attend and/or preside over meetings with stakeholders on a regular basis;

- Maintain a grievance and appeals process that meets Federal and State requirements; and,
- As a core objective, seek to reduce the use of fee-for-service payment as a payment methodology and to replace fee-for-service payment with Alternative Payment Methodologies ("APM") that provide incentives for better quality, outcomes, and more efficient delivery of services.

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 Core Requirements

Experience and Understanding

The Bidder must certify it meets and will comply with all requirements outlined in **Article II Section 2.1, General,** of **Appendix B, Model Contract**. The Bidder must provide supporting evidence when applicable and as required for each section.

3.1.1 Dental Plan(s) Licensure and Organizational Requirements

The Bidder must certify that it that it complies with all contractual requirements as described in **Appendix B, Model Contract, Article II, Section 2.2, Licensure/Certification**.

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

- Meets that requirements under R.I. Gen. Laws section 27-18.9-8: Benefit Determination and Utilization Review Act.
- Is certified as a utilization review entity by a nationally known health utilization management organization.

3.1.2 Dental Plan(s) Administration

The Bidder must agree to maintain sufficient administrative staff and organizational components to comply with all program standards as described in **Appendix B, Model Contract, Article II section 2.3, Dental Plan(s) Administration**. 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. At a minimum, the Bidder must include each of the following functions in accordance with the standards outlined in the section:

A. Executive Management

B. Other Administrative Components

   a. Dental Director's Office

   b. Accounting and Budgeting Function

   c. Member Services Function

   d. Provider Services Function

   e. Dental Management Function, including quality assurance, prior authorization, concurrent medical review/discharge planning, and retrospective dental review

   f. Grievance and Appeals Function

   g. Claims Processing Function

   h. Management Information System

   i. Program Integrity and Compliance

C. RI Works Participants

3.1.3 Eligibility and Program Enrollment

The Bidder(s) must comply with the eligibility and program enrollment requirements outlined and described in **Appendix B, Model Contract, Article II, Section 2.4, Eligibility and Program Enrollment.**

A. **Eligible Population**: RIte Smiles eligible population is defined to consist of information provided in (Sections 2.4.A through and including 2.4.I of **Appendix B, Model Contract**) 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 aid and are described herein. The following are eligible populations that will be enrolled in the RIte Smiles Program:
   a. Children and/or young adults born on or after May 1, 2000, up until their 21st birthday, under 250 Percent of the FPL;
   b. Children in Substitute Care; and,
   c. Children with Special Health Care Needs.

B. **Excluded Populations**: The following children and/or young adults are excluded from participation in RIte Smiles:
   a. Children and/or young adults residing in a nursing home or an intermediate care facility for the mentally retarded (ICF/MR);
   b. Children and/or young adults with third-party coverage for dental benefits; and,
   c. Children and/or young adults residing outside of Rhode Island.

C. **New Eligibility Groups:** The State reserves the right to add new eligibility groups at any time.

D. **Eligibility Determination**: The State shall have sole authority for determining whether individuals meet the eligibility criteria and therefore are eligible to enroll in a Dental Plan.

E. **Guaranteed Eligibility**: There are no eligibility guarantees for members.

F. **Voluntary Selection of Dental Plan by Members**: At the time of application or at other times determined in its sole discretion by EOHHS, applicants or beneficiaries shall be

offered the opportunity to select a Dental Plan or another program option, if applicable. In accordance with 42 CFR 438.54, beneficiary's enrollment in a Dental Plan is voluntary. If an eligible member does not select a Dental Plan or does not select another program option, he or she shall be automatically assigned to a Dental Plan. This process does not apply to periods designated for open enrollment.

G. **Automatic Assignment to Dental Plans**: EOHHS shall employ a formula, or algorithm deemed by EOHHS to be in the best interests of the members that may include quality metrics, Dental Plan performance of contract requirements, including but not limited to, Dental Plan financial performance, or other considerations such as, Market Share Capacity, to assign any eligible member that does not make a voluntary selection.

H. **Automatic Re-Assignment Following Resumption of Eligibility**: Members who are disenrolled from a Dental Plan, due to loss of eligibility and who regain eligibility within sixty (60) calendar days of disenrollment, may select a Dental Plan of their choice. Members who do not make a Dental Plan selection will be automatically re-enrolled, or assigned, into their previous Dental Plan upon reinstatement of their Medicaid eligibility. If more than sixty (60) calendar days have elapsed and the Medicaid member does not make a Dental Plan selection at the time eligibility was reinstated, the member will be auto-assigned to a Dental Plan based on EOHHS' algorithm.

I. **Lock-in**: Following their initial enrollment into a dental plan, RIte Smiles eligible children and/or young adults 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 **Appendix B, Model Contract, Section 2.5.J Member Disenrollment**.

J. **Market Share Capacity Limit**: EOHHS may, at its sole discretion, institute a market share capacity limit if more than one (1) Bidder is awarded a Contract. EOHHS may implement a market share cap using the following method:

- If two (2) Bidders are awarded the Contract, no one (1) Contractor shall be assigned more than sixty percent (60%) of the total market share;
- If three (3) or more Bidders are awarded the Contract, no one (1) Contractor shall be assigned more than fifty percent (50%) of the total market share.

EOHHS retains sole authority to determine the total market share and implementation of a market share cap.

Member choice always prevails and shall not be impacted by market share cap.

3.1.4 Member Enrollment and Disenrollment

The Bidder must comply with the eligibility and program enrollment requirements outlined and described in **Appendix B, Model Contract, Article II, Section 2.5, Member Enrollment and Disenrollment.**

A. **Dental Plan Marketing Requirements:** The successful Bidder(s) is required to submit to EOHHS for review and written approval all materials, in any media, and any other materials associated with marketing for open enrollment periods that will be distributed to members or potential members (referred to as member and marketing materials) before they are distributed. Plan materials developed or distributed by subcontractors or providers also require review and approval before being distributed. The successful Bidder(s) is required to use *RI Managed Medicaid Model Member Handbook*, *RI EOHHS Guidelines*

for Marketing and Member Communications for Medicaid Managed Care Program, *Appeals/Grievances Notification Model Documents*, as outlined further in **Appendix B, Model Contract**.

B. **Dental Plan(s) Enrollment Procedures:** EOHHS will provide successful Bidder(s) with a monthly list of members newly enrolled into the Dental Plan. Bidder(s) agrees to accept enrollment information in the data format submitted by the State. Bidder(s) agrees to have written policies and procedures for enrolling these members effective on the first (1st) day of the following month after receiving notification from the State. Newly enrolled members must be mailed notification of enrollment including effective date and how to access care within ten (10) calendar days after receiving notification from EOHHS of their enrollment.

   Bidder(s) 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 race, color, national origin, sex, sexual orientation, gender identity, disability, age, ethnicity, language needs, health status, or need for health services.

   EOHHS will, at times mutually agreed upon by the State and the Bidder(s) (such approval not to be unreasonably withheld), conduct an Open Enrollment process for existing RIte Smiles members. Each member shall be given the choice of the RIte Smiles program participating Dental Plans. Siblings within a family unit shall be required to participate in the same Dental Plan, unless there is a compelling reason not to do so, as determined by the State. Members who are so auto-assigned will be allowed to choose a different Dental Plan within the first ninety (90) days of being assigned to the Dental Plan. Enrollment shall be assigned to the Bidder(s) following the effective date upon reasonable determination of the Contractor's readiness

   Successful Bidder(s) will not use any policy or practice that has the effect of discriminating against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability.

C. **Change in Member Status:** Bidder(s) 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.

   Successful Bidder(s) 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.

   Successful Bidder(s) shall ensure through written agreements and contracts that all subcontractors will report such changes in status to the Contractor.

D. **Enrollment and Disenrollment Updates:** EOHHS shall provide the successful Bidder(s) 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.

E. **Services for New Members:** Successful Bidder(s) agrees to make available the full scope of dental benefits to which a member is entitled immediately upon new member

enrollment.

F. **New Member Orientation:** Successful Bidder(s) shall have written policies and procedures for orienting new members to their dental 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.

G. **Identification Cards:** Successful Bidder(s) agrees to issue a member identification card to its members to use when obtaining Covered Services. The member identification card may identify the holder a RIte Smiles member and as a member through an alpha or numeric indicator but shall not be overtly different in design from the membership identification card issued to other enrolled groups.

Successful Bidder(s) must agree to issue all members a permanent membership identification card within ten (10) days after receiving notification from EOHHS of their enrollment. The card must include at least the following information:

a. Dental Plan name;
b. Twenty-four (24) hour Dental Plan telephone number for use in urgent or emergent medical situations
c. Telephone number for Member Services function (if different)

H. **Member Handbook:** Successful Bidder(s) must agree to use the *RI Managed Medicaid Model Member Handbook* developed by EOHHS and make it available to all new and existing members at all times. An electronic copy of the Handbook is to be included on the Bidder(s) member website and available for viewing and downloading. Additionally, members may request an alternate version (paper, audio or specific language) by contacting the successful Bidder(s) member services department.

I. **Transitioning Members between Plans:** The successful Bidder(s) shall have written policies and procedures for transferring relevant patient information in an efficient manner, including medical records and other pertinent materials, when transitioning a member to or from another Dental Plan.

J. **Member Disenrollment:** EOHHS has sole authority for disenrolling members from Dental Plans. A member may request disenrollment without cause during the ninety (90) days following the date of the recipient's initial enrollment with the Dental Plan.

Bidder(s) cannot refuse to cover services because of moral or religious objections.

EOHHS reserves the right to disenroll members whom the Bidder(s) is unable to contact within contractual timeframes, members for whom the Bidder(s) cannot produce evidence of services provided within contractual timeframes or fails to meet readiness standards set by EOHHS.

Bidder(s) is required to provide member information, including requested written documentation, if member requests to be disenrolled from Dental Plan. Bidder is responsible for providing member assistance to submit disenrollment request to EOHHS, including translation services. Disenrollment information and EOHHS *Medicaid Health Plan Change Request Form* must be accessible to member on Bidder(s) website and mailed to member upon disenrollment request.

3.1.5 In-Plan Services/Benefits

Bidder(s) must comply with the outlined and described in **Appendix B, Model Contract, Article II, Section 2.6, In-Plan Services and ATTACHMENT A: SCHEDULE OF IN-PLAN BENEFITS**

A. Description of Comprehensive Benefit Package

1) General

The Bidder(s) is required to meet all requirements stated in **Article II, Section 2.6** of **Appendix B, Model Contract**. Specifically, the Bidder(s) must provide a full range of comprehensive dental services as In-Plan Services. These in-plan services are described in **Attachment A: Schedule of In-Plan Benefits** of **Appendix B, Model Contract**.

The Bidder(s) 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 or the member's medical managed care organization In-Plan benefit. These services are described in **Attachment B: Schedule of Out-of-Plan Benefits** the attached **Appendix B, Model Contract**.

Attachment C: Non-Covered Plan Benefits of **Appendix B, Model Contract** identifies the non-covered benefits.

2) Dental Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services

The Bidder(s) must provide dental EPSDT services as described in **Appendix B, Model Contract,** and based on the *Dental EPSDT Periodicity Schedule* in accordance with **Attachment D** of **Appendix B, 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) Interpreter/Translation Services

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

B. Member/Provider Communication

The Bidder(s) 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 **Appendix B, Model Contract**.

C. 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 non-participating provider outside the network, at no cost to the member.

D. New In-Patient Services and In-Plan Service Coverage Arrangements

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 **Appendix B, Model Contract**. 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 is formalized through an amendment to the Contract, as indicated in **Appendix B, Model Contract**.

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 3.1.I of **Appendix B, Model Contract,** and shall be accompanied by an actuarially-sound adjustment to the capitation rates in **Appendix B, Model Contract, Attachment E**. This shall be formalized through an amendment to this Agreement as provided in Article III of **Appendix B, Model Contract**.

1. Transportation

The State has a centralized nonemergency medical transportation ("NEMT") program. Through NEMT, RIte Smiles members are eligible for transportation services to Medicaid allowable services either through no cost bus pass, car/van or, when medically necessary, chair vans or ambulance. Bidder(s) agrees to coordinate the arrangement of transportation with the transportation broker for its members through this centralized service. This service is offered as transportation of last resort to members who are unable to secure transportation to their dental appointments.

3.1.6 Care Coordination

The Bidder(s) is required to ensure that it meets the Care Coordination requirements in **Article II, Section 2.7** of **Appendix B, Model Contract**.

The Bidder(s) shall coordinate all covered dental services, which involves the organizing and marshaling of personnel and other resources needed to conduct 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 a member's primary care provider ("PCP") and dental services as needed, ensure that 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.

3.1.7 Provider Networks

The Bidder(s) is required to ensure that network providers meet the Provider Network requirements in **Article II, Section 2.8** of **Appendix B, Model Contract**.

The Bidder(s) shall maintain a robust multi-disciplinary provider network (1) to provide members with the full range of covered dental services; (2) maintain adequate and sufficient providers by

number, mix and geographic area; and (3) make available all services in a timely manner through a network sufficient to serve the diverse population.

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

In establishing and maintaining the network, the Bidder(s) 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 and facility 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 and/or young adults 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 shall contain, but shall not be limited to, general dentists and pediatric dentists to meet the service accessibility standards outlined later in this section as well an adequate specialty network that includes the following specialty dentists: pediatric dentists, periodontists, endodontists, prosthodontists, oral surgeons, and orthodontists.

The Bidder must include in its network, at a minimum, the following provider types and corresponding minimum requirements as outlined in **Article II, Section 2.8 of Appendix B, Model Contract,** to meet the diverse needs of the RIte Smiles population:

- FQHCs/RHCs with Dental Clinics;
- Hospital-Based Dental Clinics;
- School-Based Clinics;
- Mobile Dental Providers;
- Indian Health Care Provider (IHCP);
- Networks Related to Indians;
- Telehealth/Teledental.

In addition, the Bidder(s) is required to provide policies and procedures which describe the organization, policies and procedures surrounding a Telehealth program. A Telehealth program shall include but is not be limited to the following covered services: patient education; medication management; equipment management; review of patient trends and/or other changes in patient condition necessitating professional intervention; and other activities deemed necessary and appropriate according to a member's plan of care.

Every quarter the Bidder(s) shall provide the State with a list of all its participating dental providers, including those whose practices are open to additional RIte Smiles members. The Bidder(s) shall notify the State on a monthly basis of any changes in its network's composition and shall have procedures in place to address changes in its network that may negatively affect the ability of members to access services.

A. Provider Credentialing

The Bidder(s) 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 such services. The Bidder(s) 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(s) shall have a uniform credentialing and re-credentialing process and shall ensure that the process complies consistently with State regulations. For organizational providers, the Bidder(s) must adopt a uniform credentialing and re-credentialing process and that consistently complies with State regulations.

The Bidder(s) does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The Bidder(s) shall not 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. Bidder(s) must submit the List of Excluded Individuals and Entities (LEIE), as outlined in **Appendix B, Model Contract, Section 3.7, Performance Standards and Damages**.

The Bidder(s) shall have written policies and procedures pertaining 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) days of any change in ownership.

Providers must disclose to the Bidder(s) the identity of any individual who has more than a five percent (5%) ownership interest in the provider or the identity of an individual who has been convicted of a criminal offense.

The Bidder(s) shall 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(s) 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 **Appendix B, Model Contract**. The Bidder(s) must promptly notify 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(s) must 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 Bidder's concern about Medicaid program integrity or quality. This includes, but is not limited to, suspension actions and settlement agreements.

3.5.2 Telehealth/Teledental

The Bidder(s) is required to identify policies and procedures which describe the organization, policies and procedures surrounding a Telehealth program. A Telehealth program should include but is not limited to the following covered services: monitoring of patient vital signs; patient education; medication management; equipment management; review of patient trends and/or other changes in patient condition necessitating professional intervention; and other activities deemed necessary and appropriate according to a member's plan of care.

3.1.8 Service Accessibility Standard

The Bidder(s) is expected to meet the standards as described in **Article II, Section 2.9** of **Appendix B, Model Contract**.

The Bidder(s) shall have written policies and procedures describing how members and providers can contact the Bidder to receive instructions for treatment of an Urgent dental problem. The Bidder(s) shall make available dental services within forty-eight (48) hours for urgent dental conditions.

The Bidder(s) is not responsible for emergency medical or dental conditions as outlined in **Attachment B: Out of Plan Benefits**.

The Bidder(s) shall 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.

The Bidder(s) shall 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.

The Bidder(s) shall offer members a choice of dental providers accepting new patients.

3.1.9 Member Services

The Bidder(s) shall meet the requirements in **Article II, Section 2.10** of **Appendix B, Model Contract**. As part of the Member Services function, the Bidder(s) has an ongoing program of member education that considers the multi-lingual, multi-cultural nature of the population and recognizes that some members have disabilities.

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

Once a year, the Bidder(s) shall notify 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 **Article II, Section 2.10** of **Appendix B, Model Contract.**

3.1.10 Provider Services

The Bidder(s) shall meet the requirement described in **Article II, Section 2.11** of **Appendix B, Model Contract**. As part of its Provider Services function, the Bidder(s) shall have an ongoing program of provider education relating to RIte Smiles benefits, program requirements, and the needs of RIte Smile members.

Bidder(s) shall 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(s) shall maintain 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), excluding State observed holidays.

The Bidder(s) shall require dental providers to report any changes in address or telephone number at least thirty (30) days prior to the change occurring.

3.1.11 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(s), therefore, shall comply 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 **Article II, Section 2.12** of **Appendix B, Model Contract,** and are highlighted below.

A. Dental Director

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

Bidder(s) shall assure that the Dental Director meets all qualifications and responsibilities as outlined in **Appendix B, Model Contract**.

B. Utilization Review and Quality Assurance (UR/QA)

The Bidder(s) shall 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. 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, provider profiling, and retrospective review of claims. As part of its utilization review function, the

Bidder(s) shall have processes to identify utilization problems and undertake corrective action. The Bidder(s) 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 that includes the basis for the denial, and any applicable appeal rights and procedures including EOHHS level appeal within fourteen (14) days of the request for authorization. The Bidder(s) shall demonstrate 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(s) may engage in direct discussions and/or patient or patient family interviews, as necessary, to consider treatment options or alternatives, and the like for cost-effective, patient-centered medically necessary dental care.

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

1) Quality Assurance

The Bidder(s) shall have 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(s) shall complete two (2) Quality Improvement Projects, approved by EOHHS, per year. The Bidder(s) must report the status and results of each project to the State, or its designees, in a format to be outlined by the State.

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

Please reference **Appendix B, Model Contract, Section 2.12.C, Utilization Review and Quality Assurance (UR/QA)**.

2) Confidentiality

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

The Bidder(s) shall 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) State and Federal Reviews

Bidder(s) shall 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. Bidder(s) agree to make available to CMS' and/or the State's outside review agency medical and other records for review as requested.

Bidder(s) shall undergo annual, external, independent reviews of the quality, timeliness, and access to the services covered under each contract, in accordance with 42 CFR 438.350.

4) Practice Guidelines

The Bidder(s) shall have developed and/or adopted and disseminated 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(s) 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 practice guidelines, the Bidder(s) follows the principles and the guidelines promulgated by the American Academy of Pediatric Dentistry (AAPD).

5) Service Provision

The Bidder(s) shall provide services in the amount, duration, and scope of service in a manner that is expected to achieve the purpose for which the services were provided. The Bidder(s) shall 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.

Contractor shall provide services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid, as set forth in 42 CFR 440.230 and for members under the age of twenty-one (21), as set forth in 42 CFR 441 Subpart B.

3.1.12 Operational Data Reporting

A. General

The Bidder(s) must comply with all EOHHS-established reporting requirements, as outlined in **Appendix B, Model Contract, Article II, Section 2.13**. EOHHS shall provide the Contactor with the appropriate reporting formats, instructions, submission timetables and technical assistance, as required. EOHHS may at its discretion, change the content, format or frequency of reports. If the Contractor delegates responsibility to a subcontractor, the Contractor shall ensure the subcontracting relationship and subcontracting documentation comply with EOHHS reporting requirements. EOHHS will develop and maintain a *Managed Care Reporting Calendar and Templates for Dental Plans* to document reporting requirements for each of the following elements of the contract:

- Encounter Data Reporting
- Grievance and Appeals Data
- Quality Assurance Data
- Member and Provider Satisfaction Report
- Fraud and Abuse
- Presentation of Findings
- HIPAA
- Certification of Data

- Patient Protection and Affordable Care Act
- MLR Reporting
- All required financial reports

Reporting templates shall be provided to successful Bidder(s) during readiness implementation timeframe.

B. Encounter Data Submission

Pursuant to 42 CFR 438.242(c), the Bidder(s) must submit to EOHHS complete, accurate, and timely encounter data for all services for which the Bidder(s) has incurred any financial liability, whether directly or through subcontracts or other arrangement. The Bidder(s) will submit encounter data monthly and in compliance with the EOHHS guidance document *Rhode Island Medicaid Managed Care Encounter Data Methodology, Thresholds and Penalties for Non-Compliance*. EOHHS reserves the right to make changes to the guidance document at any time. The Bidder(s) shall implement all changes within ninety (90) calendar days of notification. The Bidder(s) is solely responsible for submitting all subcontractor encounter data in compliance with EOHHS' encounter data requirements.

Bidder(s) is responsible for collecting, monitoring, submitting and ensuring the accuracy of all 837 submissions and subsequent 277CA reports. The Bidder(s) shall submit complete, accurate, and timely encounter data for all services that it, or its subcontractors, have incurred a financial liability within thirty (30) business days of the end of the month in which the liability was incurred. The Bidder(s) shall ensure that ninety-eight percent (98%) of submitted encounters are accepted and do not reject, upon initial submission. Bidder(s) may be subject to a monthly liquidated damage for failing to comply with timely and accurate encounter data.

Submitted encounters and encounter records must pass all the EOHHS designated Medicaid Management Information System ("MMIS") edits. Submitted encounters or encounter records must not be duplicates of a previously submitted and accepted encounter or encounter record unless submitted as an adjustment or void per HIPAA Transaction Standards.

The Bidder(s) is responsible for re-submitting any errored off/rejected claims to the State within thirty (30) business days of the receipt of the rejection and/or applicable rejection report, such as 277CA reports. The Bidder(s) is subject to corrective action and/or financial sanctions for non-submitted, late, or persistently rejected/incorrect data submissions.

3.1.13 Grievance and Appeals

The Bidder(s) shall meet the requirements governing the grievance and appeals process as described in **Article II, Section 2.14** of **Appendix B, Model Contract**.

The State has established a Grievance and Appeals function through which members can seek redress against Dental Plans. The appeal/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. In accordance with CMS Medicaid and CHIP Managed Care Final Rule, the Bidder(s) is required, per CMS Medicaid and CHIP Managed Care Final Rule, to utilize EOHHS model member notices to notify members of denied authorizations or services, appeal and grievance results and appeal and grievance rights.

The Bidder(s) is required to have written policies and procedures conforming to Federal and State requirements for resolving member complaints and for processing grievances and appeals when requested by the member or when the time allotted for complaint resolution expires. Such procedures will not be applicable to any disputes that may arise between the Bidder(s) and provider regarding the terms, conditions, termination or any other matter arising under a participation agreement or regarding any payment or other issues relating to providers. The Bidder(s) shall provide to all providers and subcontractors at the time they enter into a contract, information specified in § 438.10(g)(2)(xi)(C) about the grievance and appeal system, including the availability of assistance to enrollees with filing grievances and appeals.

The Bidder(s) shall maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy.

The Bidder(s')'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 thirty (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 **Appendix B, Model Contract**. The information that is required to be in a Notice of Action is also included in **Appendix B, 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.

Bidder may be subject to a liquidated damage for failing to comply with grievance and appeals performance standards.

3.1.14 Payments to and from Plans

The Bidder(s) shall accept the capitation rates as contained in **Appendix B, Model Contract**. The State makes capitation payments to the Dental Plan monthly via electronic funds transfer as described in **Article II, Section 2.15** of **Appendix B, Model Contract**.

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

Bidder(s) shall meet the requirement of **Appendix B, 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 (3) components of EOHHS Program Integrity efforts (compliance and fraud/abuse are the other (two) subsequently discussed herein). The Bidder(s) shall 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 acclaim 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

3.1.15 Financial Standards

A. 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(s) agrees to comply with all Rhode Island Department of Business Regulation standards in addition to specific requirements described in **Article II, Section 2.16** of **Appendix B, Model Contract**.

The success of the Rhode Island RIte Smiles 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

Bidder(s) must follow required financial data reporting as specified in the *EOHHS Medicaid RIte Smiles Requirements for Reporting and Non-Compliance*.

3.1.16 Record Retention

As required by **Article II, Section 2.17** of **Appendix B, Model Contract**, Bidder(s) must retain the source records for its operational data reports and financial records for a minimum of ten (10) years and must have written policies and procedures for storing this information. The Bidder(s) also preserves and maintains all dental records for a minimum of ten (10) 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.

3.1.17 Compliance

The compliance requirements are discussed in **Section 2.18** of **Appendix B, Model Contract.** In accordance with 42 CFR 438.608, the Bidder(s) 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 **Appendix B, Model Contract,** are submitted to EOHHS for review and approval within ninety (90) days of the execution of the contract and then on an annual basis thereafter. Compliance is one of three (3) 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 (2) 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 **Appendix B, Model Contract**.

The Bidder(s):

(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 **Appendix B, Model Contract**.

The Bidder(s) shall provide a policy and procedure to ensure compliance with H.R. 6 The SUPPORT Act Title 1; Section 1004, which mandates the following:

- Contractor must have automated drug utilization review safety edits for opioid refills;
- Automated claims review process to identify refills in excess of State limits;
- Monitor concurrent prescribing of opioids, benzodiazepines and/or antipsychotics (Including children's antipsychotics);
- Maximum daily morphine equivalent (MME) safety edits; and
- Concurrent utilization alerts for beneficiaries concurrently prescribed opioids and benzodiazepines and/or antipsychotics.

3.2 Model Contract Terms and Conditions

The attached **Appendix B** contains the **Model Contract** for the forthcoming procurement period. The Bidder(s) 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) shall 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(s) shall meet the Terms and Conditions described in Article III "Contract Terms and Conditions" of **Appendix B, 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. Bidder(s) are urged to review the specific requirements related to the terms and conditions in **Appendix B, 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 Bidder(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) shall:

- Operate a comprehensive program for providing targeted feedback to providers and vendors whose coding, documentation, or billing, although not fraudulent, appears problematic.
- Develop 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.
- Integrate 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.
- Employ 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.
- Execute systematic processes for conducting special investigations, provider site inspections, and focused clinical record reviews.
- Engage with the fraud, waste and abuse detection and investigations programs operated by the Bidder's subcontractors.
- Demonstrate 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.
- Use a cohesive approach to synthesizing quantitative and qualitative data to determine whether possible Medicaid fraud, waste and abuse have been discovered.
- Make 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.

3.3 Model Contract Addendums

Appendix B, Model Contract, contains addendums and critical requirements that the Bidder(s) shall 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.

3.4 Model Contract Attachments

Appendix B, Model Contract, contains the following Attachments which are key requisites to achieving the desired procurement results. The Bidder(s) are urged to read **Appendix B, 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) Monthly Capitation Rates;
(6) Actuarial Basis for Capitation Rates;
(7) Special Terms and Conditions;
(8) Contractor's Insurance Certification; and
(9) Contractor's Locations.

SECTION 4: PROPOSAL

Bidder must adhere to 50-page limit; any additional pages after 50 pages will not be considered. Attachments and supporting documentation are not included in page limit of Technical Proposal.

A. Technical Proposal

Narrative and format: The proposal should address specifically each of the following elements:

1. **Letter of Transmittal *(Recommended pages: 1)***

Bidder(s) 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 shall include 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 sixty (60) days from the date of submission and agree that their proposal remains in effect for an additional one hundred and twenty (120) days.
C. Identification of any proposed sub-contractor (excluding direct health service providers) arrangements in the proposal with a value of $2 million dollars or more.
D. Any other information that the Bidder may want to convey to the State

2. **Assurances/Attestations *(Recommended pages: 1)***

The Bidder(s) at minimum shall include 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 or will become so within thirty (30) days of the submission date for this LOI and will become accredited in Rhode Island as a Dental Plan within twelve (12) months after the State has notified the Contractor of an appropriate accreditation body.

B. **A statement** that the Bidder agrees to support joint quality improvement projects involving Dental Plans and EOHHS, and that the Bidder agrees to use the Quality Improvement Activity Form for reporting all quality improvement activities to the State.

C. **A statement** that the Bidder has read and accepts the mandatory requirements, responsibilities, and terms and conditions associated with this procurement.

D. **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.

E. **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 **Appendix B, Model Contract**.

F. **A statement** that the Bidder accepts the State's Capitation Rates that will be paid to the successful Bidder(s).

G. **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, Understanding, and Readiness to Perform *(Recommended pages: 5)*

The Bidder(s) shall provide a high-level summary of readiness to perform and meet the requirements outlined in **Section 3, Scope of Work**, and **Appendix B, Model Contract**. The summary must include, at a minimum, the following:

A) **A description** of how the Bidder meets the Licensure and Organizational requirement in Section 3 of this LOI and **Sections 2.1, 2.2 and 2.3** of **Appendix B, Model Contract**. Bidder submits copies of its State Licenses with their response to this LOI.

B) **A 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 or, if applicable, in other states, under a risk-based contract. The Bidder must submit an organizational chart and corresponding staffing model specific to the RIte Smiles program. Both must include dedicated or full-time equivalent ("FTE") staff for each administrative function, as well as an identification of which staff shall be located in Rhode Island. Please indicate which percentage of dedicated staff will be staffed locally and which will be located elsewhere.

   a. This description must include information on the Bidder's approaches to serve

diverse populations.

D) **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.

E) **A demonstration** of an understanding of the Rhode Island 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. If the Bidder is not currently serving as a Medicaid managed care plan in Rhode Island, then the Bidder should also describe its related experience in other states.

F) **A description** of 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.

G) **A description** of 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.).

H) **A description** of its relationship and linkages with existing Rhode Island Health Plans.

I) **Three (3) References from parties familiar with the** Bidder providing 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 previous engagement.

J) **Information** the Bidder believes is essential to provide value-based quality services to the Medicaid populations. The Bidder must describe its perspective on the Dental Plan's role in assisting the State with transforming Rhode Island's healthcare system. The Bidder should identify what would be needed from the State to be successful in aiding this transformation. Bidder might recommend appropriate metrics to help both measure and incent progress. The Bidder is encouraged to recommend appropriate metrics to both incent and measure progress toward the State's healthcare system transformation.

K) **A description** of the Bidder's ability to be ready to serve members by July 1, 2020;

L) **A clear, succinct description** of the Bidder's readiness to perform the requirements of this contract;

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

N) **A description** of how the Bidder meets the Dental Plan(s) Licensure and Organizational Requirements described in the Scope of Work and discussed further in **Appendix B, Model Contract, Section 2.2, Licensure/Certification**.

O) **Documentation** that Bidder's organization has the staffing capacity with the appropriate expertise for the Scope of Work described in Section 3 of this LOI. The Bidder must have a Dental Director that meets the requirements and adequate staffing to complete the administrative procedures, develop an organizational structure, maintain a management information system and perform all the functions required in **Appendix B, Model Contract**.

A strong presence in Rhode Island is considered essential to effective performance of the requirements of the Medicaid managed care program. Bidder is expected to have an in-

state presence to conduct outreach and approved marketing activities within all communities throughout the State and to maintain active and productive provider and member relations.

The Bidder must include an appended organization table and description of the units responsible for administering the elements of the Medicaid managed care program and identify where the respective staff is located.

P) **A clear statement** of the Bidder's acceptance of the State Capitation Rates to be paid for Medicaid enrollees. Such acceptance is to be provided as part of Bidder's submission in response to **Section 4.2** of this LOI, "Assurances/Attestations". **Section 4.2**, item #6 requires: "A statement that the Bidder accepts the State's Capitation Rates that will be paid to the successful Bidder(s). Proposal submissions that fail to include a signed attestation of acceptance of the State's Capitation Rates shall be deemed non-responsive and will not be considered.

Q) **The Bidder shall provide evidence** that it 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(s) shall satisfactorily demonstrate to EOHHS that it is able to meet the solvency requirements set forth through the Rhode Island Office of the Health Insurance Commissioner (OHIC).

R) **The Bidder(s) shall provide a description and/or provide evidence** of financial solvency as a Dental Plan operating in Rhode Island or outside of Rhode Island. Documentation to be provided by the Bidder(s) shall include:

- Presentation of the company's financial position for the past two (2) years (2018 and 2019) in relation to plan-specific levels of risk-based capital (RBC) and the company's Authorized Control Level. Bidder(s) newly entering the Rhode Island market should provide comparable documentation to demonstrate financial solvency and compliance with Rhode Island requirements.
- Annual NAIC Financial Statements;
- Most recent Quarterly NAIC Financial Statement;
- 2017 and 2018 Annual Audited Financial Statements;
- 2017 and 2018 Annual Report to Owners, Shareholders, Members, and Others;
- Company's General Liability and Directors' and Officer's Insurance Coverages;
- Claims Reinsurance Coverage and attachment points; and,
- Where applicable, evidence that the parent Company provides 100% of subsidiary's financial backing

EOHHS recognizes that: (a) for a potential new entrant into the Rhode Island Medicaid managed care program there may be some areas for which capability is still being developed; and (b) for a current participating Dental Plan there may be defined areas of enhanced capability or improvement. If this is the case, Bidder(s) should provide clear statements of Bidder(s')'s self-assessment of readiness and identify critical areas and work plans where additional development work is needed to meet requirements. In this Section Bidder(s) should address this issue at a more summary level, highlighting critical areas.

Note that for any successful Bidder(s) EOHHS shall conduct readiness reviews both to ensure the accuracy of information contained in the Technical Proposal and to ensure Bidder(s)

preparedness to perform the requirements of this engagement. Readiness shall be conducted during the tentative award and contract negotiation phase. EOHHS, with approval from the State Purchasing Agent, reserves the right to defer the contract start date for up to two (2) months beyond July 1, 2020. RI EOHHS or their designee will identify to the Bidder(s) areas where EOHHS does not deem Bidder(s) to be ready and able to meet its obligations under the tentative award. EOHHS shall provide reasonable opportunity for the Bidder(s) to correct such areas to remedy all deficiencies prior to the contract effective date.

If, for any reason, the Bidder(s) does not fully satisfy RI EOHHS that it is ready and able to perform its obligations under the tentative award prior to the contract start date and RI EOHHS does not agree to postpone the contract start date or extend the date for full compliance with the with the tentative award, then RI EOHHS may not award a final contract.

EOHHS is seeking to enter into contracts with Dental Plans that are prepared to serve the enrolled population beginning on July 1, 2020. At the same time, EOHHS will consider strong proposals with substantial evidence of both current development and concrete plans and capability to fully meet all requirements at or close to the projected start of the contract and include a timeline or project work plan that would guide a new entrant's completion of core activities needed to "go live" no later than two (2) months following this effective date.

4. Technical Response

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

The separate technical proposal should address specifically each of the required elements as set forth in this section. Bidder(s) shall respond in the order presented in this LOI. Evaluation criteria and corresponding point values for each section of the Bidder(s')'s response to this LOI is outlined in **Section 5, Evaluation and Selection**. As part of the Technical Response, further described in subsection **M**, **Plan for Enhanced Care Coordination and Member Satisfaction**, the Bidder(s) must choose whether to elect to propose a value-added benefit(s), to be offered as covered benefits to its enrollees.

The checklist indicates the key elements of the Bidder(s')'s proposal as described in this **Section 4, Proposal**, along with points assigned to each section and a suggested number of pages for the Bidder(s')'s response, excluding attachments.

The Bidder(s) shall attach the completed checklist to their proposal.

A) Plan for Best Practices *(Recommended pages: 5)*

The Bidder(s) shall provide a proposed plan(s) for designing and implementing "best practices" under the terms of **Appendix B, Model Contract**. The Bidder(s) shall submit a clear and tangible proposed design plan and an implementation plan.

The Bidder(s) shall submit 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 and/or young adults, 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 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** ***(Recommended pages: 4)***

The Bidder(s) shall clearly describe a plan for enrolling the RIte Smiles populations and meeting the requirements of **Sections 3.1.3 and 3.1.4** of the LOI and **Section 2.5** of **Appendix B, Model Contract**.

As part of its response, the Bidder(s) shall identify 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, including a flow chart and/or detailed diagram(s) that illustrate the pathways described above, as well as an organizational chart and description of the enrollment unit;

(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 (10) 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 three (3) attempts, on different days and on different times, to make a welcome call to all new members within thirty (30) 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, or, if preferred by the member, make handbook available on the website, to all members within ten (10) days of being notified of their enrollment;

(8) **An update** to the Member Handbook when material changes are needed as determined by EOHHS;

(9) **Marketing materials** developed 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**
(Recommended pages: 5)

The Bidder clearly describes its plan for providing the covered services and meeting accessibility standards contained in S**ection 3, Scope of Work,** and **Sections 2.6 and 2.9 of Appendix B, 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 **Appendix B, Model Contract,** requirements,

(5) **A draft design protocol** of how the Bidder will engage and serve RIte Smiles members with special health care needs,

(6) **A description** of how the Bidder will ensure members have access to the appropriate limited English proficiency (LEP) interpreter services, including the Bidder's plans to contract with an interpreter and/or provide access to bi-lingual staff, as well as how the Bidder will identify LEP members and their families and provide comprehensive program and benefits documentation;

(7) **A description** of how the Bidder will ensure the member cohort has access to age-appropriate services and an adequate provider network, including an example of the member and provider strategy and collaboration in support of EPSDT;

(8) **A description** of how the Bidder will monitor EPSDT and identify children and/or young adults who have not specifically received the appropriate services, as well as how this learned information will engage non-compliant members and provide sufficient access to care;

(9) **A description** of how the Bidder will design and implement a plan for honoring all existing service authorizations for the designated transition period,

(10) **A description** of the Bidder's approach to evidence-based third molar (wisdom tooth) management.

(11) **Ideas** for active, regular involvement in the Rhode Island oral health community's activities and initiatives (e.g. the RI Oral Health Commission), and

(12) **Other topics** deemed appropriate by the Bidder.

D) Plan for Care Coordination *(Recommended pages: 3)*

(1) **A description** of its plan for coordinating benefits that meet the requirements of **Section 3** of this LOI and **Section 2.7** of **Appendix B, Model Contract**.
(2) **A description** of 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 *(Recommended pages: 5)*

The Bidder(s) shall describe 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** of this LOI and in **Section 2.8** of **Appendix B, Model Contract**. Specifically, the Bidder(s) shall 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) **A description** of how the Bidder will effectively 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;

(7) **A description** of how the Bidder will communicate with providers about best practices, provider concerns, and suggested programmatic improvements (e.g., through establishing an advisory group);

(8) **A description**, as appropriate, of areas of potential weakness and the plan for continuous recruitment and retention of new providers to support ongoing network development and plans to create goal targets for specific numbers of in-network providers; and

(9) **Other topics** deemed appropriate by the Bidder.

The Bidder(s) must include as an attachment to the proposal a complete listing of its provider

network, including but not limited to provider names, addresses, town or city, telephone numbers, provider specialties, and foreign language(s) spoken (if any). The Bidder(s')'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. This analysis must address the standards for access to care the Bidder will used to determine network sufficiency, and at a minimum must include a list of the provider specialties.

F) Plan for Providing Member and Provider Services *(Recommended pages: 5)*

(1) **A clear description** of its plan for providing member and provider services as described in **Section 3** of this LOI and **Sections 2.10 and 2.11** of **Appendix B, Model Contract**, respectively.

(2) **A clear description** of 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 *(Recommended pages: 5)*

The Bidder(s) shall describe and discuss its plan for conducting dental management and quality assurance activities as described in **Section 3** of this LOI and **Section 2.12** of **Appendix B, Model Contract**.

The Bidder(s) shall include the following:

(1) **A description** of the Dental Director's background and experience as well as his/her role and responsibilities, including supporting proposal attachments that include but are not limited to the Dental Director's resume and his/her job description;

(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 and/or young adults 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;

(6) **Other topics** deemed appropriate by the Bidder; and

(7) **An outline and description** of three (3) or more performance-based and/or value-based quality measures intended to enhance the quality of services provided to the RIte Smiles population. The description must include, at a minimum: (1) the Bidder's approach to delivering the measures; (2) how quality will be monitored through a Quality Improvement Program imposed on providers; (3) actions the Bidder will take if quality issues are identified; (4) and the types of reporting to be delivered.

An example of the type of measure the State would encourage Bidders establish includes:

Caries Risk Assessment: Require that caries risk assessment be administered as part of every routine, preventive dental office visit, including input of the appropriate risk-based dental code to enable providers to focus on intervention for members with the high and moderate caries risk codes (e.g., D0602 and D0603) for value-based reimbursement.

H) Plan for Meeting the Operational Data Reporting Requirements *(Recommended pages: 2)*

The Bidder(s) description of its plan for meeting the operational data reporting requirements described in **Section 3** of the LOI and in **Section 2.13** of **Appendix B, Model Contract**.

Specifically, the Bidder(s) shall provide 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) **A description** of how the Bidder will submit a compliance dashboard report due no later than 30 days after the end of the reporting quarter;

(9) **A description** of 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 shall be prepared in conformance with reporting templates established by the State during the readiness period.

I) Plan for Meeting Grievance and Appeals Requirements *(Recommended pages: 2)*

The Bidder(s) shall clearly describe its plan for meeting the grievance and appeals process requirements described in **Section 3** of the LOI and in **Section 2.14** of **Appendix B, Model Contract**.

Specifically, the Bidder(s) shall provide 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 thirty (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) ***(Recommended pages: 2)***

The Bidder(s) shall clearly describe its plans for meeting the requirement for payments to and from the Dental Plan(s) as described in Section 3 of the LOI and in Section 2.15 of **Appendix B, Model Contract**.

Specifically, the Bidder(s) shall clearly provide 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 ***(Recommended pages: 2)***

(1) **A clear description** of 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 of the LOI and in Sections 2.16, 2.17 and 2.18 of **Appendix B, Model Contract**.

(2) **A clear description** that specifies: (a) how it will meet the financial standard requirements; (b) how it will meet the record retention requirements; and (c) how it will meet the compliance requirements.

L) Plan for Meeting Contract Terms and Conditions ***(Recommended pages: 1)***

The Bidder(s) shall clearly describe its plan for meeting the requirement for payments to and from the Dental Plan(s) as described in **Section 3.2** of the LOI and in Article III of **Appendix B, Model Contract**.

Specifically, the Bidder(s) shall provide 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.

M) Plan for Enhanced Care Coordination and Member Satisfaction *(Recommended pages: 2)*

As permitted under 42 CFR §438.3(e), managed care organizations may voluntarily agree to provide services that are in addition to covered services under the State plan. The cost of these services is not included in the capitation rates; however, the State encourages Bidder(s) to identify expanded services, known as 'value-added benefits,' to promote increased oral health outcomes to RIte Smiles members. Bidder cost-savings, increased member satisfaction and enhanced care coordination can be attributed to the addition of value-added benefits.

If the Bidder(s) elect to propose a value-added benefit(s), for each value-added benefit, the Bidder must provide, at a minimum:

(1) **A description** of the scope of the benefit, including procedure code(s) and modifier(s), if applicable;

(2) **An explanation** of how the Bidder will provide oversight of the value-added benefit(s);

(3) **An outline** of the per member per month (PMPM) actuarial value of benefit(s) based on current RIte Smiles member enrollment of 110,389 members, accompanied by a statement from the preparing/consulting actuary that is a member of the American Academy of Actuaries, certifying the accuracy of the information.

(4) **A statement** of commitment to provide the proposed value-added benefits for the entire twenty-four (24) month term of the initial contract and for any extensions, if applicable, at no additional cost.

The following are non-exhaustive examples of the types of value-added benefits the State welcomes to enhance the services and quality of care provided to the RIte Smiles member population:

- A strategic plan to encourage value-based care in which the Dental Plan would provide an incentive for oral health providers to enhance access to care using pay-for-performance measures.
- A strategic plan for early orthodontic intervention that includes coverage of procedures that would reduce the long-term, future cost of orthodontic treatment. For example, the Dental Plan could provide palatal expanders, maxillary expanders, and/or other functional appliances that would mitigate the need for more costly, future orthodontic treatment.
- Alternative pain management techniques, such as non-opioid approach(es) to post-operative pain management. For example, rather than providers prescribing traditional pain medication, the Dental Plan could provide for a long-acting local anesthetic/analgesic following a surgical procedure that would remain effective following surgery.
- Strategies and/or provision of services that support the following enhancements:
    - Improve medical-dental integration, especially concerning member data.
    - Re-evaluate the HLD Scoring Index for efficacy and equity.
    - Tuition reimbursement, discounted licensure and training for provider recruitment.

- Utilize technology for more targeted member education, marketing, and outreach.
- Implement member risk level-based dental provider incentives.
- Adopt innovative strategies to address sub-populations with special needs.

SECTION 5: EVALUATION AND SELECTION

To be considered for award(s), all Bidders must first attest to the capitated rates outlined in Model Contract Attachments E (Monthly Capitation Rates) and F (Actuarial Basis for Capitation Rates). Should a Bidder fail to attest to the acceptance of the capitated rates, that Bidder's technical proposal shall not be evaluated for Technical Evaluation Committee (TEC).

The State intends to provide multiple or singular award(s) based on TEC evaluation. It is intended that awards pursuant to this LOI will be made to qualified Dental Plan(s) whose technical proposals meet all criteria described in this LOI.

Each Bidder will submit one (1) bid proposal addressing each component of the Scope of Work, as outlined in Section 3 and further detailed in **Appendix B, Model Contract**. As detailed in Section 4, Technical Proposals will include details about the Bidder's ability to perform duties and obligations in Model Contract.

Technical Proposal Scoring

Technical Proposals accompanied by attestation of capitation rate will be reviewed by a TEC comprised of EOHHS staff. Proposals shall be scored on a **100-point scale.** Each criterion detailed in Section 4 of this LOI shall be weighted as described in the following table.

Criteria	Possible Points
1) Letter of Transmittal	Pass/Fail
2) Assurances/Attestations	Pass/Fail
3) Bidder's Experience, Understanding, and Readiness to Perform	10 points
4) Technical Response	**90 points**
A) Plan for Best Practices	10 points
B) Plan for Enrollment	8 points
C) Plan for Providing Covered Services and Meeting Accessibility Standards	10 points
D) Plan for Care Coordination	6 points
E) Plan for Maintaining a Robust Provider Network	10 points
F) Plan for Providing Member and Provider Services	10 points
G) Plan for Conducting Dental Management and Quality Assurance Efforts	11 points
H) Plan for Meeting the Operational Data Reporting Requirements	5 points
I) Plan for Meeting Grievance and Appeals Requirements	4 points
J) Plan for Payments to and From the Dental Plan(s)	4 points
K) Plan for Meeting Financial Standards, Record Retention and Compliance Requirements	4 points
L) Plan for Meeting Contract Terms and Conditions	3 points
M) Plan for Enhanced Care Coordination and Member Satisfaction	5 points
Total	**100 Points**

To be considered passing, technical proposals must receive a minimum score of 85 points. Any technical proposal scoring less than 85 points will not be considered for an award.

Bidder(s) may be required to submit additional written information or be asked to make an oral presentation before the technical evaluation committee ("TEC") to clarify statements made in the proposal.

SECTION 6: QUESTIONS

Questions concerning this solicitation must be e-mailed to the Division of Purchases at DOA.PurQuestions10@purchasing.ri.gov no later than the date and time indicated on page one of this solicitation. No other contact with State parties is permitted. Please reference LOI #7599917 on all correspondence. Questions should be submitted in writing in a Microsoft Word attachment in a narrative format with no tables. Answers to questions received, if any, shall be posted on the Division of Purchases' website as an addendum to this solicitation. It is the responsibility of all interested parties to monitor the Division of Purchases website for any procurement related postings such as addenda. If technical assistance is required, call the Help Desk at (401) 574-8100.

SECTION 7: PROPOSAL CONTENTS

RESPONSE CONTENTS
Proposals shall include the following:

1. One completed and signed RIVIP Bidder Certification Cover Form (included in the original copy only) downloaded from the Division of Purchases website at www.ridop.ri.gov. *Do not include any copies in the Technical proposal.*
2. One completed and signed Rhode Island W-9 (included in the original copy only) downloaded from the Division of Purchases website at /documents/Forms/Misc Forms/13_RI Version of IRS W-9 Form.docx. *Do not include any copies in the Technical proposal.*
3. Technical Proposal - Describing the qualifications and background of the Bidder and all requirements in Section 4 of this LOI, including any required attachments or documentation of expertise, Bidder must provide responses in a Technical Proposal. The technical proposal is limited to fifty (50) pages. This technical response page limit excludes any attachments, requested documentation, appendices, resumes of key staff that will provide services covered by this request. Any technical responses containing more than 50 pages will not be considered by TEC.

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

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

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

        - Vendor's name
        - LOI #7599917
        - LOI Title - DENTAL HEALTH PLAN(S) FOR RITE SMILES PROGRAM
        - Proposal type (e.g., technical proposal or cost proposal)
        - If file sizes require more than one CD-R, multiple CD-Rs are acceptable. Each

CD-R must include the above labeling and additional labeling of how many CD-Rs should be accounted for (e.g., 3 CD-Rs are submitted for a technical proposal and each CD-R should have additional label of '1 of 3' on first CD-R, '2 of 3' on second CD-R, '3 of 3' on third CD-R).

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

- Formatting of written documents and printed copies:
  - For clarity, the technical proposal shall be typed. These documents shall be single-spaced with 1" margins on white 8.5"x 11" paper using a font of 12-point Calibri or 12-point Times New Roman.
  - All pages on the technical proposal are to be sequentially numbered in the footer, starting with number 1 on the first page of the narrative (this does not include the cover page or table of contents) through to the end, including all forms and attachments. The Bidder(s) name should appear on every page, including attachments. Each attachment should be referenced appropriately within the proposal section and the attachment title should reference the proposal section it is applicable to unlabeled attachments related to the technical proposal shall not be considered by the TEC.
  - Printed copies are to be only bound with removable binder clips.

SECTION 8: PROPOSAL SUBMISSION

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

Proposals should be mailed or hand-delivered in a sealed envelope marked LOI #7599917to:

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

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

SECTION 9: CONCLUDING STATEMENTS

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

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

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

The State's General Conditions of Purchase contain the specific contract terms, stipulations and affirmations to be utilized for the contract awarded for this LOI. The State's General Conditions of Purchases can be found at the following URL: https://rules.sos.ri.gov/regulations/part/220-30-00-13

For more detailed information regarding the Rhode Island Medicaid Program and supplemental documentation for this RIte Smiles procurement, please visit *RIte Smiles Reference Materials Website:*

1. Rhode Island Annual Medicaid Expenditure Report
2. RI Managed Medicaid Model Member Handbook
3. RI EOHHS Guidelines for Marketing and Member Communications for Medicaid Managed Care Program
4. Appeals/Grievances Notification Model Documents
5. Medicaid Health Plan Change Request Form
6. Managed Care Reporting Calendar and Templates for Dental Plans
7. Rhode Island Medicaid Managed Care Encounter Data Methodology, Thresholds, and Penalties for Non-Compliance
8. EOHHS 837 Companion Guide (1 of 2)
9. EOHHS 837 Companion Guide (2 of 2)
10. Dental EPSDT Periodicity Schedule
11. Medicaid Managed Care Program: Medical Loss Ratio Calculation
12. EOHHS RIte Smiles Contract Requirements for Reporting and Intermediate Sanctions
13. Minimum Fraud and Abuse Prevention, Detection and Reporting Requirements for Members
14. Dental Services Provider Manual
15. Access to Dental Care 2019 RIKC
16. Dental Safety Net 2017
17. BRFSS 2016
18. Oral Health Head Start Report 2017
19. Oral Health of RI Children 2015
20. WIC Survey 2016, RI Dental Association Journal
21. Oral and Behavioral Health Teens 2018
22. Dentist Census 2018
23. Case Study: Driving Improved Teen Dental Utilization through Quality Improvement Strategies in Rhode Island
24. Innovative State Practices for Improving the Provision of Medicaid Dental Services
25. Centers for Medicare & Medicaid Services Waiver List
26. Rhode Island Medicaid Covered Dental Benefits for Children Under Age 21

27. Medicaid Health Plan Change Request Form

APPENDIX A: SAMPLE MODE CONTRACT

(PLAN NAME) (YEAR)

AGREEMENT

Between the

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

AND

(PLAN NAME)

FOR THE MEDICAID RITE SMILES PROGRAM

Basis for Agreement: (RFP/LOI #_____)

Table of Contents

ARTICLE I: DEFINITIONS 6
1.1 ABUSE 6
1.2 ACTION 6
1.3 ACTIVE CONTRACT MANAGEMENT 6
1.4 ACTUARY 6
1.5 ADVERSE BENEFIT DETERMINATION 7
1.6 AGREEMENT/CONTRACT 7
1.7 ALTERNATIVE PAYMENT METHODOLOGY (APM) 7
1.8 APPEAL 7
1.9 CAPITATION PAYMENT 7
1.10 CARE COORDINATION 7
1.11 CASE MANAGEMENT 7
1.12 CMS 8
1.13 COLD CALL MARKETING 8
1.14 CONTRACTOR 8
1.15 CONTRACT SERVICES 8
1.16 COVERED SERVICES 8
1.17 DAYS 8
1.18 DENTAL PLAN 8
1.19 DEPARTMENT 8
1.20 EMERGENCY DENTAL CONDITION 8
1.21 EMERGENCY SERVICES 8
1.22 ENROLLEE 9
1.23 EXCLUDED DENTAL SERVICES 9
1.24 EXECUTIVE OFFICE 9
1.25 EXPERIMENTAL OR INVESTIGATIONAL 9
1.26 FAMILY 9
1.27 FRAUD 9
1.28 GRIEVANCE 9
1.29 HEALTH CARE DENTAL PROFESSIONAL 9
1.30 HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH (HITECH) ACT 10
1.31 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) 10
1.32 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT PRIVACY RULE 10
1.33 HEALTH INSURANCE PORTABILITY AND ACCOUNTABLITY ACT SECURITY RULE 10
1.34 HOSPITALIZATION 10
1.35 IBNR (INCURRED BUT NOT REPORTED) 10
1.36 INDIAN 10

1.37 INDIAN HEALTH CARE PROVIDER....11
1.38 LIMITED ENGLISH PROFICIENCY....11
1.39 MARKETING....11
1.40 MARKETING MATERIALS....11
1.41 MATERIAL ADJUSTMENT....11
1.42 MEDICAL LOSS RATIO (MLR)....11
1.43 MEDICAL NECESSITY, MEDICALLY NECESSARY, OR MEDICALLY NECESSARY SERVICE....11
1.44 MEDICALLY NECESSARY DENTAL CARE....11
1.45 MEMBER....12
1.46 NON-PARTICIPATING DENTIST....12
1.47 OVERPAYMENT....12
1.48 PARTICIPATING DENTIST OR PLAN DENTIST....12
1.49 PARTICIPATING PROVIDER....12
1.50 PARTY....12
1.51 PLAN....12
1.52 PRE-AUTHORIZATION....12
1.53 PREPAID PACKAGE....13
1.54 PREVALENT....13
1.55 PRIMARY DENTAL CARE....13
1.56 PROVIDER....13
1.57 PROVIDER PREVENTABLE CONDITIONS....13
1.58 RATE CELL....13
1.59 RATING PERIOD....13
1.60 RISK CONTRACT....13
1.61 RITE CARE....14
1.62 RITE CARE ELIGIBLES....14
1.63 RITE SMILES....14
1.64 TELEHEALTH / TELEDENTAL....14
1.65 SIBLING....14
1.66 SSI....14
1.67 STATE....14
1.68 SUBCONTRACTOR....14
1.69 SUSPENSION....14
1.70 UNINSURED....14
1.71 URGENT DENTAL CONDITION....15
ARTICLE II: DENTAL PLAN PROGRAM STANDARDS....15
2.1 GENERAL....15
2.2 LICENSURE/CERTIFICATION....15
2.3 DENTAL PLAN(S) ADMINISTRATION....16
2.4 ELIGIBILITY AND PROGRAM ENROLLMENT....17
2.5 MEMBER ENROLLMENT AND DISENROLLMENT....20
2.6 IN-PLAN SERVICES....32

2.7 CARE COORDINATION 36
2.8 PROVIDER NETWORKS 37
2.9 SERVICE ACCESSIBILITY STANDARD 43
2.10 MEMBER SERVICES 44
2.11 PROVIDER SERVICES 47
2.12 DENTAL MANAGEMENT AND QUALITY ASSURANCE 47
2.13 OPERATIONAL DATA REPORTING 54
2.14 GRIEVANCE AND APPEALS 60
2.15 PAYMENTS TO AND FROM PLANS 67
2.16 FINANCIAL STANDARDS 74
2.17 RECORD RETENTION 76
2.18 COMPLIANCE 77
ARTICLE III: CONTRACT TERMS AND CONDITIONS 84
3.1 GENERAL PROVISIONS 84
3.2 INTERPRETATION AND DISPUTES 87
3.3 CONTRACT AMENDMENTS 89
3.4 PAYMENT 90
3.5 GUARANTEES, WARRANTIES, AND CERTIFICATIONS 91
3.6 PERSONNEL 98
3.7 PERFORMANCE STANDARDS AND DAMAGES 101
3.8 INSPECTION OF WORK PERFOMRED 115
3.9 CONFIDENTIALITY OF INFORMATION 117
3.10 TERMINATION OF THE CONTRACT 121
3.11 OTHER CONTRACT TERMS AND CONDITIONS 127
ADDENDUM I: FISCAL ASSURANCES 130
ADDENDUM II: NOTICE TO EOHHS CONTRACTORS OF THEIR RESPONSIBILITIES UNDER TITLE IV OF THE CIVIL RIGHTS ACT OF 1964 132
ADDENDUM III: NOTICE TO EOHHS' CONTRACTORS OF THEIR RESPONSIBILITIES UNDER SECTION USC 504 OF THE REHABILITATION ACT OF 1973 135
ADDENDUM IV: DRUG-FREE WORKPLACE POLICY 138
ADDENDUM V: DRUG-FREE WORKPLACE POLICY PROVIDER CERTIFICATE OF COMPLIANCE 140
ADDENDUM VI: SUBCONTRACTOR COMPLIANCE 141

ADDENDUM VII: CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE....142
ADDENDUM VIII: INSTRUCTIONS FOR CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS PRIMARY COVERED TRANSACTIONS....143
ADDENDUM IX: CERTIFICATION REGARDING DEBARTMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS – PRIMARY COVERED TRANSACTIONS....145
ADDENDUM X: LIQUIDATED DAMAGES....147
ADDENDUM XI: EQUAL EMPLOYMENT OPPORTUNITY....149
ADDENDUM XII: BYRD ANTI-LOBBYING AMENDMENT....151
ADDENDUM XIII: BID PROPOSAL....152
ADDENDUM XIV: CORE STAFF POSITIONS....153
ADDENDUM XV: FEDERAL SUBAWARD REPORTING....154
ADDENDUM XVI: BUSINESS ASSOCIATE AGREEMENT....157
ATTACHEMENT A: SCHEDULE OF IN-PLAN BENEFITS....169
ATTACHEMENT B: SCHEDULE OF OUT-OF-PLAN BENEIFTS....171
ATTACHEMENT C: SCHEDULE OF NON-COVERED BENEFITS....178
ATTACHEMNT D: DENTAL EPSDT PERIODICITY SCHEDULE....179
ATTACHMENT E: MONTHLY CAPITATION RATES....181
ATTACHMENT F: ACTUARIAL BASIS FOR CAPITATION RATES....182
ATTACHMENT G: SPECIAL TERMS AND CONDITIONS....183
ATTACHMENT H: CONTRACTOR'S INSURANCE CERTIFICATION....190
ATTACHMENT I: CONTRACTOR'S LOCATIONS....191

AGREEMENT

This agreement, hereinafter "Agreement", including attached ADDENDA, is hereby entered into this (DATE PRESENTED)_____day of _____ 2020 by and through the **Executive Office of Health and Human Services** (hereinafter referred to as the "EOHHS" or the "Executive Office") and _____ (hereinafter referred to as **"**the Contractor").

WHEREAS**,** EOHHS desires to engage the Contractor to offer services and activities further described, but not limited to the work described in this Agreement, including any Exhibit(s) or Addenda, that are attached hereto and are hereby incorporated by reference into this Agreement.

WHEREAS the Contractor is willing and qualified to provide services, the parties hereto do mutually agree as follows:

ARTICLE I: DEFINITIONS

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

1.1 ABUSE

Abuse is defined as provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid program, or in reimbursements for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

1.2 ACTION

Action means an adverse benefit determination made by the Contractor.

1.3 ACTIVE CONTRACT MANAGEMENT

Active Contract Management (ACM) is a set of strategies that applies high-frequency use of data and purposeful management of agency-service provider interactions to improve contract services and deliverables. ACM consists of the following process elements: (1) the Contractor shall detect and rapidly respond to performance issues; (2) the Contractor shall implement consistent improvements to address performance; and, (3) the contractor shall identify opportunities for reengineering and improvements to service delivery systems.

1.4 ACTUARY

An actuary is an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. Actuary refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates

1.5 ADVERSE BENEFIT DETERMINATION

An adverse benefit determination means any of the following: (1) the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit, (2) the reduction, suspension, or termination of a previously authorized service, (3) the denial, in whole or in part, of payment for a service, (4) the failure to provide services in a timely manner, as defined by the State, (5) the failure of the Contractor to act within the timeframes provided in 42 CFR 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals, (6) for a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network, (7) the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

1.6 AGREEMENT/CONTRACT

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

1.7 ALTERNATIVE PAYMENT METHODOLOGY (APM)

A payment methodology structured such that it provides economic incentives, rather than focusing on volume and services provided.

1.8 APPEAL

An appeal is defined as a formal request by a covered person or provider for reconsideration of a decision, including but not limited to a utilization review recommendation, a benefit payment or administrative action.

1.9 CAPITATION PAYMENT

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

1.10 CARE COORDINATION

Care coordination is defined as the delivery organization of member care activities between two or more participants (including the member) involved in a member's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling 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.

1.11 CASE MANAGEMENT

Case Management, a component of care management, is a set of activities tailored to meet a member's situational health-related needs. Situational health needs can be defined as time-limited episodes of instability. Case managers will facilitate access to services, both clinical and

non-clinical, by connecting the member to resources that support him/her in playing an active role in the self-direction of his/her health care needs.

1.12 CMS

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

1.13 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.

1.14 CONTRACTOR

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

1.15 CONTRACT SERVICES

Contract Services mean the services to be delivered by the Contractor, which are so designated in **Error! Reference source not found.**of this Agreement.

1.16 COVERED SERVICES

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

1.17 DAYS

Days means calendar days, which includes weekends and holidays, unless otherwise specified.

1.18 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 2.2 of this Agreement, and contracts with the State to provide dental services as described in Section 2.6 of this Agreement and pursuant to Title XIX of the Social Security Act to members. A Dental Plan is considered a Prepaid Ambulatory Health/dental plan (PAHP) based on CMS guidance.

1.19 DEPARTMENT

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

1.20 EMERGENCY DENTAL CONDITION

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

1.21 EMERGENCY SERVICES

Emergency services are organizations/providers who ensure public safety and health by dealing with types of emergencies. Some of these agencies exist solely for addressing certain types of emergencies while others deal with ad hoc emergencies as part of their normal responsibilities. Many of these agencies engage in community awareness and prevention programs to help the public avoid, detect, and report emergencies effectively.

1.22 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 us used synonymously with the term member.

1.23 EXCLUDED DENTAL SERVICES

Dental care services that dental insurance or plan does not pay for or cover.

1.24 EXECUTIVE OFFICE

Executive Office means the Rhode Island Executive Office of Health and Human Services (EOHHS).

1.25 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.

1.26 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.

1.27 FRAUD

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit. Includes any act that constitutes fraud under State or Federal Law.

1.28 GRIEVANCE

Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision.

1.29 HEALTH CARE DENTAL PROFESSIONAL

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

1.30 HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH (HITECH) ACT

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, was signed into law on February 17, 2009, to promote the adoption and meaningful use of health information technology. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules.

1.31 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.

1.32 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT PRIVACY RULE

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health/dental plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically.

1.33 HEALTH INSURANCE PORTABILITY AND ACCOUNTABLITY ACT SECURITY RULE

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

1.34 HOSPITALIZATION

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

1.35 IBNR (INCURRED BUT NOT REPORTED)

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

1.36 INDIAN

Indian means an individual, defined at Title 25 of the U.S.C. sections 1603(c), 1603(f). 1679(b) or who has been determined eligible, as an Indian, pursuant to 42 C.F.R. 136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian health care providers (IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization–I/T/U) or through referral under Contract Health Services ("CHS").

1.37 INDIAN HEALTH CARE PROVIDER

Health care program, including CHS, operated by the IHS or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

1.38 LIMITED ENGLISH PROFICIENCY

Limited English Proficient (LEP) means potential enrollees and enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

1.39 MARKETING

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

1.40 MARKETING MATERIALS

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

1.41 MATERIAL ADJUSTMENT

Material adjustment is an adjustment that, using reasonable actuarial judgment, has a significant impact on the development of the capitation payment such that its omission or misstatement could impact a determination whether the development of the capitation rate is consistent with generally accepted actuarial principles and practices.

1.42 MEDICAL LOSS RATIO (MLR)

The percentage of capitation payment received from the State related to this Contract that is used to pay dental expenses as defined by 42 CFR 438.8. The MLR calculation for each MCO in an MLR reporting year is the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)).

1.43 MEDICAL NECESSITY, MEDICALLY NECESSARY, OR MEDICALLY NECESSARY SERVICE

Medically necessary services are those that aid in the prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability, provides the ability for a member to achieve age-appropriate growth and development or to attain, maintain, or regain functional capacity. The Contractor will provide services for members under the age of twenty-one (21) to the same extent that services are furnished to individuals under the age of twenty-one (21) under FFS Medicaid.

1.44 MEDICALLY NECESSARY DENTAL CARE

Medically Necessary Dental 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.

1.45 MEMBER

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

1.46 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.

1.47 OVERPAYMENT

Overpayment is a payment made to a Contractor or network provider to which the Contractor or provider is not entitled to under Title XIX of the Act.

1.48 PARTICIPATING DENTIST OR PLAN DENTIST

Participating dentist or plan 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.

1.49 PARTICIPATING PROVIDER

A provider who has contracted with the health/dental plan to deliver medical/behavioral health services to covered persons. The provider may be a physician, hospital, pharmacy, other facility or other healthcare provider who has contractually accepted the terms and conditions set forth by the health/dental plan. Also known as network or in-network provider.

1.50 PARTY

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

1.51 PLAN

Plan is defined as a benefit your employer, union or other group sponsor provides to you to pay for your health care services.

1.52 PRE-AUTHORIZATION

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification.

1.53 PREPAID 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.

1.54 PREVALENT

Prevalent means a non-English language determined to be spoke by a significant number or percentage of potential enrollees and enrollees that are limited English proficient.

1.55 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.

1.56 PROVIDER

Provider means an individual or entity including physicians, nurse practitioners, physician assistants and others that is engaged in the delivery of medical/behavioral health care services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services.

1.57 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.

1.58 RATE CELL

Rate cell means a set of mutually exclusive categories of enrollees that is defined by one or more characteristics for purpose of determining the capitation rate.

1.59 RATING PERIOD

Rating period means a period of twelve (12) months selected by the State for which the actuarially sound capitation rates are developed and documented in the rate certification.

1.60 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.

1.61 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 and/or young adults under age nineteen living in households that meet specified eligibility criteria, and other specific eligible populations as designated by the State.

1.62 RITE CARE ELIGIBLES

RIte Care eligibles mean those Title XIX eligible groups described herein.

1.63 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 and/or young adults born on or after May 1, 2000. The RIte Smiles program was implemented in September 1, 2006.

1.64 TELEHEALTH / TELEDENTAL

Telehealth means the use of medical information exchanged from one (1) site to another via electronic communications to improve a patient's clinical health status.

1.65 SIBLING

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

1.66 SSI

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

1.67 STATE

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

1.68 SUBCONTRACTOR

Subcontractor means an individual or entity that has a contract with the Contractor that relates directly or indirectly to the performance of the Contractor obligations under this contract with the State.

1.69 SUSPENSION

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

1.70 UNINSURED

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

1.71 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: DENTAL PLAN PROGRAM STANDARDS

2.1 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 stated 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 1.7 and 2.15 of this Agreement), the Contractor agrees to provide eligible members with the dental 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.

2.2 LICENSURE/CERTIFICATION

The Contractor certifies that it is licensed in Rhode Island as an HMO under the provisions of Chapter 27-41, "the HMO Act" or that it will become licensed as a Health Maintenance Organization (HMO) or Health/dental plan (HP) in the State of Rhode Island by the Rhode Island Department of Business Regulation prior to signing an Agreement with EOHHS. If Contractor is not a licensed HMO in Rhode Island, the Contractor certifies that it is either a nonprofit hospital service corporation that is licensed by the Rhode Island Department of Business Regulation

(DBR) under Chapter 27-19 of the Rhode Island General Laws, a nonprofit medical service corporation that is licensed by DBR under Chapter 27-20 of the Rhode Island General Laws, or another health insurance entity licensed by DBR, and that it meets the following requirements:

- Meets that requirements under R.I. Gen. Laws section 27-18.9-8: Benefit Determination and Utilization Review Act
- Is certified as a utilization review entity by a nationally known health utilization management organization.

The Contractor agrees to forward to EOHHS any complaints received from the Rhode Island Department of Business Regulation (DBR) or OHIC. The Contractor also agrees to forward to EOHHS a copy of any correspondence sent by the Contractor to DBR or OHIC which pertains to the Contractor's contract status with any institution or provider group as it relates to it managed Medicaid network.

The Contractor shall notify EOHHS of any person or corporation that has five percent (5%) or more ownership or controlling interest in the Contractor.

At least annually, and within 30 days of any change in accreditation, the Contractor will inform EOHHS as to whether it has been accredited by a private independent accrediting entity. If the contractor has received accreditation by a private independent accrediting entity, in accordance with 42 CFR 438.332(b)(1), 42 CFR 438.332(b)(2), and 42 CFR 438.332(b)(3), the Contractor will authorize the private independent accrediting entity to provide EOHHS a copy of its most recent accreditation review, including its accreditation status, survey type, and level (as applicable); recommended actions or improvements, corrective action plans, and summaries of findings; and the expiration date of the accreditation.

2.3 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 2.3.A and 2.3.B 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 3.5.D. of the Agreement.

A. Executive Management

Contractor agrees to have an executive management function with clear authority over all of the administrative functions noted in Section 2.3.A below.

B. 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 dental review
- Grievance and Appeals Function
- Claims Processing Function
- Management Information System
- Program Integrity and Compliance

C. 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.

2.4 ELIGIBILITY AND PROGRAM ENROLLMENT

A. Eligible Population

RIte Smiles eligible population is defined to consist of information provided in (Sections 2.4.A through and including 2.4.I) 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 aid and are described herein.

B. Children and/or Young Adults Born on or After May 1, 2000 under 25 Percent (25%) of the FPL

This aid category consists of children and/or young adults born on or after May 1, 2000, living in families whose income is under 250 percent of the FPL. Coverage in the RIte Smiles program continues until the member's twenty-first (21st) birthday.

C. Children and/or Young Adults in Substitute Care

This aid category includes children and/or young adults 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 and/or young adults receive the same benefits as any other children and/or young adults (e.g., FIP and FIP-related).

D. Children and/or Young Adults with Special Health Care Needs

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

E. Excluded Populations

The following children and/or young adults are excluded from participation in RIte Smiles:

- Children and/or young adults residing in a nursing home or an intermediate care facility for the persons with intellectual/developmental disabilities (ICF/1/DD);
- Children and/or young adults with third-party coverage for dental benefits; and,
- Children and/or young adults residing outside of Rhode Island.

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

F. New Eligibility Groups

The State reserves the right to add new eligibility groups 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 3.1.I 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 3.3 of this Agreement.

G. Eligibility Determination

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

H. Guaranteed Eligibility

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

I. Voluntary Selection of Dental Plan by Members

At the time of application or at other times determined in its sole discretion by EOHHS, applicants or beneficiaries will be offered the opportunity to select a Dental Plan or another program option, if applicable. In accordance with 42 CFR 438.54, beneficiary's enrollment in a Dental Plan is voluntary. If an eligible member does not select a Dental

Plan or does not select another program option, he or she will automatically be assigned to a Dental Plan. This process does not apply to periods designated for open enrollment.

J. Automatic Assignment to Dental Plans

EOHHS will employ a formula, or algorithm deemed by EOHHS to be in the best interests of the members that may include quality metrics, Dental Plan performance of contract requirements including but not limited to, Dental Plan financial performance, or other considerations such as, Market Share Capacity Limit to assign any eligible member that does not make a voluntary selection.

K. Automatic Re-Assignment Following Resumption of Eligibility

Members who are disenrolled from a Dental Plan, due to loss of eligibility and who regain eligibility within sixty (60) calendar days of disenrollment, may select a Dental Plan of their choice. Members who do not make a Dental Plan selection will be automatically re-enrolled, or assigned, into their previous Dental Plan upon reinstatement of their Medicaid eligibility. If more than sixty (60) calendar days have elapsed and the Medicaid member does not make a Dental Plan selection at the time eligibility was reinstated, the member will be auto-assigned to a Dental Plan based on EOHHS' algorithm referenced in Section 2.4.J.

L. Lock-in

Following their initial enrollment into a dental plan, RIte Smiles eligible children and/or young adults 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 2.5.J Member Disenrollment.

M. Market Share Capacity Limit

EOHHS may, at its sole discretion, institute a market share capacity limit if more than one (1) Bidder is awarded a Contract. Under this situation, EOHHS may implement a market share limit for any Contractor using the following methodology:

- If two (2) Bidders are awarded the Contract, no one (1) Contractor will be assigned more than sixty percent (60%) of the total market share;
- If three (3) or more Bidders are awarded the Contract, no one Contractor will be assigned more than fifty percent (50%) of the total market share.

EOHHS has the sole authority to determine the total market share and the implementation of a market share capacity limit. In the event that more than one (1) Bidder is awarded a Contract and enrollment with a Contractor exceeds the market share capacity limit, EOHHS may reduce enrollment based on a process and established by EOHHS. The process established by EOHHS will provide the Contractor with sufficient, timely and appropriate notice, allow for enrollee choice, and meet the objectives and goals of the RIte Smiles program.

Member choice shall always prevail and shall not be impacted by market share capacity limit.

2.5 MEMBER ENROLLMENT AND DISENROLLMENT

A. Dental Plan(s) Marketing Requirements

The Contractor is required to submit to EOHHS for review and written approval all materials, in any media, and any other materials associated with marketing for open enrollment periods that will be distributed to members or potential members (referred to as member and marketing materials) before they are distributed. Plan materials developed or distributed by subcontractors or providers also require review and approval before being distributed. Member materials include, but are not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, system generated letters, newspaper, TV and radio advertisements, call scripts, surveys and other materials as identified by EOHHS. The Contractor agrees to submit marketing strategy and plans if requested.

The Contractor is required to use RI EOHHS Model Member Handbook and Appeals/Grievances Notification Model Documents. Contractors are required to add Plan specific language to Model Documents. EOHHS requires the review of and prior approval of all materials related to or containing information that is intended to be used for education, outreach or marketing purposes for Plan enrollees or prospective enrollees. Plans are required to comply with the information requirements and marketing guidelines under 42CFR 438.10 and 438.104; RI EOHHS Guidelines for Marketing and Member Communications for Medicaid Managed Care Program as set forth in the CMS Medicaid and CHIP Final Rule.

The Contractor may conduct marketing campaigns for members subject to the restrictions noted in RI EOHHS Guidelines for Marketing and Member Communications for Medicaid Managed Care Program, Rite Smiles, Non-Emergency Medical Transportation and Medicare-Medicaid Program (*ad hoc* materials). The Contractor agrees not to display or distribute marketing materials, nor solicit members in any other manner, within fifty (50) feet of eligibility and enrollment offices unless it has received permission to do so from EOHHS.

The Contractor agrees to develop member materials that comply with 42 CFR 438.104 and RI EOHHS Guidelines for Marketing and Member Communications for Medicaid Managed Care Program, Rite Smiles, Non-Emergency Medical Transportation and Medicare-Medicaid Program (*ad hoc* materials). Written material must use easily understood language and format and satisfy all the requirements provided for in 42 CFR 438.10 (c)(1). In accordance with 42 CFR 438.104(b)(2)(i), the Contractors may not communicate, either in writing or orally, any statements that enrollees must enroll in their Health/dental plan to obtain benefits or to not lose benefits. The Contractor may not communicate, either in writing or orally to enrollees that CMS, the Federal or State government or similar entity endorse the Contractor. All written material must be written at no higher than a sixth-grade level. Written material must be available, upon request, in

alternative formats (e.g. audio and large print) 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 written materials for members and potential enrollees must be written in a font no smaller than twelve (12) point and include a large print tagline and taglines in the prevalent non-English languages in the State which include: (1) Spanish, (2) Portuguese, (3) Chinese, (4) French Creole (Haitian Creole), (5) Mon-Khmer/Cambodian, (6) French, (7) Italian, (8) Laotian, (9) Arabic, (10) Russian, (11) Vietnamese, (12) Kru (Bassa), (13) Ibo, (14) Yoruba*, and (15) Polish. Taglines must explain the availability of written translations or oral interpretation to understand the information provided and the toll-free telephone number of the entity providing choice counseling services as required by 42 CFR 438.71(a). The Contractor must inform and make available interpretation services, including oral interpretations and auxiliary aids such as TTY/TDY and American Sign Language, to members and potential enrollees at no cost as required by 42 CFR 438.10(d)(4). Materials will be available in alternate languages for those members with limited or no English proficiency. The State will determine whether the 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 outreach staff and provider network, is encouraged to identify uninsured patients who may be Medicaid eligible and to make appropriate referrals to the appropriate contacts such as navigators, DHS and Healthsource RI to assist in determining eligibility for Medicaid programs.

When engaged in marketing its programs or in marketing targeted to potential or current members, the Contractor: (1) will not distribute marketing materials to less than the entire service area; (2) will not distribute marketing materials without the approval of EOHHS (3) will not seek to influence enrollment in the Health/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. The Contractor may provide information electronically to members if the following conditions are satisfied:

- The information is in a format that is readily accessible.
- The information is in a location on the Contractor's website that is prominent and readily accessible.
- The information is provided in an electronic form which can be electronically retained and printed.
- The information is consistent with content and language requirements.
- The Contractor notifies the enrollee that the information is available in paper form without charge upon request.
- The Contractor provides, upon request, information in paper form within five (5) business days.

Nondiscrimination Provisions (Section 1557 of the Patient Protection and Affordable Care Act) Section 1557 and its implementing regulation (Section 1557) require covered entities to post – in their significant publications and communications – nondiscrimination notices in English, as well as taglines in at least the top fifteen (15) languages spoken by individuals with limited English proficiency (LEP) in the State(s) served.

B. Dental Plan(s) Enrollment Procedures

The State will conduct enrollment activities for eligible individuals under this agreement. All eligible children and/or young adults will be enrolled in the RIte Smiles program by the State. The State will supply the Contractor monthly with a list of members newly enrolled into the Dental Plan, as discussed in Section 2.5.D 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 newly enrolled members effective on the first (1st) 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) 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 race, color, national origin, sex, sexual orientation, gender identity, disability, age, ethnicity, language needs, health status, or need for health services.

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.

The State will, at times mutually agreed upon by the State and the Contractor (such approval not to be unreasonably withheld), conduct an open enrollment process for existing Rite Smiles members. Each member will be given the choice of the Rite Smiles program participating dental plans. Siblings within a family unit will be required to participate in the same dental plan, unless there is a compelling reason as determined by the State. Members who are so auto-assigned will be allowed to choose a different dental plan within the first ninety (90) days of being assigned to the plan, pursuant to the terms as outlined in Section 2.4.J. Enrollment shall be assigned to the Contractor following the effective date upon reasonable determination of the Contractors readiness. The State may institute a Market Share cap as outlined in section 2.4.M of this Agreement.

The Contractor shall not use any policy or practice that has the effect of discriminating against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability.

C. Change in Member 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 and/or young adult 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.

The Contractor shall ensure via its contracts that all subcontractors report such changes in status to the Contractor.

D. 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.

E. 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.

F. 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 (4) 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 described 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.

G. 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 a member 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 (24) hour Dental Plan telephone number for use in urgent or emergent medical situations; and,
- Telephone number for Member Services function (if different).

H. Member Handbook

The Contractor agrees to use the Model Member Handbook developed by EOHHS and to make it available to all new and existing members at all times. An electronic copy of the Model Member Handbook shall be included on the Contractor's member website and shall be available for viewing and downloading. Additionally, members may request an alternate version (paper, audio or specific language) by contacting the Contractor's member services department.

The Contractor shall update the handbook when there are material changes needed as determined by EOHHS. The Contractor will review all their member materials on an annual basis for any needed revisions.

The Contractor agrees to mail a member handbook or new member packet to all members within ten (10) calendar days of being notified of their enrollment. In the event that a former Health/Dental plan member re-enrolls in the same Health/Dental plan within less than one (1) year from the date of disenrollment, the Health/Dental plan may defer mailing a new member packet, unless the materials have been revised since the disenrollment date.

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 (audio, larger print, alternate languages) 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 or require materials in alternate

languages. 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 or new member packet except for those members with special needs that warrant an alternative format shall be offered.

EOHHS will provide model member notices for the Contractor to use in notifying members of denied authorization or services, appeal and grievance results and grievance and appeal rights.

This is not an all-inclusive list of EOHHS model notices. The Contractor must ensure that its subcontractor and delegates use, at a minimum, these required notices.

i. Required Information

The New member packet shall be written at no higher than a sixth-grade level and contain at least the following:

- Information on how to obtain a member handbook and Provider Directory
- Information on how to obtain covered benefits, out of plan benefits and non-covered benefits
- Information on how to contact member services and the hours of operation
- What to do in case of an emergency
- To the extent available, quality and performance indicators, including enrollee satisfaction

EOHHS will provide the Model Member Handbook to be written at no higher than a sixth-grade level and will contain at specific content pursuant to 42 CFR 438.10. The Contractor will be permitted to add plan specific information to the model handbook which will contain:

- EOHHS supplied definitions
- Information on member services.
- Information on how to choose a dentist. Each member may choose his or her dentist to the extent possible and appropriate.
- Information on what to do when family size changes.
- Information on obtaining transportation.
- Information on Interpreter and Translation Services.
- Any restrictions on the member's freedom of choice among network providers.
- Information on amount, duration, and scope of Covered Services, including how to access 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 opinion.
- The extent to which, and how, after-hours and emergency coverage are provided, including:

- What constitutes an emergency dental condition.
- The fact that prior authorization is not required for Emergency Services.
- The process and procedures for obtaining Emergency Services, including use of the 911-telephone system or its local equivalent.
- The locations of any Emergency Services covered under the Agreement.
- The fact that, subject to the provisions of this section, the member has a right to use any hospital or other setting for emergency care.

- Policy on referrals for specialty care and other benefits not furnished by the member's dentist.
- Information on Advance Directives as set forth in 42 CFR 438.3(j)(2) and 42 CFR 422.128. The Contractor agrees to reflect any changes in State law with regard to Advance directives in its written material within ninety (90) days of the effective date of the change as set forth in 42 CFR 438.6(i)(4).
- Information on out-of-plan or out-of-network benefits.
- Information on member's rights and responsibilities, including, in conformance with State and Federal law. 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).
- Information that a member may request disenrollment at any time from the Health/dental plan.
- Information on cost-sharing responsibilities (if applicable; may be included as an insert).
- Information on non-covered services. How and where to access any benefits that are available under the State plan but are not covered under this Agreement, including any cost sharing, and how transportation is provided.
- Information on member and provider fraud, waste and abuse including:
  - Examples of possible Medicaid fraud and abuse which might be undertaken by providers, vendors and enrollees
  - Information for members 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
  - Instructions about how members contact EOHHS' Fraud Unit

- Information on grievance, appeal and fair hearing procedures and timeframes, as provided in 42 CFR 438.400 through 42 CFR 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 within the timeframes specified for filing; and the member may be liable for the cost of any continued benefits while the appeal is pending, if the final decision is adverse to the enrollee as defined in 42 CFR 438.420.
- Information on other resources to assist members

- Additional information that is available upon reasonable request, including the following:
  - Information on the structure and operation of the Contractor.
  - Reports of transactions between the Contractor and parties of interest that are provided to the State, or other agencies.
  - Information on any physician incentive plans as set forth in 42 CFR 438.6.

Also, to be included is the following information:

- How does the Health/Dental plan review and approve Covered Services?
- What if I refuse referral to a participating provider?
- Does the Health/Dental plan require that I get a second opinion for any services?
- How does the Health/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 Health/Dental plan pay providers?
- If I am covered by two or more Health/Dental plans, what do I do?

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

- Each enrollee is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.

- Each enrollee is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
- Each enrollee is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
- Each enrollee is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Each enrollee is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR Part 164.
- Each enrollee is guaranteed the right to received information on the managed care program and plan into which he/she is enrolled.

The Contractor must make available in electronic or paper form the provider directory as provided for in Section 2.8.H of this Agreement (Provider Network Lists).

The Contractor must provide members, in adherence with 42 CFR 438.10(f)(4) with written notice of any significant changes in enrollee rights or information at least 30 days before the intended effective date of the change.

The Contractor shall comply with requirements as specified in 42 CFR 438.10. The Contractor may provide enrollee/member information electronically if all the following conditions are satisfied:

1. The information is readily accessible and placed in a location that is prominent.
2. The information can be electronically retained and printed.
3. The information provided is consistent with the language and content requirements.
4. The enrollee is informed that the information is available in a paper form without charge upon request and the Contractor grants the request within 5 business days.

The Contractor shall comply with requirements as specified in 42 CFR 438.10(i)(1) as follows:

> (i) When appropriate Contractor must make available in electronic or paper form, the following information about its formulary:
>
> (1) Which medications are covered (both generic and name brand).
>
> What tier each medication is on.

Formulary drug lists must be made available on the Contractor's Web site in a machine readable file and format as specified by the Secretary.

ii. State Approval

The Contractor agrees to submit all member materials to EOHHS for approval prior to its use. This includes any changes made to language previously approved by EOHHS. The Contractor also agrees to make modifications in member materials if required by EOHHS. The Contractor understands that materials submitted for review and approval of revisions are subject to review and approval of the entire content and not limited to the revisions.

iii. 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.

I. Transitioning Members between Dental Plans

It may be necessary to transition a member between Dental Plans for a variety of reasons. The Contractor will have written policies and procedures for transferring relevant patient information in an efficient manner, including medical records and other pertinent materials, when transitioning a member to or from another Dental Plan. The Contractor will transfer this information at no cost to the member. The Contractor will also transfer this information at no cost to the member in instances where the member had received Covered Services from a participating network provider who is no longer in the provider network and became a Non-Participating Provider. The Contractor may make a reasonable charge to a member who requests his or her own personal copy of a medical record, not to exceed limits established in the Rhode Island Department of Health Rules and Regulations for the Licensure and Discipline of Physician (R5-37-MD/DO).

The Contractor agrees to have in effect a transition of care policy to ensure continued access to services during a transition of a member to a new MCO when in the absence of continued services, the member would suffer serious detriment to either health or be at risk of hospitalization or institutionalization. Contractor agrees to provide care plan and associated documentation to new MCO in mutually agreed upon data fields and file format per EOHHS' discretion and request. This policy must include:

- Access to services consistent with the access the member previously had, and the member is permitted to retain their current provider for a period of one-hundred and eighty (180) days if that provider is not in the Contractor's network;
- Referrals to appropriate providers that are in the network;
- Fully and timely compliance with requests for historical utilization data from the new MCO in compliance with Federal and State law; and
- Any other necessary procedures as specified by EOHHS to ensure continued access to services to prevent serious detriment to the member's health or reduce the risk of hospitalization or institutionalization.

J. Member Disenrollment

i. 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 The Contractor is responsible for providing member assistance to submit disenrollment request to EOHHS, including translation services. Disenrollment information and EOHHS *Medicaid Health Plan Change Request Form* must be accessible to member on Bidder(s) website and mailed to member upon disenrollment request.

ii. 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 ninety (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. The contract specifies that a recipient (or his/her representative) must request disenrollment by submitting an oral or written request to the State (or its agent) or the MCE, if the State allows the MCE to process disenrollment requests, per CMS contract rule 42 CFR 438.56(d)(1)(ii).

The contract allows enrollees to request disenrollment if: the enrollee needs related services to be performed at the same time; not all related services are available within the provider network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk, per CMS contract rule 42 CFR 438.56(d)(2)(iii).

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 disenrollment is 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).

iii. Disenrollment Effective Dates

Member disenrollments will occur on a monthly basis, and the Contractor will normally be notified at the first financial cycle (schedule determined by EOHHS), for disenrollments effective at midnight on 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 shall 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.

2.6 IN-PLAN SERVICES

A. Description of Comprehensive Benefit Package

i. 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 the Contractor agrees to be required to coordinate but will not be responsible to deliver and which will be reimbursed fee-for-service or through the member's medical managed care benefit.

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.

ii. Dental EPSDT Services

Contractor agrees to provide the full early and periodic screening, diagnosis, and treatment (EPSDT) related to dental services to all eligible children and/or young adults up to age twenty-one (21) in accordance with the Dental 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 Dental EPSDT Periodicity Schedule that assures that all EPSDT billable services are coded with established CPT/HCPC codes and submitted through the normal administrative claims processes. These policies and procedures shall emphasize outreach and compliance monitoring for children and/or young adults 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 and/or young adults shall be evaluated as necessary for further diagnosis. This diagnosis is used to determine the treatment needs of the enrollee.

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, if 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 and/or young adult'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.
- Reach out to providers to assure compliance with EPSDT screening including: 1) Identify the appropriate codes that providers should use to

track EPSDT services, 2) the fee schedule used to reimburse for services, and 3) assurance that the fee schedule is sufficient to incentivize providers to offer and submit the service in their normal billing cycle.

This process must consider and accommodate 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.

iii. 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 Dental 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) to allow for access to services and treatment for its members who are visually or hearing impaired and/or who may have physical or intellectual disabilities.

B. 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.

A 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 above paragraph, is not required to do so if Contractor objects on moral or religious grounds. If Contractor elects this option, Contractor shall provide information about the services that 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 implementation of such a policy.

C. 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.

D. New In-Patient 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 3.1.I 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 3.1.I 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.

E. Transportation

The State has a centralized non-emergency transportation service for all Rite Smiles members. Rite Smiles members are eligible for transportation services to Medicaid allowable services either through no cost bus pass, car/van or, when medically necessary, chair vans or ambulance. Contractor agrees to coordinate the arrangement of transportation with EOHHS transportation broker for its members through this centralized service. This service is offered as transportation of last resort to members who are unable to secure transportation to their dental appointments.

2.7 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 Dental 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 providers to whom the member was referred.

Pursuant to 42 CFR 438.208(b)(3), the Contractor will make a best effort to conduct an initial screening of each enrollee's needs, within ninety (90) days of the effective date of enrollment for all new enrollees and will make subsequent attempts to conduct an initial screening of each member's needs if the initial attempt to contact the member is unsuccessful.

In accordance with 42 CFR, 438.208(b)(5), the Contractor will ensure that each provider furnishing services to members maintains and shares an enrollee health record in accordance with professional standards.

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.

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.

2.8 PROVIDER NETWORKS

A. Network Compositions

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 shall include a sufficient number of general and pediatric dentists to meet the service accessibility standards outlined later in this section as well 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 and/or young adults 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 maintain and regularly monitor a network of appropriate providers that is supported by written agreements and can sufficiently demonstrate to EOHHS' satisfaction the Contractor's ability to provide covered services under this Agreement. The Contractor shall maintain a Network Development Plan to address 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. Members must have access to services that are at least equal to, or better than community norms. Members must be allowed to choose his or her network provider to the extent possible and appropriate. 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 and/or young adults with disabilities.

If the Contractor declines to include individual(s) or groups of providers in its network, the Contractor agrees to give the affected providers written notice of the reason for its decision and will notify EOHHS of this decision within ten (10) calendar days. Similar notice is to be provided if the Contractor removes a provider from its network for program integrity or quality of care concerns.

The Contractor agrees that if the network is unable to provide necessary services, covered under this Agreement, to a particular member, the Contractor will adequately and timely cover these services out of network, for as long as the Contractor is unable to provide them. The Contactor will require the out-of-network providers to coordinate with them for payment and ensures the member will be held financially harmless.

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 2.9 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, fully considering and focusing upon the urgency of need for services.

Nothing in this section shall 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

To meet the needs of members, the Contractor maybe required to include providers who

practice or are located outside of the State and/or allow 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 enable any such providers to become a Participating Provider. Contractor may inquire as to member's interest in switching to a closer in-State, in-network provider.

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

The Contractor shall have written agreements with all providers in its network that meet State and Federal requirements. When the Contractor contracts with providers, the Contractor shall:

- Not execute provider agreements with providers who have been excluded from participation in the Medicaid/CHIP and/or Medicare programs pursuant to Sections §1128 or §1156 of the Social Security Act or who otherwise are not in good standing with RI Medicaid.
- Have written policies and procedures for the selection and retention of providers. These policies and procedures shall not discriminate against providers who service high risk populations or specialize in conditions that require costly treatment.
- The Contractor shall have written policies and procedures for the selection and retention of providers that comply with 42 CFR 438.214 and with the State's policy for credentialing and re-credentialing.
- Not discriminate for the participation, reimbursement or indemnification of any provider who is acting within the scope of their license or certification as defined by State law, solely based on that license or certification.
- Have policies and procedures to assure providers and office staff comply with the cultural and disability competency requirements
- Give affected providers written notice if the Contractor declines to include individual or groups of providers within its network,
- Each individual or group provider in the network must has a unique identifier assigned to them.
- The Contractor shall have written agreements with all providers in its network that meet State and Federal requirements.
- The Contractor shall ensure that each provider furnishing services to enrollees maintains and shares a member health record in accordance with professional standards.

B. 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 (1) or more transition visits with a non-network provider.

C. FQHCs/RHCs with Dental Clinics

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

D. Hospital-Based Dental Clinics

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

E. 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.

F. Mobile Dental Providers

The State considers mobile dental providers to be an important part of the dental delivery system for children and/or young adults enrolled in RIte Smiles. Although mobile dental providers are not equipped to provide a child and/or young adult'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.

G. 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 of this Agreement.

H. Provider Directory

The Contractor must make available in electronic form and upon request in paper form, the following information about its network providers:

- The provider's name as well as any group affiliation
- Street address(es)
- Telephone number(s)
- Web site URL, as appropriate
- Specialty, as appropriate
- Whether the provider will accept new enrollees
- The provider's cultural and linguistic capabilities, including languages (including

American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training

- Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment

Information included in a paper provider directory must be updated at least on a monthly basis and electronic provider directories must be updated no later than thirty (30) calendar days after the Contractor receives updated provider information. Provider directories must be made available on the Contractor's, web site in a machine-readable file and format as specified by the Secretary.

I. Network Changes

The Contractor agrees to provide EOHHS, on a quarterly basis, with a list of all its participating dental providers, including those whose practices are open to additional RIte Smiles members. The Contractor will monitor the access and availability of their specialty physician/provider network and report any knowledge of suspected, impending or known significant changes to EOHHS within three (3) calendar days. A significant change in the network includes any change that would affect the adequacy of capacity and timeliness of services, including changes in the Contractor or its subcontractor's services, benefits, geographic service area, composition of or payments to its provider network. Enrollment of a new population in the MCO is also considered to be a significant change. Contractor is required to adhere to the Compliance Policy regarding member notification and choice.

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.

J. 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. Contractor must comply with the requirements as specified in 42 CFR 438.214.

K. Indian Health Care Provider (IHCP)

The Contractor agrees, in accordance with 42 CFR 438.14(c)(2), that when an IHCP that offers covered benefits is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of the Dental Plan, the IHCP has the right to receive its applicable encounter rate published annually in the Federal Register by the IHS, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State plan's FFS payment methodology.

L. Networks Related to Indians

The Contractor will permit any Indian who is enrolled in a non-Indian MCE and eligible to receive services from a participating I/T/U provider, to choose to receive covered services from that I/T/U provider, and if that I/T/U provider participates in the network as a primary care provider, to choose that I/T/U as his or her primary care provider, as long as that provider has capacity to provide the services. The Contractor is required to demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian enrollees who are eligible to receive services from such providers. The Contractor will ensure that I/T/U providers, whether participating in the network or not, be paid for covered Medicaid or CHIP managed care services provided to Indian enrollees who are eligible to receive services from such providers either (1) at a rate negotiated between the managed care entity and the I/T/U provider, or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider. The Contractor must make prompt payment to all I/T/U providers in its network as required for payments to practitioners in individual or group practices under federal regulations at 42 CFR 447.45 and 42 CFR 447.46.

M. Provider Credentialing

EOHHS requires the Contractor to ensure that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements, in accordance with 42 CFR 438.608(b), 42 CFR 455.100-106, and 42 CFR 455.400-470. This provision does not require the network provider to render services to FFS beneficiaries. This screening is to include provider assignment to risk level to determine scope of screening activity, verification of provider licensure, criminal background checks, site visits, federal database checks, review of disclosures. The following information would be provided to the State agency: the provider's identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier, Federal taxpayer identification number, and the State license or certification number of the provider. EOHHS will work with the Contractor to develop a process to provide key information to the State agency to conduct the screening and to facilitate the collection of provider disclosures directly from the providers in accordance with 42 CFR 455.104 and 42 CFR 455.106.

The Contractor may execute the network provider agreement pending the outcome of the enrollment process for up to one-hundred and twenty (120) days but must terminate the provider from its network immediately upon notification from the state that the network provider cannot be enrolled or the expiration of the one-hundred and twenty (120) day period without enrollment of the provider. The 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 the state in which the covered service is furnished, and are qualified to perform their services. The 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 the Contractor's medical management standards.

The Contractor agrees that it will not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The 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 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 is required to report providers who are denied participation via the MCO Program Integrity Quarterly Report.

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

N. Telehealth / Teledental

The Contractor is required to identify policies and procedures which describe the organization, policies and procedures surrounding a Telehealth program. A Telehealth program should include but not be limited to the following covered services; patient education; medication management; equipment management; review of patient trends and/or other changes in patient condition necessitating professional intervention; and other activities deemed necessary and appropriate according to a member's plan of care.

2.9 SERVICE ACCESSIBILITY STANDARD

A. 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 as described in Attachment B; Schedule of Non-Covered Benefits.

B. Travel Time

Contractor will develop, maintain and monitor a network that is geographically accessible to the population being served. Pursuant to 42 CFR 438.68, the Contractor must ensure its network is compliant with the State established provider-specific network adequacy standards. Contractor will make available to every member a pediatric dentist, whose office is located within the lesser of thirty (30) minutes or (30) miles of the member's place of residence. Members may, at their discretion, select a participating general dentist. Contractor will make available to every member a general dentist whose office is located within the lesser of twenty (20) minutes or (20) miles of the member's place of residence. Members, at their discretion, may select a participating provider whose office is located farther from the time/distance standards identified above. These network standards include all geographic areas covered by the Contractor. EOHHS may, at its sole discretion, grant exceptions to the time and distance standards. The Contractor shall request an exception in writing and shall provide evidence supporting the request. EOHHS's approval of an exception shall be in writing. Should EOHHS permit an exception to these standards, access to that provider type will be monitored by EOHHS on an ongoing basis and may result in additional reporting requirements for the Contractor. These standards will be published on the EOHHS web site and will be made available at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services.

C. Days to Appointment for Non-Emergent Conditions

Contractor agrees to make services available within forty-eight (48) hours 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.

D. 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

A. 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.

B. 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), excluding State observed holidays.

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

C. 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.

- 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 42 CFR 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 review and approval the written materials to be used to fulfill these requirements in accordance with *RI EOHHS Guidelines for Marketing and Member Communications for Medicaid Managed Care Program*.

D. Cultural Competency

As required by 42 CFR 438.206 and 42 CFR 438.10, the Contractor shall participate in EOHHS's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency and diverse cultural and ethnic backgrounds.

Contractor must ensure that services are provided in a culturally competent manner to all members. Culturally competency is the ability of providers and organizations to effectively deliver healthcare services that meet the social, cultural and linguistic needs of members.

Specifically, Contractor shall:

1. Develop policies and procedures for the provision of language assistance services which includes, but is not limited to interpreter and translation services and effective communication assistance in alternative formats.
2. Shall provide language and cultural competence training to all employees, subcontractors and providers. Training should include the potential impact of linguistically and cultural barriers on members obtaining services.
3. 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;
4. Must make interpreter/translation 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

5. 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 shall establish and monitor performance standards for provider service functions. 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 Attachment. The provider education program shall include a quarterly provider newsletter and shall communicate, at least annually, changes in benefits, member's rights and responsibilities.

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

A. General

The Contractor agrees to comply with all OHIC UR/QA standards, in addition to specific standards described in this section. A health care professional who has the appropriate clinical expertise in treating the member's condition or disease may decide to deny a service authorization request or to authorize a service based on Medical Necessity in an amount, duration or scope that is less than requested.

As specified in 42 CFR 438.700(b)(1), intermediate sanctions may be imposed should the Contractor fail substantially to provide medically necessary service that it is required to provide, under law or under its contract with EOHHS, to an enrollee covered under this contract.

B. Dental Director's Office

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

The Dental Director's qualifications and responsibilities shall at a minimum include, but are not limited to the following:

- Possess an unencumbered 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.

i. Change in Director Personnel

The Contractor will inform EOHHS in writing within three (3) business days if the Dental Director provides notice of resignation or if the Contractor terminates the Dental Director. The Contractor will inform EOHHS in writing as early as practicable but no later than the first business day after a Dental Director's departure as to which individual will serve in the Dental Director capacity on an interim or permanent basis during a change in personnel or during an extended absence. The Contractor will attest that any individual serving as Dental Director will meet the qualifications specified in Section 2.12.B.

C. Utilization Review and Quality Assurance (UR/QA)

i. 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

ii. Utilization Review

The Contractor agrees to have written utilization review policies and procedures that include protocols for denial of services, prior approval, physician profiling and retrospective review of claims. As part of its utilization review function, the Contractor also agrees to have processes to identify utilization problems and undertake corrective action. As part of this function, the 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. The Contractor shall provide standard authorization decisions within fourteen (14) calendar days of the request for authorization unless the member requests an extension, or the Contractor justifies a need for additional information and the Contractor can demonstrate how the extension is in the member's interest. If there is a fourteen (14) day extension, the Contractor will comply with all requirements as specified in 42 CFR 438.404(c). The Contractor is permitted to conduct utilization review and place appropriate limits on services while supporting member with ongoing or chronic conditions so long as services are authorized in a manner that reflects the

member's ongoing needs for such services and supports. The Contractor must make an expedited service authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than seventy-two (72) hours after receipt of the request for service for cases in which a provider indicates, or the Contractor determines that following the standard authorization timeframe could seriously jeopardize the enrollee's life or health or his/her ability to attain, maintain, or regain maximum function. The Contractor may extend the seventy-two (72) hour expedited authorization by up to fourteen (14) calendar days if the member requests an extension, or if the Contractor can justify a need for the additional time and the extension is in the member's best interest.

The Contractor shall demonstrate to EOHHS that compensation to individuals or entities that conduct utilization management activities is not structured 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 all tentative formats and how to access those formats.

iii. Enhancement of Prior Authorization

The Contractor is required to collaborate with a member's treating provider to ensure access to appropriate and efficient use of services that are medically necessary and of high quality. An anticipated outcome of this activity is greater member satisfaction resulting in fewer appeals that result in a Fair Hearing.

In addition, the Contractor must demonstrate as required by the Rhode Island Department of Health, Rule and Regulations for the Utilization Review of Health Care Services (R23-17-.12-UR) Section 4.1.4 and NCQA Accreditation Standards, a reasonable attempt to collaborate with the provider to obtain sufficient information as part of the prior authorization decision. If the Contractor

is unable to render a determination because of insufficient information, it must demonstrate that it has made every attempt to notify the patient and provider of the type of specific information that is needed in order to make such a decision. The Contractor is required to engage in a collaborative process between the Contractor and the treating provider. The initial authorization conversation between the Contractor and the treating provider shall include the following:

- Ongoing dialogue and sharing of information as needed to obtain the necessary information to make an informed decision. For example, the provision of evidence based clinical guidelines and/or criteria to the treating provider that is pertinent to the specific utilization review.
- As appropriate, the use of the allowed fifteen (15) day extension for receipt of additional and needed information for non-urgent cases and seventy-two (72) hours extension for urgent and emergency cases

iv. Quality Assurance

The Contractor agrees to have a written quality management plan that assesses, monitors, assures, and improves the quality of dental care delivered over a wide range of clinical and dental service delivery areas. The Contractor's quality management plan shall be developed and implemented by professionals with adequate and appropriate experience in quality management. The quality management plan shall describe the contractor's comprehensive quality assessment and performance improvement program. The quality management plan shall focus on clinical and nonclinical areas, including at least the following items:

- Quality improvement projects as further described below
- Collection and submission of performance measurement data as further described below
- Collection and submission of patient and provider satisfaction data as further described below
- Mechanisms to detect both underutilization and overutilization of services
- Mechanisms to assess the quality and appropriateness of care furnished to enrollees, especially those with special health care needs as described in the Rhode Island Comprehensive Quality Strategy
- Strategy for systematic data collection
- Strategy for providing interpretation of data to network providers
- Strategy for making needed changes when problems are found

The Contractor will also submit an annual evaluation of the quality management plan and a work plan describing the quality management activities for the upcoming year. The quality management plan, evaluation, and work plan are submitted to the state according to the reporting calendar.

Quality improvement projects: The Contractor shall complete two (2) quality

improvement projects, approved by EOHHS, within a calendar year. The Contractor shall measure performance using objective quality indicators. The Contractor shall conduct root cause analyses to identify barriers and opportunities for intervention. The Contractor agrees to implement interventions to achieve improvement in quality. The Contractor agrees to evaluate the effectiveness of the interventions. The Contractor agrees to report the status and results of each project to the State, or its designees, as required in the reporting calendar. Contractor agrees to support joint quality improvement projects involving Dental Plans and EOHHS. Contractor agrees to use the Quality Improvement Activity Form developed by NCQA for reporting all quality improvement activities to the State. The Contractor agrees to cooperate fully with the State or its designees in any efforts to validate quality improvement projects. The Contractor agrees to support joint quality improvement projects involving Health/dental plans and EOHHS.

Performance measurement data: The Contractor agrees to provide the results of HEDIS®, HEDIS®-like, and CMS quality measures for oral health to the state, or its designees, as required in the reporting calendar.

Member and Provider Satisfaction data: The Contractor agrees to perform separate member and provider satisfaction surveys on at least an annual basis. The methodology should include a representative sample of members and providers, respectively. Survey questions and methodology should be approved by EOHHS prior to administration. The Contractor agrees to provide member and provider satisfaction results to EOHHS according to the due dates on the reporting calendar.

Contractor will be required to attend monthly Oversight meetings with EOHHS staff to review contract performance, compliance, quality assurance, continuous quality improvement. As part of EOHHS' strategic efforts to move from reactive contract performance evaluation to active contracting monitoring and oversight, EOHHS has aligned vendor management efforts towards Active Contract Management (ACM) to meet the Managed Care Goals.

Contractor shall be required to apply high-frequency use of data when meeting with EOHHS during monthly Oversight meetings. Contractor shall present findings from internal analysis, provide solutions to improved delivery system performance and set reasonable improvement benchmarks with EOHHS to meet identified performance goals.

v. 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 3.9 Confidentiality of Information).

vi. 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.

The Contractor will undergo annual, external, independent reviews of the quality, timeliness, and access to the services covered under each contract, in accordance with 42 CFR 438.350.

vii. Practice Guidelines

Contractor shall 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.

viii. 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.

Contractor will provide services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid, as set forth in 42 CFR 440.230 and for members under the age of twenty-one (21), as set forth in 42 CFR 441 Subpart B.

2.13 OPERATIONAL DATA REPORTING

A. General

The Contractor shall comply with all of the reporting requirements established by EOHHS. EOHHS shall provide the Contactor with the appropriate reporting formats, instructions, submission timetables and technical assistance, as required. EOHHS may at its discretion, change the content, format or frequency of reports. If the Contractor delegates responsibility to a subcontractor, the Contractor shall ensure the subcontracting relationship and subcontracting documentation comply with EOHHS reporting requirements. EOHHS will develop and maintain a *Managed Care Reporting Calendar and Templates for Dental Plans* to be used as a living document of the reporting requirements.

EOHHS may, at its discretion, require the Contractor to submit additional reports both ad-hoc and reoccurring. If EOHHS requests any revisions to the reports already submitted, the Contractor shall make the changes and re-submit the reports, according to the time frame and format required by EOHHS.

The Contractor shall submit all reports to EOHHS, unless otherwise indicated in this contract according to the schedule below:

Deliverables		**Due Date**
Daily Reports		Within two (2) business days
Weekly Reports		Wednesday of the following week
Bi-Weekly Reports		5th and 20th of each month
Monthly Reports		Last business day of the following month
Quarterly Reports		Last business day of the month following the end of the quarter
Semi-annual Reports		January 31 and July 31
Annual Reports		As specified by the State

Ad Hoc/On Demand		As specified by the State

The Contractor will submit all reports electronically and, in the manner, and format prescribed by EOHHS and shall ensure that all reports are complete and accurate. The Contractor will submit reports to EOHHS and other State agencies or delegates as indicated. Except as otherwise specified by EOHHS, all reports shall include all Lines of Business governed by this contract.

The Contactor shall transmit to and receive from EOHHS or its designee, all transactions and code sets in the appropriate standard formats as specified under HIPAA and as directed by EOHHS.

As part of its QM/QI program, the Contractor shall review all reports and data submitted to EOHHS to identify any instances and/or patterns of such non-compliance, including missing/incorrect information, and quality improvement activities to identify and implement actions to correct instances of non-compliance and to address patterns of non-compliance, and identify and improve performance.

The Contractor agrees to provide EOHHS with uniform utilization, quality assurance, and Member satisfaction/complaint data on a regular basis, described below, and additional data in a manner acceptable to EOHHS. 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 Contractor also agrees to cooperate with EOHHS in carrying out data validation activities.

B. Encounter Data Reporting

i. **Definitions**

1. Encounter Data: The record of a member receiving any item(s) or service(s) provided through Medicaid under a prepaid, capitated, or any other risk basis payment methodology.
2. Accurate Claims: All fields reflect the service provided and paid and are completed per the data submission guideline and State's companion guide.
3. Timely Submissions: Initial submission within thirty (30) business days of paid claim date. Rejected claims are re-submitted within thirty (30) business days of notice of the rejection.

ii. General Requirements

Pursuant to 42 CFR 438.242(c), the Contractor shall submit to EOHHS

complete, accurate, and timely encounter data for all services for which the Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangement. The Contractor will submit encounter data monthly and in compliance with the EOHHS guidance document *"Rhode Island Medicaid Managed Care Encounter Data Methodology, Thresholds and Penalties for Non- Compliance"*. EOHHS reserves the right to make changes to the guidance document at any time. The Contractor is expected to implement all changes within ninety (90) calendar days of notification. The Contractor is solely responsible for submitting all subcontractor encounter data in compliance with EOHHS' encounter data requirements. The EOHHS 837 Companion Guide and related business design documents are included as an Appendix to this Agreement and incorporated herein.

Contractor is required to comply with H.R. 6 The SUPPORT Act Title 1; Section 1004, which mandates the following:

- Contractor must have automated drug utilization review safety edits for opioid refills
- Automated claims review process to identify refills in excess of State limits
- Monitor concurrent prescribing of opioids, benzodiazepines and/or antipsychotics (Including children's antipsychotics)
- Maximum daily morphine equivalent (MME) safety edits; and
- Concurrent utilization alerts for beneficiaries concurrently prescribed opioids and benzodiazepines and/or antipsychotics.

iii. Timeliness and Accuracy of Data Submittal and Correction of Rejected Claims

The Contractor is responsible for collecting, monitoring, submitting and ensuring the accuracy of all 837 submissions and subsequent 277CA reports. The Contractor will submit complete, accurate, and timely encounter data for all services that it, or its subcontractors, have incurred a financial liability within thirty (30) business days of the end of the month in which the liability was incurred. The Contractor will ensure that ninety-eight percent (98%) of submitted encounters are accepted and do not reject, upon initial submission.

Submitted encounters and encounter records must pass all the EOHHS designated Medicaid Management Information System ("MMIS") edits. Submitted encounters or encounter records must not be duplicates of a previously submitted and accepted encounter or encounter record unless submitted as an adjustment or void per HIPAA Transaction Standards.

The Contractor is responsible for re-submitting any errored off/rejected claims to the State within thirty (30) business days of the receipt of the rejection and/or applicable rejection report, such as 277CA reports. The Contractor is

subject to corrective action and/or financial sanctions for non- submitted, late, or persistently rejected/incorrect data submissions.

iv. Data Validation

The Contractor agrees to reconcile encounter data, including that of its subcontractors, and to attest to its accuracy with each submission. The Contractor agrees to assist EOHHS in its validation of utilization data by making available a sample of medical records and a sample of its claims data upon request.

The Contractor will submit monthly reports that summarize file submission status by vendor, line of business and fiscal year in a format determined by EOHHS. The report will include, at a minimum:

1. Encounter Claims Incurred (total volume and dollars)
2. Encounter Claims Submitted (total volume and dollars)
3. Encounter Claims Accepted (total volume and dollars)
4. Number of claims and dollar value by error type (total volume and dollars)

The Contractor will submit documentation and explanation with these reports if the denial rate is greater than two percent (2%) between and among the total value for categories 1-3 above for data outside of timely submission or correction timeframes described herein.

v. Participation in Encounter Data Meetings

The Contractor must participate in regular encounter data meetings with the State relating to the 837 processing and must submit reports to the State on 837 processing, at a frequency and schedule defined by the State. Topics addressed at encounter meetings shall include, but are not limited to, review of the file submission reports, documentation of variances, and comparisons of accepted claims as reflected in the MMIS to incurred claims and documented on the payer-supplied submission reports.

vi. Penalties for Non-Compliance

At the discretion of EOHHS, Contractor may be subject to monetary penalties if the encounter denial rate exceeds two percent (2%). EOHHS may assess the following penalties against the Contractor:

- Civil monetary penalties in the amount of one-hundred thousand dollars ($100,000), not to exceed one-percent (1%) of the Contractor's capitation, to be assessed each month that Contractor submits encounter data, including the encounter data of their subcontractor, for which the denial rate exceeds two percent (2%).

- Appointment of temporary management for the Contractor as contained in and accordance with 42 CFR 438.706.
- Granting members, the right to terminate enrollment with the Contractor without cause and notifying the affected members of their right to disenroll from the Contractor.
- Suspension of new enrollment, including default enrollment, after notice of the effective date of a sanction against the Contractor.
- Suspension of payment for members enrolled after the effective date of the sanction and until CMS or EOHHS is satisfied that the reason for the sanction no longer exists and is not likely to recur.

C. 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.

D. 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 as 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 implementing this methodology.

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

E. 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.

F. Fraud and Abuse

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 quarterly fraud and abuse 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 compliant
- 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.

i. Recovery Reporting

The Contractor and all subcontractors must establish a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within sixty (60) calendar days after the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment. The report of total recoveries shall be provided to EOHHS on an annual basis and will separate out recoveries made for these types of overpayments in addition to any recoveries made related to fraud, waste and abuse activities. The Contractor and subcontractors must report to EOHHS within sixty (60) calendar days any capitation payments that has been identified as exceeding the contracted capitation payments.

G. 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.

H. 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.

I. 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, on the EOHHS provided attestation form.

J. 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.

2.14 GRIEVANCE AND APPEALS

A. General

EOHHS has established a Grievances and Appeals function through which members can seek redress against Health/Dental plans, and through which Health/Dental plans can seek to disenroll members who are habitually non-compliant or who pose a threat to Health/Dental plan employees or other members. The grievance system includes a grievance process, an appeals process, an external appeal (medical review) process and access to the State's Fair Hearing system. For its part, the Contractor will have written policies and procedures conforming to EOHHS 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 will not be applicable to any disputes that may arise between the Contractor and provider regarding the terms, conditions, termination or any other matter arising under a participation agreement or regarding any payment or other issues relating to providers.

The Contractor will provide to all providers and subcontractors at the time they enter into a contract, information specified in 42 CFR 438.10(g)(2)(xi)(C) describing the grievance and appeal system, including the availability of assistance to enrollees with filing grievances and appeals.

The Contractor is required to maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy.

The record of each grievance or appeal must contain, at a minimum, all the following information:

- A general description of the reason for the appeal or grievance.
- The date received.
- The date of each review or, if applicable, review meeting.
- Resolution at each level of the appeal or grievance, if applicable.
- Date of resolution at each level, if applicable.
- Name of the covered person for whom the grievance or appeal was filed.

The record must be accurately maintained in a manner accessible to the State and available, upon request, to CMS.

B. Adverse Benefit Determination

An adverse benefit determination 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 2.12.C.ii of this Agreement (6) the failure of the Contractor to act within the timeframes required by the Rhode Island Medicaid Managed Care Grievance and Appeals Process of this Agreement or (7) the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

A Notice of Adverse Benefit Determination must be in writing and must explain:

- The action that the Contractor, or its agents, has taken or intends to take.
- The reasons for the adverse benefit determination, including the right of the member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
- The member's or provider's right to file an appeal with the Contractor, including information on exhausting the Contractor's one level of appeal, the right to an external appeal (medical review), and the right to request a State Fair Hearing.
- The procedures for exercising the rights in this section.
- The circumstances under which expedited appeal resolution is available and how to request it.
- The member's rights to have covered benefits continue pending resolution of the appeal and the final decision of EOHHS. How to request that benefits be continued and the circumstances, consistent with state policy, under which the members may be required to pay the costs of these services.

The Contractor may mail notice of adverse benefit determination on the date of the action when:

- The Contractor has factual information confirming the death of the member;
- The member submits a signed written statement requesting service termination;
- The member submits a signed written statement including information that requires service termination or reduction and indicates that he or she understands that service termination or reduction will result;
- The member has been admitted to an institution where he or she is ineligible under the plan for further services;
- The member's address is determined unknown based on returned mail with no forwarding address;
- The member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth;
- A change in the level of medical care is prescribed by the member's physician;
- The notice involves an adverse determination with regard to preadmission

screening requirements of section 1919(e)(7) of the Act; or

- The transfer or discharge from a facility will occur in an expedited fashion.

The Contractor must notify requesting providers and give members written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less that the requested authorization. The Contractor must give members timely and adequate notice of an adverse benefit determination in writing as expeditiously as the member's condition requires and consistent with timeframes pursuant to 42 CFR 438.404(c). The Contractor may extend the adverse benefit determination timeframe for standard authorization decisions that deny or limit services for up to fourteen (14) additional calendar days if either the member or the provider request the extension or the Contractor justifies a need for additional information and shows that the extension is in the member's best interest. For prior authorizations for outpatient drugs, the Contractor must respond to requests by telephone or other telecommunication device within twenty-four (24) hours of the request. In addition, the Contractor must ensure a seventy- two (72) hour supply of the requested covered outpatient drug is dispensed in an emergency situation.

If the Contractor has facts indicating that an adverse benefits determination should be made because of probable fraud by the beneficiary, and the facts have been verified, if possible, through secondary sources, the Contractor may mail the notice of adverse benefit determination as few as five (5) days prior to the date of action. The Contractor shall provide a notice of adverse determination on the date of the determination when the action is a denial of payment.

The Contractor will also meet the requirements in 42 CFR 438.10 regarding information provided to enrollees. Written materials must use easily understood language and enrollees must be informed that alternative formats are available for those with special needs including those who are visually impaired or have limited reading proficiency. All written materials must include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information per 42 CFR 438.71(a).

C. Health/Dental plan Grievance and Appeals Process

The Contractor's policies and procedures for processing grievances must permit a member, provider or authorized representative, acting on behalf of the member and with the member's written consent, to file a grievance with the Contractor at any time. The timeframe for resolution is ninety (90) calendar days from receipt of the grievance as provided in Rhode Island Medicaid Managed Care Grievance and Appeals Process.

The Contractor's policies and procedures for processing appeals must permit a member, provider or authorized representative acting on behalf of the member and with the member's written consent, to file an appeal of a notice of adverse benefit determination within sixty (60) calendar days from the date on the Contractor's notice.

In handling grievances and appeals, the 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.
- Allow members to file grievance or appeal verbally which must be confirmed in writing to establish the earliest possible filing date unless there is a request for an expedited appeal.
- Acknowledge each grievance and appeal within five (5) calendar days.
- 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 they are not subordinates of any such individual.
- Ensure that decision makers on grievance and appeals are health care professionals who have appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if they are involved in deciding on any of the following: (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
- Ensure that that decision makers on grievances and appeals consider all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.
- Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.
- Provide the member and his or her representative the member case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor considered during the appeals process. The Contractor will provide this information to the member free of charge and sufficiently in advance of the resolution timeframes for the appeals as specified in 42 CFR 438.408 (b) and (c). 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.

The Contractor must resolve each grievance and provide written notice of the resolution as expeditiously as the member's health condition requires but not to exceed ninety (90) calendar days from the date that the Contractor received the grievance. For resolution of each standard appeal, the Contractor must provide written notice of the disposition within thirty (30) calendar days from the time the Contractor receives the appeal. The timeframes for both grievances and appeals resolution may be extended by up to fourteen (14) calendar days if the member requests an extension or if the Contractor shows (to the satisfaction of EOHHS upon request) that there is need for additional

information and how the delay is in the member's best interest. If the Contractor extends the timeframes not at the request of the member, it must complete all the following:

- Make reasonable efforts to give the member prompt oral notice of the delay;
- Within two (2) calendar days, give members written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision;
- Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

Each written notice of determination 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 a next level appeal, inclusive of an external appeal at no cost to the member; the right to request a State Fair Hearing, and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request; and that the enrollee may not be held liable for the cost of those benefits if the hearing decision upholds the Contractor's notice of adverse benefit determination.
- Information on how to contact the Contractor either in writing or telephone regarding the appeal process.

In the case that the Contractor fails to adhere to the notice and timing requirements in this section, the member is deemed to have exhausted the internal appeals process. The member may initiate a State Fair Hearing.

i. Expedited Resolution of Appeals

The Contractor must also establish and maintain an expedited review process for appeals. An expedited review is permitted when the Contractor determines (for a request from a member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. Expedited appeals must be resolved within seventy-two (72) hours of receipt of the appeal. The member may submit a verbal request for an expedited resolution of appeal. The member does not need to follow an oral request for an expedited resolution of appeal with a written request. The Contractor 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.

The Contractor may extend the timeframe for an expedited appeal by fourteen (14) days if the member, the member's representative or the provider request an extension or the Contractor can show (to the satisfaction of EOHHS, upon EOHHS' request) that there is need for additional information and that the extension is in the member's interest. If the Contractor extends the timeframes not at the request of the member, it must complete all the following:

- Make reasonable efforts to give the member prompt oral notice of the delay;
- Within two (2) calendar days give the member's written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision;
- Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

The 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 the Contractor denies the request for an expedited appeal, it must transfer the appeal to the timeframe for standard resolution, make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

In the case that the Contractor fails to adhere to the notice and timing requirements in this section, the member is deemed to have exhausted the internal appeals process. The member may initiate a State Fair Hearing.

Each written notice of determination 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 a next level appeal, inclusive of an external appeal at no cost to the member; the right to request a State Fair Hearing, and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request; and that the enrollee may not be held liable for the cost of those benefits if the hearing decision upholds the Contractor's notice of adverse benefit determination.
- Information on how to contact the Contractor either in writing or telephone regarding the appeal process.

D. Continuation of Benefits

As specified in 42 CFR 438.420, the Contractor must continue the member's benefits while an appeal is in process if all the following conditions are met:

- The member filed the request for an appeal timely;
- The member files for a continuation of benefits within ten (10) days of the Contractor mailing the notice of the notice of adverse benefit determination, or the intended effective date of the Contractor's proposed action. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider; and
- The authorization period has not expired;

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 requests continuation of services within ten (10) calendar days of the Contractor's adverse benefit determination.
- A State Fair Hearing decision adverse to the member is made.

E. State Fair Hearing and External Appeal (Medical Review) Process

If the member has exhausted the Contractor's internal appeals procedures and the Contractor upholds the adverse benefit determination, the member, or a provider or representative acting on the member's behalf, may request a State Fair Hearing. The State must grant the request for a State Fair Hearing if the member submits the request within one hundred and twenty (120) calendar days of the Contractor's notice of resolution. 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.

For members who have exhausted the Contractor's internal appeals procedures and the Contractor has upheld the adverse benefit determination, the State also offers and arranges for an external medical review if the following conditions are met:

- The review must be at the member's option and must not be required before or used as a deterrent to proceed to the State fair hearing;
- The review must be independent of both EOHHS and the Contractor;
- The review must be offered at no cost to the member;
- The review must not extend any of the timeframes specified in the contract and must not disrupt the continuation of benefits.

The member must submit a request for an External Appeal (Medical Review) within four (4) months of the Contractor's notice of resolution. The External Appeal (Medical Review) is governed by the Office of the Health Insurance Commissioner (OHIC) under the external appeal procedural requirements pursuant to RIGL 27-18.9-8 of the Benefit Determination and Utilization Review Act and is a level of review which is aside and apart from the State Fair Hearing process. The Member may request either a State Fair Hearing or an External Review or, if desired, both. The External Appeal (Medical Review) can occur simultaneously or consecutively with the State Fair Hearing as long as the request is made within four (4) months of the Contractor's notice of final resolution. The Contractor will execute individual contracts with each OHIC identified Independent Review Organizations (IRO) to permit Medicaid members access to an External Appeal (Medical Review). The Contractor will use the rotational IRO registry system specified by the OHIC Commissioner. The Contractor agrees to submit appeals related reports to both EOHHS and OHIC in a format and template approved by both State Agencies. If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination and appeal resolution, The 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, State Fair Hearing officer or external reviewer reverses the decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires but no later than seventy-two (72) hours from the date it receives notice reversing the determination.

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

F. 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.

2.15 PAYMENTS TO AND FROM PLANS

A. General Capitation Payments

General Capitation Payments, as defined in Section 1.7, may only be made by the State and retained by the Contractor for managed care members eligible for Covered Services, in accordance with 42 CFR 438.3(c)(2).

In accordance with 42 CFR 438.3(c)(1)(i) Standard Contract Requirements concerning payments. The following requirements apply to the final capitation rate and the receipt of capitation payments under the contract: (1) The final capitation rate for each MCO, PIHP or PAHP must be specifically identified in the applicable contract submitted for CMS review and approval.

In accordance with 42 CFR 438.3(e)(1)(ii) the Contractor agrees that they shall cover for enrollees, services that are in addition to those covered under the State plan. Specifically, the Contractor agrees to cover such additional services that are necessary to comply with 42 CFR 438.910.

In accordance with 42 CFR 457.1201(c),(n)(2),(o),(p) Contractor agrees that State shall make the final capitation rates and payment in accordance with 42 CFR 438.3(c), 457.1207(o), 457.1240(b) (cross-referencing 42 CFR 438.330(b)(2), (b)(3), (c), and (e)) 457.1240(e) (cross-referencing 42 CFR 438.340) and 457.1250(a) (cross-referencing 42 CFR 438.350).

Contractor shall include an attestation to the accuracy, completeness, and truthfulness of claims and payment data, under penalty of perjury with all submitted claims and payment data.

Contractor guarantees that it will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources.

B. Acceptance of State Capitation Payments

Contractor shall be capitated for all in-plan services, as described in Section 2.6 of this Agreement, in the amount as 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 unless such change has been negotiated in accordance with Section 3.3 of this Agreement. Such change in rates shall not be effective until agreed upon in writing by the parties or, in the event of a change due to (1) above, until prior 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.

Notwithstanding any other provision of this agreement, the State shall, beginning the second contract period commencing July 1, 2021 and continuing each contract period thereafter, establish age band specific capitation rates so as to equitably reflect the distribution of enrollees among the RIte Smiles program participating plans. The State will utilize encounter data from the participating plans in the rate setting process.

C. Payments to Providers

i. General

The advantage of a managed care system is that it permits the Contractor and providers to enter into creative payment arrangements that 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).

ii. 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.

iii. 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 Contractor'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 (1) enrollee within a bill. A clean claim means a claim 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.

iv. 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 for 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 2.15.C.iii.

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.

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:

1. The provider must be an out-of-State provider, and
2. 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.

v. 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.

vi. 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.

vii. 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.

viii. 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.

The contract provides that the State agency must ensure that no payment is made to a network provider other than by the Contractor, except when these payments

are specifically provided for in Title XIX of the Act, in 42 CFR Chapter IV, or when the State makes direct payments to network providers for graduate medical education costs approved under the State plan, per CMS contract rule 42 CFR 438.60.

ix. 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 42 CFR 210; 42 CFR 434.67,42 CFR 434.70 and 42 CFR 1003.

x. Actuarial Basis

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

xi. 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.

The Contractor shall meet the requirements of 42 CFR 447.26 and 42 CFR 438.3(g), with respect to non-payment for provider preventable conditions for Health Care-Acquired Conditions and Other Provider-Preventable Conditions.

xii. Fee Schedule Increase and Adoption of Minimum/Maximum Fee Schedule

EOHHS may require the MCO to adopt a minimum fee schedule for network providers, provide a uniform dollar or percentage increase for network providers or adopt a max fee schedule so long as MCO retains ability to reasonably manage risk.

xiii. Health Insurer Fee

The Contractor may be subject to the Health Insurer Fee (HIF) under Section 9010 of the Patient Protection and Affordable Care Act of 2010. The HIF is imposed on qualifying health insurers based on their premiums in the previous year. If the Contractor is subject to the HIF, EOHHS shall make an annual payment to the Contractor for the amount of the HIF, including an actuarially sound adjustment to the Contractor's capitation rates. EOHHS will pay the Contractor's HIF retrospectively.

The amount due to the eligible Contractor shall be determined based on the Contractor's final Form 8963 filing, the final notification of the HIF amount owed by the Contractor received from the United States Internal Revenue Service, and any additional supporting documentation as requested by EOHHS. If Congress issues a moratorium for the HIF in any given year, EOHHS will not

issue any payment to the Contractors. Payment is contingent on the availability of State funds and CMS approval of the capitation rates including the HIF adjustment.

D. 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.

E. Alternative Payment Methodology (APM)

As a core objective of this Agreement EOHHS seeks to reduce the use of fee-for-service payment as a payment methodology and to replace fee-for-service payment with Alternative Payment Methodologies that provide incentives for better quality, outcomes and more efficient delivery of services. As such, EOHHS requires that the Contractor progressively incorporate value based Alternative Payment Methodologies into their contracts with providers.

An Alternative Payment Methodology means a payment methodology structured such that it provides economic incentives, rather than focusing on volume of services provided, focus upon such key areas as:

- Improving quality of care;
- Improving population health;
- Impacting cost of care and/or cost of care growth;
- Improving patient experience and engagement; and
- Improving access to care.

F. Exemption for Indians Served by Indian Healthcare

The Contractor shall exempt Indians from payment of enrollment fees, premiums, deductibles, coinsurance, copayments, or similar charge for any item or service covered by Medicaid if the Indian is furnished the item or service directly by an Indian health care provider, I/T/U or through Contract Services, HIS (CHS). The Contractor must pay these providers the full Medicaid payment rate for furnishing the item or service. Their payments may not be reduced by the amount of any enrollment fee, premium, deduction, copayment, or similar charge that otherwise would be due from the Indian.

G. 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 Rhode Island General Laws section 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.

H. 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 or performance condition. Contractor may not change the thresholds from those in Attachment H of this Agreement without the prior written consent of the State.

I. 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.

J. 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**.**

K. Audits

Pursuant to Section 3.8 of this 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.F 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 Rhode Island 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 3.2.E. of this Agreement.

2.16 FINANCIAL STANDARDS

A. General

The Department of Business Regulation regulates the financial stability of all licensed Health/Dental plans and Dental 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 of the Agreement.

B. Financial Benchmarks

The success of the Rhode Island Medicaid Managed Care program is contingent on the financial stability of participating Health/Dental plans. As part of its oversight activities, the State has established financial viability criteria, or benchmarks, to be used in measuring and tracking the fiscal status of Health/Dental plans. The Contractor must provide documentation on a regular basis as outlined in this contract that the Contractor is financially solvent, has the capital, and has the financial resources and management capability to operate under this risk-based contract. Contractor shall demonstrate to EOHHS that it is able to meet the solvency requirements set forth through the Rhode Island Office of the Health Insurance Commissioner (OHIC).

Contractor agrees to at least annually provide EOHHS with the information necessary for calculating benchmark levels for each of the above financial benchmarks for its RIte Smiles line of business consistent with Section 2.16.C of this Agreement. Contractor also agrees to promptly and fully comply with any and all corrective actions ordered by the State to address any identified deficiencies with respect to financial benchmarks.

C. Financial Data Reporting

The Contractor agrees to comply with the *Rhode Island Medicaid Managed Care Health Plan Financial Reporting Program.* Such compliance includes, but is not limited to, the submission of the following reports:

- Annual NAIC Financial Statements, including Risk Based Capital Reports;
- The Contractor's Annual Audited Financial Statements;
- The Contractor's Annual Report to Owners, Shareholders, members, and Others;
- Quarterly NAIC Financial Statements;
- Monthly Financial Statements;
- Company's General Liability and Directors' and Officer's Insurance Coverages;
- Claims Reinsurance Coverage and attachment points;
- Where applicable, evidence that the parent Company provides one hundred percent (100%) of subsidiary's financial backing.
- The Contractor's Risk/Gain Share Statements;
- Annual MLR Statement using the *Medicaid Managed Care Program: Medical Loss Ratio Calculation* workbook and template provided by EOHHS.
- Any other additional reports required due to special circumstances, studies, analyses, audits, and significant changes in the Contractor's financial position or performance.

The Contractor agrees to comply in a timely and complete manner with all financial reporting requirements

D. Financial Data Reporting System

EOHHS is implementing and requiring Contractors to report though a new Financial Data Reporting System (FDRS). The FDRS will utilize specific templates to be populated by the Contractor. The FDRS will capture the Contractor's membership, benefit expenses, including general ledger adjustments, sub-capitated arrangements, reinsurance arrangements, reserves, benefit expense recoveries and administrative costs for each Premium Rating Group. Reconciliation of the submitted information to the Contractor's NAIC financial statements will be required. FDRS requirements will include data for the contract period beginning July 1, 2020.

These requirements will be added to Contractor's Reporting Calendar as specified in Section 2.13.01 of this Agreement.

E. MLR Reporting

In accordance with 42 CFR 438.604(a)(2)-(4), 42 CFR 438.606, 42 CFR 438.3, 42 CFR 438.5(c), 42 CFR 438.8, and 42 CFR 438.116, the Contractor shall submit all required data to EOHHS to certify the actuarial soundness of capitation rates and the Contractor's compliance with the MLR requirements to enable the State to determine whether the Contractor has made adequate provisions against the risk of insolvency.

In accordance with 42 CFR 438.74(a)(2), the Contractor shall submit to the State a summary description that shall at a minimum include, sufficient and complete information that will enable the State to report the amount of the numerator, the amount of the denominator, the MLR percentage achieved, the number of member months, and any remittances owed by the Contractor for that MLR reporting year.

Contractor will calculate/report an MLR for each MLR reporting year, consistent with MLR standards, in compliance with all MLR requirements in 42 CFR 438.8(a).

Pursuant to 42 CFR 438.8(k)(3), the Contractor will require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within one hundred eighty (180) days of the end of the MLR reporting year or within thirty (30) days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting. See Attachment G – Special Terms and Conditions for additional requirements related to MLR.

F. Audit

In the case where the Agreement amount identified in Section 2.15.H 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.

Audits will be conducted in accordance with generally accepted accounting principles and auditing standards.

The Contractor will annually submit audited financial reports specific to this Contract. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards, in accordance with 42 CFR 438.3(m).

2.17 RECORD RETENTION

A. General

Contractor must retain, and require subcontractors to retain, as applicable, the following information: enrollee grievance and appeal records in 42 CFR 438.416, base data in 42 CFR 438.5(c), MLR reports in 42 CFR 438.8(k), and the data, information, and

documentation specified in 42 CFR 438.604, 42 CFR 438.606, 42 CFR 438.608, and 42 CFR 438.610 for a period of no less than 10 years.

B. 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.

C. 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

A. General Requirements

In accordance with 42 CFR 438.608, the Contractor or subcontractor, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under the contract between the State and 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 ninety (90) days of the execution of this Agreement and annually thereafter

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

- The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and shall report directly to the Chief Executive Officer and the Board of Directors.
- The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract.
- Effective training and education for the Compliance Officer and the organization's employees.
- Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of

suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

- Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State.
- Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including change in address and the death of a member.
- Provision for prompt response to detected offenses, and for development of corrective action initiatives.

Contractor is required to comply with H.R. 6 The SUPPORT Act Title 1; Section 1004, which mandates the following:

- Contractor must have automated drug utilization review safety edits for opioid refills
- Automated claims review process to identify refills in excess of State limits
- Monitor concurrent prescribing of opioids, benzodiazepines and/or antipsychotics (Including children's antipsychotics).
- Maximum daily morphine equivalent (MME) safety edits; and
- Concurrent utilization alerts for beneficiaries concurrently prescribed opioids and benzodiazepines and/or antipsychotics.

B. 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.

i. Procedure for Contractor Associating with Prohibited Affiliations

CMS contract rule 42 CFR 438.610(d) states: 'The contract provides that if the State learns that an MCE has a prohibited relationship with a person or entity who is debarred, suspended, or excluded from participation in federal healthcare programs, the State,:

1. Must notify the Secretary of the noncompliance;
2. May continue an existing agreement with the MCE unless the Secretary directs otherwise;
3. May not renew or extend the existing agreement with the MCE unless the Secretary provides to the State and to the Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

C. Disclosure of the Contractor's Ownership and Control Interest

In accordance with 42 CFR Section 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 disclosing entity. The address for corporate entities must include as applicable primary business address, every business location, and Post Office (P. O.) box address.

   (ii) Date of birth and Social Security Number (in the case of an individual).

   (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 percent (5%) 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 percent (5%) or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

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.

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.

D. Disclosure by Providers: Information Related to Business Transactions

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.

   (ii) Date of birth and Social Security Number (in the case of an individual).

   (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 percent (5%) 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 percent (5%) or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
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 percent (5%) 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 twelve (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.

E. 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 twelve (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.

F. Disclosures 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 percent (5%) 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.

G. 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:

1. 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
2. Has had civil money penalties or assessments imposed under Section 1129A of the Social Security Act; or
3. Has been excluded from participation in Medicare, Medicaid, or any Federal or State health care programs and such a person has:
    i. A direct or indirect ownership interest of five (5) percent or more in the entity;
    ii. 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;

iii. Is an officer or director of the entity, if the entity is organized as a corporation;

iv. Is partner in the entity, if the entity is organized as a partnership;

v. Is an agent of the entity; or

vi. 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

vii. 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 percent (10%) ownership interest in an entity at issue if he or she has a twenty percent (20%) ownership interest in a corporation that wholly owns a subsidiary that is a fifty percent (50%) 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:

1. The capital, the stock, or the profits of the entity, or

2. 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 2.8.M of this Agreement**.**

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.

H. Compliance with applicable Federal Regulation

The Contractor agrees to comply with all applicable Federal laws and regulations including but not limited to:

1. In reference to the Medicaid and CHIP Managed Care Final Rule, the Contractor will work with EOHHS on implementing all applicable aspects of the Rule in the time frames specified in the Rule.

ARTICLE III: CONTRACT TERMS AND CONDITIONS

3.1 GENERAL PROVISIONS

A. 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: Dental 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

B. 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.

C. 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/dental plan until such time as all of said requirements have been met.

D. Effective Date and Term

The term of this agreement shall commence effective July 1, 2020 and shall end, unless otherwise duly terminated, in accordance with the provisions hereof, on July 1, 2022, and shall be subject to four (4) one-year option periods by mutual agreement of the State and the Contractor, pursuant to the terms outlined in Section 3.10.

E. Contract Administration

This Agreement shall be administered for the State by the Rhode Island Executive Office of Health and Human Services (EOHHS). The Medicaid Director or their appointee will serve as the responsible party for all matters related to this Agreement.

The Medicaid Director, 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 Secretary of EOHHS or any other official in Rhode Island unless initial contact, both verbal and in writing, regarding the matter has been presented to the Medicaid Director 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 Medicaid Director or designee, or, if both the Medicaid Director or their absence or inability to act, such notice shall be signed by the Secretary of EOHHS. 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 Medicaid Director or designee.

F. Contract Officers

EOHHS will designate a Contract Officer. Such designation may be changed during the period of this Agreement 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.

G. 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.

H. 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.

I. 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: [Insert Name and Address]

Contractor’s Address

In case of notice to EOHHS: EOHHS Managed Care Director, Mark Kraics, Virks Building, 3 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.

J. Authority

Each party has full power and authority to enter into and perform this Agreement, except to the extent noted in Section 3.1.K 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.

K. 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.

L. Special Terms and Conditions

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

3.2 INTERPRETATION AND DISPUTES

A. 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.

B. 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.

C. 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.

D. 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.

E. 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 3.2.E. 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.

3.3 CONTRACT AMENDMENTS

The EOHHS 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 EOHHS 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 EOHHS 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 Contractor agrees to provide a signed amendment no later than forty-five (45) calendar days after being provided the final Amendment by EOHHS. Failure to return a signed Amendment within forty-five (45) calendar days or to negotiate a new due date with EOHHS may result in, but is not limited to, a hold placed on the approval of member materials or suspension of auto-enrollment of members, to be in place until return of an executed copy 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.

3.4 PAYMENT

A. 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.

B. 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 Dental Plan subcontractors, including providers and suppliers (see also Section 3.5.E., *Subcontracts*).

C. 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.

Pursuant to Section 1932(b)(6) of the Act, and to 42 CFR 438.106(a), in the event that the Contractor becomes insolvent, the Contractor will not hold Medicaid enrollees liable for the Contractor's debts. In accordance with 42 CFR 438.116(a), the Contractor will provide assurances satisfactory to the State that its provision against the risk of insolvency is adequate to ensure that Medicaid enrollees will not be liable for the Contractor's debt if the Contractor becomes insolvent.

3.5 GUARANTEES, WARRANTIES, AND CERTIFICATIONS

A. 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.

B. Contractor Certification of Legality

By signing this Agreement, 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.

C. Contractor Certification of 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 of this Agreement.

If Contractor is not a State-licensed HMO, Contractor certifies that it meets the other requirements specified in Section 2.2 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 2.2 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 of this Agreement.

D. Subcontractors and Delegation of Duty

The Contractor may enter into written subcontract(s) for performance of certain of its contract responsibilities listed in Article II of this Agreement. The Contractor must

evaluate any prospective subcontractor's ability to perform the delegated contract responsibilities prior to assigning the activities. 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. The Contractor shall make available all subcontracts for inspection by the State, upon request.

The HIPAA Privacy Rule requires that a covered entity obtain satisfactory assurances from its subcontracted and delegated entities that they will appropriately safeguard the protected health information it receives or creates on behalf of the covered entity. The satisfactory assurances must be in writing, whether in the form of a contract or other business associate agreement between the covered entity and the business associate.

The Contractor shall monitor the performance of all subcontractors on an ongoing basis. This include conducting formal reviews based on a schedule established by EOHHS and which is consistent with industry standards and State regulations. Both the Contractor and subcontract must take corrective action on any identified deficiencies or areas of improvement.

The Contractor shall be wholly responsible for performance of the entire contract whether or not subcontractors are used. In compliance with 42 CFR.438.230(b) and (c), the Contractor must execute a written agreement with its subcontractors that specifies that Contractor's right to revoke the subcontract, and outlines reasons for the revocation of the contract, or specify other remedies in instances where the State or the Contractor determines that the subcontractor has not performed satisfactorily. Contractor must also execute a written agreement which states that the Contractor may impose sanction on the subcontractor if the subcontractor's performance is inadequate. The Contractor must also execute a written agreement which states that subcontractor agrees that the Rhode Island Executive Office of Health and Human Services, the Rhode Island Department of Health, State Auditor General 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 Rhode Island Office of the Attorney General, or their authorized representatives may audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State for ten (10) years from the final date of the contract period or from the date of the completion of any audit, whichever is later. If The Rhode Island Executive Office of Health and Human Services, the Rhode Island Department of Health, State Auditor General of Rhode Island, the Department of Health and Human Services, Government Accountability Office, the Comptroller General of the United States, the U.S. Office of the Inspector General, the Rhode Island Office of the Attorney General Medicaid Fraud Control Unit, or their authorized representatives determine that there is a reasonable possibility of fraud, they may inspect, evaluate, and audit the subcontractors at any time. Any subcontract which the Contractor enters into with respect to performance under this Agreement shall not relieve the Contractor in any way of responsibility for performance of its duties. Further, the State will consider the

Contractor to be the sole point of contact with regards to contractual matters, including payment of any and all charges resulting from the Agreement (see also Section 3.5.E, *Assignment of the Contract*).

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

In compliance with 42 CFR 438.414; 42 CFR 438.10(g)(1), the Contractor agrees to inform providers and subcontractors, at the time they enter into a contract, about:

1. Enrollee's right to a state fair hearing,
2. How an enrollee can obtain a hearing,
3. Representation rules at a hearing
4. Right to file a grievance and appeal and,
5. The requirements and timeframe for filing a grievance and appeal
6. Right to request continuation of benefits during an appeal or State Fair Hearing filing but that the enrollee may be responsible for the cost of any continued benefit if the original action is upheld.
7. The toll-free number to file oral grievances and appeals.
8. State-determined provider's appeals rights to challenge the failure of an organization to cover a service.

All 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 3.1.K	Federal Approval of Contract
Subsection 3.2.A	Conformance with State and Federal Regulations
Subsection 3.2.C	Severability
Subsection 3.5.F	Hold Harmless
Subsection 3.5.G	Insurance
Subsection 3.5.I	Patent or Copyright Infringement Subsection 3.6.A Employment Practices
Subsection 3.6.C	Independent Capacity of Contractor Personnel
Subsection 3.7.C	Fraud and Abuse
Subsection 3.8	Inspection of Work Performed
Subsection 3.9	Confidentiality of Information
Subsection 3.11.B	Ownership of Data and Reports

E. 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.

F. 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.G.vi.

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.

G. 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.

i. 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.

ii. 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.

iii. 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.

iv. 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).

v. 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.

vi. 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.

H. 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.

I. 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.

J. 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.

K. Payments to Institutions or Entities Located Outside of the U.S.

In compliance with 42 CFR 438.602(i), the Contractor must be located within the U.S. The Contractor will make no payments to a network provider, out-of-network provider, subcontractor or financial institution located outside of the U.S. Contractor will issue no payments for items or services to providers, provider bank accounts or business agents located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Mariana

Islands, and American Samoa. Contractor is prohibited from making payments to telemedicine providers and pharmacies located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa.

3.6 PERSONNEL

A. Employment Practices

Contractor shall agree to comply with the requirements relating to fair employment practices, to the extent applicable and agrees further to include a similar provision in any and all subcontracts. Contractor shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, sexual orientation, national origin, age (except as provided by law), marital status, political affiliation, or handicap. Contractor shall take affirmative action to ensure that employees, as well as applicants for employment, are treated without regard to their race, color, religion, sex, national origin, age (except as provided by law), marital status, political affiliation, or handicap. Such action shall be taken in areas including, but not be limited to, the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship.

Contractor shall agree to post in a conspicuous place, available to employees and applicants for employment, notices setting forth the provision of this non-discrimination clause. Contractor shall, in all solicitations or advertisements for employees placed by or on behalf of Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, age (except as provided by law), marital status, political affiliation, or handicap, except where it relates to bona fide occupational qualification. Contractor shall send to each labor union or representative of workers with which he has a collective bargaining arrangement o agreement or understanding, a notice advising the labor union or workers' representative of Contractor's commitments under Section 202 of Executive Order No. 11246 of September 24, 1976, as amended, and the rules, regulations, and relevant orders of the Secretary of Labor.

Contractor shall agree 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; Title IX of the Education Amendments of 1972 (20 USC 1681 et seq); Americans with Disabilities Act of 1990 (42 USC 12101 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 which prohibit discrimination on the basis of race, color, national origin, handicap, or sex, in acceptance for or provision of services, employment, or treatment in educational or other programs or activities; Section 1557 of the Patient Protection and Affordable Care Act (ACA 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.

Contractor shall comply with all provisions of Executive Order No. 11246 of September 24, 1976, as amended, and of the rules, regulations, and relevant orders of the Secretary of Labor. Contractor shall furnish all information and reports required by Executive Order No. 11246 of September 24, 1976, as amended, and by the rules, regulations, and orders of the Secretary of Labor or pursuant thereto and will permit access to its books, records, and accounts by the Secretary of the U.S. Department of Health and Human Services and the U.S. Secretary of Labor or their authorized representatives for purposes of investigation to ascertain compliance with rules, regulations, and orders.

Contractor shall comply with the nondiscrimination clause contained in Federal Executive Order 11246, as amended by Federal Executive Orders 11625 and 11375, relative to Equal Employment Opportunity for all persons without regard to race, color, religion, sex, or national origin, and the implementing rules and regulations prescribed by the Secretary of Labor and with Title 41, Code of Federal Regulations, Chapter 60. Contractor shall comply with regulations issued by the Secretary of Labor of the United States in Title 20, Code of Federal Regulations, Part 741, pursuant to the provisions of Executive Order 11758 and the Federal Rehabilitation Act of 1973. Contractor shall be responsible for ensuring that all subcontractors comply with the above-mentioned regulations. Contractor and its subcontractors shall comply with the Civil Rights Act of 1964, and any amendments thereto, and the rules and regulations thereunder, and Section 504 of Title V of the Vocational Rehabilitation Act of 1973, as amended. Contractor shall comply with all applicable provisions of Stat. 53-1147, the Federal "Hatch Act," as amended.

Contractor shall comply with all applicable provisions of Public Law 101-336, Americans with Disabilities Act.

Pursuant to Title VI and Section 504, as listed above and as referenced in Addendums 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, must include but are not limited to the requirements detailed in Addendums II and III references in the original Contract, effective July 1, 2014, and incorporated herein.

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 Contract Amendments noted in Section 3.3.

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.

B. 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.

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 additional two thousand five hundred dollar ($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.

C. Independent Capacity of Contractor Personnel

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

employees of the State of Rhode Island by reason hereto. It is further expressly agreed that this Agreement shall not be construed as a partnership or joint venture between Contractor or any subcontractor and the State.

3.7 PERFORMANCE STANDARDS AND DAMAGES

A. Service Level Agreements

The Contractor shall meet the performance level standards in this section.

If the Contractor fails to meet the performance standards, EOHHS may assess liquidated damages as provided in the below table, for the time period in which the deficiency occurs and until such time as EOHHS, in its sole discretion, determines that the deficiency has been fully addressed, assessed and cured.

Table: Service Level Agreement

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
Enrollment and Disenrollment					
1.	Member Enrollment Processing	The Contractor shall process one hundred percent (100%) of standard eligibility files within twenty-four (24) hours of receipt.	The percentage of eligibility files ingested and applied by the Contractor to its system to trigger enrollment and Disenrollment processes.	Daily	$1,000 per occurrence
Member Grievances and Appeals					
2.	Member Appeals Resolution - Standard	The Contractor shall resolve at least ninety-eight percent (98%) of Contractor internal appeals within the specified timeframes for standard appeals.	The number of internal appeals with notices of resolution issued by the Contractor within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	$10,000 per month
4.	Member Grievance Resolution	The Contractor shall resolve at least ninety-	The number of grievances with notices	Monthly	$5,000 per month

		eight percent (98%) of Member grievances within the specified timeframes.	of resolution issued by the Contractor within the required timeframe of the filing date of the grievance divided by the total number of grievances filed during the measurement period.		
Service Lines					
5.	Service Line Outage	There shall be no more than five (5) consecutive minutes of unscheduled time in which any of the service lines are unable to accept incoming calls.	The number of consecutive minutes a service line is unable to accept new incoming calls.	Monthly	$5,000 per service line per month
6.	Call Response Time/Call Answer Timeliness - Member Services line	The Contractor shall answer at least ninety percent (90%) of calls within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
Encounters					
7.	Encounter Data Accuracy	The Contractor shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for claims.	A paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Monthly	$25,000 per month
Website Functionality					
8.	Website User Accessibility	The Contractor ’s website shall be accessible to users twenty-four (24) hours per day, seven (7) days per week, except for EOHHS-approved, pre-announced downtime due to system upgrades or		Daily	$2,500 Per occurrence

		routine maintenance.			
Administration and Management					
9.	Readiness Review	Failure to meet plan readiness review deadlines as set by EOHHS.		Daily	$5,000 per calendar day
10.	Marketing	Engaging in prohibited activities or discriminatory practices or failure to market in an entire Region.		Per Occurrence	$5,000 per occurrence

Notice to External Agencies

a) EOHHS shall provide written notice to CMS in accordance with 42 C.F.R. 438.724 no later than thirty (30) calendar days after EOHHS imposes or lifts an intermediate sanction for any violation described in 42 C.F.R. 438.700.
b) EOHHS shall provide notice as required by law to any other state or federal agency for violations of the terms, conditions, or requirements of this Contract or for any other violation of applicable laws or regulations by the Contractor.

Publication of Remedial Actions, Intermediate Sanctions, and Liquidated Damages

c) EOHHS shall publish on its website on a quarterly basis a list of Contractors that were subject to remedial action(s), intermediate sanction(s) and/or liquidated damages during the prior quarter, the type of actions imposed on the Contractor, and the basis for the actions taken by EOHHS.
d) EOHHS shall not publish, as final, any actions that are under dispute with the Contractor or any remedial action(s), intermediate sanction(s) and/or liquidated damages that have been waived or lifted by EOHHS.

EOHHS, in its sole discretion, may waive, modify, or lift the imposition of any action taken against a Contractor, for good cause as determined by EOHHS, which includes the right of EOHHS to suspend the imposition of a remedial action, liquidated damages, or an intermediate sanction while the Contractor works to resolve and correct the underlying issue that resulted in the action taken by EOHHS.

B. 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 2.4, 2.5, 2.6, and the Attachments to 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 3.7.D; (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.

At EOHHS' discretion, continued non-compliance with the program requirements specified in Article II of this Agreement may result in penalties that range from a penalty of 0.1% of the total value of outstanding or rejected claims to a 1% general withhold of the Contractor's capitation rates.

C. Suspension of New Enrollment

Whenever the State determines that Contractor is in material breach of the performance standards described in Section 3.7.B, 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 shall be for a reasonable length of time as specified by the State, depending upon the severity and circumstances of the material breach of this Agreement. The State also may notify enrollees of Contractor non-performance and permit these enrollees to transition to another Health/Dental plan.

D. Fraud and Abuse

i. 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 same meaning as 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 ninety (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.*

EOHHS and its Office of Program Integrity (OPI) may conduct audits at any time on the Contractor's formal fraud, waste and abuse program as well as any files as a result of claims audits.

The Contractor will cooperate fully with any investigations, including providing information, access to records, and access to interview Contractor employees and consultants at the time determined by the State. Provider contracts with the Contractor shall incorporate these terms and conditions.

ii. 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.

iii. 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 2.5.H.

iv. 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 3.7.C.v.

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 3.8.B.

v. 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 ninety (90) days of the execution of this Agreement and then on an annual basis thereafter. The EOMB procedures shall delineate how the Contractor will respond to subsequent feedback from enrollees, including any interactions with recipients who report that goods or services which had been billed by a 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 3.8.B (Investigating and Reporting Suspected Fraud and Abuse).

vi. Investigating and Reporting Suspected Fraud and Abuse

The Contractor shall have methods and criteria for identifying and monitoring suspected Medicaid fraud and abuse as required by 42 CFR 456.3, 42 CFR 456.4, and 42 CFR 456.23. 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

The Contractor and all subcontractors are required to report any suspected cases of provider or vendor fraud and/or waste and abuse within five (5) business days following the conclusion of its initial investigation to the EOHHS Medicaid Contract Officer and/or designee as well as the OPI. OPI will review and process the referral and, if there is a credible allegation of fraud, submit the referral to the Office of the Rhode Island Attorney General Medicaid Fraud Control Units (MFCU) and request additional evidence from the Health/Dental plan.

The Contractor will have sufficient and dedicated staff in their Special Investigations Unit (SIU) and/or auditing unit. Contractor will provide EOHHS and/or PI with the name and contact information of the designated individual within their SIU with whom the State or OPI may:

- Communicate with directly; and
- Receive access to staff that are working to identify and resolve specific investigations, audits or cases of suspected fraud

PI may initiate meetings in addition to the quarterly Medicaid Fraud Control Unit meetings (MFCU) to engage in case discussions and to facilitate closure of outstanding investigations.

The Contractor, after reporting fraud or suspected fraud, shall not take any of the following actions:

- Contact the subject; or
- Negotiate any settlement or agreement; or
- Accept any monetary or other thing of valuable in connection with the incident.

The Contractor and all subcontractors will have a process for the suspension of payments to a network provider for which the State determines there is a credible allegation of fraud. The Contractor shall check with both the OPI and EOHHS before initiating any recoupment related to the outcome of a program integrity audit or prior to implementing any withhold of any funds for program integrity related issues.

While all recoveries related to overpayments due to fraud, waste or abuse, except of whistle blower cases, are retained by the Contractor, the Contractor will develop retention policies for the treatment of recoveries. Contractor must provide an annual report of any monetary recoveries that result from reconciliation of cases of fraud.

In addition, the Contract will complete the State's updated reporting form and

report quarterly run recoupments against the anticipated findings.

Contractor will utilize EOHHS' quarterly MCO Program Integrity Report to report ongoing running totals of recoupments associated with individual cases as the mechanism by which to report the total recoupment for all cases within the calendar year.

vii. Notification and Tips

The Contractor will utilize the State provided template to make a referral in a secure, timely, and thoughtful manner as well as to alert both EOHHS and PI of a notification or "tip." In addition to reporting any suspected cases of provider or vendor fraud and/or abuse within five (5) business days following the close of an initial investigation, the Contractor shall also submit quarterly reports to EOHHS documenting the Contractor's open and closed cases. Along with a notification, the Contractor shall take steps to triage and/or substantiate these tips and provide timely updates when the concerns and/or allegations of any tips are authenticated.

Contractor will require subcontractors who are delegated the responsibility for coverage of services and payment of claims to implement and maintain arrangement or procedures that include provision for the prompt referral of any potential fraud, waste or abuse to the Contactor to be forwarded on to the OPI.

The Contractor shall notify the OPI in a timely manner regarding all incidents and/or concerns regarding the safety of its members.

The Contractor shall cooperate fully in any investigation or prosecution. Such cooperation shall include, but not be limited to, providing, upon request, information, access to records, and claims data.

viii. Program Integrity Audits

The OPI reserves the right to conduct an annual on-site audit of the Contractor's fraud and abuse/SIU unit and program integrity activities.

E. 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, settlement**s,** 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.

i. Non-Compliance with Program Standards

Contractor shall ensure that performance standards as described in Section 3.7.A 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/dental 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/dental 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.

ii. 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. Pursuant to 42 CFR 438.608(d)(l)(iii), the Contractor must specify the process, timeframes, and documentation required for payment of recoveries of overpayments to the State in situations where the Contractor is not permitted to retain some or all of the recoveries of overpayments. Written policies must include protections for whistleblowers.

iii. 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. The Contractor is required to submit a report timely, accurately, in the correct template and/or with the proper naming convention and must remedy any error within three (3) business days of notification of the error form EOHHS.

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 3.7.D.iv.

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.

F. 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.

i. Basis for Intermediate Sanctions

EOHHS may impose intermediate sanctions on the Contractor as specified in 42 CFR 438.700 and 42 CFR 438.702 if it makes any of the determinations specified in paragraphs (a) through (c). The EOHHS may base its determinations on findings from onsite surveys, member or other complaints, financial status, or any other source.

(a) EOHHS determines that the Contractor has acted or failed to act as follows:
   1. Fails substantially to provide medically necessary services that the Contractor is required to provide, under law or under its Agreement with the EOHHS, to a Member covered under this Agreement.
   2. Imposes on members' premiums or charges that are in excess of any permitted by the EOHHS.
   3. Acts to discriminate against Members on the basis of their health status or need for health care services. This includes the termination of enrollment or refusal to reenroll a Member, except as permitted by the EOHHS, or any practice that would reasonably be expected to discourage enrollment by Members whose medical condition or history indicates probable need for substantial future medical services.
   4. Misrepresents or falsifies information that it furnishes to CMS or to the EOHHS.
   5. Misrepresents of falsifies information that it furnishes to a Member, a potential Member, or health care provider.
   6. Fails to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 42 CFR 422.210.

(b) EOHHS determines that the Contractor has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the EOHHS or that contain false or materially misleading information.

(c) EOHHS determines that:

1. The Contractor has violated any of the other applicable requires of sections 1932. 1903(m) or 1905(t)(3) of the Social Security Act and any implementing regulations;
2. For any of the violations under (c)(1) of this section, only the sanctions specified in 42 CFR 438.02, paragraphs (a)(3), (a)(4), and (a)(5) may be imposed.

ii. Types of Intermediate Sanctions

EOHHS may impose the following types of intermediate sanctions:

1. Civil monetary penalties in the amounts specified in 42 CFR 438.704.
2. Appointment of temporary management for the Contractor as specified 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 default enrollment, after the effective date of the sanction.
5. Suspension of payment for Members enrolled after the effective date of the sanction and until CMS or the EOHHS is satisfied that the reason for the sanction no longer exists and is not likely to recur.

EOHHS retains the authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in 42 CFR 438.700, as well as any additional areas of noncompliance.

In addition to any civil monetary penalty levied against the Contractor, EOHHS may also:

- Appoint temporary management to the Contractor;
- Grant Members the right to disenroll without cause;
- Suspend all new enrollment to the Contractor;
- Suspend payment for new enrollments to the Contractor

As set for in 42 CFR 438.710(a), EOHHS will give the Contractor timely written notice before imposing any intermediate sanction. The notice will include the basis for the sanction and any available appeal rights.

iii. Annual Compliance Audit

The Annual Compliance Audit will be onsite and consists of a focused review of key elements of the Contractor's compliance program as described in 42 CFR 438.608 and will assess adherence to the Contractor's written compliance plan including all relevant operating policies, procedures, workflows, and relevant chart of organization. The key elements reviewed may vary from year to year. A review of administrative and management arrangements may also be conducted as part of the annual audit. A review of grievance and appeal files will be a standard part of the compliance audit as EOHHS is required to conduct random reviews to ensure Contractor is notifying members in a timely manner pursuant to 42 CFR 438.228(b).

While the findings of the compliance audit will not be scored, EOHHS will provide appropriate feedback on each of the key elements. If the findings indicate that the Contractor is out of compliance, EOHHS will make the determination of whether a corrective action plan is warranted.

G. Corrective Action Plans (CAPs)

i. CAPs developed by the Contractor

- Following notification of the original violation giving rise to the CAP, the Contractor shall immediately cease the noncompliant behavior and take actions to mitigate the harm caused by the violation until an approved CAP is implemented.
- Any CAP required to be submitted by the Contractor shall, at a minimum, identify the following:
    - The finding resulting in a request for corrective action by EOHHS;
    - A description of how the finding resulting in a request for corrective action will be remediated;
    - The timeline for the implementation and completion of the corrective action(s); and
    - The name of the responsible person who will lead all corrective action activities.
- Any CAP submitted by the Contractor shall be subject to approval by the EOHHS.
- The Contractor shall submit the CAP within fifteen (15) calendar days, or within a time determined by EOHHS depending on the nature of the violation, from the date on the written notice requesting the CAP.
- Upon receipt, EOHHS may accept the plan as submitted, accept the plan with specified modifications, or reject the plan.
- If EOHHS requests modifications or rejects the CAP, the Contractor shall revise or submit a new plan within ten (10) calendar days, or

within a time determined by EOHHS depending on the nature of the violation, that addresses the identified concerns identified.

- The Contractor shall complete the corrective action(s) contained in the plan within the time period determined and approved by EOHHS.
- The Contractor shall provide updates to EOHHS on the remediation of all findings resulting in a request for corrective action at the interval requested by EOHHS.

ii. CAPs defined by EOHHS

- The Contractor shall accept and implement an EOHHS defined CAP.

H. Sanctions

CMS contract rule 42 CFR 438.66(a) states: The contract specifies that the State agency has in effect procedures for monitoring the Contractors' operations, including, at minimum, operations related to: recepient enrollment and disenrollment, processing grievances and appeals, violations subject to intermediate sanctions, as set forth in Subpart I of 42 CFR 438, violations of the conditions for receiving federal financial participation, as set forth in Subpart J of 42 CFR 438, and all other provisions of the contract, as appropriate.

I. Annual Compliance Audit

The Annual Compliance Audit will be onsite and consists of a focused review of key elements of the Contractor's compliance program (42 CFR 438.608) and will assess adherence to the Contractor's written compliance plan, including all relevant operating policies, procedures, workflows, and relevant chart of organization. The key elements reviewed may vary from year to year. A review of administrative and management arrangements may also be conducted as part of the annual audit. A review of grievance and appeal files will be a standard part of the compliance audit.

EOHHS will provide feedback to the Contractor on audit elements. If the audit reveals issues of noncompliance, EOHHS, at its discretion, will determine if a corrective action plan will be required to remediate any issues of noncompliance.

3.8 INSPECTION OF WORK PERFOMRED

A. Access to Information

Pursuant to Section 434.6(a)(5), the EOHHS and/or its designees, including its management and external quality review organization contractors, the Medicaid Fraud Unit of the Office of the 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.

B. Inspection of Premises

The State Executive Office of Health and Human Services, the Rhode Island Department of Health, State Auditors 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 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.

The Rhode Island Executive Office of Health and Human Services, the Rhode Island Department of Health, the State Auditor General 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, The Office of the Rhode Island Attorney General Medicaid Fraud Control Unit or their authorized representatives may, at any time, inspect and audit any records or documents of the Contractor, or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

The Contractor will ensure contracts with its subcontractors require the subcontractor to agree that the right to audit by the state, CMS and the DHHS Inspector General or their designees, will exist through ten (10) years from the final date of the contract period or from the date of completion of any audit whichever is later. The Contracts with subcontractors will also require that the State, CMS or the DHS Inspector General or their designees may:

- inspect, evaluate and audit the subcontractor at any time if is there is a reasonable possibility of fraud or similar risk,
- audit, evaluate and inspect any books, records, contracts, computer or other electronic systems of the subcontractor or the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under this Agreement,
- audit, evaluate or inspect the subcontractor's premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members.

C. Approval of Written Materials

Contractor shall 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 and appeals 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.

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.

3.9 CONFIDENTIALITY OF INFORMATION

A. Maintain Confidentiality of Information

EOHHS requires the Contractor to adhere to the provisions of the HIPAA Breach Notification Rule, 45 CFR 164.400-414, as well as guidelines found in the "Health Information Technology for Economic and Clinical Health Act" (HITECH). The Contractor shall require HIPAA covered entities and their business associates to provide notification following a breach of unsecured protected health information and must specify the requirements of these notifications to the HIPAA covered entities and business associates. In addition, EOHHS requires the Contractor to notify EOHHS immediately upon becoming aware of any incident, either confirmed or provisional, that represents or may represent unauthorized access, use of disclosure of encrypted or unencrypted computerized data that materially compromises the security, confidentiality or integrity of enrollee PHI maintained or held by the Contractor, including unauthorized acquisition of enrollee PHI by an employee or otherwise authorized user of the Contractor's system. Additionally, a breach or suspected breach may be an actual or suspected acquisition, access, use of, or disclosure of PII or SI. This includes, but is not limited to, loss or suspected loss of remote computing or telework devised such as laptops, PDAs, Blackberrys or other Smartphones, USB drives, thumb drives, flash drives, CDs and/or disks. Notification to EOHHS' designated security officer shall be made by telephone call and e-mail. The Contractor shall, within three (3) business days, provide to the EOHHS's designated security officer an updated status of the breach. A full report is required to be submitted to EOHHS's designated security officer within sixty (60) calendar days and will include a full accounting of the incident along with a corrective action plan.

Upon notice of a suspected security incident, the EOHHS 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.

B. 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:

1. Contractor agrees to not use or disclose protected health information other than is permitted or required by the agreement or as required by law.
2. 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.
3. 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.
4. 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.
5. Contractor agrees to maintain the security of protected health information it receives by establishing, at a minimum, measures utilized in current industry standards.
6. 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.
7. 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.
8. 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.
9. 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.
10. Contractor agrees to implement policies and procedures to facilitate the removal, termination and final disposal of PHI in electronic format, including the storage media housing the information.

C. 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.

D. 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.

E. 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 3.9.E by Contractor or any subcontractor.

F. State Assurance of Confidentiality

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

G. 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.

H. 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

I. 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), 45 CFR 164.504(e), 45 CFR164.410, 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 anything to the contrary or any provision that may be more restrictive within this Agreement, all requirements and provisions of HITECH, and 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.
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 3.5.C of this Agreement

Pursuant to 42 CFR 438.710(b), The State will provide Contractor with:

- Written notice of its intent to terminate and reason for termination
- Pre-termination hearing
- Time and place of the Pre-termination hearing

As specified in 42 CFR 438.710(b), prior to terminating this Agreement, EOHHS will provide the Contractor with written notice of its intent to terminate, the reason(s) for termination, and the time and place of the pre-termination hearing. After the hearing, EOHHS will provide the Contractor with written notice of the decision affirming or reversing the proposed termination of the contract. If the decision to terminate is affirmed, EOHHS will provide the Contractor with the effective date of the termination. If the decision to terminate is affirmed, EOHHS will notify members of the termination and their options for receiving Medicaid services following the effective date of the termination and allow members to disenroll without cause.

A. 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 3.5.I 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.

In the event of a termination for default by the State, Contractor shall be paid for any outstanding monies due less any assessed damages.

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.

Payment for such costs may be assessed against Contractor's performance bond or substitute security. If damages exceed monies due from invoices, collection can be made from Contractor's performance bond, cash deposit, letter of credit, or substitute security.

B. 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 termination

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 of termination.

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

C. 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 advice the Contract Administrator. Contractor shall ensure that all tasks related to the subcontract are performed in accordance with the terms of this Agreement.

i. Termination for Convenience

Upon written notice sent via certified mail to the Medicaid Director, the Contractor may seek to terminate this Agreement with the EOHHS without cause. The Contractor shall have a transition period of not less than four (4) nor more than six (6) months to transition services, during which time the term and conditions of this Agreement shall continue to apply, and the Contractor shall provide Covered Services to, and shall be paid pursuant to the Capitation Rates set forth herein for each Member, up to and including the date of transition of such Member.

The Contractor will work in good faith with EOHHS and EOHHS' other Medicaid managed care Contractors to ensure the safe and orderly transition of the Contractor's Members into a new Health/Dental plan.

D. 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 Dental 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.

In the event the Contractor reasonably determines, based on adequate documentation, that they intend, either in part or in full, to cease to conduct business, in the normal course as required by the terms of this Agreement, the Contractor will immediately advise the EOHHS Contract Administrator. The Contractor will notify EOHHS Contract Administer, by certified or registered mail the nature of the termination and the date upon which such termination becomes effective.

In the event the Contractor terminates a principal sub-contractor, the Contractor will advise EOHHS Contract Administer, by certified or registered mail the nature of the termination and the date upon which such termination becomes effective.

The Contractor will provide EOHHS a Notice of Termination inclusive of date the termination becomes effective, a transition plan timeline and detailed process to ensure orderly and timely transition of current members to the extent specified in the Notice of Termination. The transition plan will include, but is not limited to, forwarding of medical and other records, facilitation and scheduling of medically necessary appointments for care and service, and identification of chronically, high risk members, including behavioral health, woman in the last trimester of pregnancy and members who are hospitalized or reside in residential facilities. The transition of any and all data will be delivered in a format determined by EOHHS.

The Contractor will be liable for all claims incurred up to the date of termination including inpatient hospitalization claims incurred at the time of termination. The Contractor will provide a claims aging report to the State on a monthly basis and in a format to be determined by EOHHS.

In the case of sub-contractor termination, the Contractor will ensure that all tasks related to the sub-contractor are performed in accordance with the terms of this Agreement. The Contractor will provide EOHHS a Notice of Termination inclusive of

date the termination becomes effective, a transition plan timeline and detailed process to ensure orderly and timely transition of specific services provided by sub-contractor, ensure record and data exchange is to the extent specified in the Notice of Termination.

E. 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.

F. 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.

G. 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 3.3, *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 3.2.E, 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.

H. Notification of Members

In the event that this Agreement is terminated for any reasons outlined 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.

I. 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

A. 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.

B. 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.

C. 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.

D. 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/Dental 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.

E. 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.

F. 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.

G. Environmental Tobacco Smoke

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

H. 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.

I. 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.

J. 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.

K. 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 3.1.I.

These administrative procedures shall include but will not be limited to participation in meetings and file exchanges with Health Source RI, the Unified Health Information Project (UHIP) and all other vendors and subcontractors involved in implementing the Medicaid eligibility system in Rhode Island.

SIGNATURES ON NEXT PAGE

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:	**PLAN NAME:**
_____	_____
SIGNATURE	SIGNATURE
_____	_____
PATRICK M. TIGUE	NAME
ASSISTANT SECRETARY FOR	TITLE

HEALTH AND MEDICAID
DIRECTOR

_____ _____

DATE DATE

ADDENDUM I: FISCAL ASSURANCES

1. THE CONTRACTOR AGREES TO SEGREGATE ALL RECEIPTS AND DISBURSEMENTS PERTAINING TO THIS AGREEMENT FROM RECEIPTS AND DISBURSEMENTS FROM ALL OTHER SOURCES, WHETHER BY SEPARATE ACCOUNTS OR BY UTILIZING A FISCAL CODE SYSTEM.

2. THE CONTRACTOR ASSURES A SYSTEM OF ADEQUATE INTERNAL CONTROL WILL BE IMPLEMENTED TO ENSURE A SEPARATION OF DUTIES IN ALL CASH TRANSACTIONS.

3. THE CONTRACTOR ASSURES THE EXISTENCE OF AN AUDIT TRAIL WHICH INCLUDES: CANCELLED CHECKS, VOUCHER AUTHORIZATION, INVOICES, RECEIVING REPORTS, AND TIME DISTRIBUTION REPORTS.

4. THE CONTRACTOR ASSURES A SEPARATE SUBSIDIARY LEDGER OF EQUIPMENT AND PROPERTY WILL BE MAINTAINED.

5. THE CONTRACTOR AGREES ANY UNEXPENDED FUNDS FROM THIS AGREEMENT ARE TO BE RETURNED TO THE DEPARTMENT AT THE END OF THE TIME OF PERFORMANCE UNLESS THE DEPARTMENT GIVES WRITTEN CONSENT FOR THEIR RETENTION.

6. THE CONTRACTOR ASSURES INSURANCE COVERAGE IS IN EFFECT IN THE FOLLOWING CATEGORIES: BONDING, VEHICLES, FIRE AND THEFT, LIABILITY AND WORKER'S COMPENSATION.

7. THE FOLLOWING FEDERAL REQUIREMENTS SHALL APPLY AS INDICATED:

___ OMB CIRCULAR A-21 COST PRINCIPLES FOR EDUCATIONAL INSTITUTIONS

___ OMB CIRCULAR A-87 COST PRINCIPLES APPLICABLE TO GRANTS AND CONTRACTS WITH STATE AND LOCAL GOVERNMENTS

___ OMB CIRCULAR A-102 UNIFORM ADMINISTRATIVE REQUIREMENTS FOR GRANTS-TO-AID TO STATE AND LOCAL GOVERNMENTS

X OMB CIRCULAR A-110 UNIFORM ADMINISTRATIVE REQUIREMENTS FOR GRANTS AND AGREEMENTS WITH INSTITUTIONS OF HIGHER EDUCATION, HOSPITALS, AND OTHER NONPROFIT ORGANIZATIONS

X OMB CIRCULAR A-122 COST PRINCIPLES FOR NONPROFIT ORGANIZATIONS

8. IF THE CONTRACTOR EXPENDS FEDERAL AWARDS DURING THE PROVIDER'S PARTICULAR FISCAL YEAR OF $500,000 OR MORE, THEN OMB CIRCULAR A-133, AUDITS OF STATES, LOCAL GOVERNMENTS AND NON- PROFIT ORGANIZATIONS SHALL ALSO APPLY.

9. THIS AGREEMENT MAY BE FUNDED IN WHOLE OR IN PART WITH FEDERAL FUNDS. IF SO, THE CFDA REFERENCE NUMBER IS **93.778**.

ADDENDUM II: NOTICE TO EOHHS CONTRACTORS OF THEIR RESPONSIBILITIES UNDER TITLE IV 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 COMPLAINCE 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 COMPLAINCE 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 COMPLAINCE 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 COMPLAINCE 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:

84.1	DISCRIMINATION PROHIBITED
84.2	REASONABLE ACCOMMODATION
84.3	EMPLOYMENT CRITERIA
84.4	PREEMPLOYMENT INQUIRIES
84.5 - 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

ADDENDUM IV: DRUG-FREE WORKPLACE POLICY

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

1. ANY UNAUTHORIZED EMPLOYEE WHO GIVES OR IN ANY WAY TRANSFERS A CONTROLLED SUBSTANCE TO ANOTHER PERSON OR SELLS OR MANUFACTURES A CONTROLLED SUBSTANCE WHILE ON DUTY, REGARDLESS OF WHETHER THE EMPLOYEE IS ON OR OFF THE PREMISES OF THE EMPLOYER WILL BE SUBJECT TO DISCIPLINE UP TO AND INCLUDING TERMINATION.

2. THE TERM “CONTROLLED SUBSTANCE” MEANS ANY DRUGS LISTED IN 21 USC, SECTION 812 AND OTHER FEDERAL REGULATIONS. GENERALLY, ALL ILLEGAL DRUGS AND SUBSTANCES ARE INCLUDED, SUCH AS MARIJUANA, HEROIN, MORPHINE, COCAINE, CODEINE OR OPIUM ADDITIVES, LSD, DMT, STP, AMPHETAMINES, METHAMPHETAMINES, AND BARBITURATES.

3. EACH EMPLOYEE IS REQUIRED BY LAW TO INFORM THE AGENCY WITHIN FIVE (5) DAYS AFTER HE/SHE IS CONVICTED FOR VIOLATION OF ANY FEDERAL OR STATE CRIMINAL DRUG STATUTE. A CONVICTION MEANS A FINDING OF GUILT (INCLUDING A PLEA OF NOLO CONTENDERE) OR THE IMPOSITION OF A SENTENCE BY A JUDGE OR JURY IN ANY FEDERAL OR STATE COURT.

4. THE EMPLOYER (THE HIRING AUTHORITY) WILL BE RESPONSIBLE FOR REPORTING CONVICTION(S) TO THE APPROPRIATE FEDERAL GRANTING SOURCE WITHIN TEN (10) DAYS AFTER RECEIVING NOTICE FROM THE EMPLOYEE OR OTHERWISE RECEIVES ACTUAL NOTICE OF SUCH CONVICTION(S). ALL CONVICTION(S) MUST BE REPORTED IN WRITING TO THE OFFICE OF PERSONNEL ADMINISTRATION (OPA) WITHIN THE SAME TIME FRAME.

5. IF AN EMPLOYEE IS CONVICTED OF VIOLATING ANY CRIMINAL DRUG STATUTE WHILE ON DUTY, HE/SHE WILL BE SUBJECT TO DISCIPLINE UP TO AND INCLUDING TERMINATION. CONVICTION(S) WHILE OFF DUTY MAY RESULT IN DISCIPLINE OR DISCHARGE.

6. THE STATE ENCOURAGES ANY EMPLOYEE WITH A DRUG ABUSE PROBLEM TO SEEK ASSISTANCE FROM THE RHODE ISLAND EMPLOYEE ASSISTANCE PROGRAM (RIEAP). YOUR DEPARTMENT PERSONNEL OFFICER HAS MORE INFORMATION ON RIEAP.

7. THE LAW REQUIRES ALL EMPLOYEES TO ABIDE BY THIS POLICY.

EMPLOYEE RETAINS THIS COPY

ADDENDUM V: DRUG-FREE WORKPLACE POLICY PROVIDER CERTIFICATE OF COMPLIANCE

I, **NAME, TITLE, HEALTH/DENTAL PLAN**, 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

_____
NAME

_____
TITLE

_____
DATE

ADDENDUM VI: SUBCONTRACTOR COMPLIANCE

I, **NAME, T I T L E , HEALTH/DENTAL PLAN,** 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 3.5.F **HOLD HARMLESS**

SECTION 3.6.A **EMPLOYMENT PRACTICES**

_____
SIGNATURE

_____
NAME

_____
TITLE

_____
DATE

ADDENDUM VII: CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

PUBLIC LAW 103-227, PART C - ENVIRONMENTAL TOBACCO SMOKE, ALSO KNOWN AS THE PRO-CHILDREN AND/OR YOUNG ADULTS 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 AND/OR YOUNG ADULTS 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

_____
NAME

_____
TITLE

_____
DATE

ADDENDUM VIII: INSTRUCTIONS FOR CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS PRIMARY COVERED TRANSACTIONS

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

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

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

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

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

THE PROSPECTIVE PRIMARY PARTICIPANT AGREES BY SUBMITTING THIS CONTRACT THAT, SHOULD THE PROPOSED COVERED TRANSACTION BE ENTERED INTO, IT SHALL NOT KNOWINGLY ENTER INTO ANY LOWER TIER COVERED TRANSACTION WITH A PERSON WHO IS DEBARRED, SUSPENDED,

DECLARED INELIGIBLE, OR VOLUNTARILY EXCLUDED FROM PARTICIPATION IN THIS COVERED TRANSACTION, UNLESS AUTHORIZED BY THE EXECUTIVE OFFICE. THE PROSPECTIVE PRIMARY PARTICIPANT FURTHER AGREES BY SUBMITTING THIS CONTRACT THAT IT WILL INCLUDE THE CLAUSE TITLED CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION - LOWER TIER COVERED TRANSACTIONS, PROVIDED BY EOHHS, WITHOUT MODIFICATION, IN ALL LOWER TIER COVERED TRANSACTIONS AND IN ALL SOLICITATIONS FOR LOWER TIER COVERED TRANSACTIONS.

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

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

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

ADDENDUM IX: CERTIFICATION REGARDING DEBARTMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS – PRIMARY COVERED TRANSACTIONS

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

1. ARE NOT PRESENTLY DEBARRED, SUSPENDED, PROPOSED FOR DEBARMENT, DECLARED INELIGIBLE, OR VOLUNTARILY EXCLUDED FROM COVERED TRANSACTIONS BY ANY FEDERAL DEPARTMENT OR AGENCY;

2. HAVE NOT WITHIN A THREE (3) YEAR PERIOD PRECEDING THIS CONTRACT BEEN CONVICTED OF OR HAD A CIVIL JUDGMENT RENDERED AGAINST THEM FOR COMMISSION OF FRAUD OR A CRIMINAL OFFENSE IN CONNECTION WITH OBTAINING, ATTEMPTING TO OBTAIN, OR PERFORMING A PUBLIC (FEDERAL, STATE OR LOCAL) TRANSACTION OR CONTRACT UNDER PUBLIC TRANSACTION; VIOLATION OF FEDERAL OR STATE ANTITRUST 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.

SIGNAURE ON NEXT PAGE

_____
SIGNATURE

_____
NAME

_____
TITLE

_____
DATE

ADDENDUM X: LIQUIDATED DAMAGES

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

1. WHERE THE FAILURE IS THE SOLE AND EXCLUSIVE FAULT OF THE EXECUTIVE OFFICE, NO LIQUIDATED DAMAGES SHALL BE IMPOSED. TO THE EXTENT THAT EACH PARTY IS RESPONSIBLE FOR THE FAILURE, LIQUIDATED DAMAGES SHALL BE REDUCED BY THE APPORTIONED SHARE OF SUCH RESPONSIBILITY.

2. FOR ANY FAILURE BY THE CONTRACTOR TO MEET ANY PERFORMANCE STANDARD, MILESTONE OR PROJECT DELIVERABLE, THE EXECUTIVE OFFICE MAY REQUIRE THE CONTRACTOR TO PAY LIQUIDATED DAMAGES IN THE AMOUNT(S) AND AS SET FORTH IN THE STATE'S GENERAL CONDITIONS OF PURCHASE AS DESCRIBED PARTICULARLY IN THE LOI, RFP, RFQ, OR SCOPE OF WORK. CONTRACT WILL GOVERN FOR PROGRAM DELIVERABLES AND LIQUIDATED DAMAGES.

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 AMENDEMENT (31 U.S.C 1352) AS PUBLISHED IN THE FEDERAL REGISTER MAY 27, 2003, VOLUME 68, NUMBER 101.

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

FINAL RULE REQUIREMENTS CAN BE FOUND AT:

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

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

_____
SIGNATURE

_____
NAME

_____
TITLE

_____
DATE

ADDENDUM XIII: BID PROPOSAL

Please see attached technical proposal for LOI # _____ related to the Medicaid Rite Smiles Program, received from {INSERT PLAN NAME} Company on or about {DATE}, incorporated into this Contract by reference.

ADDENDUM XIV: CORE STAFF POSITIONS

NAME:
TITLE:
COMPANY:
OFFICE:
CELL:
EMAIL:

NAME:
TITLE:
COMPANY:
OFFICE:
CELL:
EMAIL:

NAME:
TITLE:
COMPANY:
OFFICE:
CELL:
EMAIL:

NAME:
TITLE:
COMPANY:
OFFICE:
CELL:
EMAIL:

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.

_____ _____

SIGNATURE DATE

_____ _____

PRINT NAME TITLE

IMPORTANT ITEMS TO NOTE ABOUT NEW REQUIREMENT

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

- Includes both mandatory and discretionary grants

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

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

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

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

ADDENDUM XVI: BUSINESS ASSOCIATE AGREEMENT

Except as otherwise provided in this Business Associate Agreement Addendum, United Healthcare Insurance Company (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 45 CFR 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 45 CFR162, and Part 164, Subparts A and C. The application of Security Provisions Sections 164.308, 164.310, 164.312, and 164.316 of title 45, Code of Federal Regulations shall apply to Business Associate of Covered Entity in the same manner that such sections apply to the Covered Entity.

N. "Suspected breach" is a suspected acquisition, access, use or disclosure of

protected health information ("PHI") in violation of HIPPA privacy rules, as referenced above, that compromises the security or privacy of PHI.

O. "Unsecured PHI" means PHI that is not secured, as defined in this section, through the use of a technology or methodology specified by the Secretary of the U.S. Department of Health and Human Services.

2. Obligations and Activities of Business Associate.

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

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

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

D. Business Associate agrees to report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement, including breaches of unsecured PHI as required by 45 C.F.R. § 164.410, and any Security Incident of which it becomes aware, within five (5) days of the incident.

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

F. Business Associate agrees to provide paper or electronic access, at the request of Covered Entity and in the time and manner designated by Covered Entity, to PHI in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. § 164.524. If the Individual requests an electronic copy of the information, Business Associate must provide Covered Entity with the information requested in the electronic form and format requested by the Individual and/or Covered Entity if it is readily producible in such form and format; or, if not, in a readable electronic form and format as requested by Covered Entity.

G. Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 C.F.R. §164.526 at the request of Covered Entity or an Individual, and in the time and

manner designated by Covered Entity. If Business Associate receives a request for amendment to PHI directly from an Individual, Business Associate shall notify Covered Entity upon receipt of such request.

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

I. Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. §164.528.

J. Business Associate agrees to provide to Covered Entity or an Individual, in a time and manner designated by Covered Entity, information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an individual for an accounting of disclosures for PHI in accordance with 45 C.F.R. 164.528.

K. If Business Associate accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses Unsecured Protected Health Information (as defined in 45 C.F.R. § 164.402) for Covered Entity, it shall, following the discovery of a breach of such information, notify Covered Entity of such breach within a period of five (5) days after discovery of the breach. Such notice shall include: a) the identification of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by Business Associate to have been accessed, acquired or disclosed during such breach; b) a brief description of what happened, including the date of the breach and discovery of the breach; c) a description of the type of Unsecured PHI that was involved in the breach; d) a description of the investigation into the breach, mitigation of harm to the individuals and protection against further breaches; e) the results of any and all investigation performed by Business Associate related to the breach; and f) contact information of the most knowledgeable individual for Covered Entity to contact relating to the breach and its investigation into the breach.

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

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

N. Business Associate agrees that it will not receive remuneration for certain communications that fall within the exceptions to the definition of Marketing

under 45 C.F.R. §164.501, unless permitted by 45 C.F.R. § 164.508(a)(3)(A)-(B).

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

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

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

ii. The safeguards set forth in this Agreement shall apply equally to PHI, confidential and "personal information." Personal information means an individual's first name and last name or first initial and last name in combination with any one or more of the following data elements that relate to such resident: (a) Social Security number; (b) driver's license number or state-issued identification card number; or (c) financial account number, or credit or debit card number, with or without any required security code, access code, personal identification number or password, that would permit access to a resident's financial account; provided, however, that "personal information" shall not include information that is lawfully obtained from publicly available information, or from federal, state or local government records lawfully made available to the general public.

3. Permitted Uses and Disclosures by Business Associate.

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

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

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

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

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

4. Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45

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

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

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

5. Permissible Requests by Covered Entity

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

6. Term and Termination.

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

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

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

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

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

d. In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon Covered Entity's written agreement that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

7. Miscellaneous.

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

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

c. The respective rights and obligations of Business Associate under Section 6 (c) and (d) of this Agreement shall survive the termination of this Agreement.

d. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with HIPAA and HITECH.

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

f. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer upon any person other than Covered Entity, Business Associate and their respective successors and assigns, any rights, remedies, obligations or liabilities whatsoever.

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

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

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

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

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

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

m. Business Associate shall maintain or cause to be maintained sufficient insurance coverage as shall be necessary to insure Business Associate and its employees, agents, representatives or subcontractors against any and all claims or claims for damages arising under this Business Associate Agreement and such insurance coverage shall apply to all services provided by Business Associate or its agents or subcontractors pursuant to this Business Associate Agreement. Business Associate shall indemnify, hold harmless and defend Covered Entity from and against any and all claims, losses, liabilities, costs and other expenses (including but not limited to, reasonable attorneys' fees and costs, administrative penalties and fines, costs expended to notify individuals and/or to prevent or remedy possible

identity theft, financial harm, reputational harm, or any other claims of harm related to a breach) incurred as a result of, or arising directly or indirectly out of or in connection with any acts or omissions of Business Associate, its employees, agents, representatives or subcontractors, under this Business Associate Agreement, including, but not limited to, negligent or intentional acts or omissions. This provision shall survive termination of this Agreement.

8. Acknowledgment.

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

Acknowledged and agreed to by:

STATE OF RHODE ISLAND:	**PLAN NAME:**
_____	_____
SIGNATURE	SIGNATURE
PATRICK M. TIGUE	_____
NAME	NAME
_____	_____
ASSISTANT SECRETARY FOR HEALTH AND MEDICAID DIRECTOR	TITLE
_____	_____
DATE	DATE

ATTACHMENT I

TO BUSINESS ASSOCIATE AGREEMENT

SOCIAL SECURITY DATA

This DUA requires that the REQUESTOR may not disclose Social Security Administration (SSA) provided data beyond the list of employees submitted to RI EOHHS and approved by EOHHS at the time of signing this DUA. Any additions or amendments to that list must be approved by EOHHS prior to sharing SSA data with additional employees. The REQUESTOR has been provided a copy of the Technical Security Requirements for the Electronic Exchange and Security of Information provided to State and Local Entities for the Exchange and Sharing of Information from the Social Security Information (hereinafter, the "TSSR"). The TSSR requirements are applicable to the REQUESTOR who receives verified SSA data and information obtained from EOHHS.

EOHHS requires that all contractors and REQUESTORS who process, handle, receive or transmit information provided to the state agency by SSA follow the terms of the EOHHS TSSR data exchange agreement with SSA. This is a requirement from SSA of EOHHS. EOHHS requires that the REQUESTOR and its agents receive SSA security awareness training as to the confidentiality and TSSR requirements for SSA verified data. The REQUESTOR shall maintain awareness-training records for their employees and require mandatory annual certification procedures which will be provided to EOHHS upon request. REQUESTOR shall ensure that users granted access to SSA-provided information receive adequate training on the sensitivity of the information, associated safeguards, operating procedures, and the civil and criminal consequences or penalties for misuse or improper disclosure.

EOHHS requires the REQUESTOR to certify to EOHHS that it conducts ongoing security compliance reviews that must meet SSA TSSR standards. EOHHS will conduct compliance reviews at least triennially commencing no later than three (3) years after the approved and executed DUA. Upon request, EOHHS will provide SSA with documentation of the EOHHS recurring compliance reviews of all contractors and agents.

The REQUESTOR agrees that it will ensure that SSA-provided information is not processed, maintained, transmitted, or stored in or by means of data communications channels, electronic devices, computers, or computer networks located in geographic or virtual areas not subject to U.S. law. Off-shore or overseas data access, transfer, transmittance, communication or sharing in any manner or method is not permitted under this agreement. Access to the SSA data received by this REQUESTOR is to authorized users who need the data to perform their official duties and shall be used on a need-to-know basis.

Cloud computing or cloud storage of SSA data is not permitted without explicit written permission from SSA's Chief Information Officer. This REQUESTOR must have formal Personally Identifiable Information (PII) incident response procedures as defined under the HIPAA and HITECH Acts. The REQUESTOR must have technology controls sufficient to meet

the TSSR requirements to prevent unauthorized retrieval of SSA-provided information by computer, remote terminal, or other means.

Onsite Reviews and Audits. At its discretion, EOHHS has the option to conduct onsite security reviews or make request of the REQUESTOR data recipient to ensure adequate security controls to safeguard the information EOHHSs provides to REQUESTOR. EOHHS may periodically review the REQUESTOR's system for employee access to determine if the same levels and types of access remain applicable as the date of the executed agreement.

The REQUESTOR will provide upon request to EOHHS a full audit trail of all persons who access, view, print or transfer SSA data in the format requested by EOHHS.

Access to the audit file must be restricted to authorized users with a "need to know," audit file data must be unalterable (read-only) and maintain for seven (7) years so that EOHHS may comply with its Records Retention requirements. Information in the audit file must be retrievable by an automated method and must allow EOHHS the capability to make the audit trail available to SSA upon request.

REQUESTOR acknowledges and agrees that the SSA, at its discretion, may request to include in the onsite compliance review an onsite inspection of the contractor's facility because the REQUESTOR will be using and accessing this SSA data off-site from EOHHS

PII loss is a reportable incident to EOHHS and must be reported to EOHHS within one hour but no later than twenty-four hours of a breach or a suspected breach. The term suspected breach is defined in the EOHHS Business Associate Agreement. PII means information that can be used to distinguish or trace an individual's identity, either alone or when combined with other personal or identifying information that is linked or linkable to a specific individual. 2 CFR §200.79. A PII would include a partial SSA data number along with any other personally identifying information that is shared with or accessed by an unauthorized user.

A breach is, generally, an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of the protected health information. An impermissible use or disclosure of protected health information is presumed to be a breach unless the covered entity or business associate, as applicable, demonstrates that there is a low probability that the protected health information has been compromised based on a risk assessment of at least the following factors: The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification; The unauthorized person who used the protected health information or to whom the disclosure was made; Whether the protected health information was actually acquired or viewed; and The extent to which the risk to the protected health information has been mitigated.

REQUESTOR agrees to report to EOHHS a breach of SSA data or access of SSA data by an unauthorized user by telephone and e-mail the discovery of any use or disclosure of any SSA verified data provided to REQUESTOR by EOHHS under this Agreement, including breaches of

unsecured SSA data and any security incident of which it becomes aware, within one (1) hour of the breach**,** suspected breach, and/or security incident.

Security Incident is defined as any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access or destroy information or misuse SSA data for a purpose outside of this agreement.

Before granting access to SSA-provided information, EOHHS will verify the identities of any REQUESTOR employees who will have access to SSA-provided information.

ATTACHEMENT A: SCHEDULE OF IN-PLAN BENEFITS

The covered dental benefit package for which the Contractor will be responsible is shown below.

DENTALBENEFITS/RITE SMILES	
Dental Service	Benefit Package Provided When Medically Necessary
Preventive Services	Prophylaxis, sealants, topical application of fluoride, space maintainers
Diagnostic and Radiology Services	Oral examinations, intraoral radiographs, biopsies of oral tissue, all medically necessary diagnostic evaluation and radiographs/diagnostic images
Endodontic Services	Complete root canal therapy, including pulpectomy, apexification/recalcification procedures, other reinforcements, 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, temporary and permanent 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, including routine and surgical extractions
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.

ATTACHEMENT B: SCHEDULE OF OUT-OF-PLAN BENEIFTS

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 avulsed 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, down fracture, 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 down fracture, this code would entail a reduced service and should be "by report."
D7948	LeFort II or LeFort HI (osteoplasty of facial bones for midface hypoplasia or retrusion)- without bone graft Surgical section of upper jaw. This includes the surgical exposure, bone cuts, down fracture, 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.

ATTACHEMENT C: SCHEDULE OF NON-COVERED BENEFITS

- **Cosmetic Procedures (e.g., Tooth Whitening)**
- **Dental Implants**
- **Procedures considered Experimental or Investigational**

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).

ATTACHEMNT D: DENTAL EPSDT PERIODICITY SCHEDULE

Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

Since each child and/or young adult is unique, these recommendations are designed for the care of children and/or young adults who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children and/or young adults with special health care needs or if disease or trauma manifests variations from normal. The Rhode Island Department of Health and emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child.

Refer to the text below for supporting information and references.

	Age				
	6 TO 12 MONTHS	12 TO 24 MONTHS	2 TO 6 YEARS	6 TO 12 YEARS	12 YEARS AND OLDER
Clinical oral examination[1]	•	•	•	•	•
Assess oral growth and development[2]	•	•	•	•	•
Caries-risk assessment[3]	•	•	•	•	•
Radiographic assessment[4]	•	•	•	•	•
Prophylaxis and topical fluoride[3,4]	•	•	•	•	•
Fluoride supplementation [5]	•	•	•	•	•
Anticipatory guidance/counseling[6]	•	•	•	•	•
Oral hygiene counseling[7]	Parent	Parent	Patient/Parent	Patient/Parent	Patient
Dietary counseling[8]	•	•	•	•	•
Injury prevention counseling[9]	•	•	•	•	•
Counseling for nonnutritive habits[10]	•	•	•	•	•
Counseling for speech/language development	•	•	•		
Substance abuse counseling				•	•
Counseling for intraoral/perioral piercing				•	•
Counseling for HPV vaccination[11]				•	•
Assessment and treatment of developing malocclusion			•	•	•
Assessment for pit and fissure sealants[12]			•	•	•
Assessment and /or removal of third molars					•
Transition to adult dental care					•

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 and/or young adult's risk status/susceptibility to disease. Includes assessment of pathology and injuries.

2. By clinical examination.

3. Must be repeated regularly and frequently to maximize effectiveness.

4. Timing, selection, and frequency determined by Child and/or young adult's history, clinical findings, and susceptibility to oral disease.

5. Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.

6. Appropriate discussion and counseling should be an integral part of each visit for care.

7. Initially, responsibility of parent; as child and/or young adult matures, jointly with parent; then, when indicated, only child.

8. At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.

9. Initially play objects, pacifiers, car seats; when learning to walk; then with sports and routine playing, including the importance of mouthguards.

10. 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/or young adults and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.

11. For children and/or young adults age 11 and older, discuss with parents HPV vaccine as prevention against oral and pharyngeal cancer.

12. For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

ATTACHMENT E: MONTHLY CAPITATION RATES

The Capitation rates for the SFY 2021 rating period are considered preliminary and will be updated using an additional year of data prior to the effective date of July 1, 2020. An actual certification of capitation rates will be issued at that time for SFY 2021 rates based on the updated base experience data.

State of Rhode Island
Executive Office of Health and Human Services
State Fiscal Year 2021 Dental Capitation Rate Development
RIte Smiles Dental Program
Rate Change Summary

	Projected Exposure	Base Benefit Expense	New Benefit Add On	Base Benefit Expense with Add On	Administrative Cost Allowance	Risk Margin	SFY 2021 Effective Rate	Prior Effective Rate	% Change
RIte Smiles									
Age 0-2	195,463	$ 4.26	$ 0.04	$ 4.30	$ 0.33	$ 0.10	$ 4.73	$ 4.53	4.4%
Age 3-5	224,059	15.19	0.05	15.25	1.17	0.34	16.76	16.20	3.5%
Age 6-10	352,049	20.96	0.05	21.01	1.62	0.46	23.09	22.37	3.2%
Age 11-15	350,207	22.82	0.03	22.85	1.76	0.50	25.11	24.42	2.8%
Age 16-21	276,805	17.89	0.04	17.93	1.38	0.39	19.70	20.15	(2.2%)
Total RIte Smiles	1,398,583	$ 17.56	$ 0.04	$ 17.60	$ 1.36	$ 0.39	$ 19.34	$ 18.96	2.0%

State of Rhode Island
Executive Office of Health and Human Services
State Fiscal Year 2021 Dental Capitation Rate Development
RIte Smiles Dental Program
Rate Change Summary

	SFY 2021 Effective Rate	Premium Tax	SFY 2021 Capitation Rate	Prior Capitation Rate	% Change
RIte Smiles					
Age 0-2	$ 4.73	$ 0.10	$ 4.83	$ 4.62	4.5%
Age 3-5	16.76	0.34	17.10	16.53	3.4%
Age 6-10	23.09	0.47	23.56	22.83	3.2%
Age 11-15	25.11	0.51	25.62	24.92	2.8%
Age 16-21	19.70	0.40	20.10	20.56	(2.2%)
Total	$ 19.34	$ 0.39	$ 19.74	$ 19.35	2.0%

ATTACHMENT F: ACTUARIAL BASIS FOR CAPITATION RATES

Please refer to the following Data Book and Actuarial Certification related to the Medicaid RIte Smiles Program, incorporated into this Contract by reference.

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 2.6 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 EOHHS 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 EOHHS 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 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 EOHHS requests Contractor to perform a reconciliation of encounter data, Contractor agrees to submit the reconciliation to EOHHS within fifteen (15) business days. In the event Contractor's response takes longer to be submitted, EOHHS may at its discretion move forward to final settlement without regard to any additional 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.

42 CFR 438.6(b)(1) Special contract provisions related to payment **(b)***Basic requirements.* **(1)** If used in the payment arrangement between the State and the MCO, PIHP, or PAHP, all applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, must be described in the contract, and must be developed in accordance with 42 CFR § 438.4, the rate development standards in 42 CFR§ 438.5, and generally accepted actuarial principles and practices.

II. MLR Reporting: In accordance with the *Medicaid Managed Care Program: Medical Loss Ratio Calculation*, appended to this Amendment, the Contractor is required to comply with the 42 CFR MLR reporting requirements, as follows:

1. The Contractor will calculate/report an MLR for each MLR reporting year, consistent with MLR standards, in accordance with 42 CFR 438.8(a).

2. For each reporting year, the Contractor must calculate MLR in accordance with the following definition: The MLR calculation is the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)).

3. The Contractor will include each of its MCO expenses under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses, in accordance with 42 CFR 438.8(g)(1)(i).

4. The Contractor will allocate expenses based on a generally accepted accounting method that is expected to yield the most accurate results, in accordance with 42 CFR 438.8(g)(2)(i).

5. The Contractor's shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense, in accordance with 42 CFR 438.8(g)(2)(ii).

6. The Contractor's expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities, in accordance with 42 CFR 438.8(g)(2)(iii).

7. The Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible, in accordance with 42 CFR 438.8(h)(1).

8. The Contractor must add the credibility adjustment to the reported MLR calculation before calculating any remittances, if required by the State, in accordance with 42 CFR 438.8(h)(1).

9. The Contractor is not permitted to add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible, in accordance with 42 CFR 438.8(h)(2).

10. The Contractor's experience is presumed to meet or exceed the MLR calculation standards if the Contractor's experience is non-credible, in accordance with 42 CFR 438.8(h)(3).

11. The Contractor is required to aggregate data for all Medicaid eligibility groups covered under the contract with the State unless the State requires separate reporting and a separate MLR calculation for specific populations, in accordance with 42 CFR 438.8(i).

12. The Contractor must submit to the State an MLR report that includes total incurred claims for each MLR reporting year, in accordance with 42 CFR 438.8(k)(1)(i).

13. The Contractor must submit to the State an MLR report that includes expenditures on quality improving activities for each MLR reporting year, in accordance with 42 CFR 438.8(k)(1)(ii).

14. The Contractor must submit to the State an MLR report that includes expenditures related to activities compliant with program integrity requirements for each MLR reporting year, in accordance with 42 CFR 438.8(k)(1)(iii), 42 CFR 438.608(a)(1)-(5), 42 CFR 438.608(a)(7)-(8), and 42 CFR 438.608(b).

15. The Contractor must submit to the State an MLR report that includes non-claim costs for each MLR reporting year, in accordance with 42 CFR 438.8(k)(1)(iv).

16. The Contractor must submit to the State an MLR report that includes premium revenue for each MLR reporting year, in accordance with 42 CFR 438.8(k)(1)(v).

17. The Contractor must submit to the State an MLR report that includes taxes for each MLR reporting year, in accordance with 42 CFR 438.8(k)(1)(vi).

18. The Contractor must submit to the State an MLR report that includes licensing fees for each MLR reporting year, in accordance with 42 CFR 438.8(k)(1)(vi).

19. The Contractor must submit to the State an MLR report that includes regulatory fees for each MLR reporting year, in accordance with 42 CFR 438.8(k)(1)(vi).

20. The Contractor must submit to the State an MLR report that includes methodology(ies) for allocation of expenditures for each MLR reporting year, in accordance with 42 CFR 438.8(k)(1)(vii).

21. The Contractor must submit to the State an MLR report that includes any credibility adjustment applied for each MLR reporting year, in accordance with 42 CFR 438.8(k)(1)(viii).

22. The Contractor must submit to the State an MLR report that includes the calculated MLR for each MLR reporting year, in accordance with 42 CFR 438.8(k)(1)(ix).

23. The Contractor must submit to the State an MLR report that includes any remittance owed to the State, if applicable, for each MLR reporting year, in accordance with 42 CFR 438.8(k)(1)(x).

24. The Contractor must submit to the State an MLR report that includes a comparison of the information reported with the audited financial report for each MLR reporting year, in accordance with 42 CFR 438.8(k)(1)(xi) and 42 CFR 438.3(m).

25. The Contractor must submit to the State an MLR report that includes a description of the aggregation method used to calculate total incurred claims for each MLR reporting year, in accordance with 42 CFR 438.8(k)(1)(xii) and 42 CFR 438.8(i).

26. The Contractor must submit to the State an MLR report that includes the number of member months for each MLR reporting year, in accordance with 42 CFR 438.8(k)(1)(xiii).

27. The Contractor must submit the MLR report in a timeframe and manner determined by the State, which must be within 12 months of the end of the MLR reporting year, in accordance with 42 CFR 438.8(k)(2) and 42 CFR 438.8(k)(1).

28. The Contractor must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting, in accordance with 42 CFR 438.8(k)(3).

29. The Contractor must re-calculate the MLR for all MLR reporting years affected by a retroactive change to the capitation payments for an MLR reporting year where the MLR report has already been submitted to the State, in accordance with 42 CFR 438.8(m) and 42 CFR 438.8(k).

30. The Contractor must submit a new MLR report that meets requirements applicable to any instance in which the State makes a retroactive change to the capitation payments for an MLR reporting year where the MLR report has already been submitted to the State, in accordance with 42 CFR 438.8(m) and 42 CFR 438.8(k).

31. The Contractor must attest to the accuracy of the MLR calculation in accordance with the MLR standards when submitting required MLR reports, in accordance with 42 CFR 438.8(n) and 42 CFR 438.8(k).

32. 42 CFR 438.74(a)(2) State oversight of the minimum MLR requirement. (a) State reporting requirement. (2) The summary description must include, at a minimum, the amount of the numerator, the amount of the denominator, the MLR percentage achieved, the number of member months, and any remittances owed by each MCO, PIHP, or PAHP for that MLR reporting year.

ATTACHMENT H: CONTRACTOR'S INSURANCE CERTIFICATION

Please refer to the Parental Guaranty of Performance from [PLAN NAME] on the next page.

ATTACHMENT I: CONTRACTOR'S LOCATIONS

INDEX

2 CFR §200.79, 167
34 CFR, parts 104 and 106, 98
40 CFR, Part 15, 127
42 CFR 434.70, 71
42 CFR § 438.4, 186
42 CFR 1001.1001, 82, 83
42 CFR 1002.3, 82
42 CFR 1003, 71
42 CFR 210, 71
42 CFR 422.128, 26
42 CFR 422.208, 71, 112
42 CFR 422.210, 112
42 CFR 431.210, 50
42 CFR 431.230(b), 67
42 CFR 431.304, 120
42 CFR 431.305, 120, 121
42 CFR 434.67, 71
42 CFR 438, 115
42 CFR 438.02, 113
42 CFR 438.10, 25, 28, 46, 62
42 CFR 438.10 (c), 50
42 CFR 438.10 (c)(1), 20
42 CFR 438.10(d)(4), 21
42 CFR 438.10(f)(4), 28
42 CFR 438.10(g)(1), 26, 45, 93
42 CFR 438.100, 26, 45
42 CFR 438.104, 8, 20, 21
42 CFR 438.104(b)(2)(i), 20
42 CFR 438.106(a), 91
42 CFR 438.116, 76
42 CFR 438.116(a), 91
42 CFR 438.14(c)(2), 41
42 CFR 438.206, 38, 46
42 CFR 438.208(b)(3), 36
42 CFR 438.214, 39, 41
42 CFR 438.228(b), 114
42 CFR 438.230, 92
42 CFR 438.236, 53
42 CFR 438.242(c), 55
42 CFR 438.3, 76
42 CFR 438.3(c)(1)(i), 67
42 CFR 438.3(c)(2), 67
42 CFR 438.3(g), 71
42 CFR 438.3(j)(2), 26
42 CFR 438.3(m), 76, 188
42 CFR 438.332(b)(1), 16
42 CFR 438.332(b)(2), 16
42 CFR 438.332(b)(3), 16
42 CFR 438.350, 49, 53
42 CFR 438.400, 26
42 CFR 438.404(c), 49, 62
42 CFR 438.408 (b), 63
42 CFR 438.408(b)(1) and (2), **7**
42 CFR 438.414, 93
42 CFR 438.416, 76
42 CFR 438.420, 27, 65, 67
42 CFR 438.424, 26
42 CFR 438.5(c), 76
42 CFR 438.52(b)(2)(ii), 7
42 CFR 438.56(b)(2), 31
42 CFR 438.56(d)(1)(ii)., 31
42 CFR 438.56(d)(2)(iii), 31
42 CFR 438.6, 15, 87
42 CFR 438.6(b)(1), 186
42 CFR 438.6(c), 90
42 CFR 438.6(i)(4), 26
42 CFR 438.6., 27
42 CFR 438.60, 70, 71
42 CFR 438.602(i), 97
42 CFR 438.604, 77
42 CFR 438.604(a)(2)-(4), 76
42 CFR 438.606, 76, 77
42 CFR 438.608, 77, 114, 115
42 CFR 438.608(a)(1)-(5), 187
42 CFR 438.608(a)(7)-(8), 187
42 CFR 438.608(b), 42, 187
42 CFR 438.608(d)(l)(iii), 111
42 CFR 438.610, 77, 78
42 CFR 438.610(d), 79
42 CFR 438.66(a), 115
42 CFR 438.68, 44
42 CFR 438.700, 112, 113
42 CFR 438.700(b)(1), 47
42 CFR 438.702, 112
42 CFR 438.702(a) (3), 31
42 CFR 438.704, 111, 113
42 CFR 438.706, 58, 104, 113
42 CFR 438.71(a), 21, 62

42 CFR 438.710(a), 113
42 CFR 438.710(b), 122
42 CFR 438.74(a)(2), 76, 189
42 CFR 438.8, 11, 76
42 CFR 438.8(a), 76, 186
42 CFR 438.8(e), 11, 186
42 CFR 438.8(f), 11, 186
42 CFR 438.8(g)(1)(i), 186
42 CFR 438.8(g)(2)(i), 186
42 CFR 438.8(g)(2)(ii), 186
42 CFR 438.8(g)(2)(iii), 186
42 CFR 438.8(h)(1), 187
42 CFR 438.8(h)(2), 187
42 CFR 438.8(h)(3), 187
42 CFR 438.8(i), 187, 188
42 CFR 438.8(k), 76, 189
42 CFR 438.8(k)(1), 188
42 CFR 438.8(k)(1)(i), 187
42 CFR 438.8(k)(1)(ii), 187
42 CFR 438.8(k)(1)(iii), 187
42 CFR 438.8(k)(1)(iv), 187
42 CFR 438.8(k)(1)(ix), 188
42 CFR 438.8(k)(1)(v), 187
42 CFR 438.8(k)(1)(vi), 187
42 CFR 438.8(k)(1)(vii), 188
42 CFR 438.8(k)(1)(viii), 188
42 CFR 438.8(k)(1)(x), 188
42 CFR 438.8(k)(1)(xi), 188
42 CFR 438.8(k)(1)(xii), 188
42 CFR 438.8(k)(1)(xiii), 188
42 CFR 438.8(k)(2), 188
42 CFR 438.8(k)(3), 76, 188
42 CFR 438.8(m), 189
42 CFR 438.8(n), 189
42 CFR 440.230, 53
42 CFR 441 Subpart B, 53
42 CFR 447.26, 71
42 CFR 447.45, 42, 69
42 CFR 447.46, 42, 69
42 CFR 447.50, 72
42 CFR 447.60, 72
42 CFR 455.100-106, 42
42 CFR 455.104, 42, 79
42 CFR 455.106, 42
42 CFR 455.17, 58
42 CFR 455.2, 105
42 CFR 455.20, 107
42 CFR 455.400-470, 42
42 CFR 456.111, 55
42 CFR 456.23, 108
42 CFR 456.3, 108
42 CFR 456.4, 108
42 CFR 457.1201(c),(n)(2),(o),(p), 67
42 CFR Chapter IV, 71
42 CFR MLR, 186
42 CFR Part 447, 71
42 CFR Section 1001.1001(a)(1), 81, 82
42 CFR Section 455.104, 79, 80
42 CFR Section 455.105, 81
42 CFR Section 455.106, 81
42 CFR, 438.208(b)(5), 36
42 CFR.438.230(b), 92
42 CFR§ 438.5, 186
42CFR 438.10, 20
42CFR 438.6(h), 46
438.104, 20
45, 161, 162
45 C.F.R. § 164.314, 159
45 C.F.R. § 164.402, 160
45 C.F.R. § 164.410, 159
45 C.F.R. § 164.502(a)(5)(ii)(B)(2), 160
45 C.F.R. § 164.508(a)(3)(A)-(B), 161
45 C.F.R. § 164.524, 159
45 C.F.R. §164.501, 161
45 C.F.R. §164.502(j)(1), 162
45 C.F.R. §164.504 (e)(2)(i)(B), 162
45 C.F.R. §164.522, 162
45 C.F.R. §164.526, 159
45 C.F.R. §164.528, 160
45 C.F.R. 164.528, 160
45 C.F.R.§164.514(d), 161
45 CFR 160.103, 158
45 CFR 164.400-414, 117
45 CFR 164.502(e), 121
45 CFR 164.504(e), 121
45 CFR 74.161, 93
45 CFR Part 160, 158
45 CFR Part 164, 28, 158
45 CFR PART 76, 143
45 CFR PART 93, 151
45 CFR, PART 80, 132
45 CFR, PART 84, 135

45 CFR, parts 160, 162 and 164, 157
45 CFR, parts 80 and 84, 98
45 CFR162, 158
45 CFR164.410, 121
7 CFR 272.6, 98