

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

INTERAGENCY AGREEMENT

Between

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES

And

DEPARTMENT OF HEALTH

For PARTICIPATION in THE RHODE ISLAND MEDICAID PROGRAM

This Agreement, by and between the STATE OF RHODE ISLAND, EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES, hereinafter known as EOHHS and the DEPARTMENT OF HEALTH, hereinafter known as HEALTH, governs participation by HEALTH in the Rhode Island Medicaid Program, and the ability of HEALTH to access federal funding pursuant to Titles XIX and XXI (where appropriate) of the Social Security Act hereinafter known as “Medicaid” for the purposes of this agreement.

In accordance with 42 CFR §431.10 (e) (3), the parties agree mutually that as a State agency performing services for the Medicaid agency, HEALTH does not have the authority to change or disapprove of any administrative decision or otherwise substitute its judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by EOHHS.

Regular scheduled meetings between EOHHS and Health will be conducted in order to communicate on the administration of the Rhode Island Medicaid Program.

Paragraph 1 – Single State Agency

EOHHS affirms that it is the single state agency duly authorized by the Centers for Medicare and Medicaid Services (“CMS”) to administer the Medicaid program in and for the State of Rhode Island, and that it is further authorized to delegate specific elements of its authority and responsibility to HEALTH, as set forth in this agreement.

HEALTH

Paragraph 2 – General Terms and Conditions

As defined herein, as well as any Attachments or subsequent Amendments, HEALTH shall be authorized to claim federal matching funds for specified administrative and program support of services authorized under the Rhode Island Medicaid State Plan or the Rhode Island Section 1115 Demonstration Waiver, including Costs Not Otherwise Matchable (CNOM), to individuals determined by EOHHS, or for CNOM by HEALTH, to be eligible recipients of those services. Claiming for CNOM shall not include administrative support, except as expressly approved by the U.S. Centers for Medicare and Medicaid (CMS). Execution of this Agreement and any Amendments constitutes an acknowledgement by EOHHS that the services and activities described herein support the overall administration of the Rhode Island Medicaid Program and qualify for federal claiming. In the conduct of these services and activities, HEALTH agrees to be subject to: Title 40 Chapter 8 and Title 42 Chapter 12.3 of the Rhode Island General Laws; Titles XIX and XXI of the Social Security Act as well as all other applicable provisions of state and federal statute and regulation applicable to the Medicaid and/or CHIP Programs; the Medicaid or CHIP States Plan; and/or EOHHS in its capacity as the Single State Agency. Therefore, by entering into this Agreement, the parties mutually agree that, as the Single State Agency, the EOHHS is accountable to CMS and the Governor, General Assembly and the people of the State for any such actions the HEALTH takes in providing the administrative services, duties or benefits for which HEALTH seeks federal financial participation as set forth herein. In the event of any conflict between these provisions and any other provision of law or regulation as may affect the operation of HEALTH's responsibilities, these provisions shall govern for services and activities authorized by this agreement. Further, HEALTH understands and acknowledges the exclusive right of EOHHS to determine federal policy defining all aspects of the Rhode Island Medicaid Program.

Paragraph 3 – General Construction

This Agreement is comprised of a basic Agreement and five (5) Attachments:

Attachment A	Special Terms and Conditions
Attachment B	Administrative and Program/Services Qualifying for Medicaid Funding
Attachment C	Contracts and Subcontracts Qualifying for Medicaid Funding
Attachment D	Confidentiality and Privacy Rule Requirements
Attachment E	Costs Not Otherwise Matchable

Paragraph 4 – Scope of Services

The scope of services and billable activities authorized by this agreement are defined in Attachments B and C, as well as any subsequent Amendments. No other services or activities for which reimbursement or payment will be sought pursuant to this agreement are permitted. All Amendments shall be considered to be prospective in application, except as expressly specified to the contrary.

EOHHS and HEALTH agree to make changes to this Agreement to reflect changes in federal law, regulation or policy or to reflect material changes in state law, organization and policy as required by submission of state plans/plan amendments 42CFR430.12(c).

Paragraph 5 – Funding

In consideration of the services performed pursuant to this agreement, EOHHS agrees to present claims to CMS on behalf of HEALTH for federal reimbursement under Titles XIX and XXI, and HEALTH confirms that it has appropriated funds sufficient to act as the matching portions for these reimbursements.

Paragraph 6 – Approval of Contracts

Any contract or subcontract, including any purchase of goods, software or equipment, between HEALTH and any third party with a value of \$25,000 or more that is proposed to be funded, in whole or in part, by Title XIX or Title XXI must be approved in advance by EOHHS. Additionally, any contract between HEALTH and any third party that involves transfer or use of data concerning Medicaid expenditures or eligibility must be approved in advance by EOHHS.

Paragraph 7 – Rate Administration

EOHHS has sole authority to establish rates for payment for participating Medicaid providers. Any request for establishment of rates or changes in existing rates shall be forwarded in advance of the date of application to EOHHS in writing, accompanied by a description of the methodology used to develop the rate or change in rate, as well as the calculations and formulae employed to derive the rate.

Paragraph 8 – Appeals

Medicaid-eligible recipients have a final right of appeal for denials of service or other controversies concerning their benefits. Notwithstanding the prior determinations by HEALTH, EOHHS resolution of such appeals shall take precedence, provided however, that EOHHS shall not direct HEALTH to take any action that is in conflict with or contradictory to any express duties or obligations of HEALTH under any other governing statute or regulation.

Paragraph 9 – Reimbursement Denied

It is understood and agreed that, in the event that full federal funding is not received by EOHHS or is subsequently denied by CMS due to failure of HEALTH to comply with the terms of this agreement or other provision of federal statute or regulation, HEALTH shall be liable to pay or restore an amount equal to the federal disallowance, plus any interest and penalties, and that this amount is payable in full upon demand of EOHHS.

Paragraph 10 – Payment by the Rhode Island Executive Office of Health & Human Services

Except as described in Attachment A, HEALTH and any direct services under the control and direction of HEALTH shall present detailed claims for all direct services pursuant to this Agreement to the fiscal agent for EOHHS in a format and frequency acceptable to EOHHS. In no event shall claims or other requests for payment be presented or paid prior to completion of the services or activities in question. The fiscal agent for EOHHS or the State Controller, as appropriate, shall render prompt payment following submission and adjudication of a properly prepared payment request.

HEALTH affirms, in accordance with OMB-Circular A-87 and state plan requirements 45CFR95.507 (b) (6) that any billing by HEALTH will be based on the actual cost incurred. HEALTH agrees to comply with the requirements at 42CFR447.206, which limits the cost for providers operated by units of government.

Paragraph 11 – Records

HEALTH agrees to make accessible to State and/or Federal officials or their agents, at reasonable times and at such site(s) as may be designated by EOHHS, all fiscal and activity records pertaining to services purchased under this agreement for up to 3 previous fiscal years,.

Paragraph 12 – Representations of Compliance

HEALTH agrees to comply with the Requirements of Title VI of the Civil Rights Act of 1964 (U.S.C., 2000d et seq.), Section 504 of the Rehabilitation Act of 1973 as amended (29 U.S.C. 794), and EOHHS implementing regulations found in 45 CFR Parts 80 and 84, which prohibit discrimination on the basis of race, color, national origin, or handicap in acceptances for or provision of services, or employment services and activities.

HEALTH agrees to comply with all other provisions of applicable law, including the Governor’s Executive Order 96-14 which prohibits discrimination on the basis of race, color, religion, sex, age, national origin, handicap, sexual orientation or disability.

HEALTH also agrees to require similar representations and assurances in any contract or subcontract using Title XIX or Title XXI funding.

Failure to comply with these items may be the basis for termination of this contract.

Paragraph 13 – Confidentiality and Privacy Rule Requirements

HEALTH agrees to comply with the requirements of EOHHS for the safeguarding of client-specific information. Failure to comply with this item may be the basis for termination of this contract. EOHHS reserves the right to require HEALTH to implement procedures within thirty (30) days of receipt of notice from EOHHS to prevent reoccurrence.

Except as otherwise limited in this Agreement, HEALTH may use or disclose Protected Health information in accordance with the provisions outlined in Attachment D on behalf of, or to provide services to, EOHHS for the purposes defined by this Agreement, if such use or disclosure of Protected Health Information would not violate the provisions of the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR part 160 and part 164,

HEALTH

AGREEMENT NAME: DOH Medicaid ISA (4)

subparts A and E) if done by EOHHS or the minimum necessary policies and procedures established by EOHHS.

Paragraph 14 – Personnel Resources to be Delivered

Where reimbursement is sought to underwrite activities of state personnel, contract employees, or contractors employed or engaged by HEALTH other than in provision of direct services, HEALTH certifies in providing services/products identified in Attachments B and C that all claims reflect the actual cost incurred by HEALTH.

Paragraph 15 – Reporting Procedures

HEALTH will produce reports describing activity pursuant to this agreement as requested by EOHHS during the term of this Agreement. Reports shall be delivered in hard copy and in an electronic format acceptable to EOHHS, unless otherwise specified. HEALTH will complete the EOHHS Fiscal Report, Medical Assistance Quarterly Summary, and submit to EOHHS within forty-five (45) calendar days following the end of each quarter.

Paragraph 16 – Termination

This agreement may be terminated by either party with thirty (30) days written notice.

Paragraph 17 – Changes

EOHHS may at any time, with written notice to and concurrence by HEALTH, make changes to the scope and terms and conditions governing this agreement. All changes shall be in writing in the form of an Amendment to this Agreement.

Paragraph 18 – Effective Date

This agreement contract shall be in effect from April 1, 2015 and continue in force, subject to annual review, unless terminated or amended by both parties, and supersedes all previous agreements for these purposes.

AGREEMENT NAME: DOH Medicaid ISA (4)

Paragraph 19 – Execution

This Agreement is executed in two or more counterparts, each of which shall be deemed an original.

IN WITNESS THEROF, the parties have executed this Agreement as follows:

For the EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES

Elizabeth H. Roberts, Secretary

Date

For the DEPARTMENT OF HEALTH

Nicole Alexander Scott, MD, Director

Date

ATTACHMENT A

SPECIAL TERMS and CONDITIONS

The parties mutually agree that the following will occur yearly by HEALTH and be submitted to EOHHS for approval no later than ninety (90) days after the close of the federal fiscal year:

1. Conduct of a Benefit Claiming Review to assure that all Medicaid benefit claiming complies with the terms of this Agreement, the Rhode Island State Plan, and applicable federal rules.
2. Conduct of an Administrative Claiming Review to assure that all administrative claiming complies with the terms of this Agreement and the approved Cost Allocation Plan (Indirect Cost Rate) for HEALTH.
3. Provide certification that Medicaid claims are in compliance with the terms of this Agreement, all applicable federal laws and state laws, the Rhode Island Medicaid State Plan and/or the Global Compact Waiver. See attached: Form 1.

ATTACHMENT B

**ADMINISTRATION AND PROGRAM SUPPORT AREAS QUALIFYING FOR
MEDICAID FUNDING**

HEALTH is authorized to claim federal Medicaid match for administrative and program support to the following programs and services and/or accounts for the pro rata share of qualifying Medicaid treatment costs provided to Medicaid-eligible beneficiaries:

Administration

1. Infectious Disease
2. Environmental Health
3. Maternal and Child Health
4. Nursing Assistant Registry
5. Nursing Facility (Home) Nursing Care Provider State Survey
6. Primary Care
7. Data Collection (BRFSS)
8. CMS HIT (Implementation Advanced Planning Document)
9. Health Data Analysis

Program/Services

10. Lead Inspections-State Plan Attachment 3.1 A, supplement to page 5
11. CNOM Women's Breast and Cervical Cancer Screening
12. Poison Control Center Services

The following pages provide specific detail, by program, regarding claims eligible for Medicaid funding.

INTERAGENCY AGREEMENT
PROGRAM SUMMARY

State Fiscal Year: 2015

DEPARTMENT:	Health
DIVISION:	Infectious Disease and Epidemiology
Account Number(s):	10.075.2227102.01 10.075.2231101.02
Program Name:	Infectious Disease: <ul style="list-style-type: none"> • Acute Infectious Disease • HIV/AIDS, Viral Hepatitis, STD, and TB
Contact Person:	Utpala Bandy, MD, MPH

PROGRAM PLAN

DIRECT SERVICES:	NA
ADMINISTRATIVE ACTIVITIES:	The Division of Infectious Disease and Epidemiology maintains an administrative infrastructure that is responsible for the surveillance, prevention, and control of more than 80 mandatorily reportable infectious diseases including HIV and STDs. The Division plans and implements activities to prevent disease, to reduce disease transmission, and to assure appropriate connection to care for those who have contracted or have been exposed to infectious diseases.
POPULATION SERVED:	HEALTH's infectious disease programs serve those who have contracted /or have been exposed to reportable infectious diseases, including persons enrolled in the Medicaid program or potentially eligible for Medicaid.

PROGRAM GOALS AND OBJECTIVES	Protect the public's health by preventing and controlling the spread of infectious disease. <ul style="list-style-type: none"> • Prevent disease through policy development and education • Monitor reportable diseases to identify new cases of disease and analyze trends • Locate and case manage individuals
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AGREEMENT NAME: DOH Medicaid ISA (4)

	<p>who have contracted or been exposed to infectious disease to yield optimal health outcomes</p> <ul style="list-style-type: none"> Control disease outbreaks by working with the public and providers to mount an appropriate public health response
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BUDGET

PAYMENT RATES:	Standard administrative rate equivalent to 50% Federal Financial participation (FFP) for non-clinical services and 75% for enhanced FFP. Appropriate personnel expenses are charged to HEALTH's accounts and EOHHS reimburses HEALTH by drawing Medicaid dollars directly into the federal Medicaid account.
BASIS FOR DETERMINATION:	Reimbursement rate is based on existing Medicaid rate structure and Medicaid reimbursement protocols.
2015 ENACTED BUDGET	10.075.2227102.01 \$306,276 10.075.2231101.02 \$303,848

BILLING

ESTIMATED ANNUAL LEVEL OF BILLING	10.075.2227102.01 \$306,276 10.075.2231101.02 \$303,848
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DELIVERABLES

CHECK ALL THAT APPLY:	
X	Quarterly Financial Report

REVIEW BY OHHS

DISPOSITION:	<input type="checkbox"/> APPROVED <input type="checkbox"/> APPROVED with Conditions
OHHS CONTRACT AGREEMENT LIAISON:	
APPROVAL DATE:	

INTERAGENCY AGREEMENT

HEALTH

AGREEMENT NAME: DOH Medicaid ISA (4)

PROGRAM SUMMARY

State Fiscal Year: 2015

Program: 2

DEPARTMENT:	Health
DIVISION:	Community, Family Health and Equity
Account Number(s):	10.075.2161113.01 10.075.2171119.02
Program Name:	Environmental Health Administrative Match Agreement
Contact Person:	Ana Novais

PROGRAM PLAN

DIRECT SERVICES:	NA
ADMINISTRATIVE ACTIVITIES:	To develop and implement healthy home and environmental activities that improve the healthy span of life and improve access to timely, high quality services that protect and promote health, prevent disease, and ultimately reduce health care costs. Activities involve those, which improve the availability and quality of programs for the State's Medicaid and Medicaid eligible population to reduce morbidity and mortality of childhood lead poisoning, asthma, and poisonings. Administrative activities include quality management, environmental consultation, technical assistance and training, interagency coordination, licensing and certification, program planning and development and public education and outreach.
POPULATION SERVED:	The total state population is served with the level of effort based primarily on the Medicaid and Medicaid eligible populations.

PROGRAM GOALS AND OBJECTIVES	The total state population is served with the level of effort based primarily on the Medicaid and Medicaid eligible populations with a focus on comprehensive lead poisoning and other poison prevention and control services and asthma prevention and control services.
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HEALTH

AGREEMENT NAME: DOH Medicaid ISA (4)

BUDGET

PAYMENT RATES:	Standard administrative rate equivalent to 50% Federal Financial participation (FFP). Appropriate personnel expenses are charged to Health's accounts and OHHS reimburses Health by drawing Medicaid dollars directly into the federal Medicaid account.
BASIS FOR DETERMINATION:	Reimbursement rate is based on existing Medicaid rate structure and Medicaid reimbursement protocols.
2015 ENACTED BUDGET	10.075.2161113.01 \$163,057 10.075.2171119.02 \$195,919

BILLING

ESTIMATED ANNUAL LEVEL OF BILLING	10.075.2161113.01 \$163,057 10.075.2171119.02 \$195,919
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DELIVERABLES

CHECK ALL THAT APPLY:	
X	Quarterly Financial Report

REVIEW BY OHHS

DISPOSITION:	<input type="checkbox"/> APPROVED <input type="checkbox"/> APPROVED with Conditions
OHHS CONTRACT AGREEMENT LIAISON:	
APPROVAL DATE:	

INTERAGENCY AGREEMENT
PROGRAM SUMMARY

State Fiscal Year: 2015

DEPARTMENT:	Health
DIVISION:	Community, Family Health and Equity
Account Number(s):	10.075.2161102.01 10.075.2171104.02
Program Name:	MATERNAL AND CHILD HEALTH
Contact Person:	Ana Novais

PROGRAM PLAN

DIRECT SERVICES:	NA
ADMINISTRATIVE ACTIVITIES:	To assure improved availability, accessibility and quality of health care services for the state's maternal and child health Medicaid population.
POPULATION SERVED:	Maternal and child health Medicaid population

PROGRAM GOALS AND OBJECTIVES	

BUDGET

PAYMENT RATES:	Standard administrative FFP rates equivalent to 50% for non-clinical services and 75% for enhanced FFP. Appropriate personnel expenses are charged to Health's accounts and OHHS reimburses Health by drawing Medicaid dollars directly into the federal Medicaid account.
BASIS FOR DETERMINATION:	Reimbursement rate is based on existing Medicaid rate structure and Medicaid reimbursement protocols.
2015 ENACTED BUDGET	10.075.2161102.01 \$217,291 10.075.2171104.02 \$260,942

BILLING

ESTIMATED ANNUAL LEVEL OF BILLING	10.075.2161102.01 \$217,291 10.075.2171104.02 \$260,942
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HEALTH

AGREEMENT NAME: DOH Medicaid ISA (4)

DELIVERABLES

CHECK ALL THAT APPLY:	
X	Quarterly Financial Report

REVIEW BY OHHS

DISPOSITION:	<input type="checkbox"/> APPROVED <input type="checkbox"/> APPROVED with Conditions
OHHS CONTRACT AGREEMENT LIAISON:	
APPROVAL DATE:	

INTERAGENCY AGREEMENT
PROGRAM SUMMARY

State Fiscal Year: 2015

DEPARTMENT:	Health
DIVISION:	Environmental Health Services Regulation
Account Number(s):	10.028.2017103.01 and 10.028.2018108.02
Program Name:	Nursing Assistant Registry Program
Contact Person:	Donna Valetta

PROGRAM PLAN

DIRECT SERVICES:	Provide review and approval of Nursing Aide Training and Competency Evaluation Programs (NATCEP) for nurse aides employed by Medicare and Medicaid participating nursing facilities and maintain a nurse aide registry. Provide review and approval of Nursing Assistant applications for state licensure. Conduct initial and biennial on-site program reviews and monitoring. Provide for the selection and design of the qualifying clinical and written examinations. Review annual applications for initial licensure, process biennial license renewals, investigate complaints and administer any necessary discipline.
ADMINISTRATIVE ACTIVITIES:	Operate and maintain the nurse aide registry and certification program. Distribute and collect candidate applications; collect registration fees; secure examination sites; schedule administrative dates for the written and clinical portions of the examination; administer as required a written/oral examination and clinical competency examination; qualify all eligible nurse aide candidates; notify candidates of failure and make arrangements for review and re-examination; approve and monitor training programs for nurse aides; investigate complaints and conduct hearings; implement program audits; review for compliance with state and federal statutes and regulations. Prepare reports of examinations success rates; program employment rates.
POPULATION SERVED:	Trainees enrolled in adult educational career and technical programs as well as those individuals trained in grant-funded programs or trained/employed in health care facilities – 50 programs, 1,500 nursing assistant trainees per year. Maintain nurse aide registry of 15,000 individuals.

AGREEMENT NAME: DOH Medicaid ISA (4)

PROGRAM GOALS AND OBJECTIVES	Continue to train and license Nursing Assistants; increase training program availability; coordinate institutional NATCEP and RN coordinator training with CCRI; increase the frequency of site visits to programs and meet with adjunct training program staff.
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BUDGET

PAYMENT RATES:	The department of Human Services (DHS) is responsible for financing the state matching requirements for cost associated with the above responsibilities of the Department of Health (DOH)
BASIS FOR DETERMINATION:	The Federal Omnibus Budget Reconciliation Act of 1987, as amended and Chapter 23-17.9 of the RI General Laws.
2015 ENACTED BUDGET	10.028.2017103.01 \$42,000 10.028.2018108.02 \$42,000

BILLING

ESTIMATED ANNUAL LEVEL OF BILLING	10.028.2017103.01 \$96,539 10.028.2018108.02 \$96,539
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DELIVERABLES

CHECK ALL THAT APPLY:	
X	Quarterly Financial Report

REVIEW BY OHHS

DISPOSITION:	<input type="checkbox"/> APPROVED <input type="checkbox"/> APPROVED with Conditions
OHHS CONTRACT AGREEMENT LIAISON:	
APPROVAL DATE:	

INTERAGENCY AGREEMENT
PROGRAM SUMMARY

Program: 5

State Fiscal Year: 2015

DEPARTMENT:	Health
DIVISION:	Environmental Health Services Regulation
Account Number(s):	10.075.2201107.01 10.075.2206114.02
Program Name:	Nursing Facility/Home Nursing Care Provider State Survey
Contact Person:	Ray Rusin

PROGRAM PLAN

DIRECT SERVICES:	The Office of Facilities Regulation (OFR) issues the operating license and monitors the health and safety and quality of services provided in RI nursing facilities (NF) and home nursing care providers (HNCP) homes. Additionally, OFR is the designated single-state survey agency to conduct certification inspections of nursing homes for their participation in the Medicare and Medicaid program. The certification system provides onsite, objective and outcome-based verification by a team of multi-disciplinary professionals who are knowledgeable and trained to assure that basic standards of care and the quality of services provided are being met by the health care provider, or, if not met, that appropriate remedies are promptly applied and implemented effectively. NF and HNCP providers are subject to survey and certification inspections and monitoring, through onsite surveys and inspections on a periodic basis as determined by the Center for Medicare and Medicaid Services (CMS)
ADMINISTRATIVE ACTIVITIES:	Maintain licensure and certification provider records. Implement an on-going inspection schedule to monitor compliance; Investigate allegations of abuse, mistreatment, and neglect, and nursing home provider's response and actions to reportable incidents and events per state and

AGREEMENT NAME: DOH Medicaid ISA (4)

	federal regulations. Document non-compliance through public inspection reports; Follow-up and review of compliance; Recommend federal enforcement sanction and take state licensure enforcement actions; Review informal disputes and appeals of providers; Collaboration with the states Quality Improvement Organization (QIO), the CMS quality contractor (Quality Partners of RI)
POPULATION SERVED:	Social Security Act Agreement 1864 Sections 1864(a) and 1902 (a)(33)(B)

PROGRAM GOALS AND OBJECTIVES	To ensure the health and safety of the public residing in nursing homes, and that all state licensed and federally certified nursing facilities meet the applicable conditions of the law and the rules and regulations of the Rhode Island Department of Health and the U.S. Department of Health and Human Services, thereby ensuring that individuals receive appropriate high quality services in a proper environment. To ensure providers meet the conditions for participation in Medicare and Medicaid and state licensing requirements, the Office of Facilities Regulation endeavors to raise the quality of life of residents and the quality of care provided to as high a level as possible.
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BUDGET

PAYMENT RATES:	In accordance with the Social Security Act, Section 1864 agreement, the Executive Office of Health and Human Services is responsible for reimbursing the Department of Health for reasonable costs associated with the above responsibilities.
BASIS FOR DETERMINATION:	The federally related activities are authorized by Title XVIII (Medicare) of the Social Security Act, and Title XIX (Medicaid) of the Social Security Act. Under Sections 1864 and 1902 of the Social Security Act..

AGREEMENT NAME: DOH Medicaid ISA (4)

2015 ENACTED BUDGET	10.075.2201107.01 \$ 303,287 10.075.2206114.02 \$1,474,857
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BILLING

ESTIMATED ANNUAL LEVEL OF BILLING	10.075.220117.01 \$ 303,287 10.075.2206114.02 \$1,474,857
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DELIVERABLES

CHECK ALL THAT APPLY:	
X	Quarterly Financial Report
X	Annual Financial Report

REVIEW BY OHHS

DISPOSITION:	<input type="checkbox"/> APPROVED <input type="checkbox"/> APPROVED with Conditions
OHHS CONTRACT AGREEMENT LIAISON:	
APPROVAL DATE:	

AGREEMENT NAME: DOH Medicaid ISA (4)

**INTERAGENCY AGREEMENT
PROGRAM SUMMARY**

Program: 6

State Fiscal Year: 2015

DEPARTMENT:	Health
DIVISION:	Community, Family Health and Equity
Account Number(s):	10.075.2161107.01 10.075.2171115.02
Program Name:	PRIMARY CARE
Contact Person:	Ana Novais

PROGRAM PLAN

DIRECT SERVICES:	NA
ADMINISTRATIVE ACTIVITIES:	To develop and implement programs that improve access to timely, high quality, cost-effective primary health care.
POPULATION SERVED:	The total state population is served with the level of effort based primarily on the Medicaid and uninsured populations.

PROGRAM GOALS AND OBJECTIVES	To improve the availability, accessibility, and quality of primary care services for the State's Medicaid population.

BUDGET

PAYMENT RATES:	Standard administrative rate equivalent to 50% Federal Financial participation (FFP). Appropriate personnel expenses are charged to Health's accounts and OHHS reimburses Health by drawing Medicaid dollars directly into the federal Medicaid account.
BASIS FOR DETERMINATION:	Reimbursement rate is based on existing Medicaid rate structure and Medicaid reimbursement protocols.
2015 ENACTED BUDGET	10.075.2161107.01 \$184,418 10.075.2171115.02 \$221,735

BILLING

ESTIMATED ANNUAL LEVEL OF BILLING	10.075.2161107.01 \$184,418 10.075.2171115.02 \$221,735

HEALTH

AGREEMENT NAME: DOH Medicaid ISA (4)

DELIVERABLES

CHECK ALL THAT APPLY:	
X	Quarterly Financial Report

REVIEW BY OHHS

DISPOSITION:	<input type="checkbox"/> APPROVED <input type="checkbox"/> APPROVED with Conditions
OHHS CONTRACT AGREEMENT LIAISON:	
APPROVAL DATE:	

INTERAGENCY AGREEMENT
PROGRAM SUMMARY

State Fiscal Year: 2015

DEPARTMENT:	Health
DIVISION:	Center for Health Data Analysis
Account Number(s):	10.028.2017103.01 and 2018108.02.
Program Name:	Data Collection (BRFSS)
Contact Person:	Tara Cooper

PROGRAM PLAN

DIRECT SERVICES:	N/A
ADMINISTRATIVE ACTIVITIES:	The BRFSS program includes a state-wide question on individuals' primary source of health care coverage.
POPULATION SERVED:	Entire Adult population 18+ through sample survey mechanism

PROGRAM GOALS AND OBJECTIVES	<p>The Rhode Island Department of Health, in partnership with a variety of public and private programs, is responsible for planning, implementing, evaluating, and tracking disease and injury health promotion and prevention programs. The ultimate goal of the RI Behavioral Risk Factor Surveillance System (BRFSS) survey is to provide valid data to assist in these tasks. To achieve these goals, RI BRFSS has established the following objectives:</p> <ul style="list-style-type: none"> · Determine prevalence of personal health behaviors associated with the leading causes of premature death. · Monitor behavioral risk factors over time and focus on factors that are not improving among RI adults and in subgroups (ie elderly, Hispanics, uninsured). · Assess progress in meeting the national health objectives for health promotion and disease prevention. · Assess the impact of state legislation on behavioral risks. · Share BRFSS data with state and local agencies involved with health-related issues.
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AGREEMENT NAME: DOH Medicaid ISA (4)

BUDGET

PAYMENT RATES:	The Executive Office of Health and Human Services (EOHHS) is responsible for financing the state matching requirements for cost associated with the above responsibilities of the Department of Health (DOH).
BASIS FOR DETERMINATION:	Cost of added survey question on state-wide survey of entire adult population 18+ identifying the primary source of health care coverage.
2015 ENACTED BUDGET	10.028.2017103.01 \$4,000 10.028.2018108.02 \$4,000

BILLING

ESTIMATED ANNUAL LEVEL OF BILLING	10.028.2017103.01 \$4,000 10.028.2018108.02 \$4,000
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DELIVERABLES

CHECK ALL THAT APPLY:	
X	Quarterly Financial Report

REVIEW BY OHHS

DISPOSITION:	<input type="checkbox"/> APPROVED <input type="checkbox"/> APPROVED with Conditions
OHHS CONTRACT AGREEMENT LIAISON:	
APPROVAL DATE:	

INTERAGENCY AGREEMENT
PROGRAM SUMMARY

State Fiscal Year: 2015

DEPARTMENT:	Health
DIVISION:	Center for Health Data Analysis
Account Number(s):	10.075.2181103.01 10.075.2191103.02
Program Name:	CMS HIT (Implementation Advanced Planning Document)
Contact Person:	Samara Viner-Brown

PROGRAM PLAN

DIRECT SERVICES:	N/A
ADMINISTRATIVE ACTIVITIES:	Revising, administering and analyzing RI's annual HIT Survey.
POPULATION SERVED:	Survey representative of the population of adults 18+ in State of Rhode Island

PROGRAM GOALS AND OBJECTIVES	To support the EHR Incentive program by revising, administering and analyzing RI's annual HIT survey.
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BUDGET

PAYMENT RATES:	The Executive Office of Health and Human Services (EOHHS) is responsible to provide 90/10 match rate, making \$45,000 available annually for 2 years, the Department of Health (DOH) will contribute match of \$5,000 per year for 2 years.
BASIS FOR DETERMINATION:	Cost of added survey question on state-wide survey of entire adult population 18+.
2015 ENACTED BUDGET	10.075.2181103.01 \$5,000 10.075.2191103.02 \$45,000

BILLING

ESTIMATED ANNUAL LEVEL OF BILLING	10.075.2181103.01 \$5,000 10.075.2191103.02 \$45,000
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DELIVERABLES

HEALTH

AGREEMENT NAME: DOH Medicaid ISA (4)

CHECK ALL THAT APPLY:	
X	Quarterly Financial Report

REVIEW BY OHHS

DISPOSITION:	<input type="checkbox"/> APPROVED <input type="checkbox"/> APPROVED with Conditions
OHHS CONTRACT AGREEMENT LIAISON:	
APPROVAL DATE:	

AGREEMENT NAME: DOH Medicaid ISA (4)

**INTERAGENCY AGREEMENT
PROGRAM SUMMARY**

Program: 9

State Fiscal Year: 2015

DEPARTMENT:	Health
DIVISION:	Center for Health Data Analysis
Account Number(s):	10.075.2181103.01 10.075.2191103.02
Program Name:	Health Data Analysis
Contact Person:	Samara Viner-Brown

PROGRAM PLAN

DIRECT SERVICES:	N/A
ADMINISTRATIVE ACTIVITIES:	Leads, supports and coordinates the acquisition, provision and use of clear, accurate and appropriate data and analysis for all Divisions.
POPULATION SERVED:	

PROGRAM GOALS AND OBJECTIVES	Managing and developing effective and useful health datasets and systems; standardizing data management, procedures and quality throughout Health; providing and coordinating analytic capacity throughout Health; expanding dissemination of information; building the quantity and effectiveness of mutually beneficial internal and external partnerships; assure that Center for Health Data Analysis services and products are effective and timely and result in a high level of customer/partner satisfaction.
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BUDGET

PAYMENT RATES:	Standard administrative rate equivalent to 50% Federal Financial participation (FFP) for non-clinical services.
BASIS FOR DETERMINATION:	Reimbursement rate is based on existing Medicaid rate structure and Medicaid reimbursement protocols.
2015 ENACTED BUDGET	10.075.2181103.01 \$236,210 10.075.2191103.02 \$236,210

BILLING

HEALTH

AGREEMENT NAME: DOH Medicaid ISA (4)

ESTIMATED ANNUAL LEVEL OF BILLING	10.075.2181103.01 \$236,210 10.075.2191103.02 \$236,210
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DELIVERABLES

CHECK ALL THAT APPLY:	
X	Quarterly Financial Report
X	Annual Report to include total number of children served by program by CDC. Total number of full and partial inspections completed.

REVIEW BY OHHS

DISPOSITION:	<input type="checkbox"/> APPROVED <input type="checkbox"/> APPROVED with Conditions
OHHS CONTRACT AGREEMENT LIAISON:	
APPROVAL DATE:	

**INTERAGENCY AGREEMENT
PROGRAM SUMMARY**

Program: 10

State Fiscal Year: 2015

DEPARTMENT:	Health
DIVISION:	Community, Family Health and Equity
Account Number(s):	10.075.2161111.01 10.075.2171118.02
Program Name:	LEAD INSPECTION
Contact Person:	Ana Novais

PROGRAM PLAN

DIRECT SERVICES:	The Healthy Homes & Environments' Childhood Lead Program provides environmental case management services to Medicaid eligible children under age six with significant lead poisoning.
ADMINISTRATIVE ACTIVITIES:	To provide surveillance and monitoring activities to all children under 6 years.
POPULATION SERVED:	Medicaid-eligible children. Estimated 35 homes annually.

PROGRAM GOALS AND OBJECTIVES	To improve the availability, accessibility and quality of programs for the State's Medicaid population to reduce childhood lead poisoning, especially among individuals who are in high-risk groups, low-income, minority and/or non-English speaking.
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BUDGET

PAYMENT RATES:	\$675 per inspection plus an additional administrative cost of \$100 per inspection.
BASIS FOR DETERMINATION:	Reimbursement rate is based on existing Medicaid rate structure and Medicaid reimbursement protocols.
2015 ENACTED BUDGET	10.075.2161111.01 \$15,873 10.075.2171118.02 \$15,892

BILLING

ESTIMATED ANNUAL LEVEL OF BILLING	10.075.2161111.01 \$15,873 10.075.2171118.02 \$15,892

HEALTH

AGREEMENT NAME: DOH Medicaid ISA (4)

DELIVERABLES

CHECK ALL THAT APPLY:	
X	Quarterly Financial Report
X	Annual Report to include total number of children served by program by CDC. Total number of full and partial inspections completed.

REVIEW BY OHHS

DISPOSITION:	<input type="checkbox"/> APPROVED <input type="checkbox"/> APPROVED with Conditions
OHHS CONTRACT AGREEMENT LIAISON:	
APPROVAL DATE:	

INTERAGENCY AGREEMENT
PROGRAM SUMMARY

Program: 11

State Fiscal Year: 2015

DEPARTMENT:	Health
DIVISION:	Community, Family Health and Equity
Account Number(s):	10.075.2161143.01 10.075.2171178.02
Program Name:	CNOM WOMEN'S BREAST AND CERVICAL CANCER SCREENING
Contact Person:	Ana Novais

PROGRAM PLAN

DIRECT SERVICES:	Benefits limited to services covered by FQHC's - office visits, colposcopy, and mammogram.
ADMINISTRATIVE ACTIVITIES:	NA
POPULATION SERVED:	Women under 250% FPL who are eligible for Women's Cancer Screening procedures rendered by and paid to federally qualified health centers (FQHC's). Women must meet Medicaid eligibility criteria which includes under age 65, US citizen, and permanent residency greater than 5 years.

PROGRAM GOALS AND OBJECTIVES	To improve the availability, accessibility and the quality of care for women receiving cancer screening services in RI.
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BUDGET

PAYMENT RATES:	Based on Provider Reimbursement Schedule for covered services.
BASIS FOR DETERMINATION:	Reimbursement rate is based on existing Medicaid rate structure and Medicaid reimbursement protocols.
2015 SUPPLEMENTAL BUDGET	10.075.2161143.01 \$21,908 10.075.2171178.02 \$21,935

BILLING

ESTIMATED ANNUAL LEVEL OF BILLING	10.075.2161143.01 \$21,908 10.075.2171178.02 \$21,935
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HEALTH

AGREEMENT NAME: DOH Medicaid ISA (4)

DELIVERABLES

CHECK ALL THAT APPLY:	
X	WCS Provider Remittance Monthly Report

REVIEW BY OHHS

DISPOSITION:	<input type="checkbox"/> APPROVED <input type="checkbox"/> APPROVED with Conditions
OHHS CONTRACT AGREEMENT LIAISON:	
APPROVAL DATE:	

AGREEMENT NAME: DOH Medicaid ISA (4)

AMENDMENT to AGREEMENT: Health

Program 12:

**INTERAGENCY AGREEMENT
PROGRAM SUMMARY**

State Fiscal Year: 2015

DEPARTMENT:	Health
DIVISION:	Community, Family Health and Equity
Account Number(s):	10.075. 10.075.
Program Name:	POISON CONTROL CENTER SERVICES
Contact Person:	Ana Novais

PROGRAM PLAN

DIRECT SERVICES:	The regional contract with Boston's Children's Hospital will provide telephone consultation services to reduce morbidity and mortality from poisonings and to improve availability, accessibility and quality of health care information in a timely manner to the state's Medicaid and Medicaid eligible population.
ADMINISTRATIVE ACTIVITIES:	NA
POPULATION SERVED:	All residents of Rhode Island.

PROGRAM GOALS AND OBJECTIVES	To prevent morbidity and mortality from poisonings through an education program and to disseminate knowledge and to improve the public's preparation for the treatment and prevention of poisonings.

BUDGET

PAYMENT RATES:	Reimbursement will be XXX of the total Poison Control Center costs. Total annual costs for this program are apportioned based on numbers of Medicaid users and Medicaid eligible users of the poison control system.
BASIS FOR DETERMINATION:	Reimbursement formula based on the estimated Medicaid and Medicaid eligible population utilizing poison control center

HEALTH

AGREEMENT NAME: DOH Medicaid ISA (4)

	services. Calls to the regional center will be monitored annually for usage rates for the population served.
2015 ENACTED BUDGET	10.075. 10.075.

BILLING

ESTIMATED ANNUAL LEVEL OF BILLING	10.075. 10.075.

DELIVERABLES

CHECK ALL THAT APPLY:	
X	Quarterly Financial Report
	Monthly and Annual Program Report that includes number and type of calls and breakdown of the callers by age and insurance status of the patient.

REVIEW BY OHHS

DISPOSITION:	<input type="checkbox"/> APPROVED <input type="checkbox"/> APPROVED with Conditions
OHHS CONTRACT AGREEMENT LIAISON:	
APPROVAL DATE:	

ATTACHMENT C

CONTRACTS AND SUBCONTRACTS QUALIFYING FOR MEDICAID FUNDING

No contracts eligible for Medicaid reimbursement have been identified at this time.

ATTACHMENT D

CONFIDENTIALITY AND PRIVACY RULE REQUIREMENTS

STATEMENT OF AGREEMENT

§ 1. Definitions

Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy Rule.

Examples of specific definitions:

(a) Business Associate. "Business Associate" shall mean HEALTH.

(b) Covered Entity. "Covered Entity" shall mean EOHHS.

(c) Individual. "Individual" shall have the same meaning as the term "individual" in 45 CFR 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

(d) Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.

(e) Protected Health Information. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR 164.501, limited to the information created or received by Business Associate from or on behalf of a Covered Entity.

(f) Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR 164.501.

(g) Secretary. "Secretary" shall mean the Secretary of the Office of Health and Human Services or his designee.

§ 2. Obligations and Activities of the Business Associate

(a) Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by the Agreement or as Required by Law.

(b) Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.

(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 Protected Health Information 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 Protected Health Information not provided for by this Agreement of which it becomes aware.

(e) Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information 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 the Business Associate with respect to such information.

(f) Business Associate agrees to provide access, at the request of Covered Entity, and in the time and manner, to Protected Health Information in a Designated Record Set, to

AGREEMENT NAME: DOH Medicaid ISA (4)

Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR 164.524.

(g) Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR 164.526 at the request of Covered Entity or an Individual, and in the time and manner specified by the Covered Entity.

(h) Business Associate agrees to make its internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of the Covered Entity, available to the Secretary, in a time and manner specified by the Covered Entity or designated by the Secretary, for purposes of the Secretary determining the Covered Entity's compliance with the Privacy Rule.

(i) Business Associate agrees to document such disclosures of Protected Health Information 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 Protected Health Information in accordance with 45 CFR 164.528.

(j) Business Associate agrees to provide to the Covered Entity or an Individual, in a time and manner specified by the Covered Entity, information collected in accordance with § 2(i) of this Agreement, to permit the Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

(k) Business Associate agrees to maintain the security of Protected Health Information it receives by establishing, at a minimum, the following security measures:

(1) Limit authorized access to Protected Health Information to persons having a "need to know" that information; additional employees or agents may have access to that information which does not contain information from which an individual can be identified.

(2) At the sole discretion of the Business Associate, provide a written statement to each employee or agent as to the necessity of maintaining the security and confidentiality of Protected Health Information, and of the penalties provided for the unauthorized release, use, or disclosure of this information. Receipt of the statement is to be acknowledged by the employee or agent, who is to sign and return the statement to his or her employer or principal, who then is to retain the signed original. The employee or agent is also to be furnished with a copy of the signed statement.

(3) Take no disciplinary or punitive action against any employee or agent solely for bringing evidence of violation of the referenced security requirements to the attention of the Covered Entity.

(l) In accordance with generally accepted 'best practices' and at the sole discretion of the Business Associate, it is recommended that the Business Associate train all the members of its workforce on the various elements and procedures with respect to PHI required by this Agreement, as necessary and appropriate for the members of its workforce to carry out their functions within the Business Associate organization. The Business Associate may wish to provide such training as follows:

(1) To each appropriate member of the Business Associate workforce within a reasonable time after the effective date of this Agreement.

(2) Thereafter, to each appropriate new member of the Business Associate workforce within a reasonable period of time after the person joins the Business Associate's workforce.

(3) To each appropriate member of the Business Associate workforce whose functions are affected by a material change in the elements or procedures with respect to PHI required by this Agreement, within a reasonable period of time after the material change becomes effective.

(4) Business Associate may elect to document that such training has been provided to its workforce members.

§ 3. Permitted Uses and Disclosures by the Business Associate

General Use and Disclosure Provisions:

Except as otherwise limited in this Agreement, HEALTH may use or disclose Protected Health Information in accordance with the provisions outlined in Attachment B on behalf of, or to provide services to, EOHHS for the purposes defined by this Agreement, if such use or disclosure of Protected Health Information would not violate the provisions of the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR part 160 and part 164, subparts A and E) if done by EOHHS or the minimum necessary policies and procedures established by EOHHS.

Except as otherwise limited in this Agreement, the Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, the Covered Entity as specified in this Interagency Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by the Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

Specific Use and Disclosure Provisions:

(a) Except as otherwise limited in this Agreement, the Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

(b) Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or the 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.

(c) Except as otherwise limited in this Agreement, the Business Associate may use Protected Health Information to provide Data Aggregation services to the Covered Entity as permitted by 45 CFR 164.504(e)(2)(i)(B).

(d) Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with § 164.502(j) (1) of the Privacy Rule.

§ 4. Obligations of the Covered Entity

Provisions for the Covered Entity to inform the Business Associate of privacy practices and restrictions:

(a) Covered Entity shall notify the Business Associate of any limitation(s) in its Notice of Privacy Practices of the Covered Entity in accordance with 45 CFR 164.520, to the extent that such limitation may affect the Business Associate's use or disclosure of Protected Health Information.

(b) Covered Entity shall notify the Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect the Business Associate's use or disclosure of Protected Health Information.

(c) Covered Entity shall notify the Business Associate of any restriction to the use or disclosure of Protected Health Information that the Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of Protected Health Information.

Permissible Requests by the Covered Entity

The Covered Entity shall not request that the Business Associate use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

Term and Termination

(a) Term. The Term of this Agreement shall be effective as of the date of signature below, and shall terminate when all of the Protected Health Information provided by the Covered Entity to the Business Associate, or created or received by the Business Associate on behalf of the Covered Entity, is destroyed or returned to the Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

(b) Termination for Cause. Upon the Covered Entity's knowledge of a material breach by the Business Associate, the Covered Entity shall either:

- (1) Provide an opportunity for the Business Associate to cure the breach or end the violation and terminate this Agreement if the Business Associate does not cure the breach or end the violation within the time specified by the Covered Entity.
- (2) Immediately terminate this Agreement if the Business Associate has breached a material term of this Agreement and cure is not possible; or
- (3) If neither termination, nor cure, is feasible, the Covered Entity shall report the violation to the Secretary.

(c) Effect of Termination.

(1) Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, the Business Associate shall return or destroy all Protected Health Information received from the Covered Entity, or created or received by the Business Associate on behalf of the Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of the Business Associate. The Business Associate shall retain no copies of the Protected Health Information.

(2) In the event that the Business Associate determines that returning or destroying the Protected Health Information is infeasible, the Business Associate shall provide to the Covered Entity notification of the conditions that make return or destruction infeasible. Upon satisfaction of specific terms decided by the Covered Entity, that return or destruction of Protected Health Information is infeasible, the Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as the Business Associate maintains such Protected Health Information.

§ 5. Miscellaneous

(a) Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.

(b) Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for the Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

(c) Survival. The respective rights and obligations of the Business Associate under § 4 "Effects of Termination" of this Agreement shall survive the termination of this Agreement.

(d) Interpretation. Any ambiguity in this Agreement shall be resolved to permit the Covered Entity to comply with the Privacy Rule.

(e) Where permitted by the context, each pronoun used in this Agreement includes the same pronoun in other genders and numbers, and each noun used in this Agreement includes the same noun in other numbers. The headings of the various sections of this Agreement are not part of the context of this Agreement, but are merely labels to assist in locating such sections, and shall be ignored in construing this Agreement.

(f) This Agreement constitutes the entire agreement and supersedes all prior agreements and understandings, both written and oral, among the Parties with respect to the subject matter of this Agreement.

(g) This Agreement shall be binding upon, inure to the benefit of, and be enforceable by and against the Parties and their respective heirs, personal representatives, successors, and assigns. Neither this Agreement nor any of the rights, interests or obligations under this Agreement shall be transferred or assigned by the Business Associate without the prior written consent of the Covered Entity.

(h) With respect to any provision of this Agreement finally determined by a court of competent jurisdiction to be unenforceable, such court shall have jurisdiction to reform such provision so that it is enforceable to the maximum extent permitted by applicable law, and the Parties shall abide by such court's determination. In the event that any provision of this Agreement cannot be reformed, such provision shall be deemed severed from this Agreement, but every other provision of this Agreement shall remain in full force and effect. This Agreement shall be governed by, and construed in accordance with, the laws of the State of Rhode Island.

(i) All representations, covenants, and agreements in or under this Agreement, or any other documents executed in connection with the transactions contemplated by this Agreement, shall survive the execution, delivery, and performance of this Agreement and such other documents.

(j) Each Party shall execute, acknowledge or verify, and deliver any and all documents that may, from time to time, be reasonably requested by the other Party to carry out the purpose and intent of this Agreement.

ATTACHMENT E

Costs Not Otherwise Matchable (CNOM)

The Rhode Island Section 1115 Research and Demonstration Waiver sets forth waiver and expenditure authority for certain populations and services; these include authority to claim federal Medicaid matching payments under the waiver for costs not otherwise matchable (CNOM). This Attachment is established to assure compliance with the statutory and regulatory requirements, state and federal, applicable to the reimbursements for CNOM eligible expenditures.

Paragraph 1. Single State Agencies

In accordance with Rhode Island General Laws, the Rhode Island Executive Office of Health & Human Services (EOHHS) is designated as the single state agency responsible for the administration of the Medicaid program and the lead agency in implementing and administering the Rhode Island Section 1115 Research and Demonstration Waiver.

In accordance with Rhode Island General Laws and authorization by OHHS for CNOM Medicaid eligibility, HEALTH is the principal Department charged with managing the State's services for Women's Breast and Cervical Cancer Screening.

Paragraph 2. General Terms and Conditions

(a) Health will provide to EOHHS, on a quarterly basis the following:

- Total amount of payment in the quarter for services to Medicaid eligible CNOM Budget populations;
- Total amount that will be claimed as CNOM in that quarter for Women's Breast and Cervical Cancer Screening;
- The rationale and basis supporting the CNOM claim submitted for that quarter with regard to both the financial eligibility of the individuals served and the eligibility of the covered service for Medicaid reimbursement.

(b)HEALTH will provide findings of an audit on a yearly basis, based on statistically valid sampling, of individuals served and the services received during the quarter claimed. The purpose of the audit is to validate that CNOM claiming is based on expenditures for CNOM covered services provided to persons who have been determined to be eligible for those services in order to recognize any deficiencies that might be found in the program records included in the audit.

(c) In the event of a CNOM cost disallowance based upon HEALTH submissions for CNOM reimbursement, including but not limited to findings emanating from the Health audit described

AGREEMENT NAME: DOH Medicaid ISA (4)

in (b) above, State or federal audits, limited cost studies, and any other financial reviews, whether this event occurs during the effective dates of an ISA between EOHHS and Health, or during the effective dates of any amendment to the said ISA, or at any date in the future beyond those effective dates, HEALTH shall be solely responsible for repaying any and all amounts due owing as to any disallowed costs arising from HEALTH submissions for CNOM reimbursement.

(d) In addition, HEALTH shall provide to EOHHS a Certification, signed by the HEALTH representative designated to review and verify the data submitted for the quarterly CNOM reimbursements and has found it to be sound and that it meets all requirements, terms and conditions of CNOM reimbursements under the Rhode Island Section 1115 Demonstration Waiver as described in this Attachment. This Certification shall be presented using FORM 2, attached hereto and incorporated by reference herein. The Certification shall be attached to each quarterly submission as described in (a) above. The reporting requirements described herein are pursuant to the Special Terms and Conditions of the Rhode Island Section 1115 Demonstration Waiver.

FORM 1

MEDICAID CLAIMING CERTIFICATION

I certify that I am the executive officer of HEALTH or his/her formally recognized designee authorized to submit these claims. These claims only include approved expenditures that are allowable in accordance with all applicable federal and state statues, regulations, policies and the Rhode Island Medicaid State Plan and/or the Global Compact Waiver. These expenditures are based on accounting by HEALTH of actual recorded expenditures. The required amount of state funds were available and used to match allowable expenditures by the state and state funds were in accordance with all applicable federal requirements for the nonfederal share of expenditures. I certify that the information above and in this submission is correct to the best of my knowledge and belief.

Printed Name

Signature

Director

Department

Date

FORM 2

CNOM CERTIFICATION

I attest that I have reviewed all pertinent documentation submitted in the attached quarterly submission, which is a requirement of Attachment E of the Interagency Service Agreement between EOHHS and HEALTH related to the CNOM for Women’s Breast and Cervical Cancer Screening for Medicaid eligible women pursuant to that CNOM.

I attest that HEALTH has reviewed the pertinent documentation related to the requirements for claiming CNOM reimbursements as described above and in Attachment E of the Interagency Service Agreement. The attached quarterly submission certifies the eligibility of individuals for whom CNOM payments have been claimed for Women’s Breast and Cervical Cancer Screening and meets all the requirements, terms and conditions of CNOM reimbursements under the Rhode Island Section 1115 Demonstration Waiver.

Printed Name

Signature

Director

Department

Date