CONTRACT DECLARATIONS AND EXECUTION

Procurement Type/Number	Contract #
Open Contract	MED-25-011

Title of Contract
Iowa Dental Wellness Pre-Paid Ambulatory Health Plan (PAHP)

This Contract must be signed by all parties before the Contractor provides any Deliverables. The Agency is not obligated to make payment for any Deliverables provided by or on behalf of the Contractor before the Contract is signed by all parties. This Contract is entered into by the following parties:

Agency of the State (hereafter "Agency")	
Name/Principal Address of Agency: Iowa Department of Health and Human Services 1305 E. Walnut Des Moines, IA 50319-0114	**Agency Billing Contact Name / Address:** Sarah Petersen 1305 E. Walnut Des Moines, IA 50319 **Phone:** 515-883-0104
Agency Contract Manager (hereafter "Contract Manager") /Address ("Notice Address"): Sarah Petersen 1305 E. Walnut Des Moines, IA 50319 **Phone:** 515-883-0104 **E-Mail:** speters9@dhs.state.ia.us	**Agency Contract Owner (hereafter "Contract Owner") / Address:** Elizabeth Matney 1305 E. Walnut Des Moines, IA 50319 **E-Mail:** ematney@dhs.state.ia.us

Notice of Future Address Change: It is anticipated the main offices of the Department of Health and Human Services will be moving to the Lucas State Office Building at 321 E. 12th Street, in Des Moines, Iowa, by the end of 2024. The Agency will share the date of this change of address with contractors at a later date.

Contractor: (hereafter "Contractor")	
Legal Name: MCNA Insurance Company **Doing Business As Name(s):** MCNA Dental	**Contractor's Principal Address:** P.O. Box 740370 Atlanta, GA 30374-0370
Tax ID #: 52-2459969	**Organized under the laws of:** Iowa
Contractor's Contract Manager Name/Address ("Notice Address"): Shannon LePage 200 West Cypress Creek Rd, Ste 500 Fort Lauderdale, FL 33309 **Phone:** 830-431-5051 **E-Mail:** sturne84@mcna.net	**Contractor's Billing Contact Name/Address:** Michael Humphreys - Associate VP Finance 200 West Cypress Creek Rd, Ste 500 Fort Lauderdale, FL 33309 **Phone:** 305-582-6152 **E-Mail**: mhumphr6@mcna.net

Contract Information	
Start Date: 07/01/24	**End Date of Base Term of Contract:** 06/30/2026
Possible Extension(s): N/A	
Contract Contingent on Approval of Another Agency: Yes **Which Agency?** Centers for Medicare & Medicaid Services	**DSPOR Number: 2024-160**
Contract Include Sharing SSA Data? No	**DoIT Number:** N/A

Contract Execution

This Contract consists of this Contract Declarations and Execution Section, the Special Terms, any Special Contract Attachments, the General Terms for Services Contracts, and the Contingent Terms for Service Contracts.

In consideration of the mutual covenants in this Contract and for other good and valuable consideration, the receipt, adequacy and legal sufficiency of which are hereby acknowledged, the parties have entered into this Contract and have caused their duly authorized representatives to execute this Contract.

Contractor, Managed Care of North America	**Agency, Iowa Department of Health and Human Services**
Signature of Authorized Representative:	Signature of Authorized Representative: Kelly Garcia
Printed Name: Colleen Van Ham	Printed Name: Kelly Garcia
Title: CEO	Title: Director
Date: June27. 2024	Date: Jun 27, 2024

Table of Contents

SECTION 1: SPECIAL TERMS

1.1 Special Terms Definitions.
Special Terms Definitions are stated in Section 3 Special Contract Exhibits, Exhibit B: Glossary of Terms/Definitions.

1.2 Contract Purpose & Interpretive Intent.
The Iowa Department of Health and Human Services ("Agency") intends to contract for the delivery of high-quality dental health care services for the Iowa Dental Wellness Plan and Healthy and Well Kids in Iowa (Hawki) programs.

The Agency seeks to improve the quality of care and health outcomes for Medicaid and Children's Health Insurance Program (CHIP) populations while leveraging the strength and success of current initiatives. This Contract is designed to align with Iowa Medicaid's commitment to ensure all members have equitable access to high quality services in all areas of healthcare, including dental care. This process will build stability for Iowa Medicaid members and providers by providing covered benefits in a highly coordinated manner, integrate care and improve quality outcomes and efficiencies across the healthcare delivery system, and decrease costs through the reduction of unnecessary, inappropriate, and duplicative services. Specifically, the Agency aims to accomplish the following key goals, identified as drivers for improved dental health equity, access, and outcomes:

1. Improve Network Adequacy and availability of services.
2. Increase recall and prevention services.
3. Improve oral health equity among Medicaid members.
4. Improve coordination and continuity of care between managed care plans and enhance medical/dental integration.

This Section 1 addresses core contractual obligations of the parties. Section 1.8 incorporates by reference the General Terms for Service Contracts required by State law. Section 1.9 incorporates by reference the Agency's Contingent Terms for Services Contracts. Section 2 sets forth the Program-specific requirements of this Contract. The sections set forth in Section 2 largely mirror the content and structure of the current federal Medicaid Managed Care Contract Review and Approval guidance (at the time of this writing, available at: https://www.medicaid.gov/medicaid/managed-care/guidance/contract-review/index.html). Clauses from the CMS checklist are designated at the end of each statement by a reference to the corresponding CMS checklist statement, designated by the acronym "CMSC." All such CMS checklist clauses are to be interpreted in accordance with federal law, including but not limited to the statutory, regulatory, and guidance listed at the end of each clause.

It is the intent of the parties to this Contract that the Contract be interpreted in a manner consistent with all Applicable Law, as well as the obligations imposed on the State, the Agency, and/or the PAHP under the Iowa State Plan under Title XIX of the Social Security Act Medical Assistance Program ("State Plan"), CMS approved waivers under the State Plan, and federal guidance, as well as any and all future amendments, changes, and additions to the State Plan, approved waivers, or federal guidance as of the effective date of such change.

1.3 Scope of Work.
1.3.1 Deliverables.
The Contractor shall provide services meeting all of the requirements as set forth in this Contract.

1.3.2 Monitoring, Review, and Problem Reporting

The provisions of this Section 1.3.2 are in addition to any Agency activity, reporting, or procedures specifically allowed or required in the Section 2. If there is a conflict between the provisions of this Section and the provisions of Section 2, Section 2 supersedes the provisions of this Section.

1.3.2.1 Agency Monitoring Clause. The Contract Manager or designee will:

- Verify Invoices and supporting documentation itemizing work performed prior to payment;
- Determine compliance with general contract terms, conditions, and requirements; and
- Assess compliance with Deliverables, Performance Measures, or other associated requirements in accordance with the monitoring activities set forth in the Contract

1.3.2.2 Agency Review Clause. The Contract Manager or designee will use the results of monitoring activities and other relevant data to assess the Contractor's overall performance and compliance with the Contract. At a minimum, the Agency will conduct a review annually; however, reviews may occur more frequently at the Agency's discretion. As part of the review(s), the Agency may require the Contractor to provide additional data, may perform on-site reviews, and may consider information from other sources.

The Agency may require one (1) or more meetings to discuss the outcome of a review. Meetings may be held in person. During the review meetings, the parties will discuss the Deliverables that have been provided or are in process under this Contract, achievement of the performance measures, and any concerns identified through the Agency's contract monitoring activities.

The Contractor agrees that the Agency or the Agency's duly authorized and identified agents or representatives of the State and federal governments shall have the right to access any and all information pertaining to the Contract, conduct site visits, conduct quality assurance reviews, review Contract compliance, assess management controls, assess the Contract services and activities, and provide technical assistance.

1.3.2.3 Problem Reporting. As stipulated by the Agency, the Contractor and/or Agency shall provide a report listing any problem or concern encountered. Records of such reports and other related communications issued in writing during the course of Contract performance shall be maintained by the parties. At the next scheduled meeting after a problem has been identified in writing, the party responsible for resolving the problem shall provide a report setting forth activities taken or to be taken to resolve the problem together with the anticipated completion dates of such activities. Any party may recommend alternative courses of action or changes that will facilitate problem resolution. The Contract Owner has final authority to approve problem-resolution activities.

The Agency's acceptance of a problem report shall not relieve the Contractor of any obligation under this Contract or waive any other remedy. The Agency's inability to identify the extent of a problem or the extent of damages incurred because of a problem shall not act as a waiver of performance or damages under this Contract.

1.3.2.4 Addressing Deficiencies. To the extent that Deficiencies are identified in the Contractor's performance and notwithstanding other remedies available under this Contract, the Agency may require the Contractor to develop and comply with a plan acceptable to the Agency to resolve the Deficiencies.

1.3.3 Contract Payment Clause.

1.3.3.1 Pricing. In accordance with the payment terms outlined in this section and the Contractor's completion of the Scope of Work as set forth in this Contract, the Agency will make Capitation Payments to the Contractor on a monthly basis (as outlined in Section 1.3.3.2 below). The Capitation Payments include per member per month capitation rates as further defined in this section. The Capitation Payments shall be payment in full for goods and services provided pursuant to this Contract. Retroactive adjustments to the capitation rates to reflect

the actual cost of goods and services provided pursuant to the Contract are prohibited. For more information on retroactive adjustments please see Sections 1.3.3.4, 1.3.3.6, and Special Contract Exhibit A.

The parties anticipate Contractor to begin providing managed care services to its assigned Medicaid population on July 1, 2024. However, if the implementation date is delayed for any reason, Contractor shall not be entitled to payments pursuant to this Contract until Contractor begins providing services for its patient population consistent with the Scope of Work as set forth in this Contract. The Agency has sole discretion to determine the implementation date.

For each capitated rate period as defined on the rate sheet, the parties will agree on a rate sheet specifying the payment for each Enrolled Member by the categories determined by the Agency to be appropriate. These categories will be determined by the Agency. Nothing in this Contract shall limit the ability of the Agency to require the determination of a state-wide average even if the Contractor is not providing services for members in all counties in the State. The rate-setting methodology will be in compliance with federal requirements.

The Agency's actuarial contractor will analyze data to determine actuarially sound rates to be offered to Contractor. The Agency and Contractor may discuss proposed capitation rates, but the Agency's actuarial contractor will ultimately be responsible for establishing the actuarially-sound rates to be offered and attesting to the capitation rates to be presented to CMS. After the first rate period, subsequent capitated rates will be added to the Contract in sequentially numbered Special Contract Exhibits (i.e., Exhibit A-01, Exhibit A-02, etc.). Contractor and the Agency must mutually agree to the capitation rates and signify this agreement by executing the Contract amendment. Capitation rates within any rate period are subject to amendment, which shall only occur through formal Contract amendment. The parties agree to work diligently and in good faith to establish and agree to capitation rates before the expiration of any rate period. If the parties are unable to establish new annual capitation rates for a subsequent rate period due to delays or disagreements, the Agency or Contractor may terminate the Contract upon ninety (90) days written notice. Effective date of the termination shall be no sooner than ninety (90) days from expiration of the current rate period and contract amendment term or, if notice is given after the expiration of the current rate period, ninety (90) days written notice from the date of the notice.

> **Examples**:
> Example 1: Current agreed rates expire June 30, 2025. The PAHP determines that it does not want to agree to continue with the managed care contract and provides notice of termination on January 1, 2025. Because the parties are currently performing under agreed rates that run through June 30, 2025, the first day of the ninety (90) day notice period is July 1, 2025 – the first day of the new rate period. The effective date of contract termination is September 30, 2025 – the last day of the month that is ninety (90) days from the first day of the notice period.
>
> Example 2: Rates expired on June 30, 2026. The Agency and PAHP are unable thereafter to come to terms on new rates after expiration of the current rates. The MCO provides notice of termination on August 1, 2026. The first day of the ninety (90) day notice period is August 1, 2026. The last day of the notice period is October 31, 2026 – the last day of the month that is ninety (90) days from the beginning of the notice period.

Upon agreement to the capitation rates, the Agency will perform a reconciliation between the capitation rates paid and the newly agreed upon rates for the rate period. Any discrepancy will be reconciled through the capitation rate payment process.

By agreeing to the rates offered to Contractor through the Contract amendment process, Contractor irrevocably and unconditionally releases, acquits, and forever discharges the State of Iowa, the Agency, and all of the Agency's officers, directors, employees, agents, and attorneys, from any and all liability whatsoever from any

and all claims, demands and causes of action of every nature whatsoever that Contractor may have or may ever claim to have now existing or hereafter arising that relate to or arise out of any assertion regarding the actuarial soundness of the agreed rates.

The Agency will make Capitation Payments to the Contractor based on the Contractor's Medicaid-member enrollment as reflected on the monthly HIPAA 834 file (full positive file). Contractor shall reconcile Contractor's HIPAA 820 capitation file with the monthly HIPAA 834 file (full positive file) on a monthly basis. Any discrepancies found between these two (2) files shall be reported to the Agency within ninety (90) Days from the date the Contractor receives the HIPAA 820 capitation file. No adjustments to the Capitation Payment may be claimed by Contractor for any discrepancies reported after the ninety (90) Day period. The Capitation Payments will be subject to retroactive changes to the Medicaid-member eligibility criteria. This may include, but is not limited to, Medicaid-members moving from Medicaid-only eligibility to Medicare and Medicaid eligibility. The Agency will adjust payments to Contractor to reflect the Member enrollment changes.

The capitation rates will be subject to a withhold amount as shown in the capitation rate sheet. The withhold will be retained by the Agency until the period for determination of return of the withhold to the Contractor. The determination of the return of the withhold is outlined in Special Contract Exhibits, Exhibit A.

The Agency will exclude from the capitation rates the services and treatments as set forth in Special Contract Exhibits, Exhibit A. Contractor shall continue to provide coverage for these services and treatments, and the Agency will reimburse the Contractor based on Contractor's invoice to the Agency for Special Contract Exhibits, Exhibit A services and treatments paid. Contractor may only invoice for the lower of (1) actual cost to the Contractor or (2) the actual cost paid. All such invoices must be submitted by Contractor within twelve (12) months of the date of service, with the exception of coordination of benefits situations, in which Contractor shall invoice for these treatments within six (6) months from the Contractor's receipt date of the claim and explanation of benefits from a primary carrier. The Agency will pay Contractor the lesser of the amount that would be paid under the fee-for-service system for the treatment, or the amount the Contractor actually paid for the treatment. Contractor must include with the invoice details as required by the Agency to document that the claim was appropriately paid, as well as verification regarding oversight to ensure appropriate utilization. At minimum, Contractor's invoice must include claim level detail sufficient to support the invoices. The selected services and treatments included in Special Contract Exhibits, Exhibit A are intended to be those which are new, emerging, high cost, and/or not accounted for in capitation rate development. Special Contract Exhibits, Exhibit A is subject to change upon Agency approval, and Agency may remove any previously included service or treatment from Special Contract Exhibits, Exhibit A when its financial impact has been quantified and incorporated into the capitation rates.

1.3.3.2 Payment Methodology
The Agency will make capitated payments to the Contractor as early in the month as possible, but no later than the tenth (10^{th}) Day of each month. The Agency will pay all other approved invoices in conformance with Contract Section 1.3.3.6.

1.3.3.3 Reserved.

1.3.3.4 Timeframes for Regular Submission of Initial and Adjusted Invoices. The Contractor shall submit an Invoice for services rendered in accordance with this Contract. Invoice(s) shall be submitted. Unless a longer timeframe is provided by federal law, or otherwise specified in this Contract, and in the absence of the express written consent of the Agency, all Invoices shall be submitted within six (6) months from the last day of the month in which the services were rendered. All adjustments made to Invoices shall be submitted to the Agency within ninety (90) days from the date of the Invoice being adjusted. Invoices shall comply with all applicable rules concerning payment of such claims.

1.3.3.5 Reserved.

1.3.3.6 Payment of Invoices.
The Agency shall verify the Contractor's performance of the Deliverables before making payment. The Agency will not automatically pay end of state fiscal year claims that are considered untimely. If the Contractor seeks payment for end of state fiscal year claim(s) submitted after August 1st, the Contractor may submit the late claim(s), The Agency may require a justification from the Contractor for the untimely submission. The Agency may reimburse the claim if funding is available after the end of the state fiscal year. If funding is not available after the end of the state fiscal year, the Agency may submit the claim to the Iowa State Appeal Board for a final decision regarding reimbursement of the claim.

The Agency shall pay all approved Invoices in arrears and in conformance with Iowa Code 8A.514. The Agency may pay in less than sixty (60) days, but an election to pay in less than sixty (60) days shall not act as an implied waiver of Iowa law.

1.3.3.7 Reimbursable Expenses. Unless otherwise agreed to by the parties in an amendment or change order to the Contract that is executed by the parties, the Contractor shall not be entitled to receive any other payment or compensation from the Agency for any Deliverables provided by or on behalf of the Contractor pursuant to this Contract. The Contractor shall be solely responsible for paying all costs, expenses, and charges it incurs in connection with its performance under this Contract.

1.3.3.8. Loss of Program Authority. Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor shall not work on that part after the effective date of the loss of program authority. The Agency must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If the Agency paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the Agency. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the Agency included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.
See: https://www.medicaid.gov/medicaid/managed-care/guidance/contract-review/index.html

1.4 Insurance Coverage.
The Contractor shall obtain the following types of insurance for at least the minimum amounts listed below:

Type of Insurance	**Limit**	**Amount**
General Liability (including contractual liability) written on occurrence basis	General Aggregate	$5 Million
	Product/Completed Operations Aggregate	$5 Million
	Personal Injury	$5 Million
	Each Occurrence	$2 Million
Automobile Liability (including any auto, hired autos, and non-owned autos)	Combined Single Limit	$1 Million

Excess Liability, Umbrella Form	Each Occurrence Aggregate	$2 Million $5 Million
Workers' Compensation and Employer Liability	As required by Iowa law	As Required by Iowa law
Property Damage	Each Occurrence Aggregate	$1 Million $2 Million
Professional Liability	Each Occurrence Aggregate	$2 Million $2 Million

1.5 Data and Security.

1.5.1 Security Framework. The Contractor shall comply with either of the following:

- Provide certification of compliance with a minimum of one of the following security frameworks: NIST SP 800-53, NIST Cybersecurity Framework, HITRUST, HIPAA/HITECH, COBIT, CSA STAR, ISO 27001, SOC 2 Type II, CIS Controls or PCI-DSS prior to implementation of the system and when the certification(s) expire, or
- Provide attestation of a passed information security risk assessment, passed network penetration scans, and passed web application scans (when applicable) prior to implementation of the system and annually thereafter. Passed means no unresolved high or critical findings.

1.5.2 Vendor Security Questionnaire. If not previously provided to the Agency through a procurement process, the Contractor shall provide a fully completed copy of the Agency's Vendor Security Questionnaire (VSQ).

1.5.3 Cloud Services. The Contractor shall comply with either of the following:

- Provide written designation of FedRAMP authorization with impact level moderate prior to implementation of the system, or
- Provide certification of compliance with a minimum of one of the following security frameworks: NIST 800-53, NIST Cybersecurity Framework, HITRUST, CSA STAR, ISO 27001, SOC 2 Type II, CIS Controls or PCI-DSS prior to implementation of the system and when the certification(s) expire.

1.5.4 Addressing Concerns. The Contractor shall timely resolve any outstanding concerns identified by the Agency regarding the Contractor's submissions required in this section.

1.5.5 Business Associate. If the Contractor is designated as a Business Associate through this Contract, the Contactor agrees to follow Section 3.2 of the Contingent Terms for Service Contracts. By signing this Contract, the Business Associate certifies it will comply with the Business Associate Agreement Addendum ("BAA"), and any amendments thereof, as posted to the Agency's website: https://hhs.iowa.gov/media/2904/download?inline=.

1.6 Reserved. (Labor Standards Provisions.)

1.7 Reserved. (Performance Security.)

1.8 Incorporation of General and Contingent Terms.

1.8.1 General Terms for Service Contracts. The version of the General Terms for Services Contracts Section posted to the Agency's website at https://hhs.iowa.gov/initiatives/contract-terms is in effect as of the date of last

signature in the Contract Declarations and Execution section, or a more current version if agreed to by amendment, is incorporated into the Contract by reference.

The contract warranty period (hereafter "Warranty Period") referenced within the General Terms for Services Contracts is as follows: The term of this Contract, including any extensions.

1.8.2 Contingent Terms for Service Contracts. The version of the Contingent Terms for Services Contracts posted to the Agency's website at https://hhs.iowa.gov/initiatives/contract-terms that is in effect as of the date of last signature in the Contract Declarations and Execution section, or a more current version if agreed to by amendment, is incorporated into the Contract by reference.

All of the terms set forth in the Contingent Terms for Service Contracts apply to this Contract unless indicated otherwise in the table below:

<table>
<tr><td>Contractor a Business Associate? Yes</td><td>Contractor a Qualified Service Organization? Yes</td></tr>
<tr><td>Contractor subject to Iowa Code Chapter 8F? No</td><td>Contract Includes Software (modification, design, development, installation, or operation of software on behalf of the Agency)? Yes</td></tr>
<tr><td colspan="2">Contract Payments include Federal Funds? Yes
The Contractor for federal reporting purposes under this Contract is a: Vendor
Federal Funds Include Food and Nutrition Service (FNS) funds? No
UEI #: G8HWKM9ADJ74
The Name of the Pass-Through Entity: Iowa Department of Health and Human Services</td></tr>
<tr><td>ALN #: 93.778
Grant Name: Medical Assistance Program</td><td>Federal Awarding Agency Name: Department of Health and Human Services/Centers for Medicare & Medicaid Services</td></tr>
</table>

SECTION 2: PROGRAM SPECIFIC STATEMENTS

The Program Specific Statements in this section are a part of the Contract.

Any and all requirements of and references to Healthy and Well Kids in Iowa (Hawki) contained herein shall be considered by the Parties as void and struck from this Agreement. The Contractor's scope of work under this Agreement does not contain any work or activities related to Hawki.

A. General

A.01. *Effects of the Federal Waiver.* The Contract is contingent upon continued federal approval of the State's waiver authority. If CMS withdraws federal waiver authority, the Agency may terminate the Contract immediately in writing to the Contractor without penalty.

A.02. *Licensure.* Prior to the Contract effective date, the Contractor shall be licensed and in good standing in the State of Iowa as a health maintenance organization (HMO), Limited Service Organization (LSO) or Certificate of Authority (COA) and shall comply with all applicable law.

A.03. *Organizational Structures.* The Contractor shall have in place an organizational and operational structure capable of fulfilling all Contract requirements. This structure shall support collection and integration of data across the Contractor's delivery system and internal functional units to accurately report the Contractor's performance. The Contractor shall have in place sufficient administrative and clinical staff and organizational components to achieve compliance with all Contract requirements and performance standards. The Contractor shall manage the functional linkage of the following major operational areas: (i) administrative and fiscal management; (ii) Member services; (iii) Provider services; (iv) Care Coordination (v) Marketing; (vi) Provider Enrollment; (vii) Network development and management; (viii) quality management and improvement; (ix) utilization and care management; (x) member health and outcomes; (xi) information systems; (xii) performance data reporting and encounter Claims submission; (xiii) Claims payments; and (xiv) Grievance and Appeals.

A.04. *Staffing Requirements.* The Contractor shall provide staff to perform all tasks specified in the Contract. The Contractor shall maintain a level of staffing necessary to perform and carry out all of the functions, requirements, roles and duties as contained herein, regardless of the level of staffing submitted to the Agency as part of the Staffing Plan approval. The information provided in this section is not intended to define the overall staffing levels needed to meet Contract requirements. In the event that the Contractor does not maintain a level of staffing sufficient to fully perform the functions, requirements, roles and duties or otherwise fails to maintain compliance with the performance metrics of the Contract, the Agency may require additional staffing obligations in addition to other remedies provided for in the Contract. The Contractor shall, at all times, employ sufficient staff to achieve compliance with contractual requirements and performance metrics.

A.05. *Staffing Plan.* The Contractor shall provide an initial operational staffing plan to the Agency following the parameters and time periods outlined in this Section A.

A.06. *Purpose and General Framework of the Staffing Plan.* Through the staffing plan, the Contractor shall achieve consistent, dependable service regardless of changes that may directly influence work volume. The Contractor shall include no less than the staffing areas suggested in Table 1.

A.07. *Inclusion in Staffing Plan.* In its staffing plan, the Contractor shall:

a) Ensure that staff delivering in-person services are based in Iowa as appropriate;
b) Include no less than the staffing areas suggested in Table 1:

c) Encourage a local presence in Iowa, particularly in relation to the delivery of Member and Provider services;
d) Include a backup personnel plan, including a discussion of the staffing contingency plan for:
    1) the process for replacement of personnel in the event of a loss of Key Personnel or others before or after signing the Contract;
    2) allocation of additional resources to the Contract in the event of an inability to meet a performance standard;
    3) replacement of staff with key qualifications and experience and new staff with similar qualifications and experience;
    4) the time frame necessary for obtaining replacements; and
    5) the method of bringing replacement or additions up to date regarding the Contract;
e) Include Key Personnel positions including the following:
    1) *Chief Executive Officer (CEO):* Responsible for overseeing the entire healthcare plan of the Contractor. Has full and final responsibility for Contract compliance.
    2) *Chief Operating Officer (COO):* Responsible for oversight of all day-to-day operations of the healthcare plan operations. Has oversight of all functional operational areas within the healthcare plan. Reports directly to the CEO.
    3) *Dental Director*: Shall be an Iowa-licensed dentist in good standing. Shall ensure oversight of all clinical functions. Shall ensure for the coordination and implementation of the Quality Management and Improvement Program. Shall attend and actively participate in any scheduled Quality committee meetings as directed by the Agency. Directs the Contractor's internal UM committee.
    4) *Chief Financial Officer*: Shall oversee the Contractor's budget, accounting systems and financial reporting for the Contract.
    5) *Compliance Officer*: The Contractor shall employ a Compliance Officer who is accountable to the Contractor's executive leadership and dedicated full-time to the Contract with the requirements of Section I.5. This individual will be the primary liaison with the Agency (or its Designees) to facilitate communications between the Agency, the Agency's contractors and the Contractor's executive leadership and staff. This individual shall maintain a current knowledge of federal and State legislation, legislative initiatives and regulations that may impact the Contract. It is the responsibility of the Compliance Officer to comply with all HIPAA and privacy regulations as well as coordinate reporting to the Agency and to review the timeliness, accuracy and completeness of reports and data submissions to the Agency. The Compliance Officer, in close coordination with other Key Personnel, has primary responsibility for ensuring all Contractor functions are in compliance with the terms of the Contract.
    6) *Grievance & Appeals Manager*: Manages the Contractor's Grievance and Appeals process, ensuring compliance with processing timelines and policy and procedure adherence.
    7) *Quality Management Manager*: The QM Manager shall oversee the Contractor's Quality Management and Improvement program and ensure compliance with Quality management requirements and Quality improvement initiatives.
    8) *Utilization Management Manager*: This position manages all elements of the Contractor's UM program and staff under the supervision of the Dental Director. This includes but is not limited to functions related to Prior Authorization, medical necessity determinations, concurrent and retrospective reviews, and other programs as described in the Contract.
    9) *Member Services Manager*: Shall provide oversight of the Member services functions of the Contract, including, but not limited to, Member helpline telephone performance, Member e-mail communications, Member education, the Member website, Member outreach programs, development, approval, and distribution of Member materials. The Member Services Manager shall oversee the interface with the Agency or its Subcontractors regarding such issues as Member Enrollment and Disenrollment.
    10) *Provider Services Manager*: The Provider Services Manager shall provide oversight of the Provider services function of the Contract. This includes, but is not limited to, the Provider services helpline,

Provider recruitment, contracting, and Credentialing, facilitating the Provider Claims dispute process, developing and distributing the Provider manual and education materials, and developing Provider outreach programs. The Provider Services Manager, in close coordination with other Key Personnel, shall ensure that all of the Contractor's Provider services operations are in compliance with the terms of the Contract.

11) *Information Systems Manager*: Serves as a liaison between the Contractor and the Agency, or its Designee, regarding Enrolled Member Encounter Data submissions, Capitation Payment, Member eligibility, Enrollment, and other data transmission interface and management issues. The IS Manager, in close coordination with other Key Personnel, shall ensure all information system security and controls, program data transactions, data exchanges, and other information system requirements are in compliance with the terms of the Contract, and all data submissions required for federal reporting. The IS Manager shall oversee all systems testing, including during the Readiness Review.
12) *Claims Administrator*: Shall ensure prompt and accurate Provider Claims processing in accordance with the terms of the Contract.
13) *Care Coordination Manager*: Shall ensure oversight of the Contractor's Care Coordination program.
14) *Program Integrity Manager and Special Investigations Unit Staffing.* Shall ensure oversight of the Contractor's SIU activity. The Contractor shall ensure that their Program Integrity Manager has demonstrated experience in providing leadership, oversight and direction in the development and implementation of Medicaid Managed Care program integrity programs. The Program Integrity Manager shall lead the implementation of strategic direction from State of Iowa Medicaid program administrators and leadership. The Program Integrity Manager shall lead collaboration of managed care plan's program integrity efforts with CMS and federal/state law enforcement partners, including supporting all efforts by Iowa Medicaid to hold providers and suppliers responsible for fraud, waste, and abuse. Specifically, the Program Integrity Manager shall meet the following requirements:
    1) Demonstrated knowledge and experience in managing health care delivery, program integrity, utilization management, or public health program functions within a large-scale health plan or programs.
    2) Comprehensive knowledge of laws, policies, and regulations that apply to the administration of Medicaid Managed Care program health care delivery and program integrity. Demonstrated ability to use this knowledge and associated metrics to assess and improve program effectiveness, management processes, and systems to achieve program integrity priorities and results.
    3) Demonstrated experience, in a senior leadership position working with government agencies and programs, law enforcement organizations, and/or public and private organizations on complex and controversial issues relating to program administration and the protection of the integrity of the Medicaid programs.
    4) Qualification Requirements:
        - Graduation from an accredited four-year college or university with a degree in any field (e.g., public or business administration, social work, public health, law, education, engineering), and experience equal to five years of full-time professional-level work in program administration, program development, program operations, or management; or
        - A total of nine years of combined education and/or full-time experience in any field and profession experience as defined above.

    The Program Integrity Manager will serve as the liaison between the Contractor and State agencies, law enforcement, and federal agencies. The Program Integrity Manager shall be informed of current trends in Fraud, waste, and Abuse as well as mechanisms to detect such activity. The Program Integrity Manager shall be located in the Iowa offices. The position shall be dedicated at least (one

hundred percent) 100% of the time to the oversight and management of the Program Integrity efforts required under the Contract. The Program Integrity Manager shall have open and immediate access to all Claims, Claims processing data and any other electronic or paper information sufficient to meet the requirements of the Agency. The duties shall include, but not be limited to: (i) oversight of the Program Integrity function under the Contract; (ii) liaison with the Agency in all matters regarding Program Integrity; (iii) development and operations of a Fraud control program within the Contractor Claims payment system; (iv) liaison with Iowa's MFCU and/or the Office of the Attorney General; (v) assure coordination of efforts with the Agency and other agencies with regards to Program integrity issues.

15) *Primary Point of Contact.* In addition to management positions above, the Contractor shall designate a primary point of contact with the Agency for delivery system reform activities, including managing a specific project plan and reporting on activity and progress towards identified goals. The point person will also serve as the liaison between the Contractor and various state agencies, leaders from the healthcare delivery system, other payers, stakeholders, and federal agencies. The point person shall also be informed of current trends in delivery system reports and have the specific experience within the dental healthcare delivery system in Iowa. The point person shall be located in the Iowa offices.

f) Include a resume for each Key Personnel member; and

g) Describe what functions are proposed to be conducted outside of Iowa and how out-of-State staff will be supervised to ensure compliance with Contract requirements.

Table 1: Suggested Staffing

Suggested Staffing	Suggested Roles & Responsibilities
Prior Authorization	Authorize requests for services.
Member Services Staff	Respond to Member inquiries via a member services helpline, as well as written and electronic correspondence.
Provider Services Staff	Respond to Provider inquiries and disputes and provide outreach on Provider policies and procedures.
Claims Processing Staff	Ensure timely and accurate processing of Claims.
Reporting and Analytics Staff	Ensure timely and accurate reporting and analytics needed to meet the requirements of the Contract.
Quality Management Staff	Perform Quality management and improvement activities.
Marketing & Outreach Staff	Manage Marketing and outreach efforts.
Compliance Staff	Support the Compliance Officer and ensure compliance with laws and regulations, internal policies and procedures, and terms of the Contract.
SIU Staffing (One (1) full-time Iowa-dedicated SIU staff member for each one hundred thousand (100,000) Enrolled Members assigned to the Contractor and a majority of SIU staff located in Iowa.)	Review, investigate, and audit Contractor's Providers and Enrolled Members to identify Fraud, waste, and Abuse.

A.08. *Final Operational Staffing Plan Staffing Plan Submission/Agency Review.* On or before the tenth (10^{th}) day following execution of the Contract, the Contractor shall provide to the Agency a final operational staffing plan. On or before the fifteenth day after receiving the final operational staffing plan, the Agency will review and approve or disapprove the plan. If the tenth (10^{th}) or the fifteenth (15^{th}) day falls on a weekend, the approval will be issued the next business day.

A.09. *Subsequent Staffing Plans.* The Contractor shall provide the Agency with subsequent staffing plans after the final operational staffing plan within ten (10) business days following any change.

A.10. *Agency Right to Approve Deny Key Personnel.* The Agency reserves the right to approve or deny Contractor Key Personnel based on performance or Quality of care concerns. In addition, the Agency reserves the right to approve other executive positions, key managers, or supervisors working under Key Personnel.

A.11. *Initial Staff Onboarding Obligation.* Contractor shall onboard in excess of fifty percent (50%) of local staff in each functional area of Contract performance within one hundred and twenty (120) Days of Contract execution.

A.12. *Staffing Changes.* The Contractor shall notify the Agency, in writing, when changes to key staffing of the Contract occur, including changes in the Key Personnel and other management and supervisory level staff at least five (5) business days prior to the last date the employee is employed to the extent possible. The Contractor shall provide written notification to the Agency at least thirty (30) Days in advance of any plans to change, hire, or re-assign designated Key Personnel. At that time, the Contractor shall present an interim plan to cover the responsibilities created by the Key Personnel vacancy. Likewise, the Contractor shall submit the name and resume of the candidate filling a Key Personnel vacancy within ten (10) Days after a candidate's acceptance to fill a Key Personnel position or ten (10) Days prior to the candidate's start date, whichever occurs first. The Contractor shall ensure that knowledge is transferred from an employee leaving a position to a new employee to the extent possible. All Key Personnel positions shall be approved by the Agency and filled within sixty (60) Days of departure, unless a different time frame is approved by the Agency.

A.13. *Staff Training and Qualifications.* The Contractor shall ensure on an ongoing basis that all staff has the appropriate credentials, education, experience and orientation to fulfill the requirements of their position. The Contractor shall provide initial and ongoing training and shall ensure all staff are trained in the major components of the Contract. As applicable, based on the scope of services provided under subcontract, the Contractor shall ensure all Subcontractor staff are trained in accordance with this section. Staff training shall include: (i) Contract requirements and State and Federal requirements specific to job functions; (ii) initial and ongoing training on identifying and handling Quality of care concerns, including access to dental services as outlined in the Contract; (iii) cultural sensitivity training; (iv) training on Fraud and Abuse and the False Claims Act as further described in Section I; (v) HIPAA training; (vi) clinical protocol training for all clinical staff; (vii) training regarding interpretation and application of UM guidelines for all UM staff; (viii) training and education to understand Abuse, neglect, exploitation and prevention including the detection, mandatory reporting, investigation and remediation procedures and requirements; and (ix) training specific to Iowa providers and non-Medicaid resources. Training material shall be updated on a regular basis to reflect any Program changes. The Contractor shall maintain documentation to confirm staff training, curriculum, schedules, and attendance. The Agency reserves the right as part of the standard remedy process to request the Contractor to implement additional staff training in the event that performance issues are identified by the Agency.

A.14. *Business Location.* The Contractor shall set up and maintain a business office or work site within the State of Iowa, staffed with the primary Contract personnel and managers for the services provided under the Contract. The Contractor shall be responsible for all costs related to securing and maintaining the facility for interim start-up support and the subsequent operational facility, including, but not limited to, hardware and software acquisition and maintenance, leasehold improvements, utilities, telephone service, office equipment, supplies, janitorial services, security, storage, transportation, document shredders, and insurance. If any activities are approved by the Agency to be performed offsite, then the Contractor shall provide toll-free communications with the Agency staff to conduct business operations. The Contractor shall provide meeting space to the Agency as requested when onsite at the Contractor's location. The Agency will not provide

workspace for the Contractor's staff. Contractor shall have more than fifty percent (50%) of all work under the Contract in each functional area performed locally in Iowa, with less than fifty percent (50%) of all work performed under the Contract performed by Contractor's other corporate locations, unless otherwise approved by the Agency.

A.15. *Out of State Operations.* The Contractor shall ensure the location of any staff or operational functions outside of the State of Iowa does not compromise the delivery of integrated services and a seamless experience for Enrolled Members and Providers. Additionally, the Contractor shall assure availability of personnel to the Agency to address out-of-State operations during normal Agency hours of operation. In accordance with 42 C.F.R. § 438.602(i), no Claims paid by Contractor to a Network Provider, Out-of-Network Provider, Subcontractor or financial institution located outside of the U.S. may be considered in the development of actuarially sound capitation rates.

A.16. *Agency Meeting Requirements.* The Contractor shall comply with all meeting requirements established by the Agency, including, but not limited to, preparation, attendance, participation and documentation. Contractor shall have subject appropriate staff members attend onsite meetings as requested and required by the Agency. The Agency reserves the right to cancel any regularly scheduled meetings, change the meeting frequency or format or add meetings to the schedule as it deems necessary. The Agency may also require the participation of subcontracted entities when determined necessary. All expenses for attendance at all meetings are considered to be included in the capitation rates and shall be at no additional cost to the Agency.

A.17. *Coordination with Other State Agencies and Program Contractors.* The Contractor agrees to reasonably cooperate with and work with the other Program Contractors, Subcontractors, State agencies and third-party representatives and to support community-based efforts as requested by the Agency, including but not limited to:

a) *Program Contractors*. The Contractor shall reasonably cooperate and work with other Dental Pre-paid Ambulatory Health Plans (PAHPs) contracted under the Iowa Dental Wellness Plan and Hawki Dental programs, i.e. Program Contractors, in areas, including but not limited to, the development of policies, processes and initiatives identified by the Agency intended to improve Quality Outcomes in the Program or streamline Provider and Enrolled Member processes The Agency reserves the right to mandate cross-contractor requirements to facilitate the development of streamlined Provider and Member processes.
b) *Iowa Health and Human Services Wellness and Preventive Services Bureau.* The Wellness and Preventive Services Bureau, to include their Title V contractors, I-Smile, is a critical partner of the Agency. The Contractor shall coordinate with the Bureau of Wellness and Prevention Services and I-Smile contractors to ensure access to and delivery of high-quality dental services, which shall include collaboration to identify additional dental offices willing to serve enrolled children. Contractor shall not duplicate services performed by the Bureau of Wellness and Prevention Services and I-Smile contractors, including but not limited to informing newly eligible Medicaid members, ages zero (0) to twenty (20) and pregnant women, of their eligibility benefits and Care Coordination services for Enrolled Members they serve for preventive purposes.
c) *Iowa Department of Education*. The Contractor shall work closely with the Iowa Department of Education.
d) *Ombudsman's Office*. The Contractor shall work closely and cooperatively with any State Ombudsman's Office to ensure the satisfaction and safety of Members; resolution of conflicts, complaints, and Grievances; and transition of Members during Provider closure.
e) *Community Based Agencies*. The Contractor is expected to support community-based efforts to build better interfaces with agencies, such as: (i) school districts; (ii) area education agencies; and (iii) local public health entities. The Agency will work with the Contractor to prioritize community-based efforts to support the success of the Program.

f) *Iowa Department of Inspections and Appeals*. The Iowa Department of Inspections and Appeals (DIA) is responsible for inspecting and licensing/certifying various health care entities, as well as health care Providers and suppliers operating in the State of Iowa; for conducting the State Fair Hearing process; and investigating alleged Fraud in the State's public assistance programs. The Contractor shall work closely with DIA throughout the term of the Contract.
g) *Iowa Department of Aging*. The Contractor shall work closely with the Iowa Department on Aging as necessary to promote positive Outcomes for Iowa's aging Medicaid population.
h) *Estate Recovery*. Contractor must coordinate activities and cooperate with the Department's Estate Recovery contractor.
i) *Iowa Health Link Managed Care Organizations (MCOs)*. The Iowa Health Link MCOs provide care for Enrolled Member's non-dental health. The Contractor shall cooperate and collaborate with the MCOs to support the Enrolled Member's overall health.

A.18. *Media Contacts.* The Contractor shall not provide to the media or give media interviews without the express consent of the Agency. Any contacts by the media or other entity or individual not directly related to the Dental Wellness Program, the Hawki Dental program, or the Contract shall be referred to the Agency.

A.19. *Written Policies and Procedures.* The Contractor shall develop and maintain written policies and procedures for each functional area in a global Policies and Procedures Manual (the "PPM"), including, but not limited to the strategies, policies, procedures, descriptions, mechanisms, and the like identified in the Contract to be included in the PPM. In drafting the PPM, the Contractor shall be guided by the scope of work of this Contract. The Contractor shall submit a draft PPM to the Agency forty-five (45) Days following execution of the Contract, unless directed otherwise by the Agency.

A.20. *Contractor Developed Materials.* All materials developed by the Contractor shall be made available to the Agency. The Contractor shall produce an archive of such materials in an electronic library to be made available to the Agency upon request. The archive shall include all written policies, procedures and all public-facing documents. The materials shall be available to the Agency throughout the Contract term and transitioned to the Agency after the Contract term.

A.21. *Participation in Readiness Reviews.* The Contractor shall undergo and shall pass a Readiness Review process and be ready to assume responsibility for Contracted services upon the Contract effective date. The Contractor shall maintain and adhere to a detailed implementation plan, subject to the Agency approval, which identifies the elements for implementing the proposed services which include, but are not limited to: (i) the Contractor's tasks; (ii) staff responsibilities; (iii) timelines; and (iv) processes that will be used to ensure Contracted services begin upon the Contract effective date. The Contractor shall be required to submit a revised implementation plan for review as part of the Readiness Review. The Contractor shall respond to all requests for information from the Agency, or the Agency's Designee, within the timeframe designated by the Agency as part of the Readiness Review. To be compliant with the Readiness Review requirements, the Contractor shall demonstrate Iowa-specific system configurations, policies, and procedures. Documentation used by the Contractor in other markets that has not been updated to reflect Iowa policies in accordance with this Contract will not satisfy Readiness Review requirements. All testing, including but not limited to Readiness Review, must occur on systems configured to be used in Iowa with all Iowa specifications.

All Contractor systems must be thoroughly end-to-end tested and approved by the Agency during the Readiness Review. Provider Claims testing with all Provider types must be conducted for a minimum of three (3) months unless otherwise approved by the Agency. All systems used during Readiness Review shall mirror the final Iowa production systems. The Contractor shall onboard and utilize staff during Readiness Review who will be in place during the Contract effective period. The Contractor shall ensure appropriate staff are hired and in place during Readiness Review to allow proper distribution of policy and technical information shared by the Agency.

The Contractor shall implement a dedicated resource library for implementation during Readiness Review.

Prior to the beginning of Readiness Review, and upon execution of the Contract, the Contractor shall participate in onboarding sessions. The Contractor shall ensure staff who will be responsible for implementing and operationalizing the Contract attend these onboarding sessions to allow proper distribution of policy and technical information shared by the Agency. The Contractor shall transfer this relevant knowledge during implementation to staff who will be responsible for implementing the Contract.

A.22. *Response to Agency Inquiries & Requests for Information.* The Agency may, at any time during the term of the Contract, request financial or other information from the Contractor. Contractor responses shall fully disclose all financial or other information requested. Information may be designated as confidential but may not be withheld from the Agency as proprietary. Information designated as confidential may not be disclosed by the Agency without the prior written consent of the Contractor except as required by law. If the Contractor believes the requested information is confidential and may not be disclosed to third parties, the Contractor shall provide a detailed legal analysis to the Agency, setting forth the specific reasons why the information is confidential and describing the specific harm or injury that would result from disclosure.

The Agency may directly receive inquiries and complaints from external entities, including but not limited to, Providers, Enrolled Members, legislators, or other constituents which require Contractor research, response, and resolution. The Contractor shall comply with requests for response to all such inquiries and complaints. Responses shall be provided in the timeframe specified by the Agency when the inquiry or complaint is forwarded to the Contractor for resolution.

A.23. *Stakeholder Education*. The Contractor shall develop a formal process for ongoing education of stakeholders prior to, during, and after implementation of the Contract. Stakeholders include, but are not limited to, Providers, advocates, Enrolled Members, and their families or caregivers. This includes publicizing methods by which Enrolled Members can ask questions regarding the program. The Contractor shall submit a Stakeholder Education Plan to the Agency for review and approval in the timeframe and manner determined by the Agency.

A.24. *Dissemination of Information.* Upon request of the Agency, the Contractor shall distribute information prepared by the Agency or the federal government to its Enrolled Members and Provider Network as appropriate.

A.25. *Future Program Guidance.* The Contractor shall operate in compliance with current and future Program manuals, guidance and policies and procedures at no additional cost to the Agency. Future modifications that have a significant impact on the Contractor's responsibilities, as set forth in this Contract, will be made through the Contract amendment process.

A.26. *Material Change to Operations.* A material change to operations is any change in overall business operations, such as policy, process or protocol which affects, or can reasonably be expected to affect, more than five percent (5%) of the Contractor's membership or Provider Network and that a reasonable person would find to be a significant change. Prior to implementing a material change in operation, the Contractor shall notify the Agency. The notification shall contain, at minimum: (i) information regarding the nature of the change; (ii) the rationale for the change; (iii) the proposed effective date; and (iv) sample Member and Provider notification materials. All material changes shall be communicated to Enrolled Members or Providers at least thirty (30) Days prior to the effective date of the change. The Agency reserves the right to deny or require modification to proposed material changes if it is determined, at the sole discretion of the Agency, that such change will adversely impact Quality or Access.

A.27. *Call Center Performance Metrics.* In addition to any performance metrics identified in relation to a specific subset of call centers, Contractor shall ensure that all call centers operated by Contractor or a Subcontractor that performs services under this Contract meet the following performance metrics:

a) Abandonment Rates must be five percent (5%) or less. Calls are considered abandoned if the caller hangs up after thirty (30) seconds and does not talk with a Customer Service Representative.
b) Service Levels must be at least eighty percent (80%) for incoming calls. The Service Level is calculated by the following formula:

Service Level = ((T – (A + B))/T) * 100, where:

T = all calls that enter the queue
A = calls that are answered after thirty (30) seconds
B = calls that are abandoned after thirty (30) seconds

c) The Contractor shall respond to all urgent requests within four (4) hours if received prior to 1:00 pm, if received after 1:00 pm, urgent requests will be responded to by 11:00 am the next business day.
d) For ninety-five percent (95%) of telephone inquiries in which a caller speaks to a CSR for which an answer is not immediately available to the CSR, the Contractor shall research and respond within two (2) business days of receipt of the inquiry.
e) The Contractor shall acknowledge receipt of an inquiry received without speaking to a CSR within one (1) business day.
f) The Contractor shall respond to at least ninety-five percent (95%) of e-mailed and voice mail inquiries within two (2) business days of receipt.
g) The Contractor shall provide final resolution of one hundred percent (100%) of inquiries within five (5) business days.
h) The Contractor shall issue responses to Enrolled Member billing inquiries within twenty (20) business days of the initial inquiry, in a format approved by the Agency.
i) Ninety-five percent (95%) of Provider billing inquiries will be responded to by phone or in writing within two (2) business days. One hundred percent (100%) of Provider billing inquiries will be responded to by phone or in writing within three (3) business days.

A.28. *Quality of Responses and Deliverables to the Agency.* The Contractor shall perform quality assurance reviews on all documentation and deliverables sent to the Agency. At a minimum, the documents should be grammatically correct and in alignment with the Medicaid Program rule and regulation.

A.29. *Coverage Area.* The coverage area for which the Contractor agrees to provide services shall be the entire State of Iowa.

A.30. *Periodic Reviews of Eligibility.* The Agency shall periodically conduct a review of each Enrolled Member's circumstances to establish the Enrolled Member's continued eligibility to participate in the DWP and Hawki dental programs.

A.31. *Enrolled Member Engagement.* The Contractor shall ensure the provision of Enrolled Member engagement by utilizing partners to work with providers and Enrolled Members to promote successful compliance with treatment plans and use of preventive care. This will include educating Enrolled Members about good oral hygiene, prevention, and maintenance of teeth and gums. The Contractor will work with key community service organizations, including the HHS Bureau of Wellness and Prevention Services and its I-Smile contractors to assist in education and awareness activities at the local level and support Enrolled Member education and compliance, including linking Enrolled Members with participating dental providers. The Contractor shall develop member education activities that increase beneficiary awareness and access to services.

The Contractor shall establish a process for ongoing care facilitation and coordination with the Enrolled Member's physical health care to ensure patient-centeredness.

A.32. *Enrolled Member Education and Outreach.* The Contractor shall manage population health by focusing on restoring basic functionalities for all Enrolled Members and improving the oral health of Enrolled Members over time through education, Enrolled Member engagement, and community support by such means as, but not limited to:

a) Increasing use of preventive and recall services.
b) Educating Enrolled Members on appropriate utilization of preventive dental services to maintain oral health.
c) Utilizing community resources and health and dental providers to educate Enrolled Members of the importance of oral health care and treatment.
d) Educating and promoting completion of the Initial Oral Health Risk Screening upon Enrollment.
e) Establishing a process to analyze data collected from the Agency-approved Oral Health Equity Self-Assessment Tool to create strategies that reduce the risk of negative dental outcomes of beneficiaries by implementing the following:
    - Use the tool for increased outreach and education efforts to beneficiaries.
    - Use the data from the Oral Health Equity Self-Assessment Tool to create Agency approved interventions targeted for outreach to members at high risk for oral health disease.

B. Enrollment and Disenrollment

B.01. *Eligible for Enrollment.* Persons eligible for Enrollment with the Contractor are set forth in Special Contract Exhibit D. The Agency shall have the exclusive right to determine an individual's eligibility for Medicaid Programs and Contract Enrollment. Such determinations are not subject to review or Appeal by the Contractor. Nothing in this Section prevents the Contractor from providing the Agency with information the Contractor believes indicates that the Enrolled Member's eligibility has changed.

B.02. *PAHP Selection and Assignment.* Enrollment with a PAHP may be the result of an Enrolled Member's selection of a particular Contractor or assignment by the Agency.

B.03. *Effective Date of Contractor Enrollment.* Assignments to the Contractor and changes to the Enrolled Members' aid type shall be made on a retroactive basis for Medicaid reinstatements only. The Contractor will not be responsible for covering newly retroactive Medicaid eligibility periods, with the exception of 1) babies born to Medicaid enrolled women who are retroactively eligible to the month of birth and 2) Hawki Enrolled Members starting the month after the date of application. For purposes of this requirement, a retroactive Medicaid eligibility period is defined as a period of time up to three (3) months prior to the Medicaid determination month.

B.04. *Estate Recovery Notification*. The Contactor shall send Comm. 123, a Agency-approved form, to Members over the age of fifty-five (55) once a year. When the Agency requests it, the Contractor shall produce documentation providing details of the information sent to the Enrolled Member. Information may include but not limited to mailing date, address, and recipient information.

B.1 No Discrimination

B.1.01. *Acceptance of New Enrolled Members.* Contractor shall accept new Enrollment from individuals in the order in which they apply without restriction, unless authorized by CMS, up to the limits set under the Contract. See: 42 C.F.R. § 438.3(d)(1); 42 C.F.R. § 457.1201(d). {From CMSC B.1.01}.

B.1.02. *Health Status & Need for Services*. Contractor shall not discriminate against individuals eligible to enroll on the basis of health status or need for Health Care Services. See: 42 C.F.R. § 438.3(d)(3); 42 C.F.R. § 457.1201(d). {From CMSC B.1.02}.

B.1.03. *Other Discrimination Prohibited.* Contractor shall not discriminate against individuals eligible to enroll on the basis of race, color, national origin, disability or sex which includes discrimination on the basis of

sex characteristics including intersex traits; pregnancy or related conditions; sexual orientation, gender identity, and sex stereotypes. See: 42 C.F.R. § 438.3(d)(4); 42 C.F.R. § 457.1201(d).

B.1.04. *Non-Discriminatory Policies.* Contractor shall not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, disability, or sex which includes discrimination on the basis of sex characteristics including intersex traits; pregnancy or related conditions; sexual orientation, gender identity, and sex stereotypes. See: 42 C.F.R. § 438.3(d)(4); 42 C.F.R. § 457.1201(d). }.

B.2 Choice of Doctor

B.2.01. *Rural Residential Exceptions.* The Agency does not operate a Rural residential exception. See: 42 C.F.R. § 438.52(b) – (d); 42 C.F.R. § 438.56(c). {From CMSC B.2.01}.

B.2.02. *Free Choice of Provider.* Contractor shall allow each Enrolled Member to choose his or her Network Provider to the extent possible and appropriate. See: 42 C.F.R. § 438.3(l); 42 C.F.R. § 457.1201(j). {From CMSC B.2.02}.

B.2.03. *Member Choice.* The Contractor shall ensure Enrolled Members the right to select the Providers of their choice without regard to variations in reimbursement. If a Member enrolls with the Contractor and is already established with a Provider who is not a part of the network, the Contractor shall make every effort to arrange for the Enrolled Member to continue with the same Provider if the Enrolled Member so desires. In this case, the Provider would be requested to meet the same qualifications as other Providers in the network.

B.3 Opt Out

B.3.01. *Mandatory Enrollment.* Enrollment in Iowa Medicaid managed care is mandatory pursuant to Iowa Medicaid's approved waiver. See: 42 C.F.R. § 438.3(d)(2). {From CMSC B.3.01}.

B.4 Reenrollment

B.4.01. *Auto-Reenrollment.* The Agency automatically reenrolls in the same PAHP any recipient who is disenrolled solely because the Enrolled Member loses Medicaid or CHIP eligibility for a period of 12 months or less. See: 42 C.F.R. § 438.56(g); 42 C.F.R. § 457.1201(m); 42 C.F.R. 457.1212. {From CMSC B.4.01}.

B.4.02. *Auto Assignment.* The auto-assignment algorithm will be designed by the Agency and comply with the provisions at 42 C.F.R. § 438.54, including striving to preserve existing Provider-beneficiary relationships. To the extent this is not possible, the algorithm will distribute equitably among qualified Contractors excluding those subject to intermediate sanctions at 42 C.F.R. § 438.702(a)(4). The Agency reserves the right to modify the auto-assignment logic at any time throughout the Contract term. The Agency reserves the right to redistribute membership due to uneven Enrollment and cap Enrollment by Contractor to ensure an excess of capacity does not impact Quality of services.

B.5 Disenrollment

B.5.01. *Contractor-Requested Disenrollment.* The Contractor may request Disenrollment of an Enrolled Member only for the reasons set forth in this Contract. See: 42 C.F.R. § 438.56(b)(1); 42 C.F.R. § 457.1201(m); 42 C.F.R. § 457.1212. {From CMSC B.5.01}.

B.5.02. *Prohibited Disenrollment Requests.* Contractor shall not request Disenrollment because of:

a) An adverse change in the Enrolled Member's health status.
b) The Enrolled Member's utilization of medical/dental services.
c) The Enrolled Member's diminished mental capacity.
d) The Enrolled Member's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued Enrollment seriously impairs the Contractor's ability to furnish services to the Enrolled Member or other Enrolled Members).

See: Section 1903(m)(2)(A)(v) of the Social Security Act; 42 C.F.R. § 438.56(b)(2); 42 C.F.R. 457.1201(m); 42 C.F.R. § 1212. {From CMSC B.5.02 - B.5.05}.

B.5.03. *Reasonable Steps Requirement*. In requesting Disenrollment, the PAHP must provide evidence to the Agency that Contractor has not violated the prohibitions set forth in this Section B. At minimum, the Contractor's request must document that reasonable steps were taken to educate the Enrolled Member regarding proper behavior and the Enrolled Member refused to comply. Further, the PAHP is required to have methods by which the Agency is assured that Disenrollment is not requested for another reason. The Agency retains sole authority for determining if this condition has been met and whether Disenrollment will be approved.

B.5.04. *Contractor Assurances.* Contractor hereby assures the Agency that it does not request Disenrollment for reasons other than those permitted under the Contract. See: 42 C.F.R. § 438.56(b)(3); 42 C.F.R. § 457.1201(m); 42 C.F.R. § 457.1212. {From CMSC B.5.06}.

B.5.05. *Enrolled Member Rights - Timing.* Enrolled Members have the right to disenroll from their Contractor:

a) For cause, at any time.
b) Without cause ninety (90) Days after initial Enrollment or during the ninety (90) Days following notification of Enrollment, whichever is later.
c) Without cause at least once every twelve (12) months.
d) Without cause upon reenrollment if a temporary loss of Enrollment has caused the Enrolled Member to miss the annual Disenrollment period.

The Agency will make all determinations regarding Enrollment and Disenrollment. See: 42 C.F.R. § 438.3(q)(5); 42 C.F.R. § 438.56(c)(1); 42 C.F.R. § 438.56(c)(2)(i) - (iii); 42 C.F.R. § 1201(m); 42 C.F.R. § 457.1212. {From CMSC B.5.07 - B.5.10}.

B.5.06. *Reserved*. N/A.

B.5.07. *Other Disenrollment Rights.* Enrolled Members may request Disenrollment if:

a) The Enrolled Member moves out of the service area.
b) The plan does not cover the service the Enrolled Member seeks, because of moral or religious objections.

See: 42 C.F.R. § 438.56(d)(2)(i) - (ii); 42 C.F.R. § 457.1201(m); 42 C.F.R. § 457.1212. {From CMSC B.5.12 - B.5.13}.

B.5.08. *Enrolled Member Disenrollment – Related Services.* Enrolled Members may request Disenrollment if the Enrolled Member needs related services to be performed at the same time and not all related services are available within the Provider Network. The Enrolled Member's PCP or another Provider must determine that receiving the services separately would subject the Enrolled Member to unnecessary risk. See: 42 C.F.R. § 438.56(d)(2)(iii); 42 C.F.R. § 457.1201(m); 42 C.F.R. § 457.1212. {From CMSC B.5.14}.

B.5.09. *Reserved*. N/A.

B.5.10. *Enrolled Member Disenrollment – Other Reasons.* Enrolled Members may request Disenrollment for other reasons, including poor Quality of care, lack of Access to services covered under the Contract, or lack of Access to Providers experienced in dealing with the Enrolled Member's care needs. See: 42 C.F.R. § 438.56(d)(2)(v); 42 C.F.R. § 457.1201(m); 42 C.F.R. § 457.1212. {From CMSC B.5.16}.

B.5.11. *Agency Initiated Disenrollment.* Agency-initiated Disenrollment may occur based on changes in circumstances including: (i) ineligibility for Medicaid; (ii) shift to an eligibility category not covered by the Contract; (iii) change of place of residence to another state; (iv) the Agency has determined that participation in HIPP is more cost-effective than Enrollment in the Contract; and (v) death.

B.6 Disenrollment Request Process

B.6.01. *Oral or Written Requests.* A recipient (or his or her representative) must request Disenrollment by submitting an oral or written request. The Enrolled Member must seek redress through Contractor's Grievance process before a determination will be made on a Disenrollment request. If the Enrolled Member remains dissatisfied with the result of the Grievance process, Contractor shall direct the Enrolled Member to contact the Agency and request Disenrollment from the Contractor. The Agency will make the final Disenrollment determination. See: 42 C.F.R. § 438.56(d)(1)(i)-(ii); 42 C.F.R. § 457.1201(m); 42 C.F.R. § 457.1212; Iowa Admin. Code r. 441-73.4(1). {From CMSC B.6.01}.

B.6.02. *Agency Disenrollment Decisions.* The Agency will process and make a determination regarding all Enrolled Member Disenrollment requests following completion of the Contractor's Grievance process. See: 42 C.F.R. § 438.56(d)(3)(i); 42 C.F.R. § 457.1201(m); 42 C.F.R. § 457.1212. {From CMSC B.6.02}.

B.6.03. *Effective Date.* The effective date of an approved Disenrollment will be no later than the first day of the second month following the month in which the Enrolled Member requests Disenrollment or the Contractor refers the request to the Agency. See: 42 C.F.R. §§ 438.56(e)(1) - (2); 42 C.F.R. § 438.56(d)(3)(ii); 42 C.F.R. § 438.3(q); 42 C.F.R. § 438.56(c); 42 C.F.R. § 457.1201(m); 42 C.F.R. § 457.1212. {From CMSC B.6.03}.

B.6.04. *Deemed Approval.* If the Agency fails to make a Disenrollment determination within the specified timeframes (i.e., the first day of the second month following the month in which the Enrolled Member requests Disenrollment or the Contractor refers the request to the Agency), the Disenrollment is considered approved for the effective date that would have been established had the Agency made a determination in the specified timeframe. See: 42 C.F.R. § 438.56(e)(1) - (2); 42 C.F.R. § 438.56(d)(3)(ii); 42 C.F.R. § 438.3(q); 42 C.F.R. § 438.56(c); 42 C.F.R. § 457.1201(m); 42 C.F.R. § 457.1212. {From CMSC B.6.04}.

B.7 Special Rules for American Indians

B.7.01. *Restricting Enrollment of Indians.* Contractor is not an Indian Managed Care Entity. As such, the Contract does not allow Contractor to restrict Enrollment of Indians in the same manner as Indian Health Programs may restrict the delivery of services to Indians. See: Section 1932(h)(3) of the Social Security Act; State Medicaid Director Letter (SMDL) 10-001; 42 C.F.R. § 438.14(d); 42 C.F.R. § 457.1209. {From CMSC B.7.01}.

B.7.02. *IHCP PCPs.* Any Indian enrolled with Contractor and eligible to receive services from an Indian Health Care Provider (IHCP) PCP participating as a Network Provider, is permitted to choose that IHCP as their PCP, as long as that Provider has capacity to provide the services. See: ARRA § 5006(d); SMDL 10-001; 42 C.F.R. § 438.14(b)(3); 42 C.F.R. § 457.1209. {From CMSC B.7.02}.

C. Beneficiary Notification

C.1 Language and Format

C.1.01. *Information Easily Understood.* Contractor shall provide information to Enrolled Members, their authorized representative, and Potential Enrolled Members in a manner and format that may be easily understood and is Readily Accessible by such Enrolled Members, authorized representatives, and Potential Enrolled Members. See: 42 C.F.R. § 438.10(c)(1); 42 C.F.R. § 457.1207. {From CMSC C.1.01}.

C.1.02. *Information for Potential Enrolled Members.* Contractor shall comply with all information requests of the Agency or its contracted representatives that is required for the development of information for Potential Enrolled Members.

C.1.03. *New Member Communications.* The Contractor shall distribute Enrollment materials to each Enrolled Member and their authorized representative. All information in the Enrollment materials shall meet the requirements set forth in this Section C and shall be submitted for the Agency review and approval prior to

distribution in accordance with the process established in Section C.10.01. In addition to information set forth in Sections C.1.01 and C.1.02, the Enrollment materials shall include the following information:

a) Contractor's contact information, including address, telephone number, web site;
b) Contractor's office hours/days, including the availability of the helplines;
c) Description of how to complete an oral health risk assessment;
d) If applicable, any cost-sharing information, and contact information where the Enrolled Member can ask questions regarding their cost-sharing obligations;
e) Procedures for obtaining out-of-network services and any special benefit provisions (for example, Co-Payments, limits or rejections of Claims) that may apply to services obtained outside the Contractor's network;
f) Standards and expectations for receiving preventive dental services;
g) Procedures for changing contractors and circumstances under which this is possible, as described in Section B.5;
h) Procedures for making complaints and recommending changes in policies and services;
i) Information on how to contact the Iowa Medicaid Enrollment Broker;
j) Information on alternative methods or formats of communication for visually and hearing-impaired and non-English speaking Enrolled Members and how Enrolled Members can access those methods or formats at no expense;
k) Information and procedures on how to report suspected Abuse and neglect, including the phone numbers to call to report suspected Abuse and neglect; and
l) Contact information and description of the role of the Ombudsman.

C.1.04. *Health Education and Initiatives.* Contractor's communication initiatives shall include information on programs, to include the I-Smile dental home initiative and contact information, and how Enrolled Members can participate in activities to enhance the general well-being and dental health of Enrolled Members. The Contractor shall develop a strategy to participate in and interface with the Healthiest State Initiative.

C.1.05. *Cost and Quality Information.* Subject to the Agency approval and with the timeframes specified, the Contractor shall implement and adhere to innovative strategies to provide price and Quality transparency to Enrolled Members. Making cost and Quality information available to Enrolled Members increases transparency and has the potential to reduce costs and improve Quality. The Contractor shall make cost and Quality information available to Enrolled Members in order to facilitate more responsible use of Dental Health Care Services and inform dental health care decision-making. Examples of quality services include education on Silver Diamine fluoride as a treatment option and/or how preventive services such as topical fluoride and sealants reduce dental caries in children. Examples of cost information includes average costs of common services, and the cost of urgent versus emergent costs.

C.1.06. *Explanation of Benefits.* The Contractor shall provide Explanation of Benefits (EOBs) to all Enrolled Members or a statistically valid sample of all Enrolled Members. This includes Enrolled Members in the Iowa Dental Wellness Plan as well as Hawki. EOBs shall be available via paper and secure web-based portal. EOBs shall be delivered to Enrolled Members based on their preferred mode of receipt of Contractor communications. At a minimum, EOBs shall be designed to address requirements in 42 C.F.R. § 433.116(e) and (f).

C.1.07. *Quality Information.* The Contractor shall make Provider Quality information available to Enrolled Members. The Contractor shall capture Quality information about its Network Providers and shall make this information available to Enrolled Members based on their preferred mode of receipt of Contractor communications as described in Section C.8.02. The Contractor may choose to quantitatively and qualitatively rate Providers, including, but not limited to, services the office provides or refers out including surgical extractions, fabrication of dentures, and providers who have not limited their acceptance of new members in the last twelve (12) months. In making the information available to Enrolled Members, the Contractor shall identify any limitations of the data.

C.1.08. *Mechanisms to Aid Understanding.* Contractor shall have in place mechanisms to help Enrolled Members and Potential Enrolled Members understand the requirements and Benefits of their plan. See: 42 C.F.R. § 438.10(c)(7); 42 C.F.R. § 457.1207. {From CMSC C.1.02}.

C.1.09. *Implementation Support.* The Contractor shall publicize methods for Enrolled Members to obtain support and ask questions during Program implementation, including information on how to contact the Ombudsman and Contractor via the Enrolled Member services hotline.

C.1.10. *Integration of Service Lines.* To facilitate the delivery of integrated dental healthcare services, the Member services helpline shall be used by all Enrolled Members, regardless of member's coverage group or what the Enrolled Member is calling about. The Contractor shall not have separate numbers for Enrolled Members to call regarding separate covered services or plans (i.e., DWP vs. Hawki). The Contractor may either route the call to another entity or conduct a "Warm Transfer" to another entity, but the Contractor shall not require an Enrolled Member to call a separate number regarding separate services or plans (i.e., DWP vs. Hawki).

C.1.11. *Member Services Helpline.* The Contractor shall maintain a dedicated toll-free Member services helpline staffed with trained personnel knowledgeable about the Program. Helpline staff shall be equipped to handle a variety of Enrolled Member inquiries. The telephone line shall be staffed with live-voice coverage during normal working days (Monday through Friday), excluding State holidays, and shall be accessible, at minimum, during working hours of 7:30 a.m. - 6:00 p.m. Central Time. The State holidays are: (i) New Years Day; (ii) Martin Luther King, Jr.'s Birthday; (iii) Memorial Day; (iv) July 4th; (v) Labor Day; (vi) Veterans Day; (vii) Thanksgiving; (viii) Day after Thanksgiving; and (ix) Christmas Day. The Contractor shall provide a voice message system that informs callers of the Contractor's business hours and offers an opportunity to leave a message after business hours. Calls received in the voice message system shall be returned within one (1) business day. The Contractor shall have the ability to Warm Transfer Enrolled Members to outside entities, such as Provider offices, the Enrollment Broker, and internal Contractor departments to facilitate the provision of high Quality customer service. The Contractor shall ensure all calls are answered by live operators who shall identify themselves by name to each caller. The Contractor may utilize an IVR system but shall ensure a caller is connected to a live person within one (1) minute if the caller chooses that option.

C.1.12. *Member Services Helpline Performance Metric.* Contractor's Member Services Helpline shall comply at all times with the performance metrics set forth in Section A.27.

C.1.13. *Availability for All Callers.* The Member services helpline shall be available for all callers. The Contractor shall maintain and operate telecommunication device for the deaf (TDD) services for hearing impaired Enrolled Members. Additionally, the Contractor shall ensure communication between the Contractor and Enrolled Member is in a language the participant understands. In cases where a participant's language is other than English, the Contractor shall offer and, if accepted by the participant, supply interpretive services at no charge to the participant. An automated telephone menu options shall be made available in English and Spanish.

C.1.14. *Helpline Staff and Knowledge.* The Contractor's Member services helpline staff shall be prepared to efficiently respond to Enrolled Member concerns or issues, including but not limited to: (i) how to Access Dental Health Care Services and dentists accepting new members who provide those services; (ii) identification or explanation of covered services; (iii) procedures for submitting a Grievance or Appeal; (iv) reporting Fraud or Abuse; (v) locating a Provider; (vi) dental health crises; (vii) balance billing issues; (viii) cost-sharing inquiries; (ix) PCP change and/or initial attribution; and (x) incentive programs.

C.1.15. *Backup System.* The Contractor shall maintain a backup plan and system to ensure that, in the event of a power failure or outage, the following are in place and functioning: (i) a back-up system capable of operating the telephone system, at full capacity, with no interruption of data collection; (ii) a notification plan that ensures the Agency is notified when the Contractor's phone system is inoperative or a back-up system is being utilized; and (iii) manual back-up procedure to allow requests to continue being processed if the system is down.

C.1.16. *Tracking and Reporting.* The Contractor shall maintain a system for tracking and reporting the number and type of Enrolled Member calls and inquiries it receives during business and non-business hours. The Contractor shall monitor its Member services helpline and report its telephone Service Level performance to the Agency in the timeframes and according to the Specifications described in the Reporting Manual.

C.1.17. *Dental Call Line.* The Contractor shall operate a toll-free Dental Call Line which provides triage telephone services for Enrolled Members to receive dental advice twenty-four (24) hours a day/seven (7) days a week from trained dental professionals. The Dental Call Line shall be well publicized and designed as a resource to Enrolled Members to help discourage inappropriate emergency room use. The Dental Call Line shall have a system in place to communicate all issues with the Enrolled Member's dental health care Providers, as applicable. The Contractor shall have a written protocol specifying when a dentist must be consulted in response to a call received. Calls requiring a dental decision shall be forwarded to the on-call dentist, and a response to each call which requires a dental decision shall be provided by the dentist within thirty (30) minutes.

C.1.18. *Redetermination Assistance*. In providing redetermination assistance, all questions and calls shall be referred to the Agency's Enrollment Broker. The Contractor shall not engage in any of the following activities when assisting the member: (i) discriminate against Enrolled Members, including particularly high-cost Enrolled Members or Enrolled Members that have indicated a desire to change Contractors; (ii) talk to Enrolled Members about changing Contractors, (iii) provide any indication as to whether the Enrolled Member will be eligible, as this decision is at the sole discretion of the Agency; (iv) engage in or support fraudulent activity in association with helping the Enrolled Member complete the redetermination process; (v) sign the Enrolled Member's redetermination form; or (vi) complete or send redetermination materials to the Agency on behalf of the Enrolled Member.

C.1.19. *Prevalent Non-English Languages.* Contractor shall make its written materials that are critical to obtaining services, including, at a minimum, Provider directories, Enrolled Member handbooks, Appeal and Grievance Notices, and denial and termination Notices available in the Prevalent non-English languages in its particular service area. See: 42 C.F.R. § 438.10(d)(3); 42 C.F.R. § 457.1207. {From CMSC C.1.03}.

C.1.20. *Formats and Taglines.* Contractor's written materials that are critical to obtaining service shall:

a) Be available in alternative formats upon request of the Potential Enrolled Member or Enrolled Member at no cost.
b) Include taglines in the Prevalent non-English languages in the State, and in a conspicuously visible font size, explaining the availability of written translation or oral interpretation to understand the information provided.
c) Include taglines in the Prevalent non-English languages in the State and in a conspicuously visible font size that provide information on how to request auxiliary aids and services.
d) Include taglines in the Prevalent non-English languages in the State and in a conspicuously visible font size that provide the toll-free and Teletypewriter Telephone/Text Telephone (TTY/TDY) telephone number of the Contractor's Enrolled Member/customer service unit.

See: 42 C.F.R. § 438.10(d)(3); 42 C.F.R. § 457.1207. {From CMSC C.1.04 - C.1.07}.

C.1.21. *Language Requirements.* All written materials shall be provided in English and Spanish, and any additional Prevalent languages identified by the Agency in the future at no additional cost to the Agency. The

Contractor shall also identify additional languages that are Prevalent among the Contractor's membership. For purposes of this requirement, Prevalent language is defined as any language spoken by at least (five percent) 5% of the general population in the Contractor's service area. Written information shall be provided in any such Prevalent languages identified by the Contractor.

C.1.22. *Auxiliary Aids & Services.* Contractor shall make auxiliary aids and services available upon request of the Potential Enrolled Member or Enrolled Member at no cost. See: 42 C.F.R. § 438.10(d)(3); 42 C.F.R. § 457.1207. {From CMSC C.1.08}.

C.1.23. *Interpretive Services.* Contractor shall make interpretation services, including oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language (ASL), free of charge to each Enrolled Member and in all non-English languages, not just those that the Agency identifies as Prevalent. See: 42 C.F.R. § 438.10(d)(4); 42 C.F.R. § 457.1207. {From CMSC C.1.09}.

C.1.24. *Notifications of Translations and Aids.* Contractor shall notify its Enrolled Members that:

a) Oral interpretation is available for any language, and how to Access those services.
b) Written translation is available in Prevalent languages, and how to Access those services.
c) Auxiliary aids and services are available upon request at no cost for Enrolled Members with disabilities, and how to Access those services.

See: 42 C.F.R. § 438.10(d)(5)(i) - (iii); 42 C.F.R. § 457.1207. {From CMSC C.1.10 - C.1.12}.

C.1.25. *Easily Understood Standard.* Contractor shall provide all written materials for Potential Enrolled Members and Enrolled Members in an easily understood language and format. See: 42 C.F.R. § 438.10(d)(6)(i); 42 C.F.R. § 457.1207. {From CMSC C.1.13}.

C.1.26. *Patient Language Preference.* Per 42 C.F.R. § 438.340(b)(6), at the time of Enrollment with the Contractor, the Agency will provide the primary language of each Enrolled Member. The Contractor shall utilize this information to ensure communication materials are distributed in the appropriate language.

C.1.27. *Written Materials Formatting.* Contractor shall:

a) Provide all written materials for Potential Enrolled Members and Enrolled Members in a font size no smaller than twelve (12) point.
b) Make written materials for Potential Enrolled Members and Enrolled Members available in alternative formats in an appropriate manner that takes into consideration the special needs of Enrolled Members or Potential Enrolled Members with disabilities or Limited English Proficiency (LEP).
c) Make written materials for Potential Enrolled Members and Enrolled Members available through auxiliary aids and services in an appropriate manner that takes into consideration the special needs of Enrolled Members or Potential Enrolled Members with disabilities or LEP.

See: 42 C.F.R. § 438.10(d)(6)(ii) - (iii); 42 C.F.R. § 457.1207. {From CMSC C.1.14 - C.1.16}.

C.2 Enrolled Member Handbook

C.2.01. *State-Developed Handbook.* Contractor shall use the Agency developed model Enrolled Member handbook. See: 42 C.F.R. § 438.10(c)(4)(ii); 42 C.F.R. § 457.1207. {From CMSC C.2.01}.

C.2.02. *Obligation to Provide Handbook.* Contractor shall provide each Enrolled Member and their authorized representative an Enrolled Member handbook, which serves as a summary of Benefits and coverage, and Member Identification (ID) Cards within seven (7) days after receiving notice of the beneficiary's Enrollment. See: 42 C.F.R. § 438.10(g)(1); 45 C.F.R. § 147.200(a); 42 C.F.R. § 457.1207. {From CMSC C.2.02}.

C.2.03. *Content of Handbook.* The content of the Enrolled Member handbook shall include information that enables the Enrolled Member to understand how to effectively use the managed care Program. See: 42 C.F.R. § 438.10(g)(2); 42 C.F.R. § 457.1207. {From CMSC C.2.03}.

C.2.04. *Information Requirements in Handbook.* Contractor shall utilize the model Enrolled Member handbook developed by the Agency that includes information:

a) On Benefits provided by the Contractor. This includes information about EPSDT Benefits and how to Access component services if individuals under age twenty-one (21) entitled to the EPSDT benefit are enrolled in the Contractor.
b) About how and where to Access any Benefits provided by the Agency, including EPSDT Benefits delivered outside the Contractor, if any.
c) About cost sharing on any Benefits carved out of the Contractor Contract and provided by the Agency.
d) About how transportation is provided for any Benefits carved out of the Contractor Contract and provided by the Agency.

See: 42 C.F.R. § 438.10(g)(2)(i) - (ii); 42 C.F.R. § 457.1207. {From CMSC C.2.04 - C.2.07}.

C.2.05. *Information Requirements – Moral or Religious Objections.* Contractor shall utilize the model Enrolled Member handbook developed by the Agency that includes detail that in the case of a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor inform Enrolled Members:

a) That the service is not covered by the Contractor.
b) How they can obtain information from the Agency about how to Access those services.

See: 42 C.F.R. § 438.10(g)(2)(ii)(A) - (B); 42 C.F.R. § 438.102(b)(2); 42 C.F.R. § 457.1207. {From CMSC C.2.08 - 2.09}.

C.2.06. *Amount, Duration & Scope.* Contractor shall utilize the model Enrolled Member handbook developed by the Agency that includes:

a) The amount, duration, and scope of Benefits available under the Contract in sufficient detail to ensure that Enrolled Members understand the Benefits to which they are entitled.
b) Procedures for obtaining Benefits, including any requirements for Service Authorizations and/or referrals for specialty care and for other Benefits not furnished by the Enrolled Member's PCP.

See: 42 C.F.R. § 438.10(g)(2)(iii) - (iv); 42 C.F.R. § 457.1207. {From CMSC C.2.10 - C.2.11}.

C.2.07. *After-Hours Care.* Contractor shall utilize the model Enrolled Member handbook developed by the Agency that includes the extent to which, and how, after-hours care is provided. See: 42 C.F.R. § 438.10(g)(2)(v); 42 C.F.R. § 457.1207. {From CMSC C.2.12}.

C.2.08. *Emergency Care Information.* Contractor shall utilize the model Enrolled Member handbook developed by the Agency that includes:

a) How emergency care is provided.
b) Information regarding what constitutes an Emergency Dental/Medical Condition.
c) Information regarding what constitutes an Emergency Service.
d) The fact that Prior Authorization is not required for Emergency Services.
e) The fact that the Enrolled Member has a right to use any dentist for emergency care.

See: 42 C.F.R. § 438.10(g)(2)(v); 42 C.F.R. § 457.1207. {From CMSC C.2.13 - C.2.17}.

C.2.09. *Information Requirements – Restrictions.* Contractor shall utilize the model Enrolled Member handbook developed by the Agency that includes:

a) Any restrictions on the Enrolled Member's freedom of choice among Network Providers.
b) Reserved (not applicable to a dental-only PAHP).

See: 42 C.F.R. § 438.10(g)(2)(vi) - (vii); 42 C.F.R. § 457.1207. {From CMSC C.2.18 - C.2.19}.

C.2.10. *Reserved.* N/A.

C.2.11. *Information Requirements – Cost Sharing.* Contractor shall utilize the model Enrolled Member handbook developed by the Agency that includes cost sharing for services furnished by the Contractor, if any is imposed under the State Plan. See: 42 C.F.R. § 438.10(g)(2)(viii); 42 C.F.R. § 457.1207. {From CMSC C.2.21}.

C.2.12. *Information Requirements – Enrolled Member Rights and Responsibilities.* Contractor shall utilize the model Enrolled Member handbook developed by the Agency that includes Enrolled Member rights and responsibilities, including the Enrolled Member's right to:

a) Receive information on beneficiary and plan information.
b) Be treated with respect and with due consideration for his or her dignity and privacy.
c) Receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrolled Member's condition and ability to understand.
d) Participate in decisions regarding his or her health care, including the right to refuse treatment.
e) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
f) Request and receive a copy of their Medical Records at no cost and request that they be amended or corrected.

See: 42 C.F.R. § 438.10(g)(2)(ix); 42 C.F.R. § 438.100(b)(2)(i) - (vi); 42 C.F.R. § 457.1207. {From CMSC C.2.22 - C.2.27}.

C.2.13. *Information Requirements – Available and Accessible Care.* Contractor shall utilize the model Enrolled Member handbook developed by the Agency that includes Enrolled Member rights and responsibilities, including the Enrolled Member's right to obtain available and accessible Health Care Services covered under the Contractor Contract. See: 42 C.F.R. § 438.10(g)(2)(ix); 42 C.F.R. § 438.100(b)(3); 42 C.F.R. § 457.1207. {From CMSC C.2.28}.

C.2.14. *Information Requirements – Selecting a PCP.* Contractor shall utilize the model Enrolled Member handbook developed by the Agency that includes the process of selecting and changing the Enrolled Member's PCP. See: 42 C.F.R. § 438.10(g)(2)(x); 42 C.F.R. § 457.1207. {From CMSC C.2.29}.

C.2.15. *Information Requirements – Grievance and Appeals Procedures & Timeframes.* Contractor shall utilize the model Enrolled Member handbook developed by the Agency that includes Grievance, Appeal, and fair hearing procedures and timeframes in a Agency-developed or Agency-approved description. See: 42 C.F.R. § 438.10(g)(2)(xi); 42 C.F.R. § 457.1207. {From CMSC C.2.30}.

C.2.16. *Information Requirements – Enrolled Member Rights Regarding Grievances & Appeals.* Contractor shall utilize the model Enrolled Member handbook developed by the Agency that:

a) Includes the Enrolled Member's right to file Grievances and Appeals.
b) Includes the requirements and timeframes for filing a Grievance or Appeal.
c) Includes information on the availability of assistance in the filing process for Grievances.
d) Includes information on the availability of assistance in the filing process for Appeals.
e) Includes the Enrolled Member's right to request a State Fair Hearing after the Contractor has made a determination on an Enrolled Member's Appeal which is adverse to the Enrolled Member.
f) Specifies that, when requested by the Enrolled Member, Benefits that the Contractor seeks to reduce or terminate will continue if the Enrolled Member files an Appeal or a request for State Fair Hearing within the timeframes specified for filing, and that the Enrolled Member may, consistent with Agency policy, be required to pay the cost of services furnished while the Appeal or State Fair Hearing is pending if the final decision is adverse to the Enrolled Member.

See: 42 C.F.R. § 438.10(g)(2)(xi)(A) - (E); 42 C.F.R. § 457.1207. {From CMSC C.2.31 - C.2.36}.

C.2.17. *Reserved.* N/A.

C.2.18. *Information Requirements – Auxiliary Aids.* Contractor shall utilize the model Enrolled Member handbook developed by the Agency that includes:

a) How to Access auxiliary aids and services, including additional information in alternative formats or languages.
b) The toll-free telephone number for Member services.
c) The toll-free telephone number for oral health management.
d) The toll-free telephone number for any other unit providing services directly to Enrolled Members.
e) Information on how to report suspected Fraud or Abuse.
f) Any other content required by the Agency.

See: 42 C.F.R. § 438.10(g)(2)(xiii) - (xvi); 42 C.F.R. § 457.1207. {From CMSC C.2.39 - C.2.44}.

C.2.19. *Notice of Significant Changes.* Contractor shall provide each Enrolled Member notice of any significant change, as defined by the Agency, in the information specified in the Enrolled Member handbook at least thirty (30) Days before the intended effective date of the change. See: 42 C.F.R. § 438.10(g)(4); 42 C.F.R. § 457.1207. {From CMSC C.2.45}.

C.2.20. *Significant Change.* A "significant change" for purposes of this Section C means any change that may impact Enrolled Member accessibility to services and Benefits, in:

a) Restrictions on the Enrolled Member's freedom of choice among Network Providers;
b) Enrolled Member rights and protections;
c) Grievance and fair hearing procedures;
d) Amount, duration and scope of Benefits available;
e) Procedures for obtaining Benefits, including authorization requirements;
f) The extent to which, and how, Enrolled Members may obtain Benefits from Out-of-Network Providers;
g) The extent to which and how after-hours and emergency coverage are provided;
h) Policy on referrals for specialty care and for other Benefits not furnished by the Enrolled Member's PCP; or
i) Cost sharing.

C.2.21. *Transition of Care Policies.* Contractor shall utilize the model Enrolled Member handbook and notices that describe the transition of care policies for Enrolled Members and Potential Enrolled Members. See: 42 C.F.R. § 438.62(b)(3); 42 C.F.R. § 438.62. {From CMSC C.2.46}.

C.3 Enrolled Member Handbook Dissemination

C.3.01. *Dissemination of Enrolled Member Handbook.* The handbook information provided to the Enrolled Member and their authorized representative shall be considered to be provided if the Contractor:

a) Mails a printed copy of the information to the Enrolled Member's mailing address and the authorized representative's mailing address,
b) Provides the information by email after obtaining the Enrolled Member's agreement to receive the information by email,
c) Posts the information on its website and advises the Enrolled Member and their authorized representative in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that Enrolled Members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost, or
d) Provides the information by any other method that can reasonably be expected to result in the Enrolled Member and authorized representative receiving that information.

See: 42 C.F.R. § 438.10(g)(3)(i) - (iv); 42 C.F.R. § 457.1207. {From CMSC C.3.01}.

C.4 Network Provider Directory

C.4.01. *Network Provider Information.* For each of the following Provider types covered under the Contract, Contractor shall make the following information on the Contractor's Network Providers available to the Enrolled Member in paper form upon request and electronic form:

a) Names, as well as any group affiliations.
b) Street addresses.
c) Telephone numbers.
d) Website URLs, as appropriate.
e) Specialties, as appropriate.
f) Whether Network Providers will accept new Enrolled Members.
g) Whether Network Providers have any limitation on members they accept (i.e., children only or adults only)
h) The cultural and linguistic capabilities of Network Providers, including languages (including ASL) offered by the Provider or a skilled medical interpreter at the Provider's office.
i) Whether Network Providers' offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

See: 42 C.F.R. § 438.10(h)(1)(i) - (viii); 42 C.F.R. § 438.10(h)(2); 42 C.F.R. § 457.1207. {From CMSC C.4.01 - C.4.08}.

C.4.02. *Forms Available.* Contractor's Provider Network information included in:

a) A paper Provider directory must be updated at least monthly unless the Contractor has a mobile-enabled electronic directory, in which case the paper Provider directory can be updated quarterly.
b) A mobile-enabled electronic Provider directory must be updated no later than 30 Days after the Contractor receives updated Provider information.

See: 42 C.F.R. § 438.10(h)(3); 42 C.F.R. § 457.1207. {From CMSC C.4.09 - C.4.10}.

C.4.03. *Availability on Website.* Contractor's Provider directories must be made available on the Contractor's website in a machine-readable file and format as specified by the Secretary. See: 42 C.F.R. § 438.10(h)(4); 42 C.F.R. § 457.1207. {From CMSC C.4.11}.

C.5 Reserved

C.5.01. *Reserved.* N/A.

C.6 Provider Terminations and Incentives

C.6.01. *Provider Terminations – Timeline.* Contractor shall make a good faith effort to give written notice of termination of a contracted Provider to each Enrolled Member who received their Primary Care from, or was seen on a regular basis by, the terminated provider no later than thirty (30) calendar days prior to the effective date of the termination, or fifteen (15) calendar days after receipt or issuance of the termination notice. See: 42 C.F.R. § 438.10(f)(1); 42 C.F.R. § 457.1207. {From CMSC C.6.01}.

C.6.02. *Information Regarding PIPs.* Contractor shall make available, upon request, any physician incentive plans in place. See: 42 C.F.R. § 438.10(f)(3); 42 C.F.R. § 438.3(i); 42 C.F.R. § 457.1207. {From CMSC C.6.02}.

C.6.03. *Performance-Based Incentive System for Providers.* The Contractor shall establish a performance-based incentive system for its Providers. The Contractor shall determine its own methodology for incenting Providers. The Contractor shall obtain Agency approval prior to implementing any Provider incentives and before making any changes to an approved incentive. The Agency encourages creativity in designing incentive programs that encourage positive Enrolled Member engagement, dental and overall health Outcomes which are tailored to issues prevalent among Enrolled Membership as identified by the Contractor. The Contractor shall

provide information concerning its provider incentive plan, upon request, to its Enrolled Members and in any Marketing Materials in accordance with the disclosure requirements stipulated in federal regulations.

C.7 Marketing

C.7.01. *Marketing Restrictions.* Contractor shall:

a) Not distribute Marketing Materials without first obtaining Agency approval.
b) Distribute Marketing Materials to its entire service area as indicated in the Contract.
c) Not seek to influence Enrollment in conjunction with the sale or offering of any Private Insurance.
d) Not directly or indirectly engaging in door-to-door, telephone, e-mail, texting, or other Cold-Call Marketing activities.

See: 42 C.F.R. § 438.104(b)(1)(i) - (ii); 42 C.F.R. § 438.104(b)(1)(iv) - (v); 42 C.F.R. § 457.1224. {From CMSC C.7.01 - C.7.04}.

C.7.02. *Agency Review.* The Contractor is encouraged to market its products to the general community and potential Members. All Marketing activities shall be provided at no additional cost to the Agency. The Contractor shall comply with all applicable laws and regulations regarding Marketing by Health Insurance issuers. The Contractor shall obtain Agency approval for all Marketing Materials at least thirty (30) Days or within the timeframe requested by the Agency, prior to distribution.

C.7.03. *Permissible Marketing Activities.* The Contractor may market via mail and mass media advertising such as radio, television and billboards. Participation in community-oriented Marketing such as participation in community health fairs is encouraged. Tokens or gifts of nominal value may be distributed at such events to potential Members, so long as the Contractor acts in compliance with all law and policy guidance regarding inducements in the Medicaid Program, including Marketing provisions provided for in 42 C.F.R. § 438.104.

C.7.04. *Marketing Obligations.* Contractor's Marketing, including plans and materials, shall be accurate and shall not mislead, confuse, or defraud the recipients or the Agency. Contractor's materials shall not contain any assertion or statement (whether written or oral) that the recipient must enroll with the Contractor to obtain Benefits or to not lose Benefits. Contractor's materials shall not contain any assertion or statement (whether written or oral) that the Contractor is endorsed by CMS, the Federal or State government, or a similar entity.
See: 42 C.F.R. § 438.104(b)(2)(i) - (ii); 42 C.F.R. § 457.1224. {From CMSC C.7.05 - C.7.07}.

C.8 General Information Requirements

C.8.01. *General.* If Contractor chooses to provide required information electronically to Enrolled Members:

a) It must be in a format that is Readily Accessible.
b) The information must be placed in a location on the Contractor's website that is prominent and Readily Accessible.
c) The information must be provided in an electronic form that can be electronically retained and printed.
d) The information is consistent with content and language requirements.
e) The Contractor must notify the Enrolled Member that the information is available in paper form without charge upon request.
f) The Contractor must provide, upon request, information in paper form within five (5) business days.

See: 42 C.F.R. § 438.10(c)(6)(i) - (v); 42 C.F.R. § 457.1207. {From CMSC C.8.01 - C.8.06}.

C.8.02. *Leveraging Electronic Communication.* Contractor shall leverage technology to promote timely, effective and secure communications with Enrolled Members. Once an Enrolled Member selects a communication pathway, Contractor shall confirm that choice through regular mail with instructions on how to change the selection if desired. Contractor shall maintain means to receive communication from Enrolled Members electronically, including via mail and website. Contractor shall respond to electronic inquiries within one (1) business day. Contractor is also encouraged to utilize mobile technology, such as electronic delivery of medication and appointment reminders.

C.8.03. *Website and Mobile Applications.* At minimum, Contractor shall maintain Member websites and mobile applications available in English and Spanish that are accessible via cell phone. The website shall include at a minimum all information made available to new Enrolled Members. The Provider Network information available via the Member website shall be searchable and updated, at minimum, every two (2) weeks. All website materials shall be submitted to the Agency for review and approval prior to posting.

C.8.04. *Reserved.* N/A.

C.8.05. *Reserved.* N/A.

C.8.06. *Information About Moral or Religious Objections.* Contractor shall notify Enrolled Members when it adopts a policy to discontinue coverage of a counseling or referral service based on moral or religious objections at least thirty (30) days prior to the effective date of the policy for any particular service. See: 42 C.F.R. § 438.102(b)(1)(i)(B), 42 C.F.R. § 438.10(g)(4); 42 C.F.R. § 457.1207; 42 C.F.R. § 457.1222. {From CMSC C.8.09}.

C.8.07. *Definitions of Terms.* Contractor shall use the Agency-developed definition for the following terms: Appeal; Durable Medical Equipment; Emergency Medical Condition; Emergency Medical Transportation; Emergency Room Care; Emergency Services; Grievance; Habilitation Services and devices; Home Health Care; Hospice Services; Hospitalization; Hospital Outpatient Care; Physician Services; Prescription Drug Coverage; Prescription Drugs; Primary Care Physician; PCP; Rehabilitation Services and Devices; Skilled Nursing Care; and Specialist. See: 42 C.F.R. § 438.10(c)(4)(i); 42 C.F.R. § 457.1207. {From CMSC C.8.10 - C.8.29}.

C.8.08. *Additional Definitions.* Contractor shall use the Agency-developed definition for the following terms: Co-Payment; Excluded Services; Health Insurance; Medically Necessary; Network; Non-Participating Provider; Plan; Prior Authorization; Participating Provider; Premium; Provider; Urgent Care. See: 42 C.F.R. § 438.10(c)(4)(i); 42 C.F.R. § 457.1207. {From CMSC C.8.30 - C.8.41}.

C.8.09. *Exclusions.* For purposes of this Contract, Contractor is not responsible for paying for services excluded from coverages as set forth in Special Contract Exhibit D, Table D.02.

C.8.10. *Dissemination of Practice Guidelines.* Contractor shall disseminate practice guidelines to Enrolled Members and Potential Enrolled Members upon request. See: 42 C.F.R. § 438.236(c); 42 C.F.R. § 457.1233(c). {From CMSC C.8.42}.

C.8.11. *State-Developed Notices.* Contractor shall use Agency developed Enrolled Member notices. See: 42 C.F.R. § 438.10(c)(4)(ii); 42 C.F.R. § 457.1207. {From CMSC C.8.43}.

C.8.12. *State Fair Hearing Timely Notice.* Contractor shall provide timely notice to the Enrolled Member of the Enrolled Member's right to pursue a State Fair Hearing. See: 42 C.F.R. § 438.228(b). {From CMSC C.8.44}.

C.9 Reserved

C.9.01. *Reserved.* N/A.

C.10 State Member Communication Approval.

C.10.01. *Agency Approval of Enrolled Member Communications.* The Contractor shall obtain Agency prior approval of all Contractor developed Enrolled Member communications. All materials shall be submitted at least thirty (30) Days or within the timeframe requested by the Agency, prior to expected use and distribution. All substantive changes to previously approved communications shall also be submitted to the Agency for

review and approval at least thirty (30) Days or within the timeframe requested by the Agency, prior to use. In cases of Emergency Communication to ensure the health and safety of members, and when obtaining Agency approval would introduce unnecessary delay in issuing the communication, the Contractor may issue information to Enrolled Members without prior Agency approval in alignment with Agency guidance. The Contractor shall comply with any the Agency processes implemented to facilitate submission and approval of materials. For example, the Agency may opt to mandate use of an inventory control number on all submissions or the use of specific cover sheets with document submission. Information that includes the Agency's name and correspondence that may be sent to participants on behalf of the Agency shall also be submitted by the Contractor for the Agency review and approval. Any approval given for the Agency or other State agency name or logo is specific to the use requested and shall not be interpreted as blanket approval. The Contractor shall include the Agency Program logo(s) in their Marketing or other Enrolled Member communication materials upon the Agency request. The Agency reserves the right to mandate that specific language be included in Enrolled Member communication materials. Contractor must provide/produce the number of brochures determined by the Agency to be placed in the Enrollment packets. Brochures must be full color, tri-fold, eight-and-a-half by eleven inches (8.5x11), front-back.

C.11 Value-Added Services

C.11.01. *Value Added Services.* Additional services for coverage are referred to as "Value-Added Services." The Agency is particularly interested in the promotion of evidence-based programs and direct services that improve the dental health and overall well-being of Medicaid Enrolled Members. Value-Added Services may be actual dental Health Care Services, Benefits, or positive incentives that will promote healthy lifestyles and improved dental and/or overall health Outcomes among Enrolled Members. Examples of Value-Added Services may include, but are not limited to, items such as: (i) incentives for obtaining preventive dental services; (ii) medical equipment or devices not already covered under the Program to assist in prevention, wellness, or management of dental health conditions; (iii) supports to enable workforce participation; and (iv) cost effective supplemental services that can provide services in a less restrictive setting. Contractor shall take all measures necessary to confirm the legality and impact on any Enrolled Member's eligibility of any value-added services, including but not limited to the permissibility of any such service under the Anti-Kickback Statute and the Stark law. 42 U.S.C. § 1320a-7b (Anti-Kickback Statute); 42 U.S.C. § 1395nn (Stark law). This includes but is not limited to obtaining an advisory opinion under the federal statutory schemes where necessary. *See* 42 C.F.R. § 411.370 (Stark); 42 U.S.C. § 1320a-7d(b) (Anti-Kickback).

C.11.02. *Applicability.* Contractor shall submit any proposed Value-Added Services to the Agency for evaluation, review and approval at least 30 days prior to implementation. Agency approval does not confirm the legality of any Value-Added Service.

C.11.03. *Costs.* Any Value-Added Services that a Contractor elects to provide shall be provided at no additional cost to the Agency. The costs of Value-Added Services are not reportable as allowable medical or administrative expenses, and therefore are not factored into the rate setting process. In addition, the Contractor shall not pass on the cost of the Value-Added Services to Providers. The Contractor shall specify the conditions and parameters regarding the delivery of the Value-Added Services in the Contractor's Marketing Materials and Member communication materials.

C.11.04. *Program Description.* Contractor shall clearly describe in its Policy and Procedure Manual: (i) any limitations, restrictions, or conditions specific to the Value-Added Services; (ii) the Providers responsible for providing the Value-Added Service; (iii) how the Contractor will identify the Value-Added Service in administrative (encounter) data; (iv) how and when the Contractor shall notify Providers and Enrolled Members about the availability of such Value-Added Services while still meeting the federal Marketing requirements; and (v) how an Enrolled Member may obtain or Access the Value-Added Services.

C.11.05. *Approval & Implementation of Value-Added Services.* In implementing such services, the Contractor shall: (i) track participation in the Program; (ii) establish standards and dental health status targets; and (ii) evaluate the effectiveness of the Program.

D. Payment

D.1 General

D.1.01. *General.* Capitation rates for Contractor are set forth in separate Special Contract Exhibits, which represent the separate rate periods. The final capitation rates are identified and developed, and payment is made in accordance with 42 C.F.R. § 438.3(c). See: 42 C.F.R. § 438.3(c)(1)(i); 42 C.F.R. § 457.1201(c). {From CMSC D.1.01}.

D.1.02. *Medicaid-Eligibility Requirement.* Capitation Payments may only be made by the Agency and retained by the Contractor for Medicaid-eligible Enrolled Members. See: 42 C.F.R. § 438.3(c)(2); 42 C.F.R. § 457.1201(c). {From CMSC D.1.02}.

D.1.03. *Risk-Sharing Mechanisms.* All applicable risk-sharing mechanisms, such as reinsurance, Risk Corridors, or stop-loss limits, are described in this Contract. See: 42 C.F.R. § 438.6(b)(1). In relation to CHIP rates, the rates are based on public or private payment rates for comparable services for comparable populations, consistent with actuarially sound principles as defined at 42 C.F.R. § 457.10. 42 C.F.R. § 457.1203(a). {From CMSC D.1.03}.

D.1.04. *Reserved.* N/A.

D.1.05. *Reserved.* N/A

D.1.06. *Reserved.* N/A.

D.1.07. *Delivery System and Payment Initiatives.* This Contract includes all delivery system and payment initiatives at the Agency's option as outlined in 42 C.F.R. § 438.6(c) so long as the initiative has been approved prior to the implementation of the Contract and is described consistently with the approval of that initiative under separate cover. See: 42 C.F.R. § 438.6(c).

D.1.08. *Reserved.* N/A.

D.1.09. *Reserved.* N/A

D.1.10. *Reserved.* N/A

D.1.11. Reserved. N/A

D.1.12. *Mandatory Rates*. For the Dental Wellness Plan program, the Contractor shall reimburse in-network direct care provider types at a rate that is equal to or exceeds the Agency defined Iowa Medicaid fee for service rate, or as otherwise mutually agreed upon by the Contractor and the Provider. Capitation rates for SFY2025 were developed reflecting provider reimbursement of 110% of the Medicaid fee schedule in aggregate across all rating cells for non-FQHC services, since FQHC services are reimbursed at the PPS rate. The Agency reserves the right to limit reimbursement for any given provider within the base data used for prospective contact periods' capitation rates at 105% if there is no demonstration of network adequacy for a particular provider.

For the Hawki program, the Contractor shall reimburse in-network dental providers at a rate that is mutually agreed upon by the Contractor and the Provider, no greater than usual and customary provider rates, or as otherwise directed by the Agency. At any point, the Agency may provide a fee schedule defining rates for the

Hawki program. The Contractor shall then reimburse in-network Hawki dental providers at a rate that is equal to or exceeds the Agency defined rates, or as otherwise mutually agreed upon by the Contractor and the Provider.

The Contractor must share its reimbursement rates and/or fee schedules upon Agency request, and at minimum annually. These rates and/or fee schedules shall not be considered Contractor proprietary information.

D.1.13. *Risk Assessment Platform*. The Contractor is required to utilize the Agency-Approved Oral Health Equity Self-Assessment Tool to meet the requirements of 42 CFR § 438.208.

D.2 Incentive Arrangements

D.2.01. *General.* Under this Contract, the Agency does not use any Incentive Arrangements but rather uses an actuarially sound Withhold Arrangement. See: 42 C.F.R. § 438.6(b)(2)(i). {From CMSC D.2.01}.

D.3 Withhold Arrangements

D.3.01. *Withhold Arrangement.* The Agency will implement a Withhold Arrangement to reward the Contractor's efforts to improve Quality and Outcomes as described in the relevant rate certification. See: Special Contract Exhibit A. The Agency has established a set of Pay for Performance Measures for Contractors for the Iowa Dental Wellness Plan and Hawki Dental program in Exhibit A.

D.3.02. *General.* For all Withhold Arrangements authorized by this Contract:

a) The arrangement is for a fixed period of time.
b) \ The withhold amount shall be two percent (2%) of capitation payments. The withhold amount is based on the capitation rates.
c) That performance is measured during the Rating Period under the Contract in which the Withhold Arrangement is applied.
d) The arrangement is not to be renewed automatically.
e) The arrangement is made available to both public and private contractors under the same terms of performance.
f) The arrangement does not condition Contractor participation in the Withhold Arrangement on the Contractor entering into or adhering to intergovernmental transfer agreements.
g) The arrangement is necessary for the specified activities, targets, Performance Measures, or Quality-based Outcomes that support Program initiatives as specified in the Agency's Dental Quality strategy.

See: 42 C.F.R. § 438.6(b)(3)(i) - (v); 42 C.F.R. § 438.340. {From CMSC D.3.01 - D.3.06}.

D.4 Medical Loss Ratio (MLR)

D.4.01. *Medical Loss Ratio (MLR) Applicability*. The Contractor shall submit the MLR in accordance with MLR standards and the Agency's instructions outlined in the reporting manual. The following MLR standards apply to both Title XIX and Title XXI Capitation Payments. Contractor shall report separate MLRs for the Title XIX and Title XXI populations and aggregate across both populations for minimum MLR application.

D.4.02. *Medical Loss Ratio (MLR) Definitions*. The following terms have the indicated meanings:

a) *Credibility Adjustment* means an adjustment to the MLR for a partially credible MCO, PIHP, or PAHP to account for a difference between the actual and target MLRs that may be due to random statistical variation.
b) *Full credibility* means a standard for which the experience of an MCO, PIHP, or PAHP is determined to be sufficient for the calculation of a MLR with a minimal chance that the difference between the actual and target medical loss ratio is not statistically significant. An MCO, PIHP, or PAHP that is assigned full credibility (or is fully credible) will not receive a Credibility Adjustment to its MLR.
c) *Member months* mean the number of months a member or a group of members is covered by Contractor over a specified time period, such as a year.

d) *MLR reporting year* means a period of twelve (12) months consistent with the State fiscal year.
e) *No credibility* means a standard for which the experience of an MCO, PIHP, or PAHP is determined to be insufficient for the calculation of an MLR. An MCO, PIHP, or PAHP that is assigned no credibility (or is non-credible) will not be measured against any MLR requirements.
f) *Non-Claims costs* means those expenses for administrative services that are not: Incurred Claims; expenditures on activities that improve dental health care quality; or licensing and regulatory fees, or Federal and State taxes.
g) *Partial credibility* means a standard for which the experience of an MCO, PIHP, or PAHP is determined to be sufficient for the calculation of a MLR but with a non-negligible chance that the difference between the actual and target medical loss ratios is statistically significant. An MCO, PIHP, or PAHP that is assigned partial credibility (or is partially credible) will receive a Credibility Adjustment to its MLR.

D.4.03. *Medical Loss Ratio (MLR) Requirement*. A minimum MLR of eighty-five percent (85%) must be reported for each MLR reporting year by the Contractor, consistent with this section.

D.4.04. *Calculation of the Medical Loss Ratio (MLR) Requirement.* The MLR experienced for Contractor in a MLR reporting year is the ratio of the numerator to the denominator. A MLR may be increased by a Credibility Adjustment.

D.4.05. *Numerator*. The numerator of Contractor's MLR for a MLR reporting year is the sum of the Contractor's incurred Claims; the Contractor's expenditures for activities that improve dental health care quality; and fraud reduction activities.

D.4.06. *Incurred Claims*. Incurred Claims must include the following:
a) Direct Claims that the Contractor paid to Providers (including under capitated contracts with network Providers) for services or supplies covered under the contract and services meeting the requirements of 42 C.F.R. § 438.3(e) provided to members.
b) Unpaid Claims liabilities for the MLR reporting year, including Claims reported that are in the process of being adjusted or Claims incurred but not reported.
c) Withholds from payments made to network providers to the extent that such withholds have been finalized to be paid or have been paid.
d) Claims that are recoverable for anticipated coordination of benefits.
e) Claims payments recoveries received as a result of subrogation.
f) Incurred but not reported Claims based on past experience, and modified to reflect current conditions, such as changes in exposure or Claim frequency or severity.
g) Changes in other Claims-related reserves.
h) Reserves for contingent benefits and the medical Claim portion of lawsuits.
i) Amounts paid by the Contractor above an Enrolled Member's Annual Benefit Maximum (ABM), until the Agency otherwise provides written notice to the Contractor. The evaluation of these expenditures above the ABM are subject to Agency review and may be adjusted by the Agency.

Amounts that must be deducted from incurred Claims include the following:
a) Cost sharing and overpayment recoveries received from network providers.

Expenditures that must be included in incurred Claims include the following:
a) The amount of incentive and bonus payments to network providers to the extent that such bonus payments have been finalized to be paid or have been paid.
b) The amount of Claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses must not include activities specified

in this section.

Amounts that must either be included in or deducted from incurred Claims include, respectively, net payments or receipts related to State mandated solvency funds.

Amounts that must be excluded from incurred Claims:

a) Non-Claims costs, which include the following:
    a. Amounts paid to Third Party vendors for secondary network savings.
    b. Amounts paid to Third Party vendors for network development, administrative fees, Claims processing, and Utilization Management.
    c. Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in 42 C.F.R. § 438.3(e) and provided to a member. Payments under this subsection are only to be considered incurred Claims if the following four-factor test is met:
        i. The entity contracts with an issuer to deliver, provide, or arrange for the delivery and provision of clinical services to the issuer's Enrolled Members but the entity is not the issuer with respect to those services;
        ii. The entity contractually bears financial and utilization risk for the delivery, provision, or arrangement of specific clinical services to Enrolled Members;
        iii. The entity delivers, provides, or arranges for the delivery and provision of clinical services through a system of integrated care delivery that, as appropriate, provides for the coordination of care and sharing of clinical information, and which includes programs such as provider performance reviews, tracking clinical outcomes, communicating evidence-based guidelines to the entity's clinical providers, and other, similar care delivery efforts; and
        iv. Functions other than clinical services that are included in the payment (capitated or fee-for-service) must be reasonably related or incident to the clinical services and must be performed on behalf of the entity or the entity's providers.
    d. Fines and penalties assessed by regulatory authorities.
    e. Amounts paid to the Agency as remittance.
    f. Amounts paid to Network Providers under to 42 C.F.R. § 438.6(d).

Incurred Claims paid by one Contractor that is later assumed by another entity must be reported by the assuming Contractor for the entire MLR reporting year and no incurred Claims for that MLR reporting year may be reported by the ceding Contractor.

D.4.07. *Activities that improve health care quality*. Activities that improve health care quality must be in one of the following categories. See: 42 C.F.R. § 438.8(e)(3):

a) A Contractor activity that meets the requirements of 45 C.F.R. § 158.150(b) and is not excluded under 45 C.F.R. § 158.150(c).
b) A Contractor activity related to any EQR-related activity as described in 42 C.F.R. § 438.358(b) and (c).
c) Any Contractor expenditure that is related to Health Information Technology and meaningful use, meets the requirements placed on issuers found in 45 C.F.R. § 158.151, and is not considered incurred Claims.

D.4.08. *Fraud Prevention Activities*. Contractor expenditures on activities related to fraud prevention as adopted for the private market at 45 C.F.R. part 158. Expenditures under this section must not include expenses for fraud reduction efforts.

D.4.09. *Denominator*. The denominator of Contractor's MLR for a MLR reporting year must equal the adjusted premium revenue. The adjusted premium revenue is the Contractor's premium revenue minus the Contractor's Federal, State, and local taxes, licensing and regulatory fees, and if applicable to the Contractor community benefit expense.

D.4.10. *Premium Revenue*. Premium revenue includes the following for the MLR reporting year:

a) Agency Capitation Payments, developed in accordance with 42 C.F.R. § 438.4, to the Contractor for all members under a Risk Contract approved under 42 C.F.R. § 438.3(a), excluding payments made under to 42 C.F.R. § 438.6(d).
b) Agency-developed one-time payments, for specific life events of members.
c) Other payments to the Contractor approved under 42 C.F.R. § 438.6(b)(3).
d) Unpaid cost-sharing amounts that the Contractor could have collected from members under the Contract, except those amounts the Contractor can show it made a reasonable, but unsuccessful, effort to collect.
e) All changes to unearned premium reserves.
f) Net payments or receipts related to risk sharing mechanisms developed in accordance with 42 C.F.R. § 438.5 or 42 C.F.R. § 438.6.

D.4.11. *Federal, State, and local taxes and licensing and regulatory fees.* Taxes, licensing, and regulatory fees for the MLR reporting year include:

a) Statutory assessments to defray the operating expenses of any State or Federal department.
b) Examination fees in lieu of premium taxes as specified by State law.
c) Federal taxes and assessments allocated to Contractor, excluding Federal income taxes on investment income and capital gains and Federal employment taxes.
d) State and local taxes and assessments including:
    a. Any industry-wide (or subset) assessments (other than surcharges on specific Claims) paid to the State or locality directly.
    b. Guaranty fund assessments.
    c. Assessments of State or locality industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.
    d. State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.
    e. State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes.
e) Payments made by Contractor that are otherwise exempt from Federal income taxes, for community benefit expenditures as defined in 45 C.F.R. § 158.162(c), limited to the highest of either:
    a. Three percent (3%) of earned premium; or
    b. The highest premium tax rate in the State for which the report is being submitted, multiplied by the Contractor's earned premium in the State.
    c. The Agency reserves the right to review any community benefit expenditures and may disallow all or part of the expenditure for inclusion in the MLR. Additional detail on community benefit expenditures may be provided in the financial reporting template.

D.4.12. *Denominator when Contractor is Assumed*. The total amount of the denominator for Contractor if Contractor is later assumed by another entity must be reported by the assuming MCO, PIHP, or PAHP for the entire MLR reporting year and no amount under this section for that year may be reported by Contractor.

D.4.13. *Allocation of Expense*. Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses.

Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.

D.4.14. *Methods used to Allocate Expenses*. Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense. 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.

D.4.15. *Credibility Adjustment*. Contractor may add a Credibility Adjustment to a calculated MLR if the MLR reporting year experience is partially credible. The Credibility Adjustment must be added to the reported MLR calculation before calculating any remittances. Contractor may not add a Credibility Adjustment to a calculated MLR if the MLR reporting year experience is fully credible. If Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards in this section. On an annual basis, CMS will publish base credibility factors for MCOs, PIHPs, and PAHPs that are developed according to the following methodology:

a) CMS will use the most recently available and complete managed care encounter data or FFS Claims data, and Enrollment data, reported by the states to CMS. This data may cover more than 1 year of experience.
b) CMS will calculate the Credibility Adjustment so that a MCO, PIHP, or PAHP receiving a Capitation Payment that is estimated to have a medical loss ratio of eighty-five percent (85%) would be expected to experience a loss ratio less than eighty-five percent (85%) one (1) out of every four (4) years, or twenty-five percent (25%) of the time.
c) The minimum number of member months necessary for a MCO's, PIHP's, or PAHP's medical loss ratio to be determined at least partially credible will be set so that the Credibility Adjustment would not exceed ten percent (10%) for any partially credible MCO, PIHP, or PAHP. Any MCO, PIHP, or PAHP with Enrollment less than this number of member months will be determined non-credible.
d) The minimum number of member months necessary for an MCO's, PIHP's, or PAHP's medical loss ratio to be determined fully credible will be set so that the minimum Credibility Adjustment for any partially credible MCO, PIHP, or PAHP would be greater than one percent (1%). Any MCO, PIHP, or PAHP with Enrollment greater than this number of member months will be determined to be fully credible.
e) A MCO, PIHP, or PAHP with a number of member months between the levels established for non-credible and fully credible plans will be deemed partially credible, and CMS will develop adjustments, using linear interpolation, based on the number of member months.
f) CMS may adjust the number of member months necessary for a MCO's, PIHP's, or PAHP's experience to be non-credible, partially credible, or fully credible so that the standards are rounded for the purposes of administrative simplification. The number of member months will be rounded to one hundred (100) or a different degree of rounding as appropriate to ensure that the credibility thresholds are consistent with the objectives outlined herein.

D.4.16. *Aggregation of Data*. MCOs, PIHPs, or PAHPs will aggregate data for all Medicaid eligibility groups covered under the contract with the Agency and will aggregate data for all Title XXI eligibility groups covered under the Contract with the Agency consistent with the requirement to report the two populations separately. MCOs will additional aggregate data for the Title XIX and Title XXI populations for application of the minimum MLR of eighty-five percent (85%).

D.4.17. *Remittance to the Agency if MLR is Not Met*. Contractor must provide a remittance for an MLR reporting year if the MLR for that MLR reporting year does not meet the minimum MLR standard of eighty-

five percent (85%). Contractor shall remit payment to the Agency within ninety (90) days of submission of the MLR report for any MLR falling below the MLR standard.

D.4.18. *Reporting Requirements*. Contractor shall submit a report in accordance with MLR standards and Agency instructions outlined in the reporting manual that includes at least the following information for each MLR reporting year:

a) Total incurred Claims with IBNR reported separately.
b) Expenditures on quality improving activities.
c) Expenditures related to activities compliant with 42 C.F.R. § 438.608(a)(1) through (5), (7), (8) and (b).
d) Non-Claims costs.
e) Premium revenue.
f) Community benefit expenditures (subject to Agency review and/or disallowance in part or whole)
g) Taxes, licensing and regulatory fees.
h) Methodology(ies) for allocation of expenditures.
i) Any Credibility Adjustment applied.
j) The calculated MLR.
k) Any remittance owed to the Agency, if applicable.
l) A comparison of the information reported in this paragraph with the audited financial report required under 42 C.F.R. § 438.3(m).
m) A description of the aggregation method used.
n) The number of member months.

Contractor must submit the report in a timeframe and manner determined by the Agency, which must be within twelve (12) months of the end of the MLR reporting year. Contractor must require any third-party vendor providing Claims adjudication activities to provide all underlying data associated with MLR reporting to Contractor within one hundred and 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.

D.4.19. *Newer experience.* The Agency, in its discretion, may exclude a Contractor that is newly contracted with the Agency from the requirements in this section for the first year of the Contractor's operation. Such Contractors must be required to comply with the requirements in this section during the next MLR reporting year in which the Contractor is in business with the Agency, even if the first year was not a full twelve (12) months.

D.4.20. *Recalculation of MLR.* In any instance where an Agency makes a retroactive change to the Capitation Payments for a MLR reporting year where the report has already been submitted to the Agency, the Contractor must re-calculate the MLR for all MLR reporting years affected by the change and submit a new report meeting the requirements in this section.

D.4.21. *Attestation.* Contractor must attest to the accuracy of the calculation of the MLR in accordance with requirements of this section when submitting the report required under this section.

D.4.22. *Medical Loss Ratio Guarantee.* Contractor has a Target Medical Loss Ratio of eighty-five percent (85%) aggregate for all covered populations. If the Medical Loss Ratio calculated as set forth below is less than the Target Medical Loss Ratio, Contractor shall refund to the Agency an amount equal to the difference between the calculated Medical Loss Ratio and the Target Medical Loss Ratio (expressed as a percentage) multiplied by the Coverage Year Revenue. The Agency shall prepare a Medical Loss Ratio Calculation which shall summarize Contractor's Medical Loss Ratio for Enrolled Members under this Contract for each Coverage Year. The Medical Loss Ratio Calculation shall be determined as set forth below; however, the Agency may

adopt modified reporting standards and protocols after giving written notice to Contractor.

D.4.23. *Revenue.* The revenue used in the Medical Loss Ratio calculation will consist of both Capitation and Risk Corridor revenue. Capitation revenue will be the Capitation Payments made by the Agency to each Contractor adjusted to exclude any payments not at risk to the PAHPs, taxes, and regulatory fees due from and or received from the Agency for services provided during the Coverage Year. Any unearned withhold amounts and any reconciled supplemental/directed payments will not be included in the capitation revenue for the purposes of the medical loss ratio calculation. Any Risk Corridor payments from the Agency to the Contractor or from the Contractor to the Agency will be considered as premium revenue in the calculation of the contractually required eighty-five percent (85%) minimum loss ratio.

D.4.24. *Benefit Expense.* The Agency shall determine the Benefit Expense using the following data:

a) Paid Claims. Paid Claims shall be included in Benefit Expense. The Agency shall use Encounter Data Claims for all dates of service during the Coverage Year and accepted by the Agency within six (6) months after the end of the Coverage Year. If the Contractor and Agency are unable to resolve Encounter Data systems issues prior to calculation of the MLR, a mutually agreed upon alternative method of calculating paid Claims expense will be used. Encounter Data Claims covered by sub-capitation contracts shall be priced at Contractor's Fee-For-Service rate for Covered Services or the Agency's designated pricing. Contractor shall provide clear supporting documentation of these sub-capitated arrangements. Incurred expenditures may, at the discretion of the Agency, be repriced at the Agency's Medicaid fee-for-service equivalent rates.
b) Incurred But Not Paid Claims. Claims that have been incurred but not paid (IBNP), as submitted by the Contractor. The Agency's actuary will review this submission for accuracy and reasonableness.
c) Provider Incentive Payments. Provider incentive payments shall be made within the Contract requirements. Incentive payments to providers paid within six (6) months after the end of the Coverage Year for performance measured during the Coverage Year provided the payments are made pursuant to agreements in place at the start of the measurement period under which the benchmarks triggering payments and the methodology for determining payment amounts are clearly set forth shall be included in Benefit Expense.
d) Other Benefit Expense. Any service provided directly to an Enrolled Member not capable of being sent as Encounter Data due to there not being appropriate codes or similar issues may be sent to the Agency on a report identifying the Enrolled Member, the service and the cost, along with clear documentation of the methodology for determining payment amounts. Such costs will be included in Benefit Expense upon the Agency's approval. Other Benefit Expense will be limited to State Plan approved services and B3 services for the Member and will not include any additional Value-Added Services.
e) Directed Payments. Any reconciled supplemental/directed payments that are not included in the capitation rates shall be excluded from the Benefit Expense.

D.4.25. *Data Submission.* Contractor shall submit data to the Agency, in the form and manner prescribed by the Agency in the Contract. The Contractor shall submit information to the Agency within thirty (30) days following the six (6) month Claims run-out period.

D.4.26. *Medical Loss Ratio Calculation and Payment.* Within ninety (90) days following data submission, the Agency shall calculate the Medical Loss Ratio by dividing the Benefit Expense by the Revenue. The Medical Loss Ratio shall be expressed as a percentage rounded to the second decimal point. For example, a Medical Loss Ratio calculated at eighty-seven and ninety-five hundredths' percent (87.95%) does not meet the minimum Medical Loss Ratio requirements of eighty-five percent (85%). Contractor shall have sixty (60) days to review the Agency's Medical Loss Ratio Calculation. The Agency and Contractor shall have the right to review all data and methodologies used to calculate the Medical Loss Ratio. Any payments due to the Agency are due and payable by the Contractor within fifteen (15) days of the end of the third calendar quarter of each Coverage

Year.

D.4.27. *Coverage Year.* Each Coverage Year will be considered a twelve (12) month period. The Medical Loss Ratio Calculation shall be prepared using all data available from the Coverage Year, including IBNP and six (6) months of run-out for Benefit Expense.

D.4.28. *Risk Corridor*. Agency shall include a Risk Corridor for the rate period beginning July 1, 2024 running through June 30, 2025. The Agency reserves the right to prospectively modify the terms of the Risk Corridor described though a contract amendment and may include terminating the Risk Corridor after the first Contract year.

D.4.29. *Overview*. The Risk Corridor settlement is the calculated gain or loss determined when comparing the actual medical loss ratio (MLR) to the risk sharing corridor percentages outlined in the table below. The actual MLR is calculated as the total adjusted medical expenditures divided by the total capitation revenue for all populations.

D.4.30. *Total Capitation Revenue*. Revenue represents the capitation rates paid by the Agency to the Contractor for the contract period and shall exclude:

a) Taxes and fees explicitly built into the capitation rates,
b) Revenue associated with directed payments that are implemented by the Agency and are not included in regular monthly capitation rates for the contract period.
c) Any unearned withhold amounts will not be included within the capitation revenue for purposes of the Risk Corridor calculation.
d) Payments to the Contractor including any amounts due from the Agency to the Contractor for the fiscal year associated with services carved-out of capitation.

The capitation rates utilized in the revenue calculation have been determined to be actuarially sound by an actuary that meets the qualifications and standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board.

D.4.31. *Total Adjusted Medical Expenditures.* Total adjusted medical expenditures shall be determined by the Agency/Agency's contracted actuaries based on encounter data and Contractor submitted financial and encounter data in a format prescribed by the Agency.

Adjusted medical expenditures include services covered by the Agency and the Contractor and exclude the following:

a) Expenditures associated with carved-out services as reflected in Special Contract Exhibits, Exhibit A and Section 1.3.3.1 Pricing.
b) Expenditures for services that were incurred before or after the contract period.
c) Expenditures for services rendered to Enrolled Members who are not eligible on the incurred date of service.
d) Quality improvement expenses, Case Management expenses, or other administrative expenses.
e) Expenditures for value-added services.
f) Expenditures associated with any directed payments established as separate payment terms that may be implemented by the Agency for the Contract period.

The Agency reserves the right to audit Claims expenditures. For purposes of the Risk Corridor in the Dental Wellness Plan program, the Agency may limit the overall level of reimbursement to one hundred and five percent (105%) of the Medicaid fee schedule if there is no demonstration of network adequacy for a particular

provider. Reimbursement associated with Agency approved incentives and value-based purchasing arrangements as outlined in Section E.8.03 are not included in the one hundred and five percent (105%) review noted above.

The data used by the Agency and its actuaries for the Risk Corridor settlement will be the accepted MMIS encounter data and financial data submitted by the Contractor. The Agency and the Contractor agree that to the extent there are differences between Claims expenditures as reflected in the encounter data and the financial data submitted by the Contractor, the Agency and Contractor will confer and make a good faith effort to reconcile those differences before the calculation of the final settlement as described below.

D.4.32. *Risk Corridor Percentage*. The Risk Corridor Percentage is calculated as the total adjusted medical expenditures divided by the total capitation revenue for all populations. The Agency will determine the specific Risk Corridor percentages prospectively for each Contract year and communicate the percentages to the Contractor through annual Contract amendments.

The Risk Sharing Corridor for the DWP program is defined as follows:

Risk Corridor Minimum Percentage	Risk Corridor Maximum Percentage	Contractor Share	State / Federal Share
0.0%	85.0%	0.0%	100.0%
85.0%	87.0%*	100.0%	0.0%
87.0%*	89.0%	100.0%	0.0%
89.0%	89.0%+	0.0%	100.0%

**The target Risk Corridor percentage 87.0% reflected in the table above is based on the weighted average of the total administrative load amounts, excluding margin, built into capitated rates for the July 1, 2024, to June 30, 2025, contract period based on the capitation rate development base data period Enrollment distribution. The actual target used for the Risk Corridor reconciliation is subject to change and will vary based on the final actuarially sound capitation rates for the contract period and the actual population distribution for the Contractor during the contract period. To the extent the target Risk Corridor percentages varies from the target MLR using the actual Enrollment mix during the contract period, the Risk Corridor bands will remain +/- 2.0% from the revised target.*

D.4.33. *Timelines.* Within two hundred and forty-five(245) days following the end of the contract period, the Contractor shall provide Agency with a complete and accurate report of actual medical expenditures for Enrolled Members, by category of service, based on Claims incurred for the contract period including six (6) months of Claims run-out, and its best estimate of any Claims incurred but not reported (IBNR) for Claims run-out beyond six (6) months, and any applicable IBNR completion factors.

Prior to twelve (12) months following contract period, Agency shall provide the Contractor with a final settlement under the risk share program for the contract period. Any balance due between Agency and the Contractor, as the case may be, will be paid within sixty (60) days of receiving the final reconciliation from Agency. These timelines may be modified at the Agency's discretion based on incomplete data from the Contractor or other reasons that influence the Risk Corridor calculation.

Notwithstanding the above, for the contract period, the minimum medical loss ratio (MLR) is outlined in Special Contract Exhibits, Exhibit A.

D.5 Payment for Indian Health Care Providers (IHCP)

D.5.01. *Timely Payment Obligation.* Contractor shall meet the requirements of fee for service (FFS) timely payment for all Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) Providers in its

network, including the paying of ninety percent (90%) of all Clean Claims from practitioners (i.e. those who are in individual or group practice or who practice in shared health facilities) within fourteen (14) Days of the date of receipt; ninety-five percent (95%) of all Clean Claims from practitioners (i.e. those who are in individual or group practice or who practice in shared health facilities) within twenty-one (21) Days of the date of receipt; and paying ninety-nine percent (99%) of all Clean Claims from practitioners (who are in individual or group practice or who practice in shared health facilities) within ninety (90) Days of the date of receipt. See: 42 C.F.R. § 438.14(b)(2)(iii); ARRA § 5006(d); 42 C.F.R. § 447.45; 42 C.F.R. § 447.46; SMDL 10-001); 42 C.F.R. § 457.1209. {From CMSC D.5.01}.

D.5.02. *Payment Obligations When IHCP is an FQHC.* For IHCPs enrolled in Medicaid as an FQHC but which are not Participating Providers of a Contractor, Contractor shall pay an amount equal to the amount the Contractor would pay a FQHC that is a Network Provider but is not an IHCP, including any supplemental payment from the Agency to make up the difference between the amount the Contractor pays and what the IHCP FQHC would have received under Fee For Service (FFS). See: 42 C.F.R. § 438.14(c)(1); 42 C.F.R. § 457.1209. {From CMSC D.5.02}.

D.5.03. *Payment Obligations When IHCP is Not an FQHC.* When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of a Contractor, it has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service (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. See: 42 C.F.R. § 438.14(c)(2); 42 C.F.R. § 457.1209. {From CMSC D.5.03}.

D.6 Timely Payment

D.6.01. *Timely Payment Obligation*. Contractor shall meet the requirements of FFS timely payment (see also D.6.04), including the paying of ninety percent (90%) of all Clean Claims from practitioners within fourteen (14) Days of the date of receipt; paying ninety-five percent (95%) of all Clean Claims within twenty-one (21) Days of the date of receipt; and paying ninety-nine percent (99%) of all Claims from practitioners within ninety (90) Days of the date of receipt. The obligation for timely payment shall be met at both an aggregate and provider type level (*e.g.*, dentist, orthodontist, screening and maternal health centers, FQHCs, etc.). Final provider type levels will be determined by the Agency. See: 42 C.F.R. §447.45(d)(2) - (3); 42 C.F.R. § 447.46; sections 1902(a)(37)(A) and 1932(f) of the Social Security Act). {From CMSC D.6.01}.

D.6.02. *Claims Reprocessing and Adjustments.* The Contractor shall accurately adjudicate ninety percent (90%) of all clean identified adjustments including Reprocessed Claims within thirty (30) business days of receipt and ninety-nine percent (99%) of all Claims identified adjustments including Reprocessed Claims within ninety (90) business days of receipt (see also D.6.04). The Contractor shall also reprocess all Claims processed in error within thirty (30) business days of identification of the error or upon a scheduled approved by the Agency. Except in cases in which system configuration is necessary, the start time begins when the Contractor identifies, or is made aware of the error, and has received all necessary information to validate the error; identification of the error could be brought forward by a Provider, the Agency, or internal Contractor staff. In the event the Contractor requests clarification from the Agency regarding a Claim reprocessing project, the time for reprocessing will begin to run on the day the Contractor receives all information necessary to accurately reprocess the Claims. The Contractor shall reprocess mass adjustments of Claims upon a schedule approved by the Agency and the Contractor. *See:* Sections 1902(a)(37)(A) and 1932(f) of the Social Security Act; 42 C.F.R. § 447.45(d)(2) - (3); 42 C.F.R. § 447.46.

D.6.03. *Additional Claims Payment Timeliness Obligations.* A "Clean Claim" is one in which all information required for processing is present. If a Claim is denied because more information was required to process the Claim, the Claim denial notice shall specifically describe all information and supporting documentation needed to evaluate the Claim for processing. As provided in 42 C.F.R. § 447.46(c)(2), the Contractor may, by mutual

agreement, establish an alternative payment schedule with in-Network Providers. The alternative payment schedule shall be outlined in the Provider contract.

D.6.04. *Timing.* Contractor shall ensure that the date of receipt is the date the Contractor receives the Claim, as indicated by its date stamp on the Claim; and that the date of payment is the date of the check or other form of payment. See: 42 C.F.R. § 447.45(d)(5) - (6); 42 C.F.R. § 447.46; sections 1932(f) and 1902(a)(37)(A) of the Social Security Act. {From CMSC D.6.02}.

D.7 Pass-through Payments

D.7.01. *Pass-Through Payments.* Contractor shall make no Pass-Through Payments to providers under this Contract even if such payments are permissible pursuant to 42 C.F.R. § 438.6(d). {From CMSC D.7.01}.

D.7.02. *Reserved.* N/A.

D.7.03. *Reserved*. N/A.

E. Providers and Provider Network

E.01. *Provider Relations and Communications.* Contractor shall develop, implement, and adhere to a comprehensive, proactive Provider relations and communications strategy.

E.02. *Provider Services Helpline.* The Contractor shall maintain a toll-free telephone hotline for all Providers with questions, concerns or complaints. The telephone line shall be staffed with live-voice coverage during normal working days (Monday through Friday), except for established State holidays. The State holidays are: (i) New Year's Day; (ii) Martin Luther King, Jr.'s Birthday; (iii) Memorial Day; (iv) July 4th; (v) Labor Day; (vi) Veterans Day; (vii) Thanksgiving; (viii) Day after Thanksgiving; and (ix) Christmas Day. The helpline shall be accessible, at minimum, during working hours of 7:30 a.m. - 6:00 p.m. Central Time. For all days with a closure, there shall be a process for Providers to process emergency Prior Authorizations as needed. The Contractor shall maintain a system for tracking and reporting the number and type of calls and inquiries in order to meet the Agency reporting requirements.

E.03. *Provider Helpline Performance Metric.* Contractor's Provider Helpline shall comply at all times with the call center performance metrics set forth in Section A.27.

E.04. *Provider Training.* The Contractor shall develop a State-wide provider training which maintains and complies with its provider training plan, subject to Agency approval. The provider training plan shall be updated no less than annually. Training may include conducting provider training workshops and individual provider training and presentations, upon Agency request. The Contractor shall collaborate with the Agency and other Iowa Medicaid Units to obtain provider feedback and identify specific training needs, to include but not limited to:

a) Identifying unique needs and benefits for different member populations;
b) Responding to urgent and emergent Enrolled Member needs;
c) Informing of updated policy and procedure changes;
d) Informing and ensuring knowledge of presumptive eligibility and qualified entity training, when applicable;
e) Identifying trends and issues of interest to or impacting providers;
f) Training on provider Enrollment as well as common errors during Enrollment and credentialling that delay those process;
g) Educating providers on the ABM and applicable impacts on services and costs for Enrolled Members; and
h) Coordinating transportation assistance and continuity care with IA Health Link MCOs in the State.

E.1 Network Adequacy

E.1.01. *Network Adequacy Obligations.* Contractor shall:

a) Provide reasonable and adequate hours of operation, including twenty-four (24) hour availability of information, referral, and treatment for a dental-related Emergency Medical Conditions.
b) Make arrangements with or referrals to, a sufficient number of dentists, oral surgeons, or other specialty medical and dental practitioners as necessary, physicians and other practitioners to ensure that the services under the Contract can be furnished promptly and without compromising the Quality of care.

See: 42 C.F.R. § 438.3(q)(1); 42 C.F.R. § 438.3(q)(3); 42 C.F.R. § 457.1201(m). {From CMSC E.1.01 - E.1.02}.

E.1.02. *Communication Review and Approval.* All Contractor-developed Provider communications shall be pre-approved by the Agency. Unless otherwise requested by the Agency, all materials shall be submitted at least thirty (30) Days prior to expected use and distribution. All substantive changes to previously approved communications shall also be submitted to the Agency for review and approval at least thirty (30) Days prior to use. In cases of Emergency Communication to ensure the health and safety of members, and when obtaining Agency approval would introduce unnecessary delay in issuing the communication, the Contractor may issue information to Providers without prior Agency approval in alignment with Agency guidance. The Contractor shall comply with any Agency processes implemented to facilitate submission and approval of materials. For example, the Agency may opt to mandate use of an inventory control number on all submissions or the use of specific cover sheets with document submission. The Agency may waive the right to review and approve Provider communications.

Information that includes the Agency's name and correspondence that may be sent to Providers on behalf of the Agency shall also be submitted by the Contractor for the Agency review and approval. Any approval given for the Agency or other State agency name or logo is specific to the use requested and shall not be interpreted as blanket approval. The Contractor shall include the Agency Program logo(s) in their Provider communication materials upon the Agency request. The Agency reserves the right to mandate that specific language be included in Provider communication materials.

E.1.03. *Provider Manual.* The Contractor shall provide and maintain a written Program manual for use by the Contractor's Provider Network. The manual shall be made available electronically, and in hard copy (upon a Provider's request) to all Network Providers, without cost. The Provider Manual shall include, at minimum, the following topics:

a) Program Benefits and limitations;
b) Claims filing instructions;
c) Criteria and process to use when requesting Prior Authorizations;
d) Cost sharing requirements;
e) Definition and requirements pertaining to urgent and emergent care;
f) Participants' rights;
g) Providers' rights for advising or advocating on behalf of his or her patient;
h) Provider non-discrimination information;
i) Policies and procedures for Grievances and Appeals in accordance with 42 C.F.R. § 438.414 and consistent with Section E.6.
j) Contractor and the Agency contact information such as addresses and phone numbers; and
k) Policies and procedures for TPL and other collections.

E.1.04. *Provider Website.* The Contractor shall maintain a website for use by Providers describing the key Program elements and requirements, including, at minimum, the information required in the Provider Manual as described in Section E.1.03 and Provider training as described in Section E.04. This website shall be accessible

and functional via cell phone. The Contractor shall update the Provider Relations regional maps at least quarterly, or more frequently as staffing changes occur.

E.1.05. *Written Agreements.* Contractor shall maintain and monitor a network of appropriate Providers that is supported by written agreements. See: 42 C.F.R. § 438.206(b)(1); 42 C.F.R. § 457.1230(a). {From CMSC E.1.03}.

E.1.06. *Provider Agreements.* In accordance with 42 C.F.R. § 438.206, the Contractor shall establish written agreements with all Network Providers. The Contractor shall identify and incorporate the applicable terms of its Contract with the Agency and any incorporated documents in the Contractor's Provider agreements. Under the terms of the Provider agreement, the Provider must agree that all applicable terms and conditions set out in the Contract, any incorporated documents and all applicable State and Federal laws, as amended, govern the duties and responsibilities of the Provider with regard to the provision of services to Enrolled Members. The Contractor shall attest that all applicable State and Federal laws and contractual requirements are met in the Provider agreement templates.

The Contractor shall also include in all of its provider agreements provisions to ensure continuation of benefits. The Contractor shall ensure that Providers are enrolled with the Agency as a condition for participation in the Contractor's network. The Contractor shall require a signed Business Associates Agreement as part of the Provider agreement when required. In addition, the Provider agreement shall specify the Provider's responsibility regarding TPL, including the Provider's obligations to identify TPL coverage, including Medicare as applicable, and except as otherwise required, seek such third-party liability payment before submitting Claims to the Contractor. The Provider agreement shall require submission of Claims, which do not involve a third-party payer, within one hundred and eighty (180) Days of the date of service.

The Contractor may execute network provider agreements, pending the outcome of screening, Enrollment, and revalidation, up to one hundred and twenty (120) days but must terminate a network provider immediately upon notification from the Agency that the network provider cannot be enrolled, or the expiration of one (1) one hundred and twenty (120) day period without Enrollment of the provider, and notify affected Enrolled Members. (See: 42 C.F.R. § 438.602(b)(2); 42 C.F.R. § 457.1285.)

E.1.07. *Reserved.* N/A.

E.1.08. *Reserved.* N/A.

E.1.09. *Reserved.* N/A.

E.1.10. *Reserved.* N/A.

E.1.11. *Reserved.* N/A.

E.1.12. *Reserved.* N/A.

E.1.13. *Reserved.* N/A.

E.1.14. *Federally Qualified Health Centers.* The Contractor shall offer to contract with all FQHCs located in Iowa. The Contractor may establish Quality standards that FQHCs shall meet to be offered network participation for the Agency's review and approval. The Contractor shall reimburse all FQHCs the Prospective Payment System (PPS) rate or Fee-for-Services in effect on the date of service for each encounter, as applicable to the Enrolled Member. The Contractor shall not enter into alternative reimbursement arrangements without prior approval from the Agency.

E.1.15. *Reserved.* N/A.

E.1.16. *Maternal Health Centers and Screening Centers and Public Health Providers.* The Contractor shall offer to contract with all Screening and Maternal Health Centers and Public Health providers located in Iowa. Contractor shall reimburse these provider types for dental services provided under the agency or individual provider number as applicable. Contractor shall handle billing disputes with agencies pursuant to Contractor's standard provider policies. Contractor shall follow the processing policies and frequency limitations established by the Agency.

The Contractor shall develop and test the systems, policies, and protocols needed to implement, support, monitor, and evaluate contracting with Maternal Health Center and Screening Centers and Public Health providers, including, but not limited to, the systems for referring clients to contracted dental care, HIPAA compliant information transfer, subcontractor billing, service documentation in the subcontractor's patient record, and Enrollment of these contracted agencies and providers.

E.1.17. *Reserved.* N/A.

E.1.18. *Other Safety Net Providers and Community Partners.* Contractor shall develop strategies, policies, and procedures describing how it intends to utilize and partner with community entities and advocates, including transportation and enabling services, and document such in the PPM. At a minimum the Contractor shall include strategies for developing member referral networks with Emergency Departments and Urgent Care Clinics to provide outreach and referral processes for members who present with urgent and emergent dental conditions and need referral including educating providers on use of the Dental Call Line.

E.1.19. *Reserved.* N/A.

E.1.20. *Access to Medical, Dental and Financial Records.* Within its Provider agreements, Contractor shall require that Contractor's Providers, within the timeframe designated by the Agency or other authorized entity, permit the Contractor, representatives of the Agency, and other authorized entities to review Enrolled Members' records for the purposes of monitoring the Provider's compliance with the record standards, capturing information for clinical studies, monitoring Quality or any other reason.

E.1.21. *Adequate Access.* Contractor shall maintain and monitor a network of appropriate Providers that is sufficient to provide adequate Access to all services covered under the Contract for all Enrolled Members, including those with LEP or physical or mental disabilities. See: 42 C.F.R. § 438.206(b)(1); 42 C.F.R. § 457.1230(a). {From CMSC E.1.04}.

E.1.22. *Compliance with Access Requirements.* The Contractor shall establish and implement procedures, subject to Agency review and approval, to ensure that Network Providers comply with all Access requirements specified in this Contract, including but not limited to appointment times set forth in Special Contract Exhibit C, and be able to provide documentation demonstrating monitoring of compliance with these standards. The Contractor shall establish and implement an Agency approved mechanism to regularly monitor Providers to ensure compliance and shall take corrective actions if a Provider is found to be noncompliant. The Contractor shall maintain an emergency/contingency plan in the event that a large Provider of services collapses or is otherwise unable to provide needed services. See Special Contract Exhibit C.

E.1.23. *Reserved.* N/A.

E.1.24. *Capacity – Assurances.* Contractor shall give assurances and provide supporting documentation that demonstrates that it has the capacity to serve the expected Enrollment in its service area in accordance with the

Agency's standards for Access and timeliness of care. See: 42 C.F.R. § 438.207(a); 42 C.F.R. § 438.68; 42 C.F.R. § 438.206(c)(1); 42 C.F.R. § 457.1230(b). {From CMSC E.1.06}.

E.1.25. *Contractor Closing Network.* With the exception of Emergency Services and continuity of care requirements described in Section G.2, once the Contractor has met the Network Adequacy standards set forth in this Section E and Special Contract Exhibit C, the Contractor may require all of its Enrolled Members to seek covered services from in-Network Providers. Prior to closing its network, the Contractor shall seek the Agency approval. The Agency retains sole authority for determining if network Access standards have been met and whether the network may be closed. If the Contractor is unable to provide medically necessary covered services to a particular Enrolled Member using contract Providers, the Contractor shall adequately and timely cover these services for that Enrolled Member using non-contract Providers for as long as the Contractor's Provider Network is unable to provide them. Contractor shall not refuse to credential and contract with a qualified Provider, on the sole basis of the network already meeting the contractual distance accessibility standard, if there is a subset of Enrolled Members in that service area that must travel beyond the average standard to Access care.

E.1.26. *Appropriate Range of Services.* Contractor shall submit documentation to the Agency, in a format specified and at the frequency requested by the Agency, to demonstrate that it offers an appropriate range of preventive, Primary Care, and specialty services available for patient referrals that is adequate for the anticipated number of Enrolled Members for the service area. See: 42 C.F.R. § 438.207(b)(1); 42 C.F.R. § 457.1230(b). {From CMSC E.1.07}.

E.1.27. *Appropriate Provider Mix.* Contractor shall submit documentation to the Agency, in a format specified by the Agency, to demonstrate that it maintains a network of Providers actively accepting patient referrals, that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrolled Members in the service area. See: 42 C.F.R. § 438.207(b)(2); 42 C.F.R. § 457.1230(b). {From CMSC E.1.08}.

E.1.28. *Provider Network.* The Contractor shall provide information as specified by the Agency about its Provider Network at no less frequently than the following: (1) at the time it enters into the Contract with the Agency, and (2) monthly thereafter, and (3) at any time there is a significant change (as defined by the Agency) in the Contractor's operations that impacts services. The Contractor shall: (i) adequately serve the expected Enrollment; (ii) offer an appropriate range of services and Access to preventive and Primary Care Services for the population expected to be enrolled; and (iii) maintain a sufficient number, mix and geographic distribution of Providers in accordance with the general Access standards set forth in Special Contract Exhibit C. These minimum requirements shall not release the Contractor from the requirement to provide or arrange for the provision of any medically necessary covered service required by its Enrolled Members, whether specified above or not. See: 42 C.F.R. § 438.207(b) - (c); 42 C.F.R. § 457.1230(b). {From CMSC E.1.09}.

E.1.29. *Provider Credentialing Performance Metric.* Contractor shall complete Credentialing of all Providers applying for Network Provider status as follows: (i) Eighty-five percent (85%) within thirty (30) Days; (ii) Ninety-eight percent (98%) within forty-five (45) Days; and (iii) One hundred percent (100%) within sixty (60) Days. The credentialling performance metric start time begins when the provider submits a formal request to contract and/or participate in the Contractor's network. If a provider has not submitted all necessary Credentialing materials, the Contractor shall notify the provider of all additional materials required within seven (7) Days from initial receipt of the formal request to contract and/or participate in the network. If the Contractor requests additional materials, not already submitted by the Provider, the time to complete Credentialling/contracting shall not be measured while the Contractor is waiting for the requested materials. Once the Provider submits the additional materials, the measurement of time to complete Credentialling/contracting will resume. Completion time ends when written communication is mailed, emailed, or faxed to the Provider notifying them of the Contractor's decision.

E.1.30. *Provider Recredentialing Performance Metric.* Contractor shall complete recredentialing of all contracted Providers no less than every three (3) years. The agency will conduct an annual audit to ensure compliance with recredentialing requirements. For contracts new to PAHP program the audit will occur on the third year of the contract. Failure to comply with the audit or recredentialing requirements may result in corrective actions in accordance with contract section J.8.08.

E.1.31. *Rural Considerations.* The availability of professionals will vary from area to area, but Access problems may be especially acute in Rural areas. The Contractor shall establish a program of assertive Provider outreach to Rural areas where services may be less available than in more Urban areas. The Contractor also shall monitor utilization across the State and in Rural and Urban areas to assure equality of service Access and availability. Where the Contractor's monitoring shows the need for increased Access to services, the Contractor shall submit an action plan to the Agency for approval.

E.1.32. *Network Adequacy.* The Agency defines a "significant change" as set forth above as a change in the Contractor's operation or the Program, changes in services, changes in Benefits, changes in payments, Enrollment of a new population, or as otherwise requested by the Agency.

E.2 No Discrimination

E.2.01. *Provider Discrimination.* Contractor shall not discriminate against any Provider (limiting their participation, reimbursement or indemnification) 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. See: 42 C.F.R. § 438.12(a)(1); 42 C.F.R. § 457.1208. {From CMSC E.2.01}.

E.3 Provider Selection

E.3.01. *Declining Enrollment – Written Notice.* Contractor shall give written notice of the reason for its decision when it declines to include individual or groups of Providers in its Provider Network. See: 42 C.F.R. § 438.12(a)(1); 42 C.F.R. § 457.1208. {From CMSC E.3.01}.

E.3.02. *Policies and Procedures.* Contractor shall implement written policies and procedures for selection and retention of Network Providers. See: 42 C.F.R. § 438.12(a)(2); 42 C.F.R. § 438.214(a); 42 C.F.R. § 457.1208; 42 C.F.R. § 457.1233(a). {From CMSC E.3.02}.

E.3.03. *Credentialing Policies and Procedures.* Contractor shall develop, implement, and adhere to written policies and procedures, subject to Agency review and approval, related to Provider Credentialing and re-Credentialing, which shall include standards of conduct that articulate Contractor's understanding of the requirements and that direct and guide Contractor's and Subcontractors' compliance with all applicable federal and State standards, and performance metrics related to Provider Credentialing, including those required in 42 C.F.R. Parts 438 and 455, Subpart E, which shall include the following: (i) a training plan designed to educate staff in the Credentialing and re-Credentialing requirements; (ii) provisions for monitoring and auditing compliance with Credentialing standards; (iii) provisions for prompt response and corrective action when non-compliance with Credentialing standards is detected; (iv) a description of the types of Providers that are credentialed; (v) methods of verifying Credentialing assertions, including any evidence of prior Provider sanctions; and (vi) prohibition against employment or contracting with Providers excluded from participation in federal health care programs. The Contractor shall ensure that the Credentialing process provides for mandatory re-Credentialing at a minimum of every three (3) years. Contractor shall document its Credentialing Policies and Procedures in the PPM.

E.3.04. *Uniform Credentialing and Recredentialing Policy.* In all contracts with Network Providers, Contractor shall follow the Agency's uniform Credentialing and recredentialing policy that addresses acute, primary, behavioral, substance use disorder, and LTSS Providers, as appropriate. See: 42 C.F.R. §

438.12(a)(2); 42 C.F.R. § 438.214(b)(1); 42 C.F.R. § 457.1208; 42 C.F.R. § 457.1233(a). {From CMSC E.3.03}.

E.3.05. *Credentialing and Recredentialing Requirements.* The Contractor's Credentialing and re-Credentialing process for all contracted Providers shall meet the guidelines and standards of the accrediting entity through which the Contractor attains accreditation and in compliance with all State and Federal rules and regulations.

E.3.06. *Licensed & Non-Licensed Providers.* The Contractor shall ensure each Provider's service delivery site or services meets all applicable requirements of Iowa law and have the necessary and current licenses, certification, accreditation, and/or designation approval per State requirements. When individuals providing services are not required to be licensed, accredited or certified, the Contractor shall ensure, based on applicable State licensure rules and/or Program standards, that they are appropriately educated, trained, qualified, and competent to perform their job responsibilities.

E.3.07. *Facility Requirements.* The Contractor shall ensure that all facilities including, but not limited to, hospitals and dental offices, are licensed as required by the State.

E.3.08. *Reserved.* N/A.

E.3.09. *Obligation to Follow Documented Processes.* In all contracts with Network Providers, Contractor shall follow a documented process for Credentialing and recredentialing of Network Providers. See: 42 C.F.R. § 438.12(a)(2); 42 C.F.R. § 438.214(b)(2); 42 C.F.R. § 457.1208; 42 C.F.R. § 457.1233(a). {From CMSC E.3.04}.

E.3.10. *Non-Discrimination.* In all contracts with Network Providers, Contractor's Provider selection policies and procedures shall not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment. See: 42 C.F.R. § 438.12(a)(2); 42 C.F.R. § 438.214(c); 42 C.F.R. § 457.1208; 42 C.F.R. § 457.1233(a). {From CMSC E.3.05}.

E.3.11. *Provider Selection Obligations.* In all contracts with Network Providers, Contractor shall comply with any additional Provider selection requirements established by the Agency. See: 42 C.F.R. § 438.12(a)(2); 42 C.F.R. § 438.214(e); 42 C.F.R. § 457.1208; 42 C.F.R. § 457.1233(a). {From CMSC E.3.06}.

E.3.12. *Contractor Limitations on Provider Network.* Under this Contract, Contractor is not required to contract with more Providers than necessary to meet the needs of its Enrolled Members. See: 42 C.F.R. § 438.12(b)(1); 42 C.F.R. § 457.1208. {From CMSC E.3.07}.

E.3.13. *Varying Reimbursements.* Under this Contract, Contractor is not precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. See: 42 C.F.R. § 438.12(b)(2); 42 C.F.R. § 457.1208. {From CMSC E.3.08}.

E.3.14. *Maintaining Quality and Cost Controls.* Under this Contract, Contractor is not precluded from establishing measures that are designed to maintain Quality of services and control costs and are consistent with its responsibilities to Enrolled Members. See: 42 C.F.R. § 438.12(b)(3); 42 C.F.R. § 457.1208. {From CMSC E.3.09}.

E.3.15. *Credentialing Obligation.* Contractor shall demonstrate that its Network Providers are credentialed as required under 42 C.F.R. § 438.214. See: 42 C.F.R. § 438.206(b)(6); 42 C.F.R. § 457.1230(a). {From CMSC E.3.10}.

E.3.16. *Restriction on Non-Compete Provider Arrangements.* Contractor shall not limit any Providers from providing services to any other Iowa Dental Wellness Plan and Hawki Dental Program Contractor.

E.3.17. *Reserved.* N/A.

E.3.18. *Iowa Medicaid Providers*. For the first six (6) months from Contractor's entry into the Iowa Dental Wellness Plan and Hawki Dental program marketplace, the Contractor shall give Providers, who are currently enrolled as Iowa Medicaid Providers, the opportunity to be part of its network.

E.3.19. *Written Notice Obligation.* Notwithstanding the requirements set forth in Section E.3.18, if the Contractor declines to include individual or groups of Providers in its network, it shall give the affected Providers and the Agency written notice of the reason for the decision.

E.4 Anti-Gag

E.4.01. *Anti-Gag Obligation.* Contractor shall not prohibit or restrict a Provider acting within the lawful scope of practice, from advising or advocating on behalf of an Enrolled Member who is his or her patient regarding

a) The Enrolled Member's health status, medical/dental care, or treatment options, including any alternative treatment that may be self-administered.
b) Any information the Enrolled Member needs to decide among all relevant treatment options.
c) The risks, benefits, and consequences of treatment or non-treatment.
d) The Enrolled 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.

See: Section 1932(b)(3)(A) of the Social Security Act; 42 C.F.R. § 438.102(a)(1)(i) - (iv); 42 C.F.R. § 457.1222. {From CMSC E.4.01 - E.4.04}.

E.4.02. *No Punitive Action.* Contractor shall take no punitive action against a Provider who either requests an expedited resolution or supports an Enrolled Member's Appeal. See: 42 C.F.R. § 438.410(b); 42 C.F.R. § 457.1260. {From CMSC E.4.05}.

E.5 Network Adequacy Standards

E.5.01. *Adequacy.* Under this Contract:

a) The Contractor and its Network Providers shall meet the Agency standards for timely Access to care and services, considering the urgency of need for services.
b) The Contractor's Network Providers shall offer hours of operation that are no less than the hours offered to commercial Enrolled Members or are comparable to Medicaid FFS, if the Provider serves only Medicaid and/or CHIP Enrolled Members.
c) The Contractor shall establish mechanisms to ensure that its Network Providers comply with the timely Access requirements.
d) The Contractor shall monitor Network Providers regularly to determine compliance with the timely Access requirements.
e) The Contractor shall take corrective action if it, or its Network Providers, fail to comply with the timely Access requirements.

See: 42 C.F.R. § 438.206(c)(1)(i) - (vi); 42 C.F.R. § 457.1230(a). {From CMSC E.5.01 - E.5.06}.

E.5.02. *Access Obligations.* Contractor shall ensure that Network Providers provide physical Access, reasonable accommodations, and accessible equipment for Medicaid and/or CHIP Enrolled Members with physical or mental disabilities. See: 42 C.F.R. § 438.206(c)(3); 42 C.F.R. § 457.1230(a). {From CMSC E.5.07}.

E.5.03. *Quantitative Network Adequacy – Provider Type and Geographic Area Requirement.* Contractor shall adhere to the quantitative Network Adequacy standards developed by the Agency in all geographic areas in

which the Contractor operates for the following Provider types, if the Provider type is covered under the Contract:

a) Adult PCPs.
b) Pediatric PCPs.
c) Obstetrics and Gynecology (OB/GYN) Providers.
d) Adult mental health Providers.
e) Adult substance use disorder Providers.
f) Pediatric mental health Providers.
g) Pediatric substance use disorder Providers.
h) Adult specialist Providers.
i) Pediatric specialist Providers.
j) Hospitals.
k) Pharmacies.
l) Pediatric dental Providers.
m) Any additional Provider types when it promotes the objectives of the Medicaid and CHIP programs for the Provider type to be subject to quantitative Network Adequacy standards, as determined by CMS.

For specific time and distance standards established by the Agency, see Special Contract Exhibit C. See: 42 C.F.R. § 438.68(b)(1)(i) - (viii); 42 C.F.R. § 457.1218. {From CMSC E.5.08 - E.5.19}.

E.5.04. *Reserved.* N/A.

E.5.05. *Reserved.* N/A.

E.5.06. *Reserved.* N/A.

E.5.07. *Reserved.* N/A.

E.5.08. *Exceptions.* The Agency-developed Provider Network standards for exceptions to the Provider Network adequacy obligation are set forth in Special Contract Exhibit C. See: 42 C.F.R. § 438.68(d)(1); 42 C.F.R. § 457.1218. {From CMSC E.5.22}.

E.6 Provider Notification of Grievance and Appeals Rights

E.6.01. *Enrolled Member Appeal Rights Notice.* Contractor shall inform Providers and Subcontractors, at the time they enter into a contract, about:

a) Enrolled Member Grievance, Appeal, and fair hearing procedures and timeframes as specified in 42 C.F.R. § 438.400 through 42 C.F.R. § 438.424 and described in the Grievance and Appeals section.
b) The Enrolled Member's right to file Grievances and Appeals and the requirements and timeframes for filing.
c) The availability of assistance to the Enrolled Member with filing Grievances and Appeals.

See: 42 C.F.R. § 438.414; 42 C.F.R. § 438.10(g)(2)(xi)(A) - (C); 42 C.F.R. § 457.1260. {From CMSC E.6.01 - E.6.03}.

E.6.02. *State Fair Hearing Rights Notice.* Contractor shall inform Providers and Subcontractors, at the time they enter into a contract, about the Enrolled Member's right to request a State Fair Hearing after the Contractor has made a determination on an Enrolled Member's Appeal which is adverse to the Enrolled Member. See: 42 C.F.R. § 438.414; 42 C.F.R. § 438.10(g)(2)(xi)(D); 42 C.F.R. § 457.1260. {From CMSC E.6.04}.

E.6.03. *Continuation of Benefits.* Contractor shall inform Providers and Subcontractors, at the time they enter into a contract, about the Enrolled Member's right to request continuation of Benefits that the Contractor seeks to reduce or terminate during an Appeal or State Fair Hearing filing, if filed within the allowable timeframes, although the Enrolled Member may be liable for the cost of any continued Benefits while the Appeal or State

Fair Hearing is pending if the final decision is adverse to the Enrolled Member. See: 42 C.F.R. § 438.414; 42 C.F.R. § 438.10(g)(2)(xi)(E); 42 C.F.R. § 457.1260. {From CMSC E.6.05}.

E.6.04. *Payment Disputes*. Contractor shall inform providers and subcontractors, at the time they enter into a contract, that providers and subcontractors do not have a right to request a state fair hearing to address a payment dispute between the provider or subcontractor and Contractor after services have been rendered. See: 42 C.F.R. § 438.402(c)(1)(ii).

E.7 Balance Billing

E.7.01. *Prohibition Against Balance Billing.* Contractor shall require that Subcontractors and referral Providers not bill Enrolled Members, for covered services, any amount greater than would be owed if the entity provided the services directly (i.e., no balance billing by Providers). See: Section 1932(b)(6) of the Social Security Act; 42 C.F.R. § 438.3(k); 42 C.F.R. § 438.230(c)(1) - (2); 42 C.F.R. § 457.1233(b). {From CMSC E.7.01}.

E.8 Provider Incentive Plan

E.8.01. *Restriction on Reducing or Limiting Services.* Contractor may only operate a provider incentive plan if no specific payment can be made directly or indirectly under a provider incentive plan to a dental provider or dental provider group as an incentive to reduce or limit Medically Necessary Services to an Enrolled Member. See: Section 1903(m)(2)(A)(x) of the Social Security Act; 42 C.F.R. § 422.208(c)(1); 42 C.F.R. § 438.3(i); 42 C.F.R. § 457.1201(h). {From CMSC E.8.01}.

E.8.02. *Stop-Loss Protection.* If Contractor puts a physician/physician group at substantial financial risk for services not provided by the physician/physician group, Contractor must ensure that the physician/physician group has adequate stop-loss protection. See: Section 1903(m)(2)(A)(x) of the Social Security Act; 42 C.F.R. § 422.208(c)(2); 42 C.F.R. § 438.3(i); 42 C.F.R. § 457.1201(h). {From CMSC E.8.02}.

E.8.03. *Value-Based Purchasing Arrangements.* All incentives and/or value-based purchasing (VBP) arrangements must be agreed upon with the Participating Provider(s) and approved by the Agency prospectively before implementation.

The Contractor's incentives and/or VBP arrangement will be monitored by the Agency at a minimum semiannually; however (based on the Agency discretion) may be monitored more frequent and must demonstrate to the Agency how the incentive and/or VBP program(s) improves member outcomes and is not solely administrative efficiencies to qualify as an incentive and/or VBP program.

Any incentives and value-based purchasing arrangements which pay above 110% of the Medicaid fee schedule will require additional reporting requirements, as described in this Contract Section.

The incentive and/or VBP, at a minimum shall include the following:

- The Contractor's overall approach to VBP;
- Initiatives, goals, targets, strategies;
- Barriers and actions to overcome barriers; and
- Data sharing arrangements established with participating dental providers.

The Contractor must share performance outcomes including Claims data and lists of attributed members with the Agency semiannually (or more frequent as directed by the Agency) for the membership that is attributed to the provider in incentive and/or VBP arrangements.

Any VBP arrangement shall recognize population dental health outcome improvement as measured through

Agency-approved metrics combined with a total cost of care measure for the population in the VBP arrangement. Driving population dental health through delivery system reform under VBP means that Providers need a clear understanding of the specific population for which they are accountable. As such, any Enrolled Members that are part of a VBP must be assigned by the Contractor to a designated dental provider. This provider information shall be immediately reported by the Contractor for use in system wide coordination enhancements as specified by the Agency. The Contractor shall notify the Agency of any risk sharing agreements it has arranged with a Provider and require in the Provider agreement for any Providers who are paid on a capitated basis the submission of encounter data within ninety (90) Days of the date of service. As applicable, the Provider agreements shall comply with the requirements set forth in this Contract for subcontracts and in accordance with 42 C.F.R. § 434.6. The Contractor shall maintain all Provider agreements in accordance with the provisions specified in 42 C.F.R. § 438.12, 438.214 and this Contract.

E.8.04. *Value-Based Purchasing Compliance.* Contractor shall ensure compliance with the obligations set forth in 42 C.F.R. § 438.6(c) by showing that the VBP arrangement with Providers:

a) Is based on utilization and delivery of services;
b) Directs expenditures equally, and using the same terms of performance, for a class of Providers providing the service under the Contract;
c) Expects to advance at least one (1) of the goals and objectives in the Quality strategy in 42 C.F.R. § 438.340;
d) Has an evaluation plan that measures the degree to which the arrangement advances at least one (1) of the goals and objectives in the Quality strategy in 42 C.F.R. § 438.340;
e) Does not condition Network Provider participation in contract arrangements under 42 C.F.R. § 438.6(c)(1)(i) through (iii) on the Network Provider entering into or adhering to intergovernmental transfer agreements; and
f) May not be renewed automatically.

E.9 Network Requirements Involving Indians, Indian Health Care Providers (IHCPs), and Indian Managed Care Entities (IMCEs)

E.9.01. *IHCPs – Timely Access.* Contractor shall demonstrate that there are sufficient IHCPs participating in the Provider Network to ensure timely Access to services available under the Contract from such Providers for Indian Enrolled Members who are eligible to receive services. See: 42 C.F.R. § 438.14(b)(1); 42 C.F.R. § 438.14(b)(5); 42 C.F.R. § 457.1209. {From CMSC E.9.01}.

E.9.02. *IHCPs – Payment Obligations.* Contractor shall pay IHCPs, whether participating or not, for covered services provided to Indian Enrolled Members, who are eligible to receive services at a negotiated rate between the Contractor and IHCP or, in the absence of a negotiated rate, at a rate not less than the level and amount of payment the managed care entity would make for the services to a Participating Provider that is not an IHCP. See: 42 C.F.R. § 438.14(b)(2)(i) - (ii); 42 C.F.R. § 457.1209. {From CMSC E.9.02}.

E.9.03. *Out-of-Network Obligation.* Contractor shall allow Indian Enrolled Members to obtain covered services from out-of-network IHCPs from whom the Enrolled Member is otherwise eligible to receive such services. See: 42 C.F.R. § 438.14(b)(4); 42 C.F.R. § 457.1209. {From CMSC E.9.03}.

E.9.04. *Out-of-Network Referrals.* Contractor shall permit an out-of-network IHCP to refer an Indian Enrolled Member to a Network Provider. See: 42 C.F.R. § 438.14(b)(6); 42 C.F.R. § 457.1209. {From CMSC E.9.04}.

F. Coverage

F.01. *Covered Populations*. Contractor shall provide services on a statewide basis. There will be no regional coverage variations. The populations covered under this Contract are set forth in the Special Contract Exhibit D, Table D.01.

F.02. *Excluded Populations*. The populations excluded from coverage under this Contract are set forth in Special Contract Exhibit D, Table D.02.

F.1 Emergency and Post-Stabilization Services

F.1.01. *Payment Obligations.* Contractor shall cover and pay for:

a) Emergency Services.
b) Post-Stabilization Care Services.

See: Section 1852(d)(2) of the Social Security Act; 42 C.F.R. § 438.114(b); 42 C.F.R. § 422.113(c); 42 C.F.R. § 457.1228. {From CMSC F.1.01 - F.1.02}.

F.1.02. *Review of Emergency Claims.* The Contractor shall pay for emergency and post-stabilization services as defined in F.1.01. The Contractor is not required to reimburse providers for non-emergency services for treatment of conditions that do not meet the prudent layperson standard. The Contractor may not limit what constitutes an emergency dental condition on the basis of lists of diagnoses or symptoms and may not deny or pay less than the allowed amount for the Current Dental Terminology (CDT) code on the Claim without a clinical record review to determine if the prudent layperson standard was met. The Contractor shall base coverage decisions for Emergency Services on the severity of the symptoms at the time of presentation and shall cover Emergency Services where the presenting symptoms are of sufficient severity to constitute an emergency dental condition in the judgment of a prudent layperson, even if the condition turned out to be non-emergency in nature. The prudent layperson review shall be conducted by a Contractor staff member who does not have dental training. The Contractor shall not impose restrictions on coverage of Emergency Services more restrictive than those permitted by the prudent layperson standard. In addition to using the prudent layperson standard, the Contractor shall endeavor to incorporate emergency dental condition as defined by the American Dental Association Emergency Dental Condition Guidelines in their review of emergency Claims.

F.1.03. *Obligation to Pay for Screening.* If an emergency dental screening or examination leads to a clinical determination that an actual dentally-related Emergency Medical Condition exists, the Contractor shall pay for both the services involved in the dental screening examination and the services required to stabilize the Enrolled Member. The Contractor shall be required to pay for all Emergency Services which are medically necessary until the dentally-related or caused emergency is stabilized.

F.1.04. *Non-Contracted Provider Payment Obligation.* Contractor shall pay non-contracted and/or non-Iowa Medicaid Enrolled providers for emergency services at the amount that would have been paid if the service had been provided under the Agency's fee-for-service Medicaid program. See: SMDL 06-010; section 1932(b)(2)(D) of the Social Security Act. {From CMSC F.1.03}.

F.1.05. *Payment Obligations.* Contractor shall:

a) Cover and pay for Emergency Services regardless of whether the Provider that furnishes the services is Iowa Medicaid enrolled or has a contract with the Contractor.
b) Not deny payment for treatment obtained when an Enrolled Member had a dentally-related Emergency Medical Condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
c) Not deny payment for dental treatment obtained when a representative of the Contractor instructs the Enrolled Member to seek Emergency Services.

Follow Agency guidance for non-Medicaid enrolled providers to assure payment for services meets Medicaid Provider Enrollment screening guidelines. See: Section 1932(b)(2) of the Social Security Act; 42 C.F.R. § 438.114(c)(1)(i); 42 C.F.R. § 438.114(c)(1)(ii)(A) - (B); 42 C.F.R. § 457.1228. {From CMSC F.1.04 - F.1.06}.

F.1.06. *Restriction on Limiting and Refusing Coverage.* Contractor shall not:

a) Limit what constitutes a dentally-related Emergency Medical Condition on the basis of lists of diagnoses or symptoms.
b) Refuse to cover Emergency Services based on the emergency room, the Provider, facility, hospital, or fiscal agent not notifying the Enrolled Member's PCP, Contractor, or applicable state entity of the Enrolled Member's screening and treatment within ten (10) Days of presentation for Emergency Services.

See: 42 C.F.R. § 438.114(d)(1)(i) - (ii); 42 C.F.R. § 457.1228. {From CMSC F.1.07 - F.1.08}.

F.1.07. *Restriction on Holding Patient Liable.* Contractor may not hold an Enrolled Member who has a dentally-related Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition. See: 42 C.F.R. § 438.114(d)(2); 42 C.F.R. § 457.1228. {From CMSC F.1.09}.

F.1.08. *Emergency and Post-Stabilization Care Services.* The Contractor shall provide Emergency Services without requiring Prior Authorization or PCP referral, regardless of whether these services are provided by a contract or non-contract Provider. The Contractor shall provide Post-Stabilization Care Services in accordance with 42 C.F.R. § 438.114.

F.1.09. *Payment Through Stabilization.* Contractor is responsible for coverage and payment of services until the attending emergency physician, or the Provider treating the Enrolled Member, determines that the Enrolled Member is sufficiently stabilized for transfer or discharge. The determination of the attending emergency physician, or the Provider treating the Enrolled Member, of when the Enrolled Member is sufficiently stabilized for transfer or discharge is binding on Contractor and the Agency for coverage and payment of emergency and post-stabilization services. See: 42 C.F.R. § 438.114(d)(3); 42 C.F.R. § 457.1228. {From CMSC F.1.10 - F.1.11}.

F.1.10. *Post-Stabilization Care Coverage.* Contractor shall cover Post-Stabilization Care Services:

a) Obtained within or outside the Contractor network that are:
    1. Pre-approved by a Contractor plan Provider or representative.
    2. Not pre-approved by a Contractor Provider or representative, but administered to maintain the Enrolled Member's stabilized condition within one (1) hour of a request to the Contractor for pre-approval of further Post-Stabilization Care Services.
b) Administered to maintain, improve, or resolve the Enrolled Member's stabilized condition without prior authorization, and regardless of whether the Enrolled Member obtains the services within the Contractor network when the Contractor:
    1. Did not respond to a request for pre-approval within one (1) hour.
    2. Could not be contacted.
    3. Representative and the treating physician or dentist could not reach agreement concerning the Enrolled Member's care and a Contractor physician was not available for consultation.

See: 42 C.F.R. § 438.114(e); 42 C.F.R. § 422.113(c)(2)(i) - (ii); 422.113(c)(2)(iii)(A) - (C); 42 C.F.R. § 457.1228. {From CMSC F.1.12 - F.1.16}.

F.1.11. *Post-Stabilization Services.* The requirements at 42 C.F.R. § 422.113(c) are applied to the Contractor. This includes all medical and dental services that may be necessary to assure, within reasonable medical probability, that no material deterioration of the Enrolled Member's condition is likely to result from, or occur during, discharge of the Enrolled Member or transfer of the Enrolled Member to another facility.

F.1.12. *Restriction on Limiting Enrolled Member Post-Stabilization Services.* Contractor shall limit charges to Enrolled Members for Post-Stabilization Care Services to an amount no greater than what the Contractor would

charge the Enrolled Member if the Enrolled Member obtained the services through the Contractor. See: 42 C.F.R. § 438.114(e); 42 C.F.R. § 422.113(c)(2)(iv). {From CMSC F.1.17}.

F.1.13. *Financial Responsibility.* Contractor's financial responsibility for Post-Stabilization Care Services if they have not been pre-approved ends when:

a) A Contractor physician with privileges at the treating hospital assumes responsibility for the Enrolled Member's care.
b) A Contractor physician assumes responsibility for the Enrolled Member's care through transfer.
c) A Contractor representative and the treating dentist/physician reach an agreement concerning the Enrolled Member's care.
d) The Enrolled Member is discharged.

See: 42 C.F.R. § 438.114(e); 42 C.F.R. § 422.113(c)(3)(i) - (iv); 42 C.F.R. § 457.1228. {From CMSC F.1.18 - F.1.21}.

F.2 Reserved

F.2.01. *Reserved.* N/A.

F.2.02. *Reserved.* N/A.

F.3 Reserved

F.3.01. *Reserved.* N/A.

F.4 Delivery Network

F.4.01. *Reserved.* N/A.

F.4.02. *Second Opinions.* Contractor shall provide for a Second Opinion from a Network Provider, or arrange for the Enrolled Member to obtain a Second Opinion outside the network, at no cost to the Enrolled Member. See: 42 C.F.R. § 438.206(b)(3); 42 C.F.R. § 457.1230(a). {From CMSC F.4.02}.

F.4.03. *Out-of-Network Provision of Care.* If Contractor's Provider Network is unable to provide necessary medical services covered under the Contract to a particular Enrolled Member, the Contractor must adequately and timely cover the services out of network, for as long as the Contractor's Provider Network is unable to provide them. See: 42 C.F.R. § 438.206(b)(4); 42 C.F.R. § 457.1230(a). {From CMSC F.4.03}.

F.4.04. *Out of Network Providers.* The Contractor shall negotiate and execute written Single Case Agreements or arrangements with non-Network Providers, when medically necessary, to ensure Access to covered services.

F.4.05. *Out of Network Care for Duals.* Generally, when an Enrolled Member is a Dual Eligible and requires services that are covered under the Contract but are not covered by Medicare, and the services are ordered by a Medicare Provider who is a non-contract Provider, the Contractor shall pay for the ordered, medically necessary service if it is provided by a contract Provider. However, under the following circumstances, the Contractor may require that the ordering physician be a contract Provider:

a) The ordered service requires Prior Authorization;
b) Dually eligible Enrolled Members have been clearly informed of the contract Provider requirement and instructed in how to obtain assistance identifying and making an appointment with a contract Provider; and
c) The Contractor assists the Enrolled Member in obtaining a timely appointment with a contract Provider upon request of the Enrolled Member or upon receipt of an order from a non-contract Provider.

F.4.06. *Out-of-Network Coordination of Payment.* Contractor shall coordinate payment with Out-of-Network Providers and ensure the cost to the Enrolled Member is no greater than it would be if the services were furnished within the network. See: 42 C.F.R. § 438.206(b)(5); 42 C.F.R. § 457.1230(a). {From CMSC F.4.04}.

F.4.07. *Limitation on Out-of-Network Payments.* With the exception of Single Case Agreements and other arrangements established with Out-of-Network Providers, the Contractor shall pay Out-of-Network Providers no less than 80% of the rate of reimbursement to in-Network Providers.

F.4.08. *Provider Restriction on Billing.* The Contractor shall ensure that no Provider bills an Enrolled Member for all or any part of the cost of a treatment service, except as allowed for Title XIX cost sharing as further described in Section F.8.

F.4.09. *Single Case Agreements.* A single case agreement may be used to provide members' medically necessary services when the Contractor's provider network is unable to provide access to necessary services to maintain a member's health and/or the member's health would be endangered if required to travel or wait for care from an in-network provider. Only under very limited circumstances may a provider or organization bill and receive payment for services without being enrolled as an Iowa Medicaid provider to ensure that members have access to covered Medicaid services. The health care provider shall be screened in accordance with 42 CFR part 455, subpart E standards. SCA standards / requirements:

- Complete an SCA for each enrolled member.
- Review SCA's every six (6) months to ensure continued medically necessity and continued lack of available services within the Enrolled Provider Network.

When the provider is out of state, the SCA is required to include an attestation to the following before the Managed Care Plan signs the SCA:

- The provider is actively enrolled with Medicaid or Medicare in the state in which they provide services.
- The individual or organization is in good standing and has not been excluded from receiving payment from state or federal programs.

F.5 Services Not Covered Based on Moral Objections

F.5.01. *Information Requirements – When Applying for Contract.* If Contractor elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, Contractor shall furnish information about the services it does not cover to the Agency with its application for a Medicaid contract. See: Section 1932(b)(3)(B)(i) of the Social Security Act; 42 C.F.R. § 438.102(b)(1)(i)(A)(1); 42 C.F.R. § 457.1222; 42 C.F.R. § 438.102(a)(2). {From CMSC F.5.01}.

F.5.02. *Information Requirements – When Policies Change.* If Contractor elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, Contractor shall furnish information about the services it does not cover to the Agency whenever it adopts such a policy during the term of the Contract. See: Section 1932(b)(3)(B)(i) of the Social Security Act; 42 C.F.R. § 438.102(b)(1)(i)(A)(2); 42 C.F.R. § 457.1222. {From CMSC F.5.02}.

F.5.03. *Advance Notice Requirement.* Contractor shall notify the Agency thirty (30) Days before implementing any such restriction on services and provide information on such restricted services to all Enrolled Members at a minimum ninety (90) Days before implementing the policy for any particular service.

F.6 Amount, Duration and Scope

F.6.01. *Generally.* This Contract identifies, defines, and specifies the amount, duration, and scope of each service the Contractor is required to offer. See: 42 C.F.R. § 438.210(a)(1); 42 C.F.R. § 457.1230(d). {From CMSC F.6.01}.

F.6.02. *FFS Equivalence Requirement.* For each service the Contractor is required to provide to adults, such service shall be furnished in an amount, duration and scope that is no less than the amount, duration and scope for the same services provided under FFS Medicaid, unless otherwise specified in an approved State Plan waiver. See: 42 C.F.R. § 438.210(a)(2); 42 C.F.R. § 457.1230(d). {From CMSC F.6.02}.

F.6.03. *FFS Equivalence Requirement – Under Twenty-One (21).* Contractor shall provide services for Enrolled 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 or, if applicable, CHIP. See: 42 C.F.R. § 438.210(a)(2); 42 C.F.R. § 457.1230(d). {From CMSC F.6.03}.

F.6.04. *Sufficiency of Services.* Contractor shall ensure that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. See: 42 C.F.R. § 438.210(a)(3)(i); 42 C.F.R. § 457.1230(d). {From CMSC F.6.04}.

F.6.05. *Prohibition on Reducing Services.* Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the Enrolled Member. See: 42 C.F.R. § 438.210(a)(3)(ii); 42 C.F.R. § 457.1230(d). {From CMSC F.6.05}.

F.6.06. *Appropriate Limits on Services.* Contractor may place appropriate limits on a service on the basis of criteria applied under the Medicaid State Plan (MSP), the CHIP State Plan, as applicable, and/or the Iowa Administrative Code, such as medical necessity or as otherwise permitted under an approved State Plan waiver. See: 42 C.F.R. § 438.210(a)(4)(i); 42 C.F.R. § 457.1230(d). {From CMSC F.6.06}.

F.6.07. *Medical Necessity Determinations.* In accordance with Section G requirements relating to UM strategies, the Contractor may establish procedures for the determination of medical necessity. The determination of medical necessity shall be made on a case-by-case basis and in accordance with the State and Federal laws and regulations. However, this requirement shall not limit the Contractor's ability to use medically appropriate cost-effective alternative services. The Contractor shall not employ and shall not permit others acting on their behalf to employ, utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each Enrolled Member and his/her medical history.

F.6.08. *Licensed Professionals – UM.* The Contractor shall use appropriate licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including Prior Authorization and decision making. The Contractor shall develop, implement, and adhere to written procedures which follow guidance from evidence-based organizations (e.g., American Dental Association, American Academy of Pediatrics) to assist in making medical necessity determinations. Any decision to deny a Service Authorization request or to authorize a service in an amount, duration or scope that is less than requested shall be made by a dental professional who has appropriate clinical expertise in treating the Enrolled Member's condition or disease.

F.6.09. *Appropriate Limits on Services.* Contractor may place appropriate limits on a service for utilization control, provided the services furnished can reasonably achieve their purpose. See: 42 C.F.R. § 438.210(a)(4)(ii)(A); 42 C.F.R. § 457.1230(d). {From CMSC F.6.07}.

F.6.10. *Prior Authorizations.* At any point that the Agency redistributes membership within the Iowa Dental Wellness Plan and Hawki Dental program or following open Enrollment, the Contractor shall honor existing authorizations for covered Benefits for a minimum of ninety (90) Days, without regard to whether such services are being provided by contract or non-contract Providers, when an Enrolled Member transitions to the Contractor from another source of coverage. The Contractor shall honor existing exceptions to policy granted by the Director for the scope and duration designated. At all other times outside of Agency member redistribution and following open Enrollment, the Contractor shall honor existing authorizations for a minimum of thirty (30) Days when an Enrolled Member transitions to the Contractor from another source of coverage, without regard to whether services are being provided by contract or non-contract Providers. The Contractor shall obtain Agency approval for policies and procedures to identify existing Prior Authorizations at the time of Enrollment. The Contractor shall implement and adhere to the Agency-approved policies and procedures. Additionally, when an Enrolled Member transitions to another Program Contractor, the Contractor shall provide the receiving entity with information on any current Service Authorizations, utilization data and other applicable clinical information such as disease management or Care Coordination notes.

F.6.11. *Transition of New Members.* The Contractor shall provide for the continuation of medically necessary covered services to newly Enrolled Members transitioning to the Contractor's care regardless of Prior Authorization or referral requirements.

F.6.12. *Chronic Conditions & LTSS – Need for Services.* Contractor may place appropriate limits on a service for utilization control, provided the services supporting individuals with ongoing or chronic conditions or who require LTSS are authorized in a manner that reflects the Enrolled Member's ongoing need for such services and supports. See: 42 C.F.R. § 438.210(a)(4)(ii)(B); 42 C.F.R. § 457.1230(d). {From CMSC F.6.08}.

F.6.13. *Reserved.* N/A.

F.6.14. *Reserved.* N/A.

F.6.15. *Covered Services.* The Contractor shall provide, at minimum, all Benefits and services deemed Medically Necessary Services that are covered under the Contract with the Agency in accordance with 42 C.F.R. § 438.210. The Contractor shall not avoid costs for services covered in the Contract by referring Enrolled Members to publicly supported health care resources. The Contractor shall ensure services are provided consistent with the United States Supreme Court's *Olmstead* decision and shall promote the Agency's goal of serving individuals in community integrated settings.

F.6.16. *Benefit Packages.* The Contractor shall ensure the provision of covered Benefits in accordance with the Enrolled Member's eligibility group as described below and in Special Contract Exhibit E.

F.6.17. *Hawki Enrolled Members.* The Contractor shall provide Benefits to Enrolled Members of the CHIP program (known as "Hawki") as described in Special Contract Exhibits D and E. Enrolled Members not otherwise specified in Section F.6.16 or who are enrolled in the Hawki program who are enrolled with the Contractor are eligible for all medically necessary covered Benefits in Iowa's State Plan as amended and all waivers approved by CMS. The Contractor shall provide services to Enrolled Members for which they are eligible as described in this Contract.

F.6.18. *Iowa Dental Wellness Plan Benefits.* The Contractor shall ensure that individuals eligible for the Iowa Dental Wellness Plan receive Iowa Dental Wellness Plan Benefits. Iowa Dental Wellness Plan coverage is described in the State Plan and summarized in Special Contract Exhibit E.

F.6.19. *External Communication and Coordination*

The Contractor shall facilitate Access to covered Benefits and monitor the receipt of services to ensure Enrolled Members' needs are being adequately met. The Contractor shall maintain ongoing communications with an Enrolled Member's community and Natural Supports to monitor and support their ongoing participation in care. The Contractor shall implement strategies to coordinate and share information with an Enrolled Member's service Providers across the healthcare delivery system, and to facilitate a comprehensive, holistic and person-centered approach to care, and to address issues and concerns as they arise. The Contractor shall also provide assistance to Enrolled Members in resolving concerns about service delivery or Providers. The Contractor shall ensure adequate and timely communication and sharing of records with other PAHP contractors in the event that an Enrolled Member transitions from one contractor to another to prevent interruption or delay in the Enrolled Member's service delivery.

F.6.20. *Reserved*. N/A.

F.6.21. *Reserved.* N/A.

F.6.22. *Changes in Covered Services.* The Agency will provide the Contractor with ninety (90) Days' advanced written notice preceding any change in covered services under the Contract unless such change is pursuant to a legislative or regulatory mandate, in which event, the Agency will use best efforts to provide reasonable notice to the Contractor. In the event the Agency provides less than ninety (90) Days' advanced written notice to the Contractor, the Contractor shall comply with the change in covered services within ninety (90) Days from the date the notice is given.

F.6.23. *Integrated Care.* In delivering services under the Contract, the Contractor shall develop, implement, and adhere to strategies to integrate the delivery of dental healthcare across the healthcare delivery system.

F.6.24. *QTL & NQTL.* Contractor shall provide all Medically Necessary Services in a manner that is no more restrictive than the State Medicaid program, including Quantitative and Non- Quantitative Treatment Limits (QTL) (NQTL), as indicated in State statutes and regulations, the MSP, and other State policies and procedures. See: 42 C.F.R. § 438.210(a)(5)(i). {From CMSC F.6.10}.

F.6.25. *Early and Periodic Screening, Diagnostic Treatment (EPSDT) Services*. The Contractor shall provide EPSDT services to all Enrolled Members under twenty-one (21) years of age in accordance with law. EPSDT covers dental services regardless of whether these services are provided under the State Plan and regardless of any restrictions that may be imposed on coverage.

a) *Partnering with Local Agencies for Screening*.
The Contractor shall partner with Maternal Health, Screening Center, and Public Health agencies to ensure the completion of dental screens and preventive visits in accordance with the EPSDT periodicity schedule. Screening exams consist of a health history, developmental history, complete physical exam, vision screening, hearing test, appropriate laboratory tests, immunizations, nutrition screen, health education including anticipatory guidance, oral health assessment, other tests as needed and referrals for treatment. Treatment consists of any treatment necessary to correct or ameliorate a child's physical, dental, or behavioral health condition as deemed medically necessary on a case-by-case basis. EPSDT medical necessity determinations shall consider a child's long-term needs.

The determination of whether a screening service outside of the periodicity schedule is necessary may be made by a child's physician or dentist, or by a health, developmental, or educational professional who encounters a child outside of the formal health care system.

Note that screenings need not be conducted by a Medicaid provider to trigger EPSDT coverage for follow up diagnostic services and medically necessary treatment by a qualified Medicaid provider.

Additionally, screening service provided before a child enrolls in Medicaid is sufficient to trigger EPSDT coverage, after Enrollment, for follow-up diagnostic services and necessary treatment.

b) *Services*.
The Contractor must assure availability and payment diagnostic services which are necessary to fully evaluate defects and physical, behavioral, or dental illnesses or conditions discovered by the screening services.

The Contractor shall provide payment for dental treatment, diagnostic or other measures which are necessary to correct or ameliorate defects and physical, behavioral, and/ or dental conditions discovered by the screening service and/or dental exam.

The Contractor must provide payment for any dental screening, diagnostic and/or treatment services, including continuing medical treatment after an initial referral, if medically necessary.

Dental services that must be provided, at minimum, under EPSDT requirements include: dental care needed for relief of pain, infection, restoration of teeth, and maintenance of dental health; emergency, preventive, and therapeutic services for dental disease that, if left untreated, may become acute dental problems or cause irreversible damage to the teeth or supporting structures; and orthodontic services to the extent necessary to prevent disease and promote oral health, and restore oral structures to health and function. Applicable services with limits can be exceeded based on medical necessity and/or provided outside of periodicity schedule.

The Contractor shall cover out-of-State services in the following circumstances under EPSDT: the out-of-State services are required because of an emergency; the child's health would be endangered if required to travel to Iowa/their home state; the Agency determines that the needed services are more readily available in another state; and when it is a general practice of the locality to use the services of an out-of-State provider (e.g., in areas that border another state).

The Contractor shall consider the child's quality of life when covering services in the most cost-effective mode if a less expensive service is equally effective and available.

c) *Transportation*.
EPSDT-eligible beneficiaries shall be offered appointment scheduling assistance and assured necessary transportation to and from medical appointments. Related travel expenses are covered if medically necessary, including meals and lodging for a child and necessary attendant.

d) *Reports and Records*.
The Agency has the obligation of assuring the Federal government that EPSDT services are being provided as required. The Contractor shall ensure that all requested records, including dental and peer review records, shall be available for inspection by State or Federal personnel or their representatives. The Contractor shall record dental screenings and examination related activities and shall report those findings in an Agency approved format at the Agency established frequency.

e) *Outreach*.
The Contractor shall implement outreach, monitoring, and evaluation strategies for EPSDT, including collaboration with local community stakeholders and public health agencies. The Contractor shall develop Provider and Enrolled Member education activities that increase beneficiary awareness of and Access to applicable EPSDT services.

F.6.26. *Prior Authorization - EPSDT.* Prior Authorization or PCP (if applicable) referral shall not be required for the provision of EPSDT screening services. While prior authorization limits may be placed on diagnostic and treatment services, EPSDT covered services are not limited to the services, amount, frequency, or duration of codes included in the State Plan, if found medically necessary during clinical review. The Contractor is required to review service prior to denial for medical necessity on a case-by-case basis. The Contractor is not required to provide payment for any service determined as not safe, not effective, or considered experimental in nature.

The Contractor shall identify members under twenty-one (21) years of age with EPSDT coverage to assure services that require Prior Authorization are reviewed according to EPSDT federal requirements for covering medically necessary services prior to denial.

F.6.27. *Reserved.* N/A.

F.6.28. *Sufficiency of Services.* Contractor shall provide all Medically Necessary Services in a manner that addresses the extent to which the Contractor is responsible for covering services that address the prevention, diagnosis, and treatment of an Enrolled Member's disease, condition, and/or disorder that results in health impairments and/or disability. See: 42 C.F.R. § 438.210(a)(5)(ii)(A). {From CMSC F.6.11}.

F.6.29. *Age-Appropriate Growth and Development.* Contractor shall cover services related to the ability for an Enrolled Member to achieve age-appropriate growth and development under the auspices of Medically Necessary Services. See: 42 C.F.R. § 438.210(a)(5)(ii)(B). {From CMSC F.6.12}.

F.6.30. *Functional Capacity.* Contractor shall cover services related to the ability for an Enrolled Member to attain, maintain, or regain functional capacity under the auspices of Medically Necessary Services. See: 42 C.F.R. § 438.210(a)(5)(ii)(C). {From CMSC F.6.13}.

F.6.31. *Reserved.* N/A.

F.6.32. *Reserved.* N/A.

F.6.33. *In Lieu of Services.* Contractor may cover services or settings for Enrolled Members that are in lieu of those covered under the State Plan if:

a) The Agency determines that the alternative service or setting is a medically appropriate substitute for the covered service or setting under the State Plan.
b) The Agency determines that the alternative service or setting is a cost-effective substitute for the covered service or setting under the State Plan.
c) The Enrolled Member is not required by the Contractor to use the alternative service or setting.
d) The approved in lieu of services are authorized and identified in the Contract.
e) The approved in lieu of services are offered to Enrolled Members at the option of the Contractor.

See: 42 C.F.R. § 438.3(e)(2)(i) - (iii); 42 C.F.R. § 457.1201(e). {From CMSC F.6.16 - F.6.20}.

F.7 Provider Preventable Conditions

F.7.01. *General.* Contractor shall not make payment to a Provider for Provider-Preventable Conditions that meet the following criteria:

a) Is identified in the State Plan.
b) Has been found by the Agency, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.
c) Has a negative consequence for the beneficiary.
d) Is auditable.

e) 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.

Pursuant to 42 C.F.R. § 447.26(c), no reduction in payment for a Provider preventable condition is imposed when the condition defined as a Provider preventable condition for a particular patient existed prior to the initiation of treatment for that patient by that Provider. Reductions in Provider payment may be limited to the extent that the identified Provider-Preventable Conditions would otherwise result in an increase in payment; and the Contractor can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the Provider-Preventable Conditions. See: 42 C.F.R. § 438.3(g); 42 C.F.R. § 434.6(a)(12)(i); 42 C.F.R. § 447.26(b). {From CMSC F.7.01}.

F.7.02. *Reporting by Providers.* Contractor shall require all Providers to report Provider-Preventable Conditions associated with Claims for payment or Enrolled Member treatments for which payment would otherwise be made. See: 42 C.F.R. § 438.3(g); 42 C.F.R. § 434.6(a)(12)(ii); 42 C.F.R. § 447.26(d). {From CMSC F.7.02}.

F.7.03. *Reporting to Agency.* Contractor shall report all identified Provider-Preventable Conditions in a form or frequency as specified by the Agency. See: 42 C.F.R. § 438.3(g). {From CMSC F.7.03}.

F.7.04. *Future Additions to Preventable Conditions.* The Contractor shall comply with any future additions to the list of non-reimbursable Provider-Preventable Conditions.

F.8 Cost Sharing

F.8.01. *Restriction on Cost Sharing.* Contractor shall limit any cost sharing imposed on Enrolled Members to the cost sharing permitted in Medicaid FFS regulations found at 42 C.F.R. § 447.50 through 42 C.F.R. § 447.82, all applicable State Plan obligations, and any approved waivers of that State Plan. See: Sections 1916(a)(2)(D) and 1916(b)(2)(D) of the Social Security Act; 42 C.F.R. § 438.108; 42 C.F.R. § 447.50 - 82; SMD letter 6/16/06. {from CMSC F.8.01}.

F.8.02. *Cost Sharing.* The Contractor and all Providers and Subcontractors shall not require any cost sharing responsibilities for covered services except to the extent that cost sharing responsibilities are required for those services in accordance with law and as described in Section F.8.

F.8.03. *Public Notice.* The Contractor shall make available to both Providers and Members the following information: (i) the groups of individuals subject to the cost sharing charges; (ii) the consequences for non-payment; (iii) the cumulative cost-sharing maximums; and (iv) mechanisms for making payments for required charges.

F.8.04. *Reserved.* N/A.

F.8.05. *Reserved.* N/A.

F.8.06. *Copayments.* The Contactor shall impose copayments, if required by the Agency, for Iowa Dental Wellness Plan participants in accordance with the Agency's 1115 waiver and Hawki Enrolled Members in accordance with the Agency's CHIP State Plan. If the Agency requires the Contractor to impose copayments it shall ensure compliance with the requirements outlined in this section.

F.8.07. *Exempt Populations.* The Contractor shall ensure, in accordance with 42 C.F.R. § 447.56, that copayments are not imposed on any of the following populations, if included under this Contract:

a) Individuals between ages one (1) and eighteen (18), eligible under 42 C.F.R. § 435.118;
b) Individuals under age one (1), eligible under 42 C.F.R. § 435.118;

c) Disabled or blind individuals under age eighteen (18) eligible under 42 C.F.R. § 435.120 or 42 C.F.R. § 435.130;
d) Children for whom child welfare services are made available under Part B of title IV of the Social Security Act on the basis of being a child in foster care and individuals receiving Benefits under Part E of that title, without regard to age;
e) Disabled children eligible for Medicaid under the Family Opportunity Act;
f) Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the sixty (60) day period following termination of pregnancy ends;
g) Any individual whose medical assistance for services furnished in an institution or HCBS setting is reduced by amounts reflecting available income other than required for personal needs;
h) An individual receiving hospice care, as defined in Section 1905(o) of the Social Security Act;
i) An Indian (as defined in Special Contract Exhibit B) who is currently receiving or has ever received an item or service furnished by an IHCP or through referral under contract health services; and
j) Individuals who are receiving Medicaid by virtue of their breast or cervical cancer diagnosis under 42 C.F.R. § 435.213.

F.8.08. *Exempt Services.* The Contractor shall ensure Co-Payments are not imposed for (i) preventive services provided to children under twenty-one (21) years of age covered under EPSDT; (ii) dental services provided during pregnancy, (ii) Provider preventable services as defined at 42 C.F.R. § 447.26(b); and (iii) Emergency Services.

F.8.09. *Reserved.* N/A.

F.8.10. *Inability to Pay.* Enrolled Members can assert to Providers that they are unable to pay the copayment. Providers may not deny care or services to any Enrolled Member because of their inability to pay the copayment. The Contractor shall implement the following mechanisms to enforce this policy: (i) Provider education; (ii) documentation in the Provider policy manual; and (iii) assisting Enrolled Members who report they have been denied services for inability to pay.

F.8.11. *Claims Payment.* As described in Section K.42, the Contractor shall reduce the payment it makes to a Provider, by the amount of the Enrolled Member's Co-Payment obligation, regardless of whether the Provider has collected the payment or waived the cost sharing, except as provided under 42 C.F.R. § 447.56(c).

F.8.12. *Reserved.* N/A.

F.8.13. *Indian Premium Exemption.* Contractor shall exempt from premiums any Indian who is eligible to receive or has received an item or service furnished by an IHCP or through referral under contract health services. See: 42 C.F.R. § 447.52(h); 42 C.F.R. § 447.56(a)(1)(x); ARRA § 5006(a); 42 C.F.R. § 447.51(a)(2); SMDL 10-001. {from CMSC F.8.02}.

F.8.14. *Indian Cost Charing Exemption.* Contractor shall exempt from all cost sharing any Indian who is currently receiving or has ever received an item or service furnished by an IHCP or through referral under contract health services. See: 42 C.F.R. § 447.52(h); 42 C.F.R. § 447.56(a)(1)(x); ARRA § 5006(a); 42 C.F.R. § 447.51(a)(2); SMDL 10-001. {from CMSC F.8.03}.

F.9 Reserved

F.9.01. *Reserved.* N/A.

F.9.02. *Reserved.* N/A.

F.10 Reserved
F.10.01. *Reserved.* N/A.

F.11 Reserved
F.11.01. *Reserved.* N/A.

F.12 Reserved
F.12.01. *Reserved.* N/A.

F.13 Reserved
F.13.01. *Reserved.* N/A.

F.14 Reserved
F.14.01. *Reserved.* N/A.

F.15 Moral Objections
F.15.01. *Generally*. If Contractor is otherwise required to provide, reimburse for, or provide coverage of a counseling or referral service, Contractor is not required to do so if the Contractor objects to the service on moral or religious grounds. See: Section 1932(b)(3)(B)(i) of the Social Security Act; 42 C.F.R. § 438.102(a)(2). {From CMSC F.15.01}.

F.16 Enrolled Member Rights
F.16.01. *Right to Receive Information.* Contractor shall have written policies guaranteeing each Enrolled Member's right to receive information on the managed care program and plan into which the Enrolled Member is enrolled. See: 42 C.F.R. § 438.100(a)(1); 42 C.F.R. § 438.100(b)(2)(i); 42 C.F.R. § 457.1220. {From CMSC F.16.01}.

F.16.02. *Right to be Treated with Respect.* Contractor shall have written policies guaranteeing each Enrolled Member's right to be treated with respect and with due consideration for the Enrolled Member's dignity and privacy. See: 42 C.F.R. § 438.100(a)(1); 42 C.F.R. § 438.100(b)(2)(ii); 42 C.F.R. § 457.1220. {From CMSC F.16.02}.

F.16.03. *Right to Participate in Community.* In recognizing each Member's dignity and privacy, Contractor shall not in any way restrict the Enrolled Members right to fully participate in the community and to work, live and learn to the fullest extent possible.

F.16.04. *Right to Receive Information on Treatment Options.* Contractor shall have written policies guaranteeing each Enrolled Member's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrolled Member's condition and ability to understand. See: 42 C.F.R. § 438.100(a)(1); 42 C.F.R. § 438.100(b)(2)(iii); 42 C.F.R. § 457.1220. {From CMSC F.16.03}.

F.16.05. *Right to Participate in Decisions.* Contractor shall have written policies guaranteeing each Enrolled Member's right to participate in decisions regarding the Enrolled Member's health care, including the right to refuse treatment. See: 42 C.F.R. § 438.100(a)(1); 42 C.F.R. § 438.100(b)(2)(iv); 42 C.F.R. § 457.1220. {From CMSC F.16.04}.

F.16.06. *Right to be Free from Restraint.* Contractor shall have written policies guaranteeing each Enrolled Member's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. See: 42 C.F.R. § 438.100(a)(1); 42 C.F.R. § 438.100(b)(2)(v); 42 C.F.R. § 457.1220. {From CMSC F.16.05}.

F.16.07. *Right to Copy of Medical Records.* Contractor shall have written policies guaranteeing each Enrolled Member's right to request and receive a copy of their Medical/Dental Records at no cost, and to request that they be amended or corrected. See: 42 C.F.R. § 438.100(a)(1); 42 C.F.R. § 438.100(b)(2)(vi); 42 C.F.R. § 457.1220. {From CMSC F.16.06}.

F.16.08. *Free Exercise of Rights.* Each Enrolled Member is free to exercise their rights without the Contractor or its Network Providers treating the Enrolled Member adversely. See: 42 C.F.R. § 438.100(a)(1); 42 C.F.R. § 438.100(c); 42 C.F.R. § 457.1220. {From CMSC F.16.07}.

F.16.09. *Exceptions to Policy.* Under the exception to policy process, an Enrolled Member can request an item or service not otherwise covered by the Agency or the Contractor. Exceptions to policy may be granted to Contractor policies, but they cannot be granted to federal or State law or regulations. Contractor may forward requests for exceptions to Agency policy to the Agency for consideration. An exception to policy is a last resort request and is not Appealable to the extent the request is for services outside of State Plan or waiver Benefits.

Waivers of administrative rules referred to as exceptions to policy may be granted in individual cases upon the DHHS Director's own initiative or upon request. Exceptions to Medicaid policy are only specifically granted by the DHHS Director with the recommendation of the Medicaid Director. The Department issues written decisions for all requests for an exception to policy.

The Contractor is not responsible for decisions regarding exceptions to policy under state rule and should not present themselves as such and shall not use the terms "exception to policy" to describe their own internal medical necessity review decisions when communicating with Enrolled Member.

The Contractor on their own and by their own determination, may make an exception to their own policies, but shall not refer to these actions as an exception to policy as defined in administrative rule. Any scenario in which the Contractor determines to provide coverage for items or services outside of their own policies must not be referred to as an exception to policy.

The Contractor on their own may determine that an exception to the administrative rules such as a request for an item or service not typically covered by Medicaid or a request to exceed service limits is appropriate to meet an Enrolled Member's assessed needs may initiate an administrative exception to policy request following the process outlined in 441 IAC 1.8.

Any scenarios in which the Contractor determines to approve, deny, reduce, or terminate an Enrolled Member's services remains subject to all applicable Iowa Administrative Code (IAC), Iowa Code and the Code of Federal Regulations, including timely notification, content of the notification, and Appeal rights.

F.17 Telehealth

F.17.01. *Telehealth.* An in-person contact between a dental health care professional and an Enrolled Member is not required as a prerequisite for payment for otherwise-covered services appropriately provided through telehealth in accordance with generally accepted dental health care practices and standards prevailing in the applicable professional community at the time the services are provided, as well as being in accordance with provisions under IAC 653-13.11 (147, 148, 272C). Dental health care services provided through in-person consultations or through telehealth shall be treated as equivalent services for the purposes of reimbursement. There is no additional payment for telehealth components of service associated with the underlying service being rendered. Payment for a service rendered via telehealth is the same as payment made for that service when rendered in an in-person setting.

G. Quality, Care Coordination, and Utilization Management

G.1 External Quality Review (EQR)

G.1.01. *Annual EQR.* Contractor shall undergo annual, external independent reviews of the Quality, timeliness, and Access to the services covered under each Contract. See: 42 C.F.R. § 438.350; 42 C.F.R. § 457.1250(a); 42 C.F.R. § 457.1240(f); 42 C.F.R. § 457.1201(n). {From CMSC G.1.01}.

G.1.02. *Process.* The Contractor shall provide all information required for the External Quality Reviews in the timeframe and format requested by the External Quality Review Organization (EQRO). The Contractor shall incorporate and address findings from these External Quality Reviews in the QM/QI program. The Contractors shall collaborate with the EQRO to develop studies, surveys, and other analytic activities to assess the Quality of care and services provided to Enrolled Members and to identify opportunities for Contractor improvement. The Contractor shall also work collaboratively with the Agency and the EQRO to annually measure identified Performance Measures to assure Quality and accessibility of health care in the appropriate setting to Enrolled Members, including the Validation of Performance Improvement Projects (PIPs) and Performance Measures. The Contractor shall respond to recommendations made by the EQRO within the timeframe established by the EQRO, the Agency or its Designee.

G.2 Care Coordination

G.2.01. *General.* Contractor shall:

a) Implement procedures to ensure that each Enrolled Member has an ongoing source of care appropriate to their needs.
b) Formally designate a person or entity as primarily responsible for coordinating services Accessed by the Enrolled Member.

See: 42 C.F.R. § 438.208(b)(1); 42 C.F.R. § 457.1230(c). {From CMSC G.2.01 - G.2.02}.

G.2.02. *Information Requirements.* Contractor shall provide Enrolled Members information on how to contact their designated person or entity. See: 42 C.F.R. § 438.208(b)(1); 42 C.F.R. § 457.1230(c). {From CMSC G.2.03}.

G.2.03. *Reserved.* N/A.

G.2.04. *Reserved.* N/A.

G.2.05. *Reserved.* N/A.

G.2.06. *Coordination with Other Contractors.* Contractor shall implement procedures to coordinate services the Contractor furnishes to the Enrolled Member with the services the Enrolled Member receives from any other MCO, PIHP, or PAHP. See: 42 C.F.R. § 438.208(b)(2)(ii); 42 C.F.R. § 457.1230(c). {From CMSC G.2.05}.

G.2.07. *Coordination with FFS Medicaid.* Contractor shall implement procedures to coordinate the services the Contractor furnishes to the Enrolled Member with the services the Enrolled Member receives in FFS Medicaid. See: 42 C.F.R. § 438.208(b)(2)(iii); 42 C.F.R. § 457.1230(c). {From CMSC G.2.06}.

G.2.08. *Coordination with Community Supports.* Contractor shall implement procedures to coordinate the services the Contractor furnishes to the Enrolled Member with the services the Enrolled Member receives from community and social support Providers. See: 42 C.F.R. § 438.208(b)(2)(iv); 42 C.F.R. § 457.1230(c). {From CMSC G.2.07}.

G.2.09. *Timeliness.* Contractor shall:

a) Make a best effort to conduct an initial screening of each Enrolled Member's needs, within ninety (90) Days of the effective date of Enrollment for all new Enrolled Members.

b) Make subsequent attempts to conduct an initial screening of each Enrolled Member's needs if the initial attempt to contact the Enrolled Member is unsuccessful.

42 C.F.R. § 438.208(b)(3); 42 C.F.R. § 457.1230(c). {From CMSC G.2.08 - G.2.09}.

G.2.10. *Initial Oral Health Risk Screening.* The Contractor shall obtain Agency approval for a plan to conduct initial oral health risk screenings for: (i) newly Enrolled Members ages twenty-one (21) years and over, within ninety (90) Days of Enrollment for the purpose of assessing need for any special dental health care or Care Coordination services; and (ii) Enrolled Members who have not been enrolled in the prior twelve (12) months. During the initial oral health risk screening process, Enrolled Members shall be offered assistance in arranging an initial visit with a dentist (as applicable) for a baseline oral health assessment and other preventive services, including an assessment or screening of the Enrolled Member's potential risk, if any, for specific diseases or conditions. The Contractor shall implement and adhere to the Agency-approved plan. Changes to the plan shall receive the Agency's prior approval. The Contractor shall assist in coordinating care for newly Enrolled Members under twenty-one (21) years of age, following the assessment and Care Coordination services provided under the Maternal Child and Adolescent Health programs. The Contractor shall utilize the Oral Health Equity Self-Assessment tool to complete initial oral health risk screenings.

G.2.11. *Oral Health Equity Self-Assessment Tool.* The Contractor shall obtain Agency approval of an oral health equity self-assessment tool. At minimum, information collected shall assess the Enrolled Member's oral status and needs. The tool shall determine the need for Care Coordination or any other health or community services. The tool shall also comply with NCQA standard for oral health risk screenings and contain standardized questions that tie to social determinants of health. Contractor tools will be compared against the current approach by the Agency, and a uniform tool is preferred across Program Contractors. In addition, the initial oral health risk screening shall include the social determinants of health questions as determined by the Agency. The Contractor shall follow the Agency's approved file exchange format and requirement specification documents to ensure uniform reporting across contractors.

G.2.12. *Screening Method.* The initial oral health risk screening may be conducted: (i) in person; (ii) by phone; (iii) electronically through a secure website; or (iv) by mail. The Contractor shall develop methods to maximize contacts with Enrolled Members in order to complete the initial oral health screening.

G.2.13. *Completion of Initial Oral Health Risk Screening.* Contractor shall complete an initial oral health risk screening no later than ninety (90) Days after Member Enrollment with the Contractor. Each quarter, at least seventy percent (70%) of the Contractor's new Enrolled Members, who have been assigned to the Contractor for a continuous period of at least ninety (90) Days, shall complete an initial oral health risk screening within ninety (90) Days. For any Enrolled Member who does not obtain an initial oral health risk screening, the Contractor shall document at least three (3) attempts to conduct the screening.

G.2.14. *Reserved.* N/A.

G.2.15. *Reserved.* N/A.

G.2.16. *Assessments – Special Conditions.* Contractor shall implement mechanisms to comprehensively assess each Enrolled Member identified as having special health care needs to identify any ongoing special conditions of the Enrolled Member that require a course of treatment or regular care monitoring. See: 42 C.F.R. § 438.208(c)(2); 42 C.F.R. § 457.1230(c). {From CMSC G.7.01}.

G.2.17. *Referral Following Initial Oral Health Screening*. The initial oral health screening described in Section G.2.10 shall include a referral to a provider within the Enrolled Member's service area and Network Adequacy requirements described in Special Contract Exhibit C, and referrals to the appropriate community resources identified during the Oral Health Equity Self-Assessment.

G.2.18. *Reserved*. N/A.

G.2.19. *Reserved.* N/A.

G.2.20. *Member Identification*. In addition to identifying Enrolled Members eligible for the Care Coordination program through the initial oral health risk screening, the Contractor shall utilize, at minimum: (i) Claims review; (ii) Enrolled Member and caregiver requests; and (iii) dentist referrals.

G.2.21. *Care Coordination Program.* The Contractor shall design and operate a Care Coordination program to monitor and coordinate the care for Enrolled Members identified as having special dental health care needs, including the need for specialty providers. Minimum requirements for the Contractor's Care Coordination program include: (i) community resource referral to address social determinants of health identified via the Oral Health Equity Self-Assessment tool (ii) disease management, including coordination of dental care during nursing and inpatient facility placement; (iii) programs to target Enrolled Members underusing, overusing and/or abusing services; (iv) special accommodations (sedation, dental anxiety, transportation) and (v) transition planning.

G.2.22. *Reserved.* N/A.

G.2.23. *Involved Parties.* When developing the Care Coordination program, in addition to working with qualified oral health care professionals, the Contractor shall collaborate with transportation companies, IA Health Link MCOs and their case managers, other dental Program Contractors, community stakeholders, and local I-Smile agencies. The Contractor shall provide an integrated care plan which avoids duplication and/or fragmentation of services, removing barriers for the member in accessing specialty providers, and assisting the Enrolled Member with health literacy and scheduling of appointments when needed including ongoing dental treatment.

G.2.24. *Reserved.* N/A.

G.2.25. *Tracking and Reporting.* The Contractor shall integrate information about Enrolled Members in order to facilitate positive Enrolled Member Outcomes through Care Coordination. The system shall have the ability to track the results of the initial oral health risk screening and Enrolled Member Outcomes and have the ability to share Care Coordination information with the Enrolled Member, their authorized representatives, and all relevant treatment Providers. The Contractor shall submit regular reporting regarding the initial oral health screenings, Care Coordination selection criteria, strategies & Outcomes of Care Coordination programs as prescribed in the Reporting Manual.

G.2.26. *Reserved.* N/A.

G.2.27. *Monitoring.* The Contractor shall develop a comprehensive program for monitoring, on an ongoing basis, the effectiveness of its Care Coordination program and processes. The Contractor shall promptly remediate all case specific findings identified through the monitoring process and track and trend findings to identify systemic issues of poor performance or non-compliance. The Contractor shall implement strategies to improve its Care Coordination program and processes and resolve areas of non-compliance.

G.2.28. *Reserved.* N/A.

G.2.29. *Information Sharing Obligation.* Contractor shall share with the Agency or other MCOs, PIHPs, and PAHPs serving the Enrolled Member the results of any identification and assessment of that Enrolled Member's

needs to prevent duplication of those activities. See: 42 C.F.R. § 438.208(b)(4); 42 C.F.R. § 457.1230(c). {From CMSC G.2.10}.

G.2.30. *Health Record Sharing Obligation.* Contractor shall ensure that each Provider furnishing services to Enrolled Members maintains and shares an Enrolled Member health record in accordance with Professional Standards. See: 42 C.F.R. § 438.208(b)(5); 42 C.F.R. § 457.1230(c). {From CMSC G.2.11}.

G.2.31. *Medical Records.* Contractor shall develop, implement, and adhere to policies, procedures and contractual requirements for Participating Provider Medical Records content and documentation in compliance with the provisions of Iowa Admin. Code r. 441-79.3. Contractor shall document its policies and procedures in its PPM. After Agency approval, the Contractor shall communicate those policies and procedures to Network Providers. The Contractor shall assure that its records and those of its Participating Providers document all medical services that the Enrolled Member receives in accordance with law and consistent with utilization control requirements in 42 C.F.R. Part 456. The Contractor's Providers shall maintain Enrolled Members' Medical Records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical Records shall be legible, signed, dated, and maintained as required by law.

G.2.32. *Maintenance and Retention.* The Contractor shall maintain a Medical Records system that: (i) identifies each medical record by State identification number; (ii) identifies the location of every medical record; (iii) places Medical Records in a given order and location; (iv) maintains the confidentiality of Medical Records information and releases the information only in accordance with applicable law; (v) maintains inactive Medical Records in a specific place; (vi) permits effective professional review in medical audit processes; and (vii) facilitates an adequate system for follow-up treatment including monitoring and follow-up of off-site referrals and inpatient stays.

G.2.33. *HIPAA Compliance.* Contractor shall use and disclose individually identifiable health information, such as Medical Records and any other health or Enrollment information that identifies a particular Enrolled Member, in accordance with the confidentiality requirements in 45 C.F.R. § parts 160 and 164. See: 42 C.F.R. § 438.208(b)(6); 42 C.F.R. § 438.224; 45 C.F.R. § 160; 45 C.F.R. § 164; 42 C.F.R. § 457.1230(c). {From CMSC G.2.12}.

G.2.34. *Transition of Care Policy.* Contractor shall implement a transition of care policy that is consistent with federal requirements and at least meets the Agency defined transition of care policy. See: 42 C.F.R. § 438.62(b)(1) - (2); 42 C.F.R. § 457.1216. {From CMSC G.2.13}.

G.2.35. *Continuity of Care Policy.* The Contractor shall implement mechanisms to ensure the continuity of care of Enrolled Members transitioning in and out of the Contractor's Enrollment pursuant to all requirements in 42 C.F.R. § 438.62 and 42 C.F.R. § 457.1216. The Contractor must demonstrate the following components are implemented to ensure continuity of care during transitions:

a) The Enrolled Member has Access to services consistent with the Access they previously had and is permitted to retain their current Provider for ninety (90) days if that Provider is enrolled in Iowa Medicaid.
b) The Enrolled Member is referred to appropriate Providers of services that are in the network.
c) The entity (Contractor or Agency) previously serving the Enrolled Member, fully and timely complies with requests for historical utilization data from the new entity in compliance with Federal and State law.
d) Consistent with Federal and State law, the Enrolled Member's new Provider(s) are able to obtain copies of the Enrolled Member's Medical Records, as appropriate.

e) Any other necessary procedures as specified by CMS to ensure continued Access to services to prevent serious detriment to the Enrolled Member's health or reduce the risk of Hospitalization or institutionalization.

Possible transitions include but are not limited to: (i) initial program implementation; (ii) initial Enrollment with the Contractor; (iii) transitions between Program Contractors during the first ninety (90) Days of a Member's Enrollment; and (iii) at any time for cause as described in the Section B.5.05.

G.2.36. *Prior Authorization.* During the first two (2) years of the Contract, the Contractor shall honor all existing authorizations for covered Benefits for a minimum of ninety (90) Days, without regard to whether such services are being provided by contract or non-contract Providers, when an Enrolled Member transitions to the Contractor from another source of coverage. The Contractor shall honor existing exceptions to policy granted by the Director for the scope and duration designated. At all other times, the Contractor shall honor all existing authorizations for a minimum of thirty (30) Days when an Enrolled Member transitions to the Contractor from another source of coverage, without regard to whether services are being provided by contract or non-contract Providers. The Contractor shall obtain Agency approval for policies and procedures to identify existing Prior Authorizations at the time of Enrollment. The Contractor shall implement and adhere to the Agency approved policies and procedures. Additionally, when an Enrolled Member transitions to another Program Contractor, the Contractor shall provide the receiving entity with information on any current Service Authorizations, utilization data and other applicable clinical information such as disease management or Care Coordination notes.

G.2.37. *Transition Period-Out of Network Care.* During the first ninety (90) Days following Contractor's entry into the Iowa Dental Wellness Plan and Hawki Dental program, the Contractor shall allow an Enrolled Member who is receiving covered Benefits from a non-Network Provider at the time of Contractor Enrollment to continue accessing that Provider, even if the network has been closed due to the Contractor meeting the network Access requirements. The Contractor is permitted to establish Single Case Agreements with Providers enrolled with Iowa Medicaid or otherwise authorize non-network care past the initial ninety (90) Days of the Contract to provide continuity of care for Enrolled Members receiving out-of-network services. The Contractor shall make commercially reasonable attempts to contract with Providers from whom an Enrolled Member is receiving ongoing care. Out-of-Network Providers will be reimbursed a percentage of the network rate unless otherwise agreed upon through a Single Case Agreement.

G.2.38. *Reserved.* N/A.

G.2.39. *Reserved.* N/A.

G.2.40. *Reserved.* N/A.

G.2.41. *Special Needs Treatment Plans.* Contractor shall use diligent efforts to identify Enrolled Members with special health care needs. This can be performed through an assessment of the Enrolled Member's health status upon Enrollment or through identification by data sharing with the member's assigned IA Health Link MCO. Contractor shall educate providers and members on the importance of routine dental care and assess for additional frequency of preventive services as included in the Medicaid State Plan, for Enrolled Members with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. See: 42 C.F.R. § 438.208(c)(3); 42 C.F.R. § 457.1230(c). {From CMSC G.7.05}.

G.2.42. *Reserved.* N/A.

G.2.43. *Special Health Care Needs Plan Obligations.* For Enrolled Members with special health care needs as required by the Agency:

a) Contractor's prevention and treatment services shall be developed in accordance with any applicable State Quality assurance and Utilization Review standards.

See: 42 C.F.R. § 438.208(c)(3)(iii) - (v); 42 C.F.R. § 441.301(c)(3); 42 C.F.R. § 457.1230(c). {From CMSC G.7.11 - G.7.13}.

G.2.44. *Specialist Direct Access.* For Enrolled Members with special health or dental care needs, determined through an exam or dental hygiene assessment to need a course of treatment or regular care monitoring, Contractor shall have a mechanism in place to allow Enrolled Members to directly access a Specialist as appropriate for the Enrolled Member's condition and identified needs. See: 42 C.F.R. § 438.208(c)(4); 42 C.F.R. § 457.1230(c). {From CMSC G.7.14}.

G.2.45. *Reserved.* N/A.

G.3 Authorization and Utilization Management

G.3.01. *Utilization Management Program.* The Contractor shall develop, operate, and maintain a UM program, which shall be documented in writing. As part of this program, the Contractor shall obtain Agency approval of policies and procedures with defined structures and processes. The UM program shall assign responsibility to appropriate individuals. The Contractor shall have mechanisms in place to ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope solely because of the diagnosis, type of illness or condition. All UM strategies, including identification of criteria to be utilized by the plan, shall be approved by the Agency prior to implementation or change. Following Agency approval, notification shall be provided to the provider community thirty (30) Days prior to implementation or change.

G.3.02. *UM Policies and Procedures.* The Contractor's UM program policies and procedures shall meet all standards of the Contractor's accrediting entity and shall have criteria that: (i) are objective and based on clinical, peer-reviewed evidence; (ii) are applied based on individual needs; (iii) include an assessment of the local delivery system; (iv) involve appropriate practitioners in developing, adopting and reviewing them; and (v) are annually reviewed and updated as appropriate.

G.3.03. *Program Elements.* The UM program shall provide for methods of assuring the appropriateness of dental care, analyzing Emergency Services utilization and diversion efforts, monitoring patient data related to dental related illnesses and outpatient dental surgeries, and monitoring Provider utilization practices and trends for any Providers who appear to be operating outside of peer standards. Prior to implementation and upon request by the Agency thereafter, the Contractor shall demonstrate the data selection criteria, algorithms, and any additional elements used within the program.

The UM Program description, policies, procedures, and evaluation mechanisms shall be exclusive to Iowa and shall not contain documentation from other state Medicaid programs or product lines operated by the Contractor. The UM program descriptions, policies, procedures, and evaluation mechanisms shall be annually submitted to the Agency for review. The Contractor shall submit all changes or deviations to the Agency for approval prior to implementation. The initial draft of all materials is due within fifteen (15) Days of Contract execution.

The initial draft shall include a work plan identifying steps to be taken to implement the UM program and including a timeline with target dates. A final work plan, incorporating any changes requested by the Agency, shall be submitted to the Agency within fifteen (15) Days after receipt of Agency comments. The Contractor shall execute, adhere to, and provide the services set forth in the Agency-approved plan. Changes to the plan shall receive prior approval from the Agency, and the Contractor shall make any updates to maintain a current version of the plan.

G.3.04. *UM Care Coordination*. The Contractor's UM program shall not be limited to traditional UM activities, such as Prior Authorization. The Contractor shall maintain a UM program that integrates with other functional units as appropriate and is supported by the Quality Management and Improvement Program. The

UM program shall have policies, procedures, and systems in place to identify instances of over- and under-utilization of dental emergency and limited exam services and other dental health care services, identify aberrant Provider practice patterns, evaluate efficiency and appropriateness of service delivery, facilitate program management and long-term Quality and identify critical Quality of care issues. The Contractor's UM program shall link Enrolled Members to the Contractor's Care Coordination program as described in Section G.2. The UM program shall work in tandem with the Contractor's Care Coordination function to coordinate dental treatment needs, ongoing prevention services, and alleviate member barriers in accessing dental services.

G.3.05. *UM Committee.* The Contractor shall have a UM committee directed by the Contractor's Dental Director. The committee is responsible for: (i) monitoring Providers' requests for rendering dental health care services to its Enrolled Members; (ii) monitoring the medical appropriateness and necessity of dental health care services provided to its Enrolled Members; (iii) reviewing the effectiveness of the Utilization Review process and making changes to the process as needed; (iv) writing policies and procedures for UM that conform to Industry Standards including methods, timelines and individuals responsible for completing each task; and (v) confirming the Contractor has an effective mechanism in place for assuring dental service access in areas, including within the State's identified Dental Health Professional Shortage Areas (DHPSAs).

The Contractor's Dental Director shall participate in quarterly Clinical Advisory Committee (CAC) and monthly IME Medical Director meetings to provide recommendations for clinical criteria to ensure clinical policies are implemented consistently. The Contractor's Dental Director shall communicate critical information from the CAC and IME Medical Director meetings internally to ensure policies and procedures are implemented as agreed upon by the clinical team. Contractor shall participate in the CAC but are not voting members of the CAC.

G.3.06. *Coverage and Authorization of Services.* Contractor and Subcontractor written policies and procedures for processing requests for initial and continuing authorizations of services are subject to Agency review and approval. The Contractor shall have in effect mechanisms to ensure consistent application of review criteria for Prior Authorization decisions that are no more restrictive than the State Medicaid FFS program and/or the State Plan Amendment. The Contractor shall have sufficient staff with clinical expertise and training to interpret and apply the UM criteria and practice guidelines to Providers' requests for dental health care or Service Authorizations for the Contractor's Enrolled Members. Consultation with the requesting Provider shall be ensured when appropriate.

G.3.07. *Medical Necessity Determinations.* The Contractor shall use appropriate licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including Prior Authorization and decision making. The Contractor shall develop, implement, and adhere to written procedures documenting access to dentists and dental hygienists to assist in making medical necessity determinations. Any decision to deny a Service Authorization request or to authorize a service in an amount, duration or scope that is less than requested shall be made by an oral health care professional who has appropriate clinical expertise in treating the Enrolled Member's condition or disease. Medical necessity determinations shall not be more restrictive than the Medicaid State Plan, State, and Federal law.

G.3.08. *Reserved.* N/A.

G.3.09. *Prior Authorization Requests*

a) *Processing.* Prior Authorization requests shall be processed in accordance with 42 C.F.R. § 438.210 and related rules and regulations, which include but are not limited to provisions regarding decisions, Notices, medical contraindications, and the failure of a Contractor to act timely upon a request. The Contractor shall have in place mechanisms to ensure that all Prior Authorization requests are processed within appropriate timeframes (as set forth in this Section G) for: (i) completing initial requests for Prior Authorization of services; (ii) completing initial determinations of medical necessity; (iii)

completing Provider and Member Appeals and expedited Appeals for Prior Authorization of service requests or determinations of medical necessity, in accordance with law; (iv) notifying Providers and Enrolled Members in writing of the Contractor's decisions on initial Prior Authorization requests and determinations of medical necessity; and (v) notifying Providers and Enrolled Members of the Contractor's decisions on Appeals and expedited Appeals of Prior Authorization requests and determinations of medical necessity.

b) *Emergency and Post-Stabilization Care Services.* The Contractor shall provide Emergency Services without requiring Prior Authorization or PCP referral, regardless of whether these services are provided by a contract or non-contract Provider. The Contractor shall provide Post-Stabilization Care Services in accordance with 42 C.F.R. § 438.114.
c) *EPSDT.* The Contractor shall not require Prior Authorization or PCP (if applicable) referral for the provision of EPSDT screening services.
d) *Transition of New Members.* Pursuant to the requirements in Section G.2 regarding transition of newly Enrolled Members, the Contractor shall provide for the continuation of medically necessary covered services regardless of Prior Authorization or referral requirements.

G.3.10. *Tracking and Reporting*

a) *PA Tracking Requirements*. The Contractor shall track all Prior Authorization requests in its information system. All notes in the Contractor's Prior Authorization tracking system shall be signed by clinical staff and include the appropriate credentials. For Prior Authorization approvals, the Contractor shall provide a Prior Authorization number to the requesting Provider and maintain a record of the following information, at a minimum, in the Contractor's information system: (i) name and title of caller or submitter, (ii) date and time of call, fax or online submission, (iii) Prior Authorization number, (iv) time to determination, from receipt and (v) approval/denial count. All information shall be produced by the Contractor to the Agency on demand.
b) *PA Denials.* For all denials of Prior Authorization requests, the Contractor shall maintain a record of the following information, at a minimum, in the Contractor's information system: (i) name and title of caller or submitter, (ii) date and time of call or submission, (iii) clinical synopsis inclusive of timeframe of illness or condition, diagnosis and treatment plan; and (iv) clinical guidelines or other rational supporting the denial (i.e. insufficient documentation). All information shall be produced by the Contractor to the Agency on demand.

G.3.11. *Policies and Procedures.* Contractor and its Subcontractors shall have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of services. See: 42 C.F.R. § 438.210(b)(1); 42 C.F.R. § 457.1230(d). {From CMSC G.3.01}.

G.3.12. *Consistent Application.* Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions. See: 42 C.F.R. § 438.210(b)(2)(i); 42 C.F.R. § 457.1230(d). {From CMSC G.3.02}.

G.3.13. *Required Provider Consult.* Contractor shall consult with the requesting Provider for medical services when appropriate. See: 42 C.F.R. § 438.210(b)(2)(ii); 42 C.F.R. § 457.1230(d). {From CMSC G.3.03}.

G.3.14. *Reserved.* N/A.

G.3.15. *Appropriate Expertise.* Any decision to deny a Service Authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by an individual who has appropriate expertise in addressing the Enrolled Member's medical, behavioral health, or long- term services and supports needs. See: 42 C.F.R. § 438.210(b)(3); 42 C.F.R. § 457.1230(d). {From CMSC G.3.05}.

G.3.16. *Reserved.* N/A.

G.3.17. *Notice – Timeframe.* For standard authorization decisions, Contractor shall provide Notice as expeditiously as the Enrolled Member's condition requires and within Agency-established timeframes that may not exceed fourteen (14) Days after receipt of request for service, with a possible extension of fourteen (14) Days if the Enrolled Member or Provider requests an extension or the Contractor justifies the need for additional information and how the extension is in the Enrolled Member's interest. See: 42 C.F.R. § 438.210(d)(1); 42 C.F.R. § 457.1230(d). {From CMSC G.3.07}.

G.3.18. *Exceptions to Notice Timeframe.* When a Provider indicates, or when the Contractor determines, that following the standard timeframe could seriously jeopardize the Enrolled Member's life or health or ability to attain, maintain, or regain maximum function, Contractor shall make an expedited authorization decision and provide Notice as expeditiously as the Enrolled Member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service. See: 42 C.F.R. § 438.210(d)(2); 42 C.F.R. § 457.1230(d). {From CMSC G.3.08}.

G.3.19. *PA Performance Metric.* Ninety-nine percent (99%) of standard authorization decisions shall be rendered within fourteen (14) Days of the request for service, or seventy-two (72) hours for expedited authorization decisions. Requests for extensions approved in accordance with previous sections of the Contract shall be removed from this timeliness measure.

G.3.20. *Reserved.* N/A.

G.3.21. *Prohibition on Incentives.* Compensation to individuals or entities that conduct UM activities shall not be structured so as to provide incentives for denying, limiting, or discontinuing Medically Necessary Services to any Enrolled Member. See: 42 C.F.R. § 438.210(e); 42 C.F.R. § 457.1230(d). {From CMSC G.3.10}.

G.4 Practice Guidelines

G.4.01. *Evidence-Based Practice Guidelines.* Contractor shall adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of Providers in the particular field and clinical practice guidelines required by the Agency. See: 42 C.F.R. § 438.236(b)(1); 42 C.F.R. § 457.1233(c). {From CMSC G.4.01}.

G.4.02. *Considering Needs of Enrolled Members.* Contractor shall adopt practice guidelines that consider the needs of the Enrolled Members. See: 42 C.F.R. § 438.236(b)(2); 42 C.F.R. § 457.1233(c). {From CMSC G.4.02}.

G.4.03. *Obligation to Consult.* Contractor shall adopt practice guidelines in consultation with network providers. See: 42 C.F.R. § 438.236(b)(3); 42 C.F.R. § 457.1233(c). {From CMSC G.4.03}.

G.4.04. *Periodic Review.* Contractor shall review and update practice guidelines periodically as appropriate. See: 42 C.F.R. § 438.236(b)(4); 42 C.F.R. § 457.1233(c). {From CMSC G.4.04}.

G.4.05. *Following Practice Guidelines.* Contractor's decisions regarding UM, Enrolled Member education, coverage of services, and other areas to which practice guidelines apply shall be consistent with such practice guidelines. See: 42 C.F.R. § 438.236(d); 42 C.F.R. § 457.1233(c). {From CMSC G.4.05}.

G.4.06. *Dissemination of Practice Guidelines.* Contractor shall disseminate practice guidelines to all affected Providers. See: 42 C.F.R. § 438.236(c); 42 C.F.R. § 457.1233(c). {From CMSC E.10.01}.

G.5 Quality

G.5.01. *Program Objectives.* The Agency seeks to improve the Quality of care and Outcomes for Medicaid and CHIP Enrolled Members across the healthcare delivery system through this Contract. The Contractor shall

improve Quality Outcomes and develop a Quality Management/Quality Improvement (QM/QI) program that incorporates ongoing review of all major Contract areas. The QM/QI program shall have objectives that are measurable, realistic and supported by consensus among the Contractor's clinical and Quality improvement staff. The Contractor shall use the result of its QM/QI activities to improve the Quality of oral health and service delivery with appropriate input from Provider and Enrolled Members.

G.5.02. *QM/QI Program Requirements.* The Contractor shall meet the requirements of 42 C.F.R. Part 438 subpart E and the standards of the Credentialing body by which the Contractor is credentialed in development of its QM/QI program. The QM/QI program descriptions, work plan and program evaluation shall be exclusive to Iowa and shall not contain documentation from other State Medicaid programs or product lines operated by the Contractor. The Contractor shall make all information about its QM/QI program available to Providers and Enrolled Members. The QM/QI program shall be submitted to the Agency for approval within sixty (60) Days after Contract initiation and include, at minimum, all of the following elements:

a) An annual and prospective five (5) year QM/QI work plan that sets measurable goals, establishes specific objectives, identifies the strategies and activities to be undertaken, monitors results and assesses progress toward the goals;
b) Dedicated resources (staffing, data sources and analytical resources), including a QM/QI committee that oversees the QM/QI functions;
c) A process to monitor variation in practice patterns and identify outliers;
d) Strategies designed to promote practice patterns that are consistent with evidence-based clinical practice guidelines through the use of education, technical support and Provider incentives;
e) Analysis of the effectiveness of treatment services, employing both standard measures of symptom reduction/management, and measures of functional status;
f) Written policies and procedures for Quality improvement including methods, timelines and individuals responsible for completing each task;
g) System for monitoring services, including data collection and management for clinical studies, internal Quality improvement activities, assessment of special needs populations and other Quality improvement activities found valuable by the Contractor or required by the Agency;
h) Incorporation of clinical studies and use of HEDIS rate data, dental health care Quality measures for Medicaid-eligible adults described in Section 1139B of the Social Security Act, using the survey tool identified by the Agency and data from other similar sources to periodically and regularly assess the Quality and appropriateness of care provided to Enrolled Members;
i) Submit a report on any Performance Measures required by CMS;
j) Implement utilization of and report on all Quality measures required by the Agency, as described in Section N, including, but not limited to quarterly health Outcomes and clinical reports, and the measures within Agency-approved value-based purchasing contracts;
k) Procedures for collecting and assuring accuracy, validity and reliability of performance outcome rates that are consistent with best practice protocols developed in the public or private sector;
l) Procedures for a Provider pay-for-performance program;
m) Enrolled Member incentive programs aligned with the Healthiest State Initiative and other Quality Outcomes; and
n) Procedures to assess Enrolled Member satisfaction not already defined.

G.5.03. *Member Incentive Program: General.* The Contractor shall establish Enrolled Member incentive programs to increase Quality Outcomes, encourage appropriate utilization of dental health services, oral hygiene practices, and education on office etiquette and what to expect at a dental visit. The Contractor shall obtain Agency approval prior to implementing any Enrolled Member incentives and before making any changes to an approved incentive. Enrolled Member incentives may be financial or non-financial. The Contractor shall determine its own methodology for incenting Enrolled Members. Programs shall be tailored to issues prevalent among Enrolled Membership as identified by the Contractor. Examples of behaviors the Contractor may consider incentivizing include: (i) obtaining recommended age/gender preventive care services; (ii) complying

with treatment in a disease management or Care Coordination program; (iii) making healthy lifestyle decisions; and (iv) encouraging responsible Emergency Services use.

G.5.04. *Member Incentive Program Payment Restrictions.* If implementing the Enrolled Member incentive programs, the Contractor shall comply with all Marketing provisions in 42 C.F.R. § 438.104 as well as federal and State regulations regarding inducements. Contractor shall take all measures necessary to confirm the legality and impact on any Enrolled Member's eligibility of any value-added services, including but not limited to the permissibility of any such service under the Anti-Kickback Statute and the Stark law. 42 U.S.C. § 1320a-7b (Anti-Kickback Statute); 42 U.S.C. § 1395nn (Stark law). This includes but is not limited to obtaining an advisory opinion under the federal statutory schemes where necessary. *See* 42 C.F.R. § 411.370 (Stark); 42 U.S.C. § 1320a-7d(b) (Anti-Kickback).

G.5.05. *QM/QI Committee.* The Contractor shall have a QM/QI committee, which shall include dental staff and Network Providers. This committee shall analyze and evaluate the result of QM/QI activities, recommend policy decisions, ensure that Providers are involved in the QM/QI program, institute needed action, and ensure that appropriate follow-up occurs. This committee shall also review and approve the QM/QI program description, annual evaluation and associated work plan prior to submission to the Agency.

a) *Minutes*. The QM/QI committee shall keep written minutes of all meetings. A copy of the signed and dated written minutes for each meeting shall be available on-file and shall be made available for review upon request by the Agency or its Designee.
b) *Notice of Meetings*. The Contractor shall provide the Agency with ten (10) Days advance notice of all regularly scheduled meetings of the QM/QI committee. The Agency may attend the QM/QI committee meetings at its option.

G.5.06. *QAPI Program.* Contractor shall establish and implement an ongoing Comprehensive Quality Assessment and Performance Improvement (QAPI) program for the services it furnishes to its Enrolled Members. See: 42 C.F.R. § 438.330(a)(1); 42 C.F.R. § 438.330(a)(3); 42 C.F.R. § 457.1240(b). {From CMSC G.5.01}.

G.5.07. *PIP – Clinical & Non-Clinical Areas.* Contractor's comprehensive QAPI program shall include PIPs, including any required by the Agency or CMS, that focus on clinical and non- clinical areas. See: 42 C.F.R. § 438.330(b)(1); 42 C.F.R. § 438.330(d)(1); 42 C.F.R. § 438.330(a)(2); 42 C.F.R. § 457.1240(b). {From CMSC G.5.02}.

G.5.08. *Performance Measurement Data.* Contractor's comprehensive QAPI program shall include collection and submission of Performance Measurement data, including any required by the Agency or CMS. See: 42 C.F.R. § 438.330(b)(2); 42 C.F.R. § 438.330(c); 42 C.F.R. § 438.330(a)(2); 42 C.F.R. § 457.1240(b). {From CMSC G.5.03}.

G.5.09. *Under- and Over-Utilization Detection.* Contractor's comprehensive QAPI program shall include mechanisms to detect both underutilization and overutilization of services. See: 42 C.F.R. § 438.330(b)(3); 42 C.F.R. § 457.1240(b); 42 C.F.R. § 457.1240(f); 42 C.F.R. § 457.1201(n). {From CMSC G.5.04}.

G.5.10. *Special Health Care Needs Obligations.* Contractor's comprehensive QAPI program shall include mechanisms to assess the Quality and appropriateness of care furnished to Enrolled Members with special health care needs, as defined by the Agency in the Quality strategy. See: 42 C.F.R. § 438.330(b)(4); 42 C.F.R. § 438.340; 42 C.F.R. § 457.1240(b). {From CMSC G.5.05}.

G.5.11. *Reserved.* N/A.

G.5.12. *Reserved.* N/A.

G.5.13. *Reserved.* N/A.

G.5.14. *Reserved.* N/A.

G.5.15. *Reserved.* N/A.

G.5.16. *Reserved.* N/A.

G.5.17. *Reserved.* N/A.

G.5.18. *Annual Measurement.* Contractor shall annually: measure and report to the Agency on its performance, using the standard measures required by the Agency; submit to the Agency data, specified by the Agency, which enables the Agency to calculate the Contractor's performance using the standard measures identified by the Agency under 42 C.F.R. § 438.330(c)(1); OR perform a combination of these activities. See: 42 C.F.R. § 438.330(c)(1) and (2); 42 C.F.R. § 457.1240(b); 42 C.F.R. § 457.1240(f); 42 C.F.R. § 457.1201(n)(2). {From CMSC G.5.09}.

G.5.19. *Improving Health Outcomes.* Each of Contractor's PIPs shall be designed to achieve significant improvement, sustained over time, in health Outcomes and Enrolled Member satisfaction. See: 42 C.F.R. § 438.330(d)(2); 42 C.F.R. § 457.1240(b). {From CMSC G.5.10}.

G.5.20. *Objective Quality Indicators.* Each of Contractor's PIPs shall include measurement of performance using objective Quality indicators. See: 42 C.F.R. § 438.330(d)(2)(i); 42 C.F.R. § 457.1240(b). {From CMSC G.5.11}.

G.5.21. *Interventions to Improve Quality and Access.* Each of Contractor's PIPs shall include implementation of interventions to achieve improvement in the Access to and Quality of care. See: 42 C.F.R. § 438.330(d)(2)(ii); 42 C.F.R. § 457.1240(b). {From CMSC G.5.12}.

G.5.22. *Evaluation of Effectiveness.* Each of Contractor's PIPs shall include an evaluation of the effectiveness of the interventions based on the Performance Measures collected as part of the PIP. See: 42 C.F.R. § 438.330(d)(2)(iii); 42 C.F.R. § 457.1240(b). {From CMSC G.5.13}.

G.5.23. *Increasing and Sustaining Improvement.* Each of Contractor's PIPs shall include planning and initiation of activities for increasing or sustaining improvement. See: 42 C.F.R. § 438.330(d)(2)(iv); 42 C.F.R. § 457.1240(b). {From CMSC G.5.14}.

G.5.24. *Reporting.* Contractor shall report the status and results of each PIP to the Agency as requested, but not less than once per year. See: 42 C.F.R. § 438.330(d)(1) and (3); 42 C.F.R. § 457.1240(b). {From CMSC G.5.15}.

G.5.25. *MAO Option.* The Agency's may permit a managed care plan exclusively serving Dual Eligibles to substitute a Medicare Advantage Organization (MAO) Quality improvement project for one (1) of more of the PIPs otherwise required. See: 42 C.F.R. § 438.330(d)(4); 42 C.F.R. § 422.152(d). {From CMSC G.5.16}.

G.5.26. *Evaluation.* Contractor shall develop a process to evaluate the impact and effectiveness of its own QAPI. See: 42 C.F.R. § 438.330(e)(2); 42 C.F.R. § 438.310(c)(2); 42 C.F.R. § 457.1240(b); 42 C.F.R. § 457.1240(f); 42 C.F.R. § 457.1201(n). {From CMSC G.5.17}.

G.5.27. *Value Based Purchasing Programs*. Contractor shall identify the goals the Contractor has set to address its strategy for improving the delivery of dental health care Benefits and services to its Enrolled Members via value-based purchasing programs. The Contractor shall identify the steps to be taken including a timeline with target dates and providing reporting on such timelines and targets consistent with the obligations in the Reporting Manual. The Contractor's VBP programs shall align with the Agency's Dental Quality Strategy plan, including specific detail for the value-based purchasing requirements described in Section E.8.

G.5.28. *Dental Quality Strategy.* The Contractor shall obtain Agency approval of an approach to support Iowa's goal of delivery system transformation consistent with the Agency's Dental Quality Strategy plan. The Dental Quality Strategy plan consists of four (4) strategic goals: 1) Improve Network Adequacy and availability of services; 2) Increase recall and prevention services; 3) Improve oral health equity among Medicaid members; and 4) Improve coordination and continuity of care between IA Health Link MCOs and enhance medical/dental integration. The Contractor shall implement and adhere to the Agency-approved strategies. Changes to these strategies shall receive the Agency's prior approval.

G.5.29. *Value-Based Purchasing – PCPs.* The specific PCP designation is required for those Enrolled Members under a value-based purchasing arrangement described in Section E.8. If using a PCP model, Contractor shall describe the types of physicians eligible to serve as a PCP, any panel size limits or requirements, and proposed policies and procedures to link Enrolled Members to PCPs in its PPM.

G.6 Cultural Competence

G.6.01. *Cultural Competence Obligation.* Contractor shall participate in the Agency's efforts to promote the delivery of services in a culturally competent manner to all Enrolled Members, including those with LEP and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex which includes sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation, gender identity, and sex stereotypes. . See: 42 C.F.R. § 438.206(c)(2); 42 C.F.R. § 457.1230(a).

G.6.02. *Promoting Cultural Competence.* The Contractor shall promote the delivery of services in a culturally competent manner to all Enrolled Members, including those with LEP and diverse cultural and ethnic backgrounds. The Contractor shall address the special health needs of Enrolled Members who are poor, homeless and/or Enrolled Members of a minority population group. The Contractor shall incorporate in its polices, administration and service practice the value of: (i) honoring Enrolled Members' beliefs; (ii) sensitivity to cultural diversity; and (iii) fostering in staff and Providers attitudes and interpersonal communication styles which respect Enrolled Members' cultural backgrounds. The Contractor shall have specific policy statements on these topics and communicate them to Network Providers and Subcontractors.

G.6.03. *Culturally Appropriate Care.* The Contractor shall permit Enrolled Members to choose Providers from among the Contractor's network based on cultural preference. The Contractor shall permit Enrolled Members to change Providers, within the Contractor's network, based on cultural preference. Enrolled Members may submit Grievances to the Contractor related to inability to obtain culturally appropriate care. Culturally appropriate care is care by a Provider who can relate to the Enrolled Member and provide care with sensitivity, understanding, and respect for the Enrolled Member's culture.

G.7 Accreditation

G.7.01. *Notice Obligation.* Contractor shall inform the Agency as to whether it has been accredited by a private independent accrediting entity. See: 42 C.F.R. § 438.332(a); 42 C.F.R. § 457.1240(c). {From CMSC G.8.01}.

G.7.02. *Provision of Information.* If Contractor has received accreditation by a private independent accrediting entity, Contractor shall authorize the private independent accrediting entity to provide the Agency a copy of its most recent accreditation review, including:

a) Its accreditation status, survey type, and level (as applicable);
b) Recommended actions or improvements, Corrective Action Plans, and summaries of findings; and
c) The expiration date of the accreditation.

See: 42 C.F.R. § 438.332(b)(1) - (3); 42 C.F.R. § 457.1240(c). {From CMSC G.8.02 - G.8.04}.

G.7.03. *NCQA Accreditation Obligation.* The Contractor shall attain and maintain accreditation from the NCQA. If not already accredited, the Contractor shall demonstrate it has initiated the accreditation process as of the Contract effective date. The Contractor shall achieve accreditation at the earliest date allowed by NCQA. Accreditation shall be maintained throughout the life of the Contract at no additional cost to the Agency. When accreditation standards conflict with the standards set forth in the Contract, the Contract prevails unless the accreditation standard is more stringent.

H. Grievances and Appeals

H.1 Grievance and Appeals System

H.1.01. *Grievance and Appeal Systems.* Contractor shall have a Grievance and Appeal System in place for Enrolled Members. See: 42 C.F.R. § 438.402(a); 42 C.F.R. § 438.228(a); 42 C.F.R. § 457.1260. {From CMSC H.1.01}.

H.1.02. *Authority to File.* An Enrolled Member may file a Grievance and request an Appeal with the Contractor. An Enrolled Member may request a State Fair Hearing after receiving Notice under 42 C.F.R. § 438.408 that the Adverse Benefit Determination is upheld by the Contractor.

H.1.03. *Eligibility, Effective Date of Coverage, Premiums, Copayments, and Exceptions to Policy*. Contractor shall direct the following types of Appeal or Grievance requests to the Agency:
a) Enrolled Member eligibility including termination of eligibility;
b) Effective dates of coverage;
c) Determinations of premium and copayment responsibilities; and
d) Exceptions to policy regarding services outside of State Plan Benefits.

H.1.04. *Single Level of Contractor Appeals.* Contractor shall have only one (1) level of Appeal for Enrolled Members. See: 42 C.F.R. § 438.402(b); 42 C.F.R. § 438.228(a); 42 C.F.R. § 457.1260. {From CMSC H.1.02}.

H.1.05. *Assistance.* Contractor shall give Enrolled Members any reasonable assistance in completing Grievance and Appeal forms and other procedural steps related to a Grievance or Appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with Teletypewriter Telephone/Telecommunication Device for the Deaf (TTY/TDD) and interpreter capability. See: 42 C.F.R. § 438.406(a); 42 C.F.R. § 438.228(a); 42 C.F.R. § 457.1260. {From CMSC H.1.03}.

H.1.06. *Acknowledging Appeals.* Contractor shall acknowledge receipt, in writing, of each Grievance and Appeal of Adverse Benefit Determinations within three (3) business days. See: 42 C.F.R. § 438.406(b)(1); 42 C.F.R. § 438.228(a); 42 C.F.R. § 457.1260. {From CMSC H.1.04}.

H.1.07. *Separation of Duties.* Contractor shall ensure that decision makers on Grievances and Appeals of Adverse Benefit Determinations were not:
a) Involved in any previous level of review or decision-making.
b) Subordinates of any individual who was involved in a previous level of review or decision-making.

See: 42 C.F.R. § 438.406(b)(2)(i); 42 C.F.R. § 438.228(a); 42 C.F.R. § 457.1260. {From CMSC H.1.05 - H.1.06}.

H.1.08. *Appropriate Knowledge of Decision Makers.* Contractor shall ensure that decision makers on Grievances and Appeals of Adverse Benefit Determinations are individuals with appropriate clinical expertise, as determined by the Agency, in treating the Enrolled Member's condition or disease:

a) If the decision involves an Appeal of a denial based on lack of medical necessity.
b) If the decision involves a Grievance regarding denial of expedited resolution of an Appeal.
c) If the decision involves a Grievance or Appeal involving clinical issues.

See: 42 C.F.R. § 438.406(b)(2)(ii)(A) - (C); 42 C.F.R. § 438.228(a); 42 C.F.R. § 457.1260. {From CMSC H.1.07 - H.1.09}.

H.1.09. *Factors that Must Be Considered.* Contractor shall ensure that decision makers on Grievances and Appeals of Adverse Benefit Determinations take into account all comments, documents, records, and other information submitted by the Enrolled Member or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination. See: 42 C.F.R. § 438.406(b)(2)(iii); 42 C.F.R. § 438.228(a); 42 C.F.R. § 457.1260. {From CMSC H.1.10}.

H.1.10. *Grievance Regarding Disenrollment.* If Contractor receives a Grievance concerning Disenrollment, Contractor shall complete review of the Grievance in time to permit the Disenrollment to be effective no later than the first day of the second month following the month in which the Enrolled Member requests Disenrollment or the Contractor refers the request to the Agency. See: 42 C.F.R. § 438.56(d)(5)(ii); 42 C.F.R. § 438.56(e)(1); 42 C.F.R. § 438.228(a); 42 C.F.R. § 457.1201(m); 42 C.F.R. § 457.1212. {From CMSC H.1.11}.

H.1.11. *Contractor Grievance Support*. Contractor is responsible for providing all support at all states of the grievance and Appeal process, including but not limited to providing the necessary factual and expert testimony necessary to support the Contractor's position taken in relation to an Enrolled Member's Claim, including providing any support required by the Attorney General's Office in relation to a judicial review proceeding arising out of the State Fair Hearing process. Contractor shall be responsible for any award of attorneys' fees and costs provided at any stage of state fair hearing or judicial review of a Contractor decision.

H.2 Notice of Adverse Benefit Determination Requirements

H.2.01. *Notice Obligations.* Contractor's Notice of Adverse Benefit Determination must explain the Adverse Benefit Determination the Contractor has made or intends to make. See: 42 C.F.R. § 438.404(b)(1); 42 C.F.R. § 457.1260. {From CMSC H.2.01}.

H.2.02. *Minimum Contents of Notice.* Contractor's Notice of Adverse Benefit Determination shall explain the reasons for the Adverse Benefit Determination, including the right of the Enrolled 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 Enrolled Member's Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. See: 42 C.F.R. § 438.404(b)(2); 42 C.F.R. § 457.1260. {From CMSC H.2.02}.

H.2.03. *Obligation to Explain Rights.* Contractor's Notice of Adverse Benefit Determination shall explain the Enrolled Member's right to request an Appeal of the Contractor's Adverse Benefit Determination, including information on exhausting the Contractor's one (1) level of Appeal and the right to request a State Fair Hearing after receiving Notice that the Adverse Benefit Determination is upheld. See: 42 C.F.R. § 438.404(b)(3); 42 C.F.R. § 438.402(b) - (c); 42 C.F.R. § 457.1260. {From CMSC H.2.03}.

H.2.04. *Obligation to Explain Procedures.* Contractor's Notice of Adverse Benefit Determination shall explain the procedures for exercising the Enrolled Member's rights to Appeal. See: 42 C.F.R. § 438.404(b)(4); 42 C.F.R. § 457.1260. {From CMSC H.2.04}.

H.2.05. *Obligation to Explain Right to Expedited Appeal.* Contractor's Notice of Adverse Benefit Determination shall explain the circumstances under which an Appeal process can be expedited and how to request it. See: 42 C.F.R. § 438.404(b)(5); 42 C.F.R. § 457.1260. {From CMSC H.2.05}.

H.2.06. *Obligation to Explain Continuation of Benefits.* Contractor's Notice of Adverse Benefit Determination shall explain the Enrolled Member's right to have Benefits continue pending the resolution of the Appeal, how to request that Benefits be continued, and the circumstances, consistent with Agency policy, under which the Enrolled Member may be required to pay the costs of continued services. See: 42 C.F.R. § 438.404(b)(6); 42 C.F.R. § 457.1260. {From CMSC H.2.06}.

H.2.07. *Notices Regarding Denied Payment.* Contractor shall issue a Notice of Adverse Benefit Determination when payment for a service has been denied. A denial, in whole or in part, of a payment for a service solely because the Claim does not meet the definition of a 'clean Claim' at 42 C.F.R. § 447.45(b) of this chapter is not an adverse benefit determination. {From CMSC H.2.01 - H.2.06 guidance}.

H.3 Notice of Adverse Benefit Determination Timing

H.3.01. *Timely Notice of Adverse Benefit Determination.* Contractor shall mail the Notice of Adverse Benefit Determination at least ten (10) Days before the date of action, when the action is a termination, suspension, or reduction of previously authorized Medicaid-covered services. See: 42 C.F.R. § 438.404(c)(1); 42 C.F.R. § 431.211; 42 C.F.R. § 457.1260. {From CMSC H.3.01}.

H.3.02. *Timely Mailing of Notice.* Contractor may mail the Notice of Adverse Benefit Determination as few as five (5) Days prior to the date of action if the Agency has facts indicating that action should be taken because of probable Fraud by the Enrolled Member, and the facts have been verified, if possible, through a secondary source. See: 42 C.F.R. § 438.404(c)(1); 42 C.F.R. § 431.214; 42 C.F.R. § 457.1260. {From CMSC H.3.02}.

H.3.03. *Mailing Obligations.* Contractor shall mail the Notice of Adverse Benefit Determination by the date of the action when any of the following occur:

a) The Enrolled Member has died.
b) The Enrolled Member submits a signed written statement requesting service termination.
c) The Enrolled Member submits a signed written statement including information that requires service termination or reduction and indicates that he understands that service termination or reduction will result.
d) The Enrolled Member has been admitted to an institution where the Enrolled Member is ineligible under the plan for further services.
e) The Enrolled Member's address is determined unknown based on returned mail with no forwarding address.
f) The Enrolled Member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.
g) A change in the level of medical care is prescribed by the Enrolled Member's physician.
h) The Notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Social Security Act.
i) The transfer or discharge from a facility will occur in an expedited fashion.

See: 42 C.F.R. § 438.404(c)(1); 42 C.F.R. § 431.213; 42 C.F.R. § 431.231(d); section 1919(e)(7) of the Social Security Act; 42 C.F.R. § 483.12(a)(5)(i); 42 C.F.R. § 483.12(a)(5)(ii); 42 C.F.R. § 457.1260. {From CMSC H.3.03}.

H.3.04. *Notice Timing when Payment Denied.* Contractor shall give Notice of Adverse Benefit Determination on the date of determination when the action is a denial of payment. See: 42 C.F.R. § 438.404(c)(2); 42 C.F.R. § 457.1260. {From CMSC H.3.04}.

H.3.05. *Fourteen (14) Day Notice Deadline.* Contractor shall give Notice of an Adverse Benefit Determination as expeditiously as the Enrolled Member's condition requires within Agency-established timeframes that may not exceed fourteen (14) Days following receipt of the request for service, for standard authorization decisions that deny or limit services. See: 42 C.F.R. § 438.210(d)(1); 42 C.F.R. § 438.404(c)(3); 42 C.F.R. § 457.1230(d). {From CMSC H.3.05}.

H.3.06. *Extensions of Fourteen (14) Day Deadline.* Contractor may extend the fourteen (14) calendar-day Notice of Adverse Benefit Determination timeframe for standard authorization decisions that deny or limit services up to fourteen (14) additional Days if the Enrolled Member or the Provider requests extension. See: 42 C.F.R. § 438.404(c)(4); 42 C.F.R. § 438.210(d)(1)(i); 42 C.F.R. § 457.1230(d). {From CMSC H.3.06}.

H.3.07. *Extensions of Standard Authorizations.* Contractor may extend the fourteen (14) calendar-day Notice of Adverse Benefit Determination timeframe for standard authorization decisions that deny or limit services up to fourteen (14) additional Days if the Contractor justifies a need (to the Agency, upon request) for additional information and shows how the extension is in the Enrolled Member's best interest. See: 42 C.F.R. § 438.210(d)(1)(ii); 42 C.F.R. § 438.404(c)(4); 42 C.F.R. § 457.1260; 42 C.F.R. § 457.1230(d). {From CMSC H.3.07}.

H.3.08. *Written Notice Obligation.* If Contractor extends the fourteen (14) calendar-day Notice of Adverse Benefit Determination timeframe for standard authorization decisions that deny or limit services, Contractor shall give the Enrolled Member written Notice of the reason for the extension and inform the Enrolled Member of the right to file a Grievance if the Enrolled Member disagrees with the decision. See: 42 C.F.R. § 438.210(d)(1)(ii); 42 C.F.R. § 438.404(c)(4)(i); 42 C.F.R. § 457.1260; 42 C.F.R. § 457.1230(d). {From CMSC H.3.08}.

H.3.09. *Duty to Make the Determination Expeditiously.* If Contractor extends the fourteen (14) calendar-day Notice of Adverse Benefit Determination timeframe for standard authorization decisions that deny or limit services, Contractor shall issue and carry out its determination as expeditiously as the Enrolled Member's health condition requires and no later than the date the extension expires. See: 42 C.F.R. § 438.210(d)(1)(ii); 42 C.F.R. § 438.404(c)(4)(ii); 42 C.F.R. § 457.1260; 42 C.F.R. § 457.1230(d). {From CMSC H.3.09}.

H.3.10. *Expedited Service Authorization Decisions.* For cases in which a Provider indicates, or the Contractor determines, that following the standard authorization timeframe could seriously jeopardize the Enrolled Member's life or health or their ability to attain, maintain, or regain maximum function, Contractor shall make an expedited Service Authorization decision and provide Notice as expeditiously as the Enrolled Member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service. See: 42 C.F.R. § 438.210(d)(2)(i); 42 C.F.R. § 438.404(c)(6); 42 C.F.R. § 457.1260; 42 C.F.R. § 457.1230(d). {From CMSC H.3.10}.

H.3.11. *Extensions of Timeline – Expedited Service Authorizations.* Contractor may extend the seventy-two (72) hour expedited Service Authorization decision time period by up to fourteen (14) Days if the Enrolled Member requests an extension, or if the Contractor justifies (to the Agency, upon request) a need for additional information and how the extension is in the Enrolled Member's interest. See: 42 C.F.R. § 438.210(d)(2)(ii); 42 C.F.R. § 438.404(c)(6); 42 C.F.R. § 457.1260; 42 C.F.R. § 457.1230(d). {From CMSC H.3.11}.

H.3.12. *Notice Obligations.* Contractor shall give Notice on the date that the timeframes expire, when Service Authorization decisions are not reached within the applicable timeframes for either standard or expedited Service Authorizations. See: 42 C.F.R. § 438.404(c)(5); 42 C.F.R. § 457.1260. {From CMSC H.3.12}.

H.3.13. *Untimely Service Authorizations.* Pursuant to 42 C.F.R. § 438.404(c)(5), untimely Service Authorizations constitute a denial, and are thus Adverse Benefit Determinations. {From CMSC H.3.12 guidance}.

H.4 Who May File Appeals and Grievances

H.4.01. *Enrolled Member Rights.* Contractor shall allow Enrolled Members to file Appeals, Grievances, and State Fair Hearing requests after receiving Notice that an Adverse Benefit Determination is upheld. See: 42 C.F.R. § 438.402(c)(1); 42 C.F.R. § 438.408; 42 C.F.R. § 457.1260. {From CMSC H.4.01}.

H.4.02. *External Medical Review.* If the Agency chooses to offer and arrange for an external medical review, that complies with 42 C.F.R. § 402(c)(1)(i)(B), the process for such review and the Contractor's obligation to comply with such review will be identified by the Agency. See: 42 C.F.R. § 438.402(c)(1)(i)(B); 42 C.F.R. § 457.1260. {From CMSC H.4.02}.

H.4.03. *Authorized Representatives.* Contractor shall allow Providers, or authorized representatives, acting on behalf of the Enrolled Member and with the Enrolled Member's written consent, to request an Appeal, file a Grievance, or request a State Fair Hearing request. See: 42 C.F.R. § 438.402(c)(1)(i) - (ii); 42 C.F.R. § 438.408; 42 C.F.R. § 457.1260. {From CMSC H.4.03}.

H.4.04. *Prohibition on Appeals Regarding Provider Payment.* Contractor shall not allow Providers, acting on behalf of the Enrolled Member, to pursue an Appeal with Contractor or in any way suggest a contracted Provider is entitled to State Fair Hearing when the sole issue in the Claimed Appeal is a payment dispute between Contractor and the Provider, such as whether a given Claim is a "Clean Claim." Such issues are to be addressed pursuant to the dispute resolution process outlined in the agreement between Contractor and the Provider.

H.5 Timeframes for Filing Appeals

H.5.01. *Deemed Exhaustion – Notice & Timing Requirements.* If Contractor fails to adhere to Notice and timing requirements, the Enrolled Member is deemed to have exhausted the Contractor's Appeals process, and the Enrolled Member may initiate a State Fair Hearing. See: 42 C.F.R. § 438.408; 42 C.F.R. § 438.402(c)(1)(i)(A); 42 C.F.R. § 457.1260. {From CMSC H.5.01}.

H.5.02. *Deemed Exhaustion – Thirty (30) Day Timeline.* The Enrolled Member is deemed to have exhausted the Contractor's Appeals process if Contractor has not resolved and provided Notice to the affected parties within thirty (30) Days from the day Contractor receives the Appeal.

H.5.03. *Contractor Sixty (60) Day Appeal Timeline.* Contractor shall allow the Enrolled Member to file an Appeal to the Contractor within sixty (60) Days from the date on the Adverse Benefit Determination Notice. See: 42 C.F.R. § 438.402(c)(2)(ii); 42 C.F.R. § 457.1260. {From CMSC H.5.02}.

H.5.04. *Contractor Sixty (60) Day Appeal Timeline – Authorized Representatives.* Contractor shall allow the Provider or authorized representative acting on behalf of the Enrolled Member, as State law permits, to file an Appeal to the Contractor within sixty (60) Days from the date on the Adverse Benefit Determination Notice. See: 42 C.F.R. § 438.402(c)(2)(ii); 42 C.F.R. § 457.1260. {From CMSC H.5.03}.

H.6 Process for Filing an Appeal or Expedited Appeal Request

H.6.01. *Right to File Orally or in Writing.* Contractor shall allow the Enrolled Member to request an Appeal either orally or in writing. See: 42 C.F.R. § 438.402(c)(3)(ii); 42 C.F.R. § 457.1260. {From CMSC H.6.01}.

H.6.02. *Authorized Representative Authority.* Contractor shall allow the Provider or authorized representative acting on behalf of the Enrolled Member, as State law permits, to request an Appeal either orally or in writing. See: 42 C.F.R. § 438.402(c)(3)(ii); 42 C.F.R. § 438.402(c)(1)(ii); 42 C.F.R. § 457.1260. {From CMSC H.6.02}.

H.6.03. *Reserved.* N/A.

H.6.04. *Acceptance of Oral Appeals.* Contractor shall ensure that oral inquiries seeking to Appeal an Adverse Benefit Determination are treated as Appeals. See: 42 C.F.R. § 438.406(b)(3); 42 C.F.R. § 457.1260. {From CMSC H.6.03}.

H.6.05. *Due Process Obligations.* Contractor shall provide the Enrolled Member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. See: 42 C.F.R. § 438.406(b)(4); 42 C.F.R. § 457.1260. {From CMSC H.6.04}.

H.6.06. *Obligation to Provide Case File.* Contractor shall provide the Enrolled Member and their representative the Enrolled Member's case file (including Medical Records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor (or at the direction of the Contractor)) in connection with the Appeal of the Adverse Benefit Determination. See: 42 C.F.R. § 438.406(b)(5); 42 C.F.R. § 457.1260. {From CMSC H.6.05}.

H.6.07. *Obligations Related to Case File.* Contractor shall provide the Enrolled Member and their representative the Enrolled Member's case file free of charge and sufficiently in advance of the resolution timeframe for standard and expedited Appeal resolutions. For standard resolution of an Appeal and Notice to the affected parties, Contractor shall comply with the Agency-established timeframe that is no longer than thirty (30) Days from the day the Contractor receives the Appeal. For expedited resolution of an Appeal and Notice to affected parties, Contractor shall comply with the Agency-established timeframe that is no longer than seventy-two (72) hours after the Contractor receives the Appeal. See: 42 C.F.R. § 438.406(b)(5); 438.408(b) - (c); 42 C.F.R. § 457.1260. {From CMSC H.6.06}.

H.6.08. *Recognition of Parties in Interest.* Contractor shall consider the Enrolled Member, their representative, or the legal representative of a deceased Enrolled Member's estate as parties to an Appeal. See: 42 C.F.R. § 438.406(b)(6); 42 C.F.R. § 457.1260. {From CMSC H.6.07}.

H.6.09. *Expedited Procedures.* Contractor shall establish and maintain an expedited review process for Appeals, when the Contractor determines (for a request from the Enrolled Member) or when the Provider indicates (in making the request on the Enrolled Member's behalf or supporting the Enrolled Member's request) that taking the time for a standard resolution could seriously jeopardize the Enrolled Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. See: 42 C.F.R. § 438.410(a); 42 C.F.R. § 457.1260. {From CMSC H.6.08}.

H.6.10. *Notice of Time Availability.* Contractor shall inform Enrolled Members of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments in the case of an expedited Appeal resolution. Contractor shall inform Enrolled Members of this sufficiently in advance of the resolution timeframe for Appeals. See: 42 C.F.R. § 438.406(b)(4); 42 C.F.R. § 438.408(b); 42 C.F.R. § 438.408(c); 42 C.F.R. § 457.1260. {From CMSC H.6.09}.

H.6.11. *Denials of Expedited Requests.* If Contractor denies a request for expedited resolution of an Appeal, Contractor shall transfer the Appeal to the standard timeframe of no longer than thirty (30) Days from the day the Contractor receives the Appeal (with a possible fourteen (14) day extension). See: 42 C.F.R. § 438.410(c); 42 C.F.R. § 438.408(b)(2); 42 C.F.R. § 438.408(c)(2); 42 C.F.R. § 457.1260. {From CMSC H.6.10}.

H.7 Timeframes for Resolving Appeals and Expedited Appeals

H.7.01. *Resolution Deadline.* Contractor shall resolve each Appeal and provide Notice, as expeditiously as the Enrolled Member's health condition requires within thirty (30) Days from the day the Contractor receives the Appeal. See: 42 C.F.R. § 438.408(a); 42 C.F.R. § 438.408(b)(2); 42 C.F.R. § 457.1260. {From CMSC H.7.01}.

H.7.02. *Resolution Extensions.* Contractor may extend the timeframe for processing an Appeal by up to fourteen (14) Days if the Enrolled Member requests the extension, or if the Contractor shows that there is need for additional information and that the delay is in the Enrolled Member's interest (upon Agency request). See: 42 C.F.R. § 438.408(c)(1); 42 C.F.R. § 438.408(b)(2); 42 C.F.R. § 457.1260. {From CMSC H.7.02 – H.7.03}.

H.7.03. *Extension Obligations.* If Contractor extends the timeline for an Appeal not at the request of the Enrolled Member, Contractor shall:

a) Make reasonable efforts to give the Enrolled Member prompt oral Notice of the delay.
b) Give the Enrolled Member written Notice, within two (2) Days, of the reason for the decision to extend the timeframe and inform the Enrolled Member of the right to file a Grievance if the Enrolled Member disagrees with that decision.
c) Resolve the Appeal as expeditiously as the Enrolled Member's health condition requires and no later than the date the extension expires.

See: 42 C.F.R. § 438.408(c)(2)(i) - (iii); 42 C.F.R. § 438.408(b)(2); 42 C.F.R. § 457.1260. {From CMSC H.7.04 - H.7.06}.

H.7.04. *Expedited Appeal Deadline.* Contractor shall resolve each expedited Appeal and provide Notice, as expeditiously as the Enrolled Member's health condition requires, within Agency-established timeframes not to exceed seventy-two (72) hours after the Contractor receives the expedited Appeal request. See: 42 C.F.R. § 438.408(a); 42 C.F.R. § 438.408(b)(3); 42 C.F.R. § 457.1260. {From CMSC H.7.07}.

H.7.05. *Extensions – Expedited Appeals.* Contractor may extend the timeframe for processing an expedited Appeal by up to fourteen (14) Days:

a) If the Enrolled Member requests the extension; or
b) If the Contractor shows that there is need for additional information and that the delay is in the Enrolled Member's interest (upon Agency request).

See: 42 C.F.R. § 438.408(c)(1)(i) - (ii); 42 C.F.R. § 438.408(b)(3); 42 C.F.R. § 457.1260. {From CMSC H.7.08 - H.7.09}.

H.7.06. *Extension Obligations.* If Contractor extends the timeline for processing an expedited Appeal not at the request of the Enrolled Member, Contractor shall:

a) Make reasonable efforts to give the Enrolled Member prompt oral Notice of the delay.
b) Give the Enrolled Member written Notice, within two (2) Days, of the reason for the decision to extend the timeframe and inform the Enrolled Member of the right to file a Grievance if the Enrolled Member disagrees with that decision.
c) Resolve the Appeal as expeditiously as the Enrolled Member's health condition requires and no later than the date the extension expires.

See: 42 C.F.R. § 438.408(c)(2)(i) - (iii); 42 C.F.R. § 438.408(b)(3); 42 C.F.R. § 457.1260. {From CMSC H.7.10 - H.7.12}.

H.8 Notice of Resolution for Appeals

H.8.01. *Notice Obligations Regarding Resolution of Appeals.* Contractor shall provide written Notice of the resolution of the Appeals process:

a) In a format and language that, at a minimum, meets applicable notification standards,
b) And include the results of the Appeal resolution,
c) And include the date of the Appeal resolution.

For Appeal decisions not wholly in the Enrolled Member's favor, the Contractor shall include the following in the written resolution Notice:

a) The right to request a State Fair Hearing.
b) How to request a State Fair Hearing.
c) The right to request and receive Benefits pending a hearing.
d) How to request the continuation of Benefits.
e) Notice that the Enrolled Member may, consistent with Agency policy, be liable for the cost of any continued Benefits if the Contractor's Adverse Benefit Determination is upheld in the hearing.

See: 42 C.F.R. § 438.408(d)(2)(i); 42 C.F.R. § 438.10; 42 C.F.R. § 438.408(e)(1) - (2); 42 C.F.R. § 457.1260. {From CMSC H.8.01 - H.8.04}.

H.8.02. *Notice Obligations – Expedited Appeals.* Contractor shall provide written Notice, and make reasonable efforts to provide oral Notice, of the resolution of an expedited Appeal. See: 42 C.F.R. § 438.408(d)(2)(ii); 42 C.F.R. § 457.1260. {From CMSC H.8.05}.

H.9 Continuation of Benefits

H.9.01. *Inapplicability.* The requirements set forth in this Section H.9 are inapplicable to Enrolled Members receiving coverage pursuant to Iowa Code ch. 514I (Hawki).

H.9.02. *Continuation of Benefits.* Contractor shall continue the Enrolled Member's Benefits while an Appeal is in process if all of the following occur:

a) The Enrolled Member files the request for an Appeal within sixty (60) Days following the date on the Adverse Benefit Determination Notice.
b) The Appeal involves the termination, suspension, or reduction of a previously authorized service.
c) The Enrolled Member's services were ordered by an authorized Provider.
d) The period covered by the original authorization has not expired.
e) The request for continuation of Benefits is filed on or before the later of the following:
    - Within ten (10) Days of the Contractor sending the Notice of Adverse Benefit Determination, or
    - The intended effective date of the Contractor's proposed Adverse Benefit Determination.

See: 42 C.F.R. § 438.420(a); 42 C.F.R. § 438.420(b)(1) - (5); 42 C.F.R. § 438.402(c)(2)(ii). {From CMSC H.9.01}.

H.9.03. *Continuation of Benefits During Appeal.* If, at the Enrolled Member's request, Contractor continues or reinstates the Enrolled Member's Benefits while the Appeal or State Fair Hearing is pending, the Benefits must be continued until one (1) of the following occurs:

a) The Enrolled Member withdraws the Appeal or request for State Fair Hearing.
b) The Enrolled Member does not request a State Fair Hearing and continuation of Benefits within ten (10) Days from the date the Contractor sends the Notice of an adverse Appeal resolution.
c) A State Fair Hearing decision adverse to the Enrolled Member is issued.

See: 42 C.F.R. § 438.420(c)(1)-(3); 42 C.F.R. § 438.408(d)(2). {From CMSC H.9.02}.

H.9.04. *Recovery from Enrolled Member.* Contractor may recover the cost of continued services furnished to the Enrolled Member while the Appeal or State Fair Hearing was pending if the final resolution of the Appeal or State Fair Hearing upholds the Contractor's Adverse Benefit Determination. See: 42 C.F.R. § 438.420(d); 42 C.F.R. § 431.230(b). {From CMSC H.9.03}.

H.9.05. *Continuation of Benefits.* Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the Enrolled Member's health condition requires (but no later than seventy-two (72) hours from the date it receives Notice reversing the determination) if the services were not furnished while the Appeal was pending and if the Contractor or State Fair Hearing officer reverses a decision to deny, limit, or delay services. See: 42 C.F.R. § 438.424(a); 42 C.F.R. § 457.1260. {From CMSC H.9.04}.

H.9.06. *Continuation of Benefits Payment Obligations.* Contractor shall pay for disputed services received by the Enrolled Member while the Appeal was pending, unless Agency policy and regulations provide for the Agency to cover the cost of such services, when the Contractor or State Fair Hearing officer reverses a decision to deny authorization of the services. See: 42 C.F.R. § 438.424(b); 42 C.F.R. § 457.1260. {From CMSC H.9.05}.

H.9.07. *Notice Obligations.* Contractor shall notify the requesting Provider and give the Enrolled Member written Notice of any decision to deny a Service Authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. See: 42 C.F.R. § 438.210(c); 42 C.F.R. § 438.404; 42 C.F.R. § 457.1260; 42 C.F.R. § 457.1230(d). {From CMSC H.9.06}.

H.10 Grievances

H.10.01. *When Grievances Must be Accepted.* An Enrolled Member may file a Grievance with Contractor at any time. See: 42 C.F.R. § 438.402(c)(2)(i); 42 C.F.R. § 457.1260. {From CMSC H.10.01}.

H.10.02. *Written and Oral Grievances.* An Enrolled Member may file a Grievance either orally or in writing. See: 42 C.F.R. § 438.402(c)(3)(i); 42 C.F.R. § 457.1260. {From CMSC H.10.02}.

H.10.03. *Grievance Filings with Contractor.* Enrolled Members may file grievances only with the Contractor. See: 42 C.F.R. § 438.402(c)(3)(i); 42 C.F.R. § 457.1260. {From CMSC H.10.03}.

H.10.04. *Timeline for Resolutions.* Contractor shall resolve each Grievance and provide Notice, as expeditiously as the Enrolled Member's health condition requires, within thirty (30) Days from the day the Contractor receives the Grievance. See: 42 C.F.R. § 438.408(a); 42 C.F.R. § 438.408(b)(1); 42 C.F.R. § 457.1260. {From CMSC H.10.04}.

H.10.05. *Extension of Timeline.* Contractor may extend the timeframe for processing a Grievance by up to fourteen (14) Days:

a) If the Enrolled Member requests the extension; or
b) If the Contractor shows that there is need for additional information and that the delay is in the Enrolled Member's interest (upon Agency request).

See: 42 C.F.R. § 438.408(c)(1)(i) - (ii); 438.408(b)(1); 42 C.F.R. § 457.1260. {From CMSC H.10.05 - H.10.06}.

H.10.06. *Extension Notice Obligation.* If Contractor extends the timeline for a Grievance not at the request of the Enrolled Member, it must:

a) Make reasonable efforts to give the Enrolled Member prompt oral Notice of the delay.
b) Give the Enrolled Member written Notice, within two (2) Days, of the reason for the decision to extend the timeframe and inform the Enrolled Member of the right to file a Grievance if the Enrolled Member disagrees with that decision.

See: 42 C.F.R. § 438.408(c)(2)(i) - (ii); 42 C.F.R. § 438.408(b)(1); 42 C.F.R. § 457.1260. {From CMSC H.10.07 - H.10.08}.

H.10.07. *Notice Requirement.* Contractor shall notify Enrolled Members in writing of the resolution of a Grievance within thirty (30) Days of receipt of the Grievance. The written Notice shall otherwise be in a format and language that, at a minimum, meets applicable notification standards. See: 42 C.F.R. § 438.408(d)(1); 42 C.F.R. § 438.10; 42 C.F.R. § 457.1260. {From CMSC H.10.09}.

H.11 Grievance and Appeal Recordkeeping Requirements

H.11.01. *Obligation to Maintain Records.* Contractor shall maintain records of Grievances and Appeals. See: 42 C.F.R. § 438.416(a); 42 C.F.R. § 457.1260. {From CMSC H.11.01}.

H.11.02. *Contents of Records.* Contractor's record of each Grievance or Appeal shall include:

a) A general description of the reason for the Appeal or Grievance.
b) The date received.
c) The date of each review or, if applicable, review meeting.
d) Resolution information for each level of the Appeal or Grievance, if applicable.
e) The date of resolution at each level, if applicable.
f) The name of the covered person for whom the Appeal or Grievance was filed.

See: 42 C.F.R. § 438.416(b)(1) - (6); 42 C.F.R. § 457.1260. {From CMSC H.11.02 - H.11.07}.

H.11.03. *Records Accessibility.* Contractor's record of each Grievance or Appeal shall be accurately maintained in a manner accessible to the Agency and available upon request to CMS. See: 42 C.F.R. § 438.416(c); 42 C.F.R. § 457.1260. {From CMSC H.11.08}.

H.11.04. *Grievance Resolution Performance Metric.* Contractor shall resolve one hundred percent (100%) of Grievances within thirty (30) Days of receipt, or within seventy-two (72) hours of receipt for expedited Grievances. The Contractor shall maintain an Enrolled Member Grievance log documenting compliance with these performance standards.

H.11.05. *Hearings and Appeals Performance Metric.* Contractor shall resolve one hundred percent (100%) of Appeals within thirty (30) Days of receipt, or within seventy-two (72) hours of receipt for expedited Appeals. Further, one hundred percent (100%) of Appeals shall be acknowledged within three (3) business days.

I. Program Integrity

I.1. Exclusions

I.1.01. *Excluded Providers.* Contractor shall not employ or contract with Providers excluded from participation in Federal health care programs. See: 42 C.F.R. § 438.214(d)(1)]. {From CMSC I.1.01}.

I.1.02. *Exclusion Checks.* Contractor shall check employees and Subcontractors every month against the OIG's List of Excluded Individuals/Entities (LEIE), the GSA System of Aware Management (SAM; formerly known as the GSA Excluded Parties List System (EPLS)), the Social Security Administration Death Master File (SSDMF), the National Plan and Provider Enumeration System (NPPES), and the Iowa Medicaid exclusion list to ensure that no employee or Subcontractor has been excluded.

I.1.03. *Actions Against Network Providers.* Contractor shall notify the Agency within twenty-four (24) hours of any action it takes to limit the ability of an individual or entity to participate in its network. This includes, but is not limited to, suspension actions, settlement agreements and situations where an individual or entity voluntarily withdraws from the network to avoid a formal sanction.

I.1.04. *Sanctioned Individual Prohibition.* Contractor shall not be controlled by a Sanctioned Individual under section 1128(b)(8) of the Act. See: 42 C.F.R. § 438.808(a); 42 C.F.R. § 438.808(b)(1); 42 C.F.R. § 431.55(h); section 1903(i)(2) of the Social Security Act; 42 C.F.R. § 1001.1901(c); 42 C.F.R. § 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09. {From CMSC I.1.02}.

I.1.05. *Contracting Prohibition – Conviction of Crimes.* Contractor shall not have a contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with an individual convicted of crimes described in section 1128(b)(8)(B) of the Social Security Act. See: 42 C.F.R. § 438.808(a); 42 C.F.R. §

438.808(b)(2); 42 C.F.R. § 431.55(h); section 1903(i)(2) of the Social Security Act; 42 C.F.R. § 1001.1901(c); 42 C.F.R. § 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09. {From CMSC I.1.03}.

I.1.06. *Contracting Prohibition – Debarment/Suspension.* Contractor shall not have a contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. See: 42 C.F.R. § 438.808(a); 42 C.F.R. § 438.808(b)(2); 42 C.F.R. § 438.610(a); 42 C.F.R. § 431.55(h); section 1903(i)(2) of the Social Security Act; 42 C.F.R. § 1001.1901(c); 42 C.F.R. § 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09; Exec. Order No. 12549. {From CMSC I.1.04}.

I.1.07. *Contracting Prohibition – Excluded Individuals or Entities.* Contractor shall not have a contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with any individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act. See: 42 C.F.R. § 438.808(a); 42 C.F.R. § 438.808(b)(2); 42 C.F.R. § 438.610(b); 42 C.F.R. § 431.55(h); section 1903(i)(2) of the Social Security Act; 42 C.F.R. § 1001.1901(c); 42 C.F.R. § 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09. {From CMSC I.1.05}.

I.1.08. *Reserved.* N/A.

I.1.09. *Reserved.* N/A.

I.1.10. *Contracting Prohibition – Debarment/Suspension, Additional Requirements*. Contractor shall not employ or contract, directly or indirectly, for the furnishing of health care, Utilization Review, medical social work, or administrative services with any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. See: 42 C.F.R. § 438.808(a), 42 C.F.R. § 438.808(b)(3)(i), 42 C.F.R. § 438.610(a); section 1903(i)(2) of the Social Security Ac; 42 C.F.R. § 1001.1901(c); 42 C.F.R. § 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09; Exec. Order No. 12549. {From CMSC I.1.06}.

I.1.11. *Contracting Prohibition – Excluded Individuals or Entities, Additional Requirements*. Contractor shall not employ or contract, directly or indirectly, for the furnishing of health care, Utilization Review, medical social work, or administrative services with any individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act. See: 42 C.F.R. § 438.808(a), 42 C.F.R. § 438.808(b)(3)(i), 42 C.F.R. § 438.610(b); section 1903(i)(2) of the Social Security Act; 42 C.F.R. § 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09. {From CMSC I.1.07}.

I.2 Submission of Data & Documents Requirements, Procedures, and Reporting

I.2.01. *Encounter Data Submission Obligation.* Contractor shall submit encounter data. See: 42 C.F.R. § 438.604(a)(1); 42 C.F.R. § 438.606; 42 C.F.R. § 438.818. {From CMSC I.2.01}.

I.2.02. *Encounter Data HIPAA Compliance.* The Contractor shall ensure that the encounter data reports comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and privacy standards, and reports must be submitted in the format required by the Medicaid Statistical Information System or format required by any successor system to the Medicaid Statistical Information System. See: 42 C.F.R. § 438.818.

I.2.03. *Data Supporting Actuarial Soundness.* Contractor shall submit data on the basis of which the Agency certifies the actuarial soundness of capitation rates paid, including base data that is generated by the Contractor. See: 42 C.F.R. § 438.604(a)(2); 42 C.F.R. § 438.606; 42 C.F.R. § 438.3; 42 C.F.R. § 438.5(c). {From CMSC I.2.02}.

I.2.04. *Data Supporting Compliance.* Contractor shall submit data on the basis of which the Agency determines the compliance of the Contractor with the MLR requirement. See: 42 C.F.R. § 438.604(a)(3); 42 C.F.R. § 438.606; 42 C.F.R. § 438.8. {From CMSC I.2.03}.

I.2.05. *Data Supporting Insolvency Protections.* Contractor shall submit data on the basis of which the Agency determines that the Contractor has made adequate provision against the risk of insolvency. See: 42 C.F.R. § 438.604(a)(4); 42 C.F.R. § 438.606; 42 C.F.R. § 438.116. {From CMSC I.2.04}.

I.2.06. *Data Supporting Accessibility, Availability, & Adequacy of Network.* Contractor shall submit documentation described in 42 C.F.R. § 438.207(b) on which the Agency bases its certification that the Contractor has complied with the Agency's requirements for availability and accessibility of services, including the adequacy of the Provider Network. See: 42 C.F.R. § 438.604(a)(5); 42 C.F.R. § 438.606; 42 C.F.R. § 438.207(b); 42 C.F.R. § 438.206. {From CMSC I.2.05}.

I.2.07. *438.104 Submission Obligations.* Contractor shall submit:

a) The name and address of any person (individual or corporation) with an ownership or control interest in the managed care entity and its Subcontractors. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
b) The date of birth and Social Security Number (SSN) of any individual with an ownership or control interest in the Contractor and its Subcontractors.
c) Other tax identification number of any corporation with an ownership or control interest in the Contractor and any Subcontractor in which the Contractor has a five percent (5%) or more interest.
d) Information on whether an individual or corporation with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling.
e) Information on whether a person or corporation with an ownership or control interest in any Subcontractor in which the Contractor has a five percent (5%) or more interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling.
f) The name of any Other Disclosing Entity in which an owner of the Contractor has an ownership or control interest.
g) The name, address, date of birth, and SSN of any managing employee of the Contractor.

See: 42 C.F.R. § 438.604(a)(6); 42 C.F.R. § 438.606; 42 C.F.R. § 455.104(b)(1)(i) - (iii); 42 C.F.R. § 455.104(b)(2) - (4); 42 C.F.R. § 438.230; 42 C.F.R. § 438.608(c)(2). {From CMSC I.2.06-I.2.12}.

I.2.08. *Making Information Available.* Contractor shall submit any other data, documentation, or information relating to the performance of the entity's obligations as required by the Agency or Secretary. This includes, but is not limited to, the submission of data including Provider type, name, address, date of birth and social security number. See: 42 C.F.R. § 438.604(b); 42 C.F.R. § 438.606. {From CMSC I.2.13}.

I.2.09. *Claims Reports and Performance Targets.* The Contractor shall submit Claims processing and adjudication data. The Contractor shall also identify specific cases and trends to prevent and respond to any potential problems relating to timely and appropriate Claims processing. The Contractor shall meet the performance targets described in Section D.6, submit the data, and report to the Agency the top ten (10) most common reasons for Claim denial.

I.2.10. *Impermissible Cost Avoidance.* Contractor shall guarantee that it will not avoid costs for services covered in this Contract by referring Enrolled Members to publicly supported health care resources. See: 42 C.F.R. § 457.1201(p). {From CHIP checklist § I.2.41}.

I.2.11. *Certification.*

a) The Contractor shall certify any data, documentation, or information specified under Sections I.2.01-I.2.09. See: 42 C.F.R. § 438.604; 42 C.F.R. § 438.606(a). {From CMSC I.2.15}.
b) The Contractor shall ensure that the certification required by Section I.2.11(a) is certified by one (1) of the following:
    1) The Contractor's Chief Executive Officer (CEO).
    2) The Contractor's Chief Financial Officer (CFO).
    3) An individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification. See: 42 C.F.R. § 438.604; 42 C.F.R. § 438.606(a). {From CMSC I.2.15}.
c) The Contractor shall ensure that the designated individual who submits data to the Agency shall provide a certification, which attests, under penalty of perjury, based on best information, knowledge, and belief that the data, documentation, and information are accurate, complete and truthful. See: 42 C.F.R. § 438.604; 42 C.F.R. § 438.606(b). {From CMSC I.2.14}.
d) Contractor shall submit certification concurrently with the submission of data, documentation, or information. See: 42 C.F.R. § 438.606(c); 42 C.F.R. § 438.604(a) - (b). {From CMSC I.2.16}.

I.2.12. *Prohibitions.* Contractor shall not knowingly have:

a) A director, officer, or partner who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
b) A person with ownership of five percent (5%) or more of the Contractor's equity who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
c) A Network Provider who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
d) An employment, consulting, or other agreement for the provision of Contract items or services with a person who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

See: Section 1932(d)(1) of the Social Security Act; 42 C.F.R. § 438.610(a)(1) - (2); 42 C.F.R. § 438.610(c)(1); 42 C.F.R. § 438.610(c)(3) - (4); SMDL 6/12/08; SMDL 1/16/09; Exec. Order No. 12549. {From CMSC I.2.17 – I.2.24}.

I.2.13. *Prohibited Affiliations.*

a) Contractor shall not knowingly have a Subcontractor of the Contractor who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non- procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. See: Section 1932(d)(1) of the Social Security Act; 42 C.F.R. § 438.610(a)(1) - (2); 42 C.F.R. § 438.610(c)(2); Exec. Order No. 12549. {From CMSC I.2.25 – I.2.26}.

b) If the Agency learns that Contractor has a prohibited relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act, the Agency may continue an existing agreement with the Contractor unless the Secretary directs otherwise. See: 42 C.F.R. § 438.610(d)(2); 42 C.F.R. § 438.610(b); 42 C.F.R. § 457.1285. {From CMSC L.5.02}
c) If the Agency learns that Contractor has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if the Contractor has relationship with an individual who is an affiliate of such an individual, the Agency may not renew or extend the existing agreement with the Contractor unless the Secretary provides to the Agency and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation. See: 42 C.F.R. § 438.610(d)(3); 42 C.F.R. § 438.610(a); Exec. Order No. 12549; 42 C.F.R. § 457.1285. {From CMSC L.5.03}.
d) If the Agency learns that an Contractor has a prohibited relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act, the Agency may not renew or extend the existing agreement with the Contractor unless the Secretary provides to the Agency and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation. See: 42 C.F.R. § 438.610(d)(3); 42 C.F.R. § 438.610(b); 42 C.F.R. § 457.1285. {From CMSC L.5.04}.

I.2.14. *Disclosures.* Contractor shall provide written disclosure of any:
a) Director, officer, or partner who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
b) Subcontractor of the Contractor who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
c) Person with ownership of five percent (5%) or more of the Contractor's equity who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
d) Network Provider who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
e) Employment, consulting, or other agreement for the provision of Contract items or services with a person who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549
f) An individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.

See: Section 1932(d)(1) of the Social Security Act; 42 C.F.R. § 438.608(c)(1); 42 C.F.R. § 438.610(a)(1) - (2); 42 C.F.R. § 438.610(b); 42 C.F.R. § 438.610(c)(1) - (4); SMDL 6/12/08; SMDL 1/16/09; Exec. Order No. 12549. {From CMSC I.2.27 – I.2.37}.

I.2.15. *Continuation of Agreement in Certain Circumstances.* If the Agency learns that Contractor has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if the Contractor has relationship with an individual who is an affiliate of such an individual, the Agency may continue an existing agreement with the Contractor unless the Secretary directs otherwise. See: 42 C.F.R. § 438.610(d)(2); 42 C.F.R. § 438.610(a); Exec. Order No. 12549; 42 C.F.R. § 457.1285. {From CMSC L.5.01}.

I.2.16. *Excluded Providers.* The Contractor is prohibited from subcontracting with Providers who have been excluded by the Agency from participating in the Iowa Medicaid program for Fraud or Abuse. The Contractor shall be responsible for checking the lists of Providers currently excluded by the State and the federal government every thirty (30) Days. In addition, the Contractor shall check the SSA's Death Master File, the NPPES, the SAM, the Medicare Exclusion Database (the MED) and any such other databases as the Secretary of DHHS may prescribe. Upon request by the Agency, the Contractor shall terminate its relationship with any Provider identified as in continued violation of law by the Agency. See: 42 C.F.R. § 438.610(d)(2); 42 C.F.R. § 438.610(a); Exec. Order No. 12549; 42 C.F.R. § 457.1285.]

I.2.17. *Medicaid Provider Enrollment Obligation.* Contractor shall ensure that all Network Providers are enrolled with the Agency as Medicaid Providers consistent with Provider disclosure, screening, and Enrollment requirements. See: 42 C.F.R. § 438.608(b); 42 C.F.R. § 455.100-106; 42 C.F.R. § 455.400-.470. {From CMSC I.2.38}.

I.2.18. *Excess Payment Reporting.* Contractor and any Subcontractor shall report to the Agency within sixty (60) Days when it has identified the Capitation Payments or other payments in excess of amounts specified in the contract. See: 42 C.F.R. § 438.608(c)(3). {From CMSC I.2.39}.

I.2.19. *Audited Financial Statements.* Contractor shall submit audited financial reports specific to the Medicaid contract on an annual basis. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards. See: 42 C.F.R. § 438.3(m). {From CMSC I.2.40}.

I.2.20. *Annual Independent Audit.* The Contractor shall submit to the Agency a copy of the annual audited financial report required by the Iowa Insurance Division. This report shall specify the Contractor's financial activities under the Contract within six (6) months following the end of each calendar year. The report, prepared using Statutory Accounting Principles as designated by the NAIC, shall be prepared by an independent Certified Public Accountant on a calendar year basis. The auditor shall be on the Iowa Insurance Division's list of approved auditors. The Contractor is responsible for the cost of the audit. The Contractor's audit format and contents shall include at a minimum: (i) TPL payments made by other third-party payers; (ii) receipts received from other insurers; (iii) a breakdown of the costs of service provision, administrative support functions, plan management and profit; (iv) assessment of the Contractor's compliance with financial requirements of the Contract including compliance with requirements for insolvency protection, surplus funds, working capital, and any additional requirements established in Administrative Rules for organizations licensed as HMOs, LSOs or COA; and (v) a separate letter from the independent Certified Public Accountant addressing non-material findings, if any.

I.2.21. *Quarterly Financing Report*. In addition to the annual audit, the Contractor shall be required to submit to the Agency copies of the quarterly NAIC financial reports. A final reconciliation shall be completed by the independent auditing firm that conducted the annual audit. The final reconciliation will make any required post-filing adjustments to estimates included in the audit completed within six (6) months of the end of the Contract year. The final reconciliation shall be completed no sooner than twelve (12) months following the end of the Contract year.

I.3 Disclosure

I.3.01. *Ownership or Control Disclosures.* Contractor and Subcontractors shall disclose to the Agency any persons or corporations with an ownership or control interest in the Contractor that:

a) Has direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the Contractor's equity;
b) Owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor if that interest equals at least five percent (5%) of the value of the Contractor's assets;
c) Is an officer or director of an MCO organized as a corporation; or
d) Is a partner in an MCO organized as a partnership.

See: Section 1124(a)(2)(A) of the Social Security Act; section 1903(m)(2)(A)(viii) of the Act; 42 C.F.R. § 438.608(c)(2); 42 C.F.R. § 455.100 - .104. {From CMSC I.3.01}.

I.3.02. *OCD Timing.* Contractor and Subcontractors shall disclose information on individuals or corporations with an ownership or control interest in the Contractor to the Agency at the following times:

a) When the Contractor submits a proposal in accordance with the Agency's procurement process.
b) When the Contractor executes a contract with the Agency.
c) When the Agency renews or extends the Contractor contract.
d) Within thirty-five (35) Days after any change in ownership of the Contractor.

See: Section 1124(a)(2)(A) of the Social Security Act; section 1903(m)(2)(A)(viii) of the Social Security Act; 42 C.F.R. § 438.608(c)(2); 42 C.F.R. § 455.100 - .103; 42 C.F.R. § 455.104(c)(3). {From CMSC I.3.02}.

I.3.03. *OCD Review.* The Agency will review the ownership and control disclosures submitted by the Contractor and any of the Contractor's Subcontractors. See: 42 C.F.R. § 438.602(c); 42 C.F.R. § 438.608(c); 42 C.F.R. § 457.1285. {From CMSC L.5.07}.

I.3.04. *US Only.* The Agency will ensure that the Contractor is not located outside of the United States. See: 42 C.F.R. § 438.602(i); 42 C.F.R. § 457.1285. {From CMSC L.5.08}.

I.4 Reserved

I.4.01. *Reserved.* N/A.

I.5 Compliance Program and Reporting

I.5.01. *Subcontractor Compliance Programs.* Contractor and 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 Agency and the Contractor, shall implement and maintain arrangements that are designed to detect Fraud, waste, and Abuse, including a compliance program that must include:

a) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements.
b) A Compliance Officer (CO) who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the CEO and the Board of Directors (BOD).
c) A Regulatory Compliance Committee (RCC) on the BOD and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract.
d) A system for training and education for the CO, the organization's senior management, and the organization's employees for the federal and State standards and requirements under the contract.
e) Effective lines of communication between the CO and the organization's employees.
f) Enforcement of standards through well-publicized disciplinary guidelines.

g) The 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.
h) Preparing an annual compliance plan on the date identified by the Agency, including the information requested and identified in the most current "Program Integrity Compliance Plan" template.
i) Preparing an annual work plan on the date identified by the Agency, including the information requested and identified in the most current "PI Annual Work Plan" template.

See: 42 C.F.R. § 438.608(a); 42 C.F.R. § 438.608(a)(1)(i) - (vii). {From CMSC I.5.01 – I.5.07}.

I.5.02. *Reporting.* 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 this Contract, shall implement and maintain arrangements or procedures to fulfill the reporting requirements in this section, which include, but are not limited to prompt reporting of all Overpayments identified or recovered, specifying the Overpayments due to Fraud. The Contractor shall certify all reports in accordance with the requirements of Section I.2.11. See: 42 C.F.R. § 438.608(a)(2). {From CMSC I.5.08}.

I.5.03. *Annual Reports.* Annually, on the date identified by the Agency, the Contractor shall submit the following reports on the identified reporting templates, including all of the information required by those templates:

a) an annual report of Overpayment recoveries.

See: 42 C.F.R. § 438.604(a)(7); 42 C.F.R. § 438.606; 42 C.F.R. § 438.608(d)(3). {From CMSC I.6.05}.

I.5.04. *Quarterly Reports.* Quarterly, on the date identified by the Agency, the Contractor shall submit the following reports on the identified reporting templates, including all of the information required by that template:

a) Cost Avoidance Cost Savings.
b) PI Activity.
c) Algorithms.
d) Single Case Agreement Template

I.5.05. *Monthly Reports.* Monthly, on the date identified by the Agency, the Contractor shall submit the following reports on the identified reporting templates, including all of the information required by that template:

a) Investigative Activities.
b) FWA Provider Notices.
c) Recovery.
d) Credible Allegation of Fraud.
e) IME Provider Action.
f) MCO Provider Action.
g) Requests for PI Information.
h) Total Non-PI Recoveries.

I.5.06. *Certification.* The Contractor shall certify all reports and plans required under this section and shall comply with all of the certification requirements identified in Section I.2.11.

I.6 Program Integrity Manager and Special Investigations Unit Staffing.

I.6.01. *Staffing Compliance.* The Contractor shall comply with the Special Investigations Manager and Staffing requirements in Section A.

I.7 Circumstances Where the Contractor May Not Recoup or Withhold Improperly Paid Funds.

I.7.01. *Prohibition on Certain Recoveries.* The Contractor shall not take any action to recoup or withhold improperly paid funds already paid or potentially due to a Provider when the issues, services, or Claim upon which the withhold or recoupment are based meet one (1) or more of the following criteria:

a) The improperly paid funds have already been recovered by the State of Iowa or the federal government directly or through resolution of a State or federal investigation or lawsuit, including but not limited to false Claims act investigations and cases; or
b) The funds have already been recovered by the RAC; or
c) The issues, services, or Claims are the subject of a pending federal or State litigation investigation, or are being audited by the Iowa RAC.

I.7.02. *Required PI Unit Communication.* The Contractor shall check with the Iowa Medicaid Program Integrity Unit before initiating any recoupment or withhold of any Program Integrity related funds to ensure that the recoupment and withhold are permissible. If the Contractor obtains funds prohibited under this Section I, the Contractor shall return the funds to the Provider.

I.8. Treatment of Recoveries.

I.8.01. *Compliance with Retention Policies.* The Contractor shall comply with the retention policies in this section and in Sections I.7 and I.9 for the treatment of all Overpayments from the Contractor to a Provider, including specifically the retention policies for the treatment of recoveries of Overpayments due to Fraud, waste, or Abuse. See: 42 C.F.R. § 438.608(d)(1)(i). {From CMSC I.6.01}.

I.8.02. *Recovery of Improper Payments.* Except as otherwise provided in this Section and Sections I.7 and I.9, the Contractor shall recover improper payments and Overpayments attributable to Claims paid by the Contractor, whether identified by the Contractor or the Agency, for five (5) years following the date the Claim was paid.

I.8.03. *Retention of Recouped Overpayments.* Except as otherwise provided in this Section and Sections I.7 and I.9, the Contractor may recoup and retain Overpayments attributable to Claims paid by the Contractor.

I.8.04. *Recoveries Not Made by Contractor.* Where a Provider Overpayment owed to the Contractor is recovered by the RAC, the State, or the federal government, by any means, including but not limited to false Claims act lawsuits and investigations or any other State or federal action or investigation, the Contractor is not entitled to recoup, retain, or be reimbursed for any such Overpayment. The Agency shall determine, in its sole discretion, if any portion of the recovered payment over which the Agency has authority will be returned to the Contractor. See: 42 C.F.R. § 438.608(d)(1). {From CMSC I.6.01-I.6.03}.

I.8.05. *Payment of Recoveries.* Contractor shall comply with the process, timeframes, and documentation the Agency requires for payment of recoveries of Overpayments to the Agency in situations where the Contractor is not permitted to retain some or all of the recoveries of Overpayments. See: 42 C.F.R. § 438.608(d)(1)(iii). {From CMSC I.6.03}.

I.9. Overpayment Audits by Agency or Designee.

I.9.01. *Recovery of Overpayments from Contractor.* The Agency or its Designee may audit Contractor's Provider Claims and recover from the Contractor the identified Provider Overpayments by following the procedures in this Section.

I.9.02. *Notice.* If the Agency identifies a Provider Overpayment owed to the Contractor, the Agency shall send notice to the Contractor identifying the Overpayment.

I.9.03. *Payment.* On or before the thirtieth (30th) day following the date of the notice, the Contractor shall either pay the Agency the amount identified as a Provider Overpayment or shall dispute the Overpayment in writing to the Program Integrity Director or other Agency representative designated by the Agency.

I.9.04. *Payment Disputes.* If the Contractor disputes the Overpayment, the Program Integrity Director or other Agency representative will consider the Contractor's dispute and shall notify the Contractor of its final decision on or before the thirtieth (30th) day following the date the written dispute is received. The Agency has the sole discretion to uphold, overturn, or amend an identified Overpayment. If the Contractor disputes the Overpayment and the Agency's final decision identifies an Overpayment, the Contractor shall pay the Agency the identified Overpayment on or before the tenth (10th) business day following the final decision.

I.9.05. *Extensions.* If the Contractor makes a written request on or before the due date for the payment of the Overpayment, the Agency, through its Program Integrity Director or other Agency representative may, in its sole discretion, grant an extension of time within which the Contractor must pay the Overpayment.

I.9.06. *Contractor Recovery from Providers.* Where the Agency has identified an Overpayment and the Contractor has been required to pay the amount of the Overpayment to the Agency, the Contractor shall recover the Overpayment from the Provider and may retain the Overpayment recovered.

I.9.07. *Offsets.* If the Contractor fails to repay an Overpayment identified under these procedures, the Agency may offset the amount of the Overpayment owed by the Contractor against any payments owing to Contractor under this Contract.

I.9.08. *Contact Before Proceeding.* If the Agency identifies an Overpayment within two (2) years of the date the Claim was paid, the Agency will contact the Contractor before proceeding with the procedures outlined in this Section.

I.10. Provider Self-Reporting Procedures.

I.10.01. *Mechanisms for Reporting.* Contractor shall have, and require the use of, a mechanism for a Network Provider to report to the Contractor when the Provider has received an Overpayment, to return the Overpayment to the Contractor within sixty (60) Days after the date on which the Overpayment was identified, and to notify the Contractor in writing of the reason for the Overpayment. See: 42 C.F.R. § 438.608(d)(2). {From CMSC I.6.04}.

I.11. Notification of Enrolled Member and Provider Changes.

I.11.01. *Screening & Enrollment of Providers.* The Agency will screen and enroll, and periodically revalidate all Contractor Network Providers as Medicaid Providers. See: 42 C.F.R. § 438.602(b)(1); 42 C.F.R. § 457.1285. {From CMSC L.5.05}.

I.11.02. *Agreements Pending Outcome of Screening.* Contractor may execute Network Provider agreements, pending the outcome of screening, Enrollment, and revalidation, of up to one hundred and twenty (120) Days. The Contractor must terminate a Network Provider immediately upon notification from the Agency that the Network Provider cannot be enrolled, or the expiration of one (1) one hundred and twenty (120) day period without Enrollment of the Provider, and notify affected Enrolled Members. See: 42 C.F.R. § 438.602(b)(2); 42 C.F.R. § 457.1285. {From CMSC L.5.06}.

I.11.03. *Notification of Enrolled Member Changes.* 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 Agency and the Contractor, shall implement and maintain arrangements or procedures for prompt notification to the Agency when it receives information about changes in an Enrolled Member's circumstances that may affect the Enrolled Member's eligibility including changes in the Enrolled Member's residence or the death of the Enrolled Member. See: 42 C.F.R. § 438.608(a)(3). {From CMSC I.5.09-I.5.10}.

I.11.04. *Notification of Provider Network Changes.* 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 Agency and the Contractor, shall implement and maintain arrangements or procedures for notification to the Agency when it receives information about a change in a Network Provider's circumstances that may affect the Network Provider's eligibility to participate in the managed care program, including the termination of the Provider agreement with the Contractor. See: 42 C.F.R. § 438.608(a)(4). {From CMSC I.5.11}.

I.11.05. *Notification of Provider Disenrollment.* Contractor shall notify the Agency of Provider decredentialing for Program Integrity reasons. The Agency will report to the Office of Inspector General in compliance with 42 C.F.R. Part 1001.

I.11.06. *Adverse Actions Taken on Provider Applications for Program Integrity Reasons.* The Contractor shall implement in its Provider Enrollment processes the obligation of Providers to disclose the identity of any person described in 42 C.F.R. § 1001.1001(a)(1) as well as other permissible exclusions that would impact the integrity of the Provider Enrollment. The Contractor shall forward such disclosures to the Agency. The Contractor shall abide by any direction provided the Department on whether to permit the applicant to be a Provider in the program. Specifically, the Contractor shall not permit the Provider to become a Network Provider if the Agency or the Contractor determines that any person who has 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 program established under Medicare, Medicaid or the Title XX Services program, or if the Agency or the Contractor determines that the Provider did not fully and accurately make any disclosure pursuant to 42 C.F.R. § 1001.1001(a)(1).

I.11.07. *Termination of Providers*. The Contractor shall comply with all requirements for provider Disenrollment and termination as required by 42 C.F.R. § 455.416.

I.12 Required Fraud, Waste, and Abuse Activities

I.12.01. *Verifying Receipt of Services.* 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 Agency and the Contractor, shall implement and maintain arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by Network Providers were received by Enrolled Members and the application of such verification processes on a regular basis. See: 42 C.F.R. § 438.608(a)(5). {From CMSC I.5.12}.

I.12.02. *Reserved.* N/A.

I.12.03. *Internal Controls.* The Contractor shall assess and strengthen internal controls to ensure Claims are submitted and paid properly. The Contractor shall educate employees, providers, and Enrolled Members about Fraud and Abuse and how to report it. The Contractor shall ensure accuracy, completeness, and truthfulness of Claims and payment data as required by 42 C.F.R. Part 438, Subpart H and 42 C.F.R. § 457.950(a)(2).

I.12.04. *FCA Policies & Procedures.* If the Contractor makes or receives annual payments under the Contract of at least $5,000,000, 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 Agency and the Contractor, shall implement and maintain written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act (FCA) and other Federal and State laws, including information about rights of employees to be protected as whistleblowers. See: Section 1902(a)(68) of the Social Security Act; 42 C.F.R. § 438.608(a)(6). {From CMSC I.5.13}.

I.12.05. *Responding to Claims of Fraud & Abuse.* The Contractor shall ensure sufficient organizational resources to effectively respond to complaints of Fraud and Abuse and shall effectively and efficiently respond to complaints of Fraud and Abuse.

I.12.06. *Data Mining.* The Contractor shall develop data mining techniques. On-site audits are conducted when potential Fraud or Abuse has been identified by the Contractor.

I.12.07. *F.W.A. Referrals – Compliance.* 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 Agency and the Contractor, shall comply with the Agency procedures and requirements for implementation and maintenance of Fraud, waste, and Abuse arrangements. This includes but is not limited to compliance with Agency procedures and requirements for the prompt referral of any potential Fraud, waste, or Abuse that the Contractor identifies to the State Medicaid Program Integrity unit or any potential Fraud directly to the State MFCU. See: 42 C.F.R. § 438.608(a)(7). {From CMSC I.5.14}.

I.12.08. *Enforcement of Iowa Medicaid Program Rules*. The Contractor and the Agency shall develop a process for referral of providers to the Agency for sanction under 441 Iowa Administrative Code § 79.2. The Contractor shall vigorously pursue Fraud, waste and abuse in the Medicaid Program and notify the Agency PI of any provider activity which would incur a sanction under 441 Iowa Administrative Code § 79.2(249A).

I.13. Credible Allegation of Fraud Temporary Suspensions

I.13.01. *Suspending Payments.* The Contractor, and all applicable subcontractors, shall comply with 42 C.F.R. § 455.23 and § 438.608(a)(8) by suspending all payments to a Provider after the Agency determines that there is a credible allegation of Fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the Agency or law enforcement (included but not limited to MFCU) has identified in writing good cause for not suspending payments or to suspend payments only in part. See: 42 C.F.R. § 438.608(a)(8); 42 C.F.R. § 455.23. {From CMSC I.5.15}.

I.13.02. *Notices.* The Contractor, and all applicable subcontractors, shall issue a notice of payment suspension that comports with 42 C.F.R. § 455.23 and retain the suspension for the time designated in that provision. In addition, the notice of payment suspension shall state that payments are being withheld in accordance with 42 C.F.R. § 455.23. The Contractor shall not suspend payments without consulting first with the MFCU and second with the Agency. The Contractor shall maintain all materials related to payments suspension for five (5) years as required by 42 C.F.R. § 455.23(g). The Contractor shall provide a Grievance process for Providers whose payments have been suspended under this provision. See: 42 C.F.R. § 438.608(a)(8); 42 C.F.R. § 455.23. {From CMSC I.5.15}.

I.13.03. *Lifting Suspensions.* When notified that the Agency suspension has been lifted, the Contractor, and all applicable subcontractors, shall lift its suspension of payments and return the suspended payments to the Provider unless the Contractor has other authority to continue to withhold those payments. See: 42 C.F.R. § 438.608(a)(8); 42 C.F.R. § 455.23. {From CMSC I.5.15}.

I.13.04. *Evaluation of SIU Activities.* The Agency will evaluate the PAHP's Program Integrity performance based on a set of standards developed by the Agency. See: 42 C.F.R. § 438.608(a)(8); 42 C.F.R. § 455.23. {From CMSC I.5.15}.

J. General Terms and Conditions

J.1 Inspection

J.1.01. *Inspection & Audit.* Contractor shall allow the Agency, CMS, the OIG, the Comptroller General, and their Designees to inspect and audit any records or documents of the Contractor, or its Subcontractors, at any time. This may include inspection of the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. See: 42 C.F.R. § 438.3(h); 42 C.F.R. § 457.1201(g). {From CMSC J.1.01}.

J.1.02. *Ten (10) Year Audit Right; Providing Information.* Notwithstanding any other timeframe found in this Contract, the right to audit under this Section J 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 and its Subcontractors shall furnish duly authorized and identified agents or representatives of the State and Federal governments with such information as they may request regarding payments Claimed for Medicaid services. The Contractor must timely provide copies of the requested records to the Agency, the Agency's Designee, or the Iowa MFCU within ten (10) business days from the date of the request unless the Agency may, at its sole discretion, sets a time period greater than ten (10) days. If such original Documentation is not made available as requested, the Contractor must provide transportation, lodging and subsistence at no cost, for all State and/or Federal representatives to carry out their audit functions at the principal offices of the Contractor or other locations of such records. Additionally, the Contractor shall grant the Agency, the Agency's Designee, or MFCU access during the Contractor's regular business hours to examine health service and financial records related to a health service billed to the program. The Agency will notify the Contractor no less than twenty-four (24) hours before obtaining access to a health service or financial record, unless the Contractor waives the notice. The Agency shall access records in accordance with 45 C.F.R. Parts 160 through 164.

J.1.03. *Access to Subcontractor Records & Documents.* Contractor shall allow the Agency, CMS, the OIG, the Comptroller General, and their Designees to inspect and audit any records or documents of the Contractor's Subcontractors at any time. See: 42 C.F.R. § 438.3(h); 42 C.F.R. § 457.1201(g). {From CMSC J.1.02}.

J.1.04. *Access to Subcontractor Premises.* Contractor shall allow Agency, CMS, the OIG, the Comptroller General, and their Designees to inspect the premises, physical facilities, and equipment where Medicaid-related activities are conducted at any time. See: 42 C.F.R. § 438.3(h); 42 C.F.R. § 457.1201(g). {From CMSC J.1.03}.

J.1.05. *Ten (10) Year Subcontractor Audit Right.* Contractor recognizes the right of the Agency, CMS, the OIG, the Comptroller General and their Designees to audit records or documents of the Contractor or the Contractor's Subcontractors for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. See: 42 C.F.R. § 438.3(h); 42 C.F.R. § 457.1201(g). {From CMSC J.1.04 - J.1.05}.

J.1.06. *Scope of Audit.* The Secretary, DHHS, and the State (or any person or organization designated by either) shall have the right to audit and inspect any books or records of the Contractor or its Subcontractors pertaining to:

a) The ability of the Contractor to bear the risk of financial losses.
b) Services performed or payable amounts under the Contract.

See: Section 1903(m)(2)(A)(iv) of the Social Security Act. {From CMSC J.1.06}.

J.1.07. *Grievance & Appeal Records.* Contractor and Contractor's Subcontractors shall retain, as applicable, Enrolled Member Grievance and Appeal records in 42 C.F.R. § 438.416, base data in 42 C.F.R. § 438.5(c), MLR reports in 42 C.F.R. § 438.8(k), and the data, information, and documentation specified in 42 C.F.R. §

438.604, (except 438.604(a)(2)), 438.606, 438.608, and 438.610 for a period of no less than ten (10) years. See: 42 C.F.R. § 438.3(u); 42 C.F.R. § 457.1201(q). {From CMSC J.1.07}.

J.2 Compliance with State and Federal Laws

J.2.01. *Compliance with Laws.* Contractor shall comply with all applicable Federal and State laws and regulations including:

a) Title VI of the Civil Rights Act (CRA) of 1964.
b) The Age Discrimination Act of 1975.
c) The Rehabilitation Act of 1973.
d) Title IX of the Education Amendments of 1972 (regarding education programs and activities).
e) The Americans with Disabilities Act.
f) Section 1557 of the PPACA.

See: 42 C.F.R. § 438.3(f)(1); 42 C.F.R. § 438.100(d); 42 C.F.R. § 457.1201(f); 42 C.F.R. § 457.1220. {From CMSC J.2.01}.

J.2.02. *Enrolled Member Rights.* Contractor shall comply with any applicable Federal and State laws that pertain to Enrolled Member rights and ensure that its employees and contracted Providers observe and protect those rights. See: 42 C.F.R. § 438.100(a)(2); 42 C.F.R. § 457.1220. {From CMSC J.2.02}.

J.3 Subcontracts

J.3.01. *Integrated Subcontracting.* Any subcontracting relationship shall provide for a seamless experience for Enrolled Members and Providers. For example, any subcontracting of Claims processing shall be invisible to the Provider so as to not result in confusion about where to submit Claims for payments. If the Contractor uses Subcontractors to provide direct services to Enrolled Members, the Subcontractors shall meet the same requirements as the Contractor, and the Contractor shall demonstrate its oversight and monitoring of the Subcontractor's compliance with these requirements. The Contractor shall require Subcontractors providing direct services to have Quality improvement goals and performance improvement activities specific to the types of services provided by the Subcontractors.

J.3.02. *Contractor Responsibility.* Contractor shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract, notwithstanding any relationship(s) that the Contractor may have with any Subcontractor. See: 42 C.F.R. § 438.230(b)(1); 42 C.F.R. § 438.3(k); 42 C.F.R. § 457.1201(i); 42 C.F.R. § 457.1233(b). {From CMSC J.3.01}

J.3.03. *Subcontractor Qualifications*. The Contractor is accountable for any functions and responsibilities that are delegated to a Subcontractor and is required to certify and warrant all Subcontractor work. Prior to delegation, the Contractor shall evaluate the prospective Subcontractor's ability to perform the activities to be delegated, including firm and staff qualifications. The Contractor shall ensure that Business Associates Agreements are in place as necessary. The Contractor shall notify the Agency in writing of all subcontracts relating to Deliverables to be provided under this Contract prior to the time the subcontract(s) become effective. The Contractor shall submit for Agency review and approval Subcontractor agreements for any Subcontractor whose payments are equal to or greater than five percent (5%) of Capitation Payments under the Contract. However, the Agency reserves the right to review and approve any subcontracts, and all subcontracts shall be accessible to the Agency and provided within three (3) business days of request. All material changes to the Subcontractor agreement previously approved by the Agency shall be submitted in writing to the Agency for approval at least sixty (60) Days prior to the effective date of the proposed subcontract agreement amendment. The Agency shall have the right to request the removal of a Subcontractor for good cause. Subcontractors shall be bound to the same contractual terms and conditions as the Contractor.

J.3.04. *Subcontractor Delegation.* If any of the Contractor's activities or obligations under the Contract with the Agency are delegated to a Subcontractor:

a) The activities and obligations, and related reporting responsibilities, shall be specified in the contract or written agreement between the Contractor and the Subcontractor.
b) The contract or written arrangement between the Contractor and the Subcontractor must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the Agency or the Contractor determines that the Subcontractor has not performed satisfactorily.

See: 42 C.F.R. § 438.230(c)(1)(i) - (iii); 42 C.F.R. § 438.3(k); 42 C.F.R. § 457.1201(i); 42 C.F.R. § 457.1233(b). {From CMSC J.3.02 - J.3.03}.

J.3.05. *Subcontractor Oversight*. The Contractor shall have policies and procedures, subject to Agency review and approval, to audit and monitor Subcontractors' data, data submission and performance, and shall implement oversight mechanisms to monitor performance and compliance with Contract requirements. The Contractor shall implement and adhere to the Agency-approved policies and procedures. Changes to these policies and procedures shall receive the Agency's prior approval. Further, the Contractor shall monitor the Subcontractor's performance on an ongoing basis. Formal reviews shall be conducted by the Contractor at least quarterly. The Agency reserves the right to audit Subcontractor data. Whenever deficiencies or areas of improvement are identified, the Contractor and Subcontractor shall take corrective action. The Contractor shall provide to the Agency the findings of all Subcontractor performance monitoring and reviews upon request and shall notify the Agency any time a Subcontractor is placed on corrective action. Additionally, the Agency will establish and provide to the Contractor through the Reporting Manual, any reporting requirements for incorporating Subcontractor performance into the reports to be submitted to the Agency.

J.3.06. *Delegated Compliance.* In any contract or written agreement that the Contractor has with any individual or entity that relates directly or indirectly to the performance of the Contractor's obligations under its Contract, the contract or written agreement between the Contractor and the individual or entity requires the individual or entity to comply with all applicable CHIP laws, Medicaid laws, applicable regulations, including applicable subregulatory guidance and Contract provisions. See: 42 C.F.R. § 438.230(c)(2); 42 C.F.R. § 438.3(k); 42 C.F.R. § 457.1201(i); 42 C.F.R. § 457.1233(b). {From CMSC J.3.04}.

J.3.07. *Subcontractor Audit/Inspection.* Contracts between the Contractor and Subcontractors that relates directly or indirectly to the performance of the Contractor's obligations under this Contract shall require the Subcontractor to agree that the Agency, CMS, the DHHS Inspector General, the Comptroller General, or their Designees have the right to 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 Agency. See: 42 C.F.R. § 438.230(c)(3)(i); 42 C.F.R. § 438.3(k); 42 C.F.R. § 457.1201(i); 42 C.F.R. § 457.1233(b). {From CMSC J.3.05}.

J.3.08. *Subcontractor Premises Access.* Contracts between the Contractor and Subcontractors that relates directly or indirectly to the performance of the Contractor's obligations under this Contract shall require the Subcontractor to make available, for the purposes of an audit, evaluation, or inspection by the Agency, CMS, the DHHS Inspector General, the Comptroller General or their Designees, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Enrolled Members. See: 42 C.F.R. § 438.230(c)(3)(ii); 42 C.F.R. § 438.3(k); 42 C.F.R. § 457.1201(i); 42 C.F.R. § 457.1233(b). {From CMSC J.3.06}.

J.3.09. *Ten (10) Year Audit Right.* Contracts between the Contractor and Subcontractors that relates directly or indirectly to the performance of the Contractor's obligations under this Contract shall require the Subcontractor to agree that the right to audit by the Agency, CMS, the DHHS Inspector General, the Comptroller 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. See: 42 C.F.R. § 438.230(c)(3)(iii); 42 C.F.R. § 438.3(k); 42 C.F.R. § 457.1201(i); 42 C.F.R. § 457.1233(b). {From CMSC J.3.07}.

J.3.10. *Fraud – Audit at Any Time.* Contracts between the Contractor and Subcontractors that relates directly or indirectly to the performance of the Contractor's obligations under this Contract shall require that if the Agency, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of Fraud or similar risk, the Agency, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time. See: 42 C.F.R. § 438.230(c)(3)(iv); 42 C.F.R. § 438.3(k); 42 C.F.R. § 457.1201(i); 42 C.F.R. § 457.1233(b). {From CMSC J.3.08}.

J.4 Third Party Liability (TPL) Activities

J.4.01. *Subcontractor TPL Delegations.* Any activities the Contractor performs related to TPL, including:

a) The activities and obligations, and related reporting responsibilities, shall be specified in the contract or written agreement between the Contractor and the Subcontractor.
b) Shall identify how the Contractor will reduce payments based on payments by a Third Party for any part of a service.
c) Shall identify whether the Agency or the Contractor retains the TPL collections.
d) Shall identify how the Agency monitors to confirm that the Contractor is upholding contractual requirements for TPL activities.

See: 42 C.F.R. § 433 Sub D; 42 C.F.R. § 447.20. {From CMSC J.4.01}.

J.4.02. *TPL Responsibility.* Pursuant to law, the Agency is the payer of last resort for all covered services. To the extent of medical assistance paid by the Contractor, the Agency assigns all of its rights to recover for such medical assistance against liable third parties under Iowa Code Ch. 249A, including but not limited to the rights of the Agency under Iowa Code §§ 249A.37 and 249A.54. Notwithstanding the foregoing sentence, the Contractor shall, upon request of the Agency, release the assignment to the Agency. The Agency reserves the right to identify, pursue, and retain any recovery of third-party resources that remain uncollected.

The Contractor shall exercise full assignment rights as applicable and shall make every reasonable effort to determine the liability of third parties to pay for services rendered to Enrolled Members under the Contract and cost avoid and/or recover any such liability from the Third Party. The Contractor shall develop, implement, and adhere to policies and procedures, subject to Agency review and approval, to meet its obligations regarding TPL when the Third Party pays a cash benefit to the Enrolled Member for medical Claim expenses, regardless of services used, or does not allow the Enrolled Member to assign their Benefits. When there is a liable Third Party, the Contractor shall pay the Enrolled Member's coinsurance, deductibles, Co-Payments and other cost-sharing expenses up to the Contractor's allowed amount. The Contractor's total liability shall not exceed the Contractor's allowed amount minus the amount paid by the primary payer. The Contractor shall follow all activities laid out in the most recent Agency Medicaid TPL Action Plan, and most recent CMS handbook called Coordination of Benefits and Third-Party Liability (COB/TPL) In Medicaid.

> J.4.02.1 *Sources of TPL.* Applicable liable third parties include any insurance company, individual, corporation or business that can be held legally responsible for the payment of all or part of the medical costs of a member. Examples of liable third parties can include: (i) Health Insurance, including Medicare, and TRICARE; (ii) worker's compensation; (iii) homeowner's insurance; (iv) automobile liability insurance; (v) non-custodial parents or their insurance carriers; or (vi) settlements or court awards for casualty/tort (accident) Claims including settlements paid through insurance. Contractor shall be able to identify trauma and accident cases where funds expended can be recovered from liable third parties and recover the funds.

J.4.03. *TPL Data.* The Contractor shall share information regarding its Enrolled Members with these other payers as specified by the Agency and in accordance with 42 C.F.R. § 438.208(b). In the process of coordinating care, the Contractor shall protect each Enrolled Member's privacy in accordance with the confidentiality requirements stated in 45 C.F.R. Parts 160 and 164. The Agency will provide information to the

Contractor on Enrolled Member TPL that was collected at the time of Medicaid application. The Contractor shall report weekly any new TPL to the Agency, in the preferred method as described by the Agency, to retain in the TPL system. The information collected on members shall contain the following:

a) First and last name of the policyholder
b) Social security number of the policyholder
c) Full insurance company name
d) Group number, if available
e) Name of policyholder's employer (if known)
f) Insurance carrier ID
g) Type of policy and coverage

Additionally, the Contractor shall implement Agency approved strategies and methodologies to ensure the collection and maintenance of current TPL data, for example, recoveries from direct billing, disallowance projects, and yield management activities.

J.4.04. *Cost Avoidance.* If an Enrolled Member is covered by another insurer, the Contractor shall coordinate Benefits so as to maximize the utilization of third-party coverage. In accordance with 42 C.F.R. § 433.139, if the probable existence of third-party liability has been established at the time a Claim is filed, the Contractor shall reject the Claim and direct the Provider to first submit the Claim to the appropriate Third Party. When the Provider resubmits the Claim following payment by the primary payer, the Contractor shall then pay the Claim to the extent that payment allowed under the Contractor's reimbursement schedule exceeds the amount of the remaining patient responsibility balance.

J.4.05. *Provider Education.* The Contractor shall educate Network Providers, and include in detailed written billing procedures, the process for submitting Claims with TPL for payment consideration. For example, explicit instructions on any requirements related to inclusion of an EOB from the primary insurer for paper Claims or any applicable requirements surrounding HIPAA Remittance Advice Remark Codes.

J.4.06. *Cost Avoidance Requirements.* If insurance coverage information is not available or if one (1) of the cost avoidance exceptions described below exists, the Contractor shall make the payment and make a Claim against the Third Party, if it is determined that the Third Party is or may be liable. The Contractor shall always ensure that cost avoidance efforts do not prevent an Enrolled Member from receiving Medically Necessary Services in a timely manner.

J.4.07. *Cost Avoidance Exceptions – Pay and Chase Activities.* Cost avoidance exceptions in accordance with 42 C.F.R. § 433.139 include the following situations in which the Contractor shall first pay the Provider and then coordinate with the liable Third Party. Providers are not required to bill the Third Party prior to the Contractor in these situations: (i) the Claim is for coverage derived from a parent whose obligation to pay support is being enforced by the State Title IV-D Agency; or (ii) the Claim is for preventive pediatric services (including EPSDT) that are covered by the Medicaid program. Following reimbursement to the Provider in these cost avoidance exception cases, the Contractor shall actively seek reimbursement from responsible third parties and adjust Claims accordingly.

J.4.08. *Collection and Reporting.* The Contractor shall identify, collect, and report TPL coverage and collection information to the Agency. As third-party liability information is a component of capitation rate development, the Contractor shall maintain records regarding TPL collections and report these collections to the Agency in the timeframe and format determined by the Agency. The Contractor shall retain all third-party liability collections made on behalf of its Enrolled Members; the Contractor shall not collect more than it has paid out for any Claims with a liable Third Party. The Contractor shall provide to the Agency or its Designee information on Enrolled Members who have newly discovered Health Insurance, in the timeframe and manner required by the Agency. The Contractor shall provide Enrolled Members and Providers instructions on how to update TPL

information on file and shall provide mechanisms for reporting updates and changes. Reports include, but are not limited to:

a) Monthly amounts billed and collected, current and year-to-date.
b) Recoveries and unrecoverable amounts by carrier, type of coverage, and reason (quarterly).
c) TPL activity reports (quarterly).
d) Internal reports used to investigate possible third-party liability when paid Claims contain a TPL amount and no resource information is on file.
e) Monthly Quality assurance sample to the Agency verifying the accuracy of the TPL updated applied during the previous month.
f) Monthly pay-and-chase carrier bills.

J.4.09. *COBA Obligations.* The Contractor shall enter into a Coordination of Benefits Agreement (COBA) with Medicare for the purpose of coordinating crossover payment. The Contractor shall have the responsibility for coordination of benefits for individuals dually eligible for Medicaid and Medicare. The Contractor shall send eligibility information to CMS and receive Medicare Claims data for processing supplemental insurance benefits from CMS' national crossover contractor, the Benefits Coordination & Recovery Center (BCRC). Therefore, Contractor shall enter into a COBA with Medicare and participate in the automated Claims crossover process. See: 42 C.F.R. § 438.3(t). {From CMSC J.4.02}.

J.4.10. *Coordination with Medicare.* The Contractor shall provide medically necessary covered services to Enrolled Members who are also eligible for Medicare if the service is not covered by Medicare. The Contractor shall ensure that services covered and provided under the Contract are delivered without charge to Enrolled Members who are dually eligible for Medicare and Medicaid. The Contractor shall coordinate with Medicare payers, Medicare Advantage Plans, and Medicare Providers as appropriate to coordinate the care and Benefits of Enrolled Members who are also enrolled with Medicare. Contractor shall develop a plan to coordinate care for duals and document such in its PPM.

J.4.11 *Lesser of Logic.* The Contractor shall ensure that the total reimbursement for any reimbursable Medicare Claims is limited to the Medicaid reimbursement amount under authority of federal law §1902(n)(2) of the Social Security Act. Effectively, Iowa Medicaid pays for the lesser of the following:

a) The cost sharing (deductible and/or coinsurance) that, absent Medicaid eligibility, would have been owed by the Medicare beneficiary, or
b) The difference between the sum of what Medicare and all other third-party insurers paid and the Medicaid fee for the same services or items.

The financial obligation of Iowa Medicaid for services is based upon Medicare and all other third-party insurer amounts, not the Provider's charge. Medicaid will not pay any portion of Medicare Part A, Part B, or Part C deductibles and coinsurance when payment that Medicare and all other third-party insurers has made for the services or items equals or exceeds what Medicaid would have paid had it been the sole payer.

J.5 Sanctions

J.5.01. *Reserved.* N/A.

J.5.02. *Reserved.* N/A.

J.5.03. *Reserved.* N/A.

J.5.04. *Reserved.* N/A.

J.5.05. *Reserved.* N/A.

J.5.06. *Reserved.* N/A.

J.5.07. *Reserved.* N/A.

J.5.08. *Reserved.* N/A.

J.5.09. *Additional State Sanctions.* The Agency may impose additional sanctions provided for under State statutes or regulations to address noncompliance. See: 42 C.F.R. § 438.702(b); 42 C.F.R. § 457.1270. {From CMSC J.5.10}.

J.5.10. *Reserved.* N/A.

J.5.11. *Reserved.* N/A.

J.5.12. *Reserved.* N/A.

J.5.13. *Reserved.* N/A.

J.5.14. *Reserved.* N/A.

J.6 Termination

J.6.01. *Termination Right.* The Agency may terminate this Contract, and place Enrolled Members into a different Contractor or provide Medicaid and/or CHIP Benefits through other State Plan authority, if the Agency determines that the Contractor has failed to carry out the substantive terms of its contracts or meet the applicable requirements of sections 1932, 1903(m) or 1905(t) of the Social Security Act. See: 42 C.F.R. § 438.708(a); 42 C.F.R. § 438.708(b); sections 1903(m); 1905(t); 1932 of the Social Security Act; 42 C.F.R. § 457.1270. {From CMSC J.6.01}.

J.7 Insolvency

J.7.01. *Enrolled Members Not Liable for Contractor Insolvency.* Medicaid and CHIP Enrolled Members shall not be held liable for the Contractor's debts, in the event the Contractor becomes insolvent. See: 42 C.F.R. § 438.106(a); section 1932(b)(6) of the Social Security Act; 42 C.F.R. § 457.1226. {From CMSC J.7.01}.

J.7.02. *No Enrolled Member Liability on Unpaid Claims.* Medicaid and CHIP Enrolled Members shall not held liable for covered services provided to the Enrolled Member, for which the Agency does not pay the Contractor, or for which the Agency or Contractor does not pay the Provider that furnished the service under a contractual, referral, or other arrangement. See: 42 C.F.R. § 438.106(b)(1) - (2); 42 C.F.R. § 438.3(k); 42 C.F.R. § 438.230; section 1932(b)(6) of the Social Security Act; 42 C.F.R. § 457.1226; 42 C.F.R. § 457.1233(b). {From CMSC J.7.02 - J.7.03}.

J.7.03. *Limitation on Enrolled Member Liability – Referrals/Other Arrangements.* Enrolled Members shall not be held liable for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the Enrolled Member would owe if the Contractor covered the services directly. See: 42 C.F.R. § 438.106(c); 42 C.F.R. § 438.3(k); 42 C.F.R. § 438.230; section 1932(b)(6) of the Social Security Act; 42 C.F.R. § 457.1226; 42 C.F.R. § 457.1233(b). {From CMSC J.7.04}.

J.7.04. *Assurances Against Insolvency.* Contractor shall provide assurances satisfactory to the Agency that its provision against the risk of insolvency is adequate to ensure that Enrolled Members will not be liable for the Contractor's debt if the Contractor becomes insolvent. See: 42 C.F.R. § 438.116(a). {From CMSC J.7.05}.

J.7.05. *Reserved.* N/A.

J.7.06. *Financial Stability.* Contractor shall be licensed and in good standing as an HMO, LSO or COA in the State of Iowa and shall comply with all applicable law. The Contractor shall comply with all applicable law regarding deposit requirements and reporting requirements. The Contractor shall copy the Agency on all required filings with the Iowa Insurance Division. The Agency will also continually monitor the Contractor's financial stability and shall provide financial reporting requirements through the Reporting Manual. The Contractor shall comply with the Agency established financial reporting requirements.

J.7.07. *Reinsurance.* The Contractor shall comply with all applicable law regarding reinsurance requirements and shall file with the Agency all contracts of reinsurance or a summary of the plan of self-insurance. The Contractor shall provide to the Agency the risk analysis, assumptions, cost estimates and rationale supporting its proposed reinsurance arrangements.

J.7.08 *Enrolled Member Liability on Unpaid Claims and ABM.* Notwithstanding Section J.7.02, a Medicaid Enrolled Member can be held liable for services provided to the Enrolled Member that normally are covered services under the Contract but which were provided to an Enrolled Member who has met or exceeded their ABM. However, the Enrolled Member may only be held liable for such services if the Enrolled Member was informed of the liability before services were delivered to the Enrolled Member and the Enrolled Member expressly accepted the liability in writing, noting expressly that the Enrolled Member would be accepting liability because of exceeding the ABM. The phrase "covered services" as used in section J.7.02-J.7.03 means those services provided to Medicaid beneficiaries through this Contract whether or not the Contractor or the Agency ultimately pay the provider for the services.

J.8 Contractual Non-Compliance

J.8.01. *Disaster Recovery.* Contractor shall execute all activities needed to recover and restore operation of information systems, data and software at an existing or alternate location under emergency conditions within twenty (24) hours of identification or a declaration of a Disaster. If the Contractor's failure to restore operations requires the Agency to transfer Enrolled Members to another contractor, to assign operational responsibilities to another contractor or the Agency is required to assume the operational responsibilities, the Agency will require the Contractor to pay any difference between the capitation rates that would have been paid to the Contractor and the actual rates being paid to the replacement contractor. In addition, the Contractor shall pay any costs the Agency incurs associated with the Contractor's failure to restore operations following a Disaster, including but not limited to costs to accomplish the transfer of Enrolled Members or reassignment of operational duties.

J.8.02. *Non-Compliance with Reporting Requirements.* In addition to any liquidated damages for reporting non-compliance as described in the relevant Special Contract Exhibit rate sheet, if the Contractor's non-compliance with reporting requirements established under the Contract or in the Reporting Manual impacts the Agency's ability to monitor the Contractor's solvency, and the Contractor's financial position requires the Agency to transfer Enrolled Members to another contractor, the Agency will require the Contractor to pay any difference between the capitation rates that would have been paid to the Contractor and the actual rates being paid to the replacement contractor as a result of Enrolled Member transfer. In addition, the Contractor shall pay any costs the Agency incurs to accomplish the transfer of Enrolled Members. Further, the Agency will withhold all Capitation Payments or require corrective action until the Contractor provides satisfactory financial data.

J.8.03. *Reserved.* N/A.

J.8.04. *Non-Compliance with Provider Network Requirements.* In addition to any liquidated damages for Provider Network requirements as described in the Special Contract Exhibit rate sheets, if the Agency determines that the Contractor has not met the network Access standards established in the Contract, the Agency will require submission of a Corrective Action Plan within ten (10) business days following notification by the Agency. Determination of failure to meet network Access standards may be made following a review of

the Contractor's Network Geographic Access Assessment Report, or other information that may be collected by the Agency. The frequency of required report submission will be outlined in the Reporting Manual. Upon discovery of noncompliance, the Contractor shall be required to submit monthly Network Geographic Access Assessment Reports, and other information as may be required by the Agency, until compliance is demonstrated for sixty (60) consecutive Days. The Agency may also require the Contractor to maintain an open network for the Provider type for which the Contractor's network is non-compliant. Further, should Contractor be out of compliance for three (3) consecutive months as a result of failure to meet network Access standards, the Agency will immediately suspend auto-Enrollment of Members with the Contractor, until such time as Contractor successfully demonstrates compliance with the network Access standards.

J.8.05. *Non-Compliance with Accreditation Requirements.* As described in Section G.7.03, the Contractor shall be required to attain and maintain accreditation through NCQA. In the event the Contractor fails to attain and maintain accreditation in the required timeframe, the Contractor shall submit a formal Corrective Action Plan for the Agency review and approval.

J.8.06. *Non-Compliance with Readiness Review Requirements.* In addition to any liquidated damages for Readiness Review non-compliance as described in the relevant Special Contract Exhibit rate sheet, if the Contractor fails to satisfactorily pass the Readiness Review at least thirty (30) Days prior to scheduled Member Enrollment (or other deadline as may be established at the sole discretion of the Agency), the Agency may delay Member Enrollment and/or may require other remedies (including, but not limited to Contract termination), and Contractor shall be responsible for all costs incurred by the Agency as a result of such delay.

J.8.07. *Non-Compliance Remedies.* It is the Agency's primary goal to ensure that the Contractor is delivering Quality care to Enrolled Members. To assess attainment of this goal, the Agency monitors certain Quality and performance standards, and holds the Contractor accountable for being in compliance with Contract terms. The Agency accomplishes this by working collaboratively with the Contractor to maintain and improve programs, and not to impair Contractor stability.

In the event that the Contractor fails to meet performance requirements or reporting standards set forth in the Contract or other standards established by the Agency, the Agency will provide the Contractor with a written notice of non-compliance and may require any of the corrective actions or remedies discussed below. The Agency will provide written notice of non-compliance to the Contractor within ninety (90) calendar days of the Agency's discovery of such non-compliance.

If the Agency elects not to exercise a corrective action clause contained anywhere in the Contract in a particular instance, this decision shall not be construed as a waiver of the Agency's right to pursue future assessment of that performance requirement and associated damages, including damages that, under the terms of the Contract, may be retroactively assessed.

J.8.08. *Corrective Actions.* The Agency may require corrective action(s), take contractual action to enforce contractual obligations, or implement intermediate sanctions when the Contractor has failed to provide the requested services. The nature of the corrective action(s) will depend upon the nature, severity and duration of the Deficiency and repeated nature of the non-compliance. The non-compliance corrective actions may be instituted in any sequence and include, but are not limited to, any of the following:

a) *Written Warning:* The Agency may issue a written warning and solicit a response regarding the Contractor's corrective action.
b) *Formal Corrective Action Plan:* The Agency may require the Contractor to develop a formal Corrective Action Plan to remedy the breach. The Corrective Action Plan shall be submitted under the signature of the Contractor's chief executive and shall be approved by the Agency. If the Corrective Action Plan is not acceptable, the Agency may provide suggestions and direction to bring the Contractor into compliance.

c) *Withholding Full or Partial Capitation Payments:* The Agency may suspend Capitation Payments for the following month or subsequent months when the Agency determines that the Contractor is materially non-compliant. the Agency will give the Contractor written notice ten (10) business days prior to the suspension of Capitation Payments and specific reasons for non-compliance that result in suspension of payments. The Agency may continue to suspend all Capitation Payments until non-compliance issues are corrected.
d) *Suspending Auto-assignment:* The Agency may suspend auto-assignment of Members to the Contractor. The Agency may suspend all auto-assignment or may selectively suspend auto-assignment for a region or county. The Agency will notify the Contractor in writing of its intent to suspend auto-assignment at least ten (10) business days prior to the first day of the suspension period. The suspension period may be for any length of time specified by the Agency. The Agency will base the duration of the suspension upon the nature and severity of the default and the Contractor's ability to cure the default.
e) *Assigning the Contractor's Enrolled Membership and Responsibilities to Another Contractor:* The Agency may assign the Contractor's Enrolled Membership and responsibilities to one (1) or more other contractors that also provide services to the program population, subject to consent by the contractor that would gain that responsibility. The Agency will notify the Contractor in writing of its intent to transfer Enrolled Members and responsibility for those Members to another contractor at least ten (10) business days prior to transferring any Enrolled Members.
f) *Appointing Temporary Management of the Contractor's Plan:* The Agency may assume management of the Contractor's plan or may assign temporary management of the Contractor's plan to the Agency's agent, if at any time the Agency determines that the Contractor can no longer effectively manage its plan and provide services to Enrolled Members.
g) *Contract Termination:* The Agency reserves the right to terminate the Contract, in whole or in part, due to the failure of the Contractor to comply with any term or condition of the Contract, or failure to take corrective action as required by the Agency to comply with the terms of this Contract.

J.8.09. *Liquidated Damages.* In the event that the Contractor fails to meet performance requirements or reporting standards set forth in the Contract, or other standards set forth by the Agency, it is agreed that damages shall be sustained by the Agency, and the Contractor shall pay to the Agency its actual or liquidated damages according to the following provisions.

It is agreed that in the event of a failure to meet specified performance or reporting requirements subject to liquidated damages, it is and will be impractical and extremely difficult to ascertain and determine the actual damages which the Agency will sustain in the event of, and by reason of, such failure; it is therefore agreed that the Contractor shall pay the Agency for such failure according to the agreed liquidated damage values set forth in the corresponding Special Contract Exhibit rate sheet. No punitive intention is inherent in the following liquidated damages provisions.

The Agency may impose remedies resulting from failure of the Contractor to provide the requested services depending on the nature, severity and duration of the Deficiency. In most cases, liquidated damages shall be assessed based on these provisions. Should the Agency choose not to assess damages for an initial infraction or Deficiency, it reserves the right to require corrective action or assess damages at any point in the future.

The Agency will notify Contractor of liquidated damages due and Contractor shall pay the Agency the full amount of liquidated damages due within ten (10) business days of receipt of the Agency's notice. The Agency may, in its sole discretion, elect at any time to offset any amount of liquidated damages due against Capitation Payments otherwise due Contractor pursuant to the Contract.

In the event liquidated damages are imposed under the Contract, the Contractor shall provide the Agency with a formal Corrective Action Plan, as well as monthly reports on the relevant performance metrics until such time

as the Deficiency is corrected for a period of sixty (60) consecutive days.

Liquidated damages applicable to any rate period are set forth in the rate sheets included in the Special Contract Exhibits.

K. Health Information Systems and Enrolled Member Data

K.01. *Health Information Technology in General.* The use of HIT has the potential to improve Quality and efficiency of health care delivery. Sharing of health care data can reduce medical errors, increase efficiency, decrease duplication and reduce Fraud and Abuse. HIT initiatives are an important part in improving public health research data Quality to aid in evidenced-based decisions, membership health management and improve compliance and oversight. The Agency reserves the right to require the Contractor to establish additional HIT initiatives in the future.

K.02. *Health Information System – Capabilities*. Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data. See: 42 C.F.R. § 438.242(a); 42 C.F.R. § 457.1233(d). {From CMSC K.1.01}.

K.03. *Health Information System – Areas of Information*. Contractor's health information system shall provide information on areas including, but not limited to, utilization, Claims, Grievances and Appeals, and Disenrollment for reasons other than loss of Medicaid eligibility. See: 42 C.F.R. § 438.242(a); 42 C.F.R. § 457.1233(d). {From CMSC K.1.02}.

K.04. *Health Information System – Compliance*. Contractor shall comply with Section 6504(a) of the ACA, which requires that State Claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized Claims processing and information retrieval systems in operation by the Agency to meet the requirements of section 1903(r)(1)(F) of the Social Security Act. See: 42 C.F.R. § 438.242(b)(1); Section 6504(a) of the ACA; section 1903(r)(1)(F) of the Social Security Act; 42 C.F.R. § 457.1233(d). {From CMSC K.1.03}.

K.05. *Health Information System – Encounter Data Compliance*. Contractor shall collect data on Enrolled Member and Provider characteristics as specified by the Agency and on all services furnished to Enrolled Members through an encounter data system or other methods as may be specified by the Agency. See: 42 C.F.R. § 438.242(b)(2); 42 C.F.R. § 457.1233(d). {From CMSC K.1.04}.

K.06. *Accuracy and Timeliness of Data*. Contractor shall verify the accuracy and timeliness of data reported by Providers, including data from Network Providers the Contractor is compensating on the basis of Capitation Payments. See: 42 C.F.R. § 438.242(b)(3)(i); 42 C.F.R. § 457.1233(d). {From CMSC K.1.05}.

K.07. *Screening of Data.* Contractor shall screen the data received from Providers for completeness, logic, and consistency. See: 42 C.F.R. § 438.242(b)(3)(ii); 42 C.F.R. § 457.1233(d). {From CMSC K.1.06}.

K.08. *Standardized Formats.* Contractor shall collect data from Providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid Quality improvement and Care Coordination efforts. See: 42 C.F.R. § 438.242(b)(3)(iii); 42 C.F.R. § 457.1233(d). {From CMSC K.1.07}.

K.09. *Availability of Data.* Contractor shall make all collected data available to the Agency and upon request to CMS. See: 42 C.F.R. § 438.242(b)(4); 42 C.F.R. § 457.1233(d). {From CMSC K.1.08}.

K.10. *Health Information System Capabilities.* Contractor's data systems shall:

a) Collect and maintain sufficient Enrolled Member encounter data to identify the Provider who delivers any item(s) or service(s) to Enrolled Members.
b) Permit submission of Enrolled Member encounter data to the Agency at a frequency and level of detail to be specified by CMS and the Agency, based on program administration, oversight, and Program Integrity needs.
c) Permit submission of all Enrolled Member encounter data that the Agency is required to report to CMS.
d) Comply with specifications for submitting encounter data to the Agency in standardized Accredited Standards Committee (ASC) X12N 837 and National Council for Prescription Drug Programs (NCPDP) formats, and the ASC X12N 835 format as appropriate.

See: 42 C.F.R. § 438.242(c)(1) - (4); 42 C.F.R. § 438.818; 42 C.F.R. § 457.1233(d). {From CMSC K.1.11 - K.1.14}.

K.11. *Actual Pricing.* Contractor shall ensure that all encounter data reflects the amount actually paid to the Provider, including but not limited to the amount paid by any Subcontractor of the Contractor.

K.12. *Required Functions.* The Contractor shall perform the following Information System (IS) functions through a system that integrates the Contractor's clinical record information, authorization and Claims payment data:

a) *Member Database*. Maintain an Enrolled Member database, using Medicaid State ID numbers, on a county-by-county basis which contains: (i) eligibility begin and end dates; (ii) Enrollment history; and (iii) utilization and expenditure information;
b) *County of Legal Residency*. County of legal residency for Enrolled Members shall be included in the Contractor's IS;
c) *Clinical Information*. Maintain a database which incorporates required clinical information described in Section K.30;
d) *Reporting.* Maintain information and generate reports required by the performance indicators established to assess the Contractor's performance;
e) *Capitation Payment*. Maintain data documenting receipt and distribution of the Capitation Payment;
f) *Incurred Claims*. Maintain data on incurred but not yet reimbursed Claims;
g) *Claims Processing Timeliness*. Maintain data on the time required to process and mail Claims payment;
h) *Clinical Data*. Maintain clinical and functional Outcomes data and data to support Quality activities;
i) *Grievance and Appeals*. Maintain data on clinical reviews, Appeals, Grievances and complaints and their Outcomes;
j) *Utilization Management*. Maintain data on services requested, authorized, provided and denied;
k) *Ad Hoc Reporting*. Maintain the capacity to perform ad hoc reporting on an "as needed" basis, with a turnaround time as determined by the Agency;
l) *Service Referrals*. Maintain data on all service referrals;
m) *Service Specific Information*. Maintain all data in such a manner as to be able to generate information specific to service type; and
n) *Age Specific Information*. Maintain all data in such a manner as to be able to generate information on Enrolled Members by age.

K.13. *General Systems Requirements.* The IS implemented by the Contractor shall include the following general system requirements but may not necessarily be limited to these requirements: (i) on-line access; (ii) on-line access to all major files and data elements within the IS; (iii) timely processing; (iv) daily file updates of Enrolled Member, Provider, Prior Authorization and Claims to be processed; and (v) weekly file updates of reference files and Claim payments.

a) *Edits, Audits and Error Tracking.* The Contractor shall employ comprehensive automated edits and audits to ensure that data are valid and that Contract requirements are met. The IS shall track errors by type and frequency and maintain adequate audit trails to allow for the reconstruction of processing

events. The Contractor shall submit edit logic to the Agency and collaborate on application of new edits as necessary due to correct coding initiative and program changes.

b) *System Controls and Balancing.* The IS shall have an adequate system of controls and balancing to ensure that all data input can be accounted for and that all outputs can be validated.
c) *Back-Up of Processing and Transaction Files.* The Contractor shall employ the following back-up timelines: (i) twenty-four (24) hour back-up of eligibility verification, Enrollment/eligibility update process, and Prior Authorization processing; (ii) seventy-two (72) hour back up of Claims processing; and (iii) two (2) week back-up of all other processes.

K.14. *Data Usage & Management.* The Contractor shall utilize the clinical data it receives to appropriately manage the care being provided to Enrolled Members. As described in this Contract and the Reporting Manual, the Contractor shall submit a number of reports to the Agency that require the use of data. In addition, the Contractor shall utilize the data in: (i) its management of Providers; (ii) assessment of care being provided to Enrolled Members; (iii) to develop new services that will increase Access and improve the cost-effectiveness of the program; and (iv) to implement evidence-based practices across the Provider Network.

K.15. *System Adaptability.* The Agency's technical requirements may require amendment during the term of the Contract. The Contractor shall adapt to any new technical requirements established by the Agency, and the Agency may require the Contractor to agree in writing to the new requirements. After the Contractor has agreed in writing to a new technical requirement, any Contractor-initiated changes to the requirements shall require the Agency's approval, and the Agency may require the Contractor to pay for additional costs incurred by the Agency in implementing the Contractor-initiated change.

K.16. *Information System Plan.* Contractor shall include in the PPM policies and procedures for receiving, creating, accessing, storing and transmitting health information data in a manner that is compliant with HIPAA standards for electronic exchange, privacy and security requirements (45 C.F.R. Parts 160, 162 and 164 and the HIPAA Security Rule at 45 C.F.R. § 164.308. The plan shall identify the steps to be taken and include a timeline with target dates. The plan shall include, but may not be limited to, a detailed explanation of the following:

a) Planning, developing, testing and implementing new operating rules, new or updated versions of electronic transaction standards, and new or updated national standard code sets;
b) Concurrent use of multiple versions of electronic transaction standards and codes sets;
c) Registration and certification of new and existing trading partners;
d) Creation, maintenance and distribution of transaction companion guides for trading partners;
e) Staffing plan for electronic data interchange (EDI) help desk to monitor data exchange activities, coordinate corrective actions for failed records or transactions, and support trading partners and business associates;
f) Compliance with all aspects of HIPAA Privacy and Security rules; and
g) Strategies for maintaining up-to-date knowledge of HIPAA-related mandates with defined or expected future compliance deadlines.

K.17. *IS Staff.* The Contractor shall assign dedicated resources to staff a technical helpdesk to monitor system performance, identify and troubleshoot system issues, monitor data exchange activities, coordinate corrective actions for failed records or transactions and support trading partners and business associates.

K.18. *HIPAA Compliance.* The Contractor's IS shall support and maintain compliance with current and future versions of HIPAA Transaction and Code Set requirements for electronic health information data exchange and Privacy and Security Rule standards as specified in 45 C.F.R. Parts 160, 162 and 164. System and operational enhancements necessary to comply with new or updated standards shall be made at no cost to the Agency. The Contractor's IS plans for privacy and security shall include, but not be limited to: (i) administrative procedures and safeguards (45 C.F.R. § 164.308); (ii) physical safeguards (45 C.F.R. § 164.310); and (iii) technical safeguards (45 C.F.R. § 164.312).

K.19. *Compliance with State Law.* For individual Medical Records and any other health and Enrollment information maintained with respect to Enrolled Members, that identifies particular Enrolled Members (in any form), Contractor shall comply with Agency procedures to abide by all applicable Federal and State laws regarding confidentiality and disclosure, including those laws addressing the confidentiality of information about minors and the privacy of minors, and privacy of individually identifiable health information. See: 42 C.F.R. § 457.1233(e); 42 C.F.R. § 457.1110(a). {CHIP checklist J.7.01}.

K.20. *Compliance with State Procedures.* For individual Medical Records and any other health and Enrollment information maintained with respect to Enrolled Members, that identifies particular Enrolled Members (in any form), Contractor shall comply with Agency procedures in compliance with Subpart F of 42 C.F.R. part 431. See: 42 C.F.R. § 457.1233(e); 42 C.F.R. § 457.1110(b). {CHIP checklist J.7.02}.

K.21. *Timely and Accurate Records.* For individual Medical Records and any other health and Enrollment information maintained with respect to Enrolled Members, that identifies particular Enrolled Members (in any form), Contractor shall comply with Agency procedures to maintain the records and information in a timely and accurate manner. See: 42 C.F.R. § 457.1233(e); 42 C.F.R. § 457.1110(c). {CHIP checklist J.7.03}.

K.22. *Purposes of Maintenance or Use.* For individual Medical Records and any other health and Enrollment information maintained with respect to Enrolled Members, that identifies particular Enrolled Members (in any form), Contractor shall comply with Agency procedures that specify and make available to any Enrolled Member requesting it, the purposes for which information is maintained or used. See: 42 C.F.R. § 457.1233(e); 42 C.F.R. § 457.1110(d)(1). {CHIP checklist J.7.04}.

K.23. *Purposes of Disclosure.* For individual Medical Records and any other health and Enrollment information maintained with respect to Enrolled Members, that identifies particular Enrolled Members (in any form), Contractor shall comply with Agency procedures that specify and make available to any Enrolled Member requesting it, to whom and for what purposes the information will be disclosed outside the State. See: 42 C.F.R. § 457.1233(e); 42 C.F.R. § 457.1110(d)(2). {CHIP checklist J.7.05}.

K.24. *Timely Provision of Information to Enrolled Member.* For individual Medical Records and any other health and Enrollment information maintained with respect to Enrolled Members, that identifies particular Enrolled Members (in any form), Contractor shall comply with Agency procedures that, except as provided by Federal and State law, ensure that each Enrolled Member may request and receive a copy of records and information pertaining to the Enrolled Member in a timely manner. See: 42 C.F.R. § 457.1233(e); 42 C.F.R. § 457.1110(e). {CHIP checklist J.7.06}.

K.25. *Supplementing and Correcting Records.* For individual Medical Records and any other health and Enrollment information maintained with respect to Enrolled Members, that identifies particular Enrolled Members (in any form), Contractor shall comply with Agency procedures that, except as provided by Federal and State law, ensure that each Enrolled Member may request and receive a copy of records and information pertaining to the Enrolled Member and that an Enrolled Member may request that such records or information be supplemented or corrected. See: 42 C.F.R. § 457.1233(e); 42 C.F.R. § 457.1110(e). {CHIP checklist J.7.07}.

K.26. *Interface with State Systems.* The Contractor shall, at a minimum, be capable of receiving, processing and reporting data to and from including, but not limited to: (i) the Agency's MMIS; (ii) the Agency's Title XIX eligibility system.

a) *The Agency MMIS*. The Contractor shall have the capacity to submit encounter data, as described in Section K.42, to the MMIS in the manner and timeframe specified by the Agency.
b) *The Agency Title XIX Eligibility System*. The Contractor's IS shall have the capacity to electronically receive Enrollment information through a file transfer process.

K.27. *Use of Common Identifier*. The Contractor may use a common identifier, including Enrolled Members' Social Security numbers, to link databases and computer systems as required in the Contract. However, the Contractor shall not publish, distribute, or otherwise make available the Social Security numbers of Enrolled Members.

K.28. *Reserved*. N/A.

K.29. *Reserved*. N/A.

K.30. *Clinical Records*. The Contractor shall maintain in its IS the information necessary to assist in authorizing and monitoring services as well as providing data necessary for Quality assessment and other evaluative activities. At the conclusion of the Contract, all clinical records generated by the Contractor shall become the property of the Agency. Upon request, the Contractor shall transfer the records to the Agency at no additional costs. The Contractor shall be permitted to keep copies of clinical records to the extent necessary to verify the accuracy of Claims submitted. The Contractor's clinical record maintained in the IS shall include, but is not limited to:

a) *Diagnosis*. Documentation of diagnoses;
b) *Services Authorized.* Documentation of clinical services requested, services authorized, services substituted, services provided; Documentation shall reflect the application of UM criteria;
c) *Services Denied*. Documentation of services not authorized, reasons for the non-authorization based on Iowa Administrative Code citations, and substitutions offered;
d) *Missed Appointments*. Documentation of missed appointments, and subsequent attempts to follow up with the Enrolled Member;
e) *Treatment Planning*. Documentation of joint treatment planning, clinical consultation, or other interaction with the Enrolled Member or Providers and/or funders providing or seeking to provide services to the Enrolled Member; and
f) *Joint Treatment Planning*. Name(s) of persons key to the treatment planning of Enrolled Members who Access multiple services.

K.31. *System Problem Resolution.* Contractor shall develop plans for system problem resolution that do not rise to the level of Disaster and document such in its PPM. The Contractor shall notify the Agency immediately upon identification of network hardware or software failures and sub-standard performance and shall conduct triage with the Agency to determine the severity level or deficiencies or defects and determine timelines for fixes.

K.32. *Escalation Procedures.* Contractor shall develop, implement, and adhere to procedures defining the methods for notifying the Agency and other applicable stakeholders regarding system problems that do not rise to the level of Disaster as defined in Section K.35. Contractor shall document its policies and procedures in its PPM.

K.33. *Release Management.* The Contractor shall develop processes for development, testing, and promotion of system changes and maintenance. The Contractor shall notify the Agency at least thirty (30) Days prior to the installation or implementation of "minor" software and hardware upgrades, modifications or replacements, and ninety (90) Days prior to the installation or implementation of "major" software and hardware upgrades, modifications or replacements.

"Major" changes, upgrades, modifications or replacements are those that impact mission critical business processes, such as Claims processing, eligibility and Enrollment processing, Service Authorization management, Provider Enrollment and data management, encounter data management, and any other processing affecting the Contractor's capability to interface with the Agency or the Agency's contractors. The Contractor

shall ensure that system changes or system upgrades are accompanied by a plan that includes a timeline, milestones and adequate testing to be completed before implementation. The Contractor shall notify and provide such plans to the Agency upon request in the timeframe and manner specified by the Agency. Contractor shall develop and submit the plan required under this section in its PPM.

K.34. *Environment Management.* The Contractor shall ensure the environment for development, system testing and UAT is separate from the production environment.

K.35. *Contingency and Continuity Plan*

a) *Continuity Planning.* Continuity planning and execution shall encompass all activities, processes and resources necessary for the Contractor to continue to provide mission-critical business functions and processes during a Disaster. Continuity planning shall be coordinated with information system contingency planning to ensure alignment. Continuity planning shall address processes for restoring critical business functions at an existing or alternate location. Continuity activities shall include coordination with the Agency and its contractors to ensure continuous eligibility, Enrollment and delivery of services.
b) *General Responsibilities.* Contractor shall develop and submit contingency and continuity planning documents and document such in its PPM. In addition, the Contractor shall ensure on-going maintenance and execution of the Agency-accepted contingency and continuity plans. The Contractor's contingency and continuity planning responsibilities include, but are not limited to:
    1. Notifying the Agency of any disruptions in normal business operations with a plan for resuming normal operations.
    2. Ensuring participants continue to receive services with minimal interruption.
    3. Ensuring data is safeguarded and accessible.
    4. Training Contractor staff and stakeholders on the requirements of the information system contingency and continuity plans.
    5. Conducting annual exercises to test current versions of information system contingency and continuity plans. The scope of the annual exercises must be approved by the Agency. The Contractor shall provide a report of activities performed, results of the activities, corrective actions identified, and modifications to plans based on results of the exercises.

K.36. *IS Contingency Planning and Execution*. The Contractor shall develop IS contingency planning in accordance with 45 C.F.R. § 164.308. Contingency plans shall include: (i) Data Backup plans; (ii) Disaster Recovery plans; and (iii) Emergency Mode of Operation plans. Application and Data Criticality Analysis and Testing and Revisions procedures shall also be addressed within the required contingency plans. The Contractor shall execute all activities needed to recover and restore operation of information systems, data and software at an existing or alternate location under emergency conditions within twenty-four (24) hours of identification or a declaration of a Disaster. The Contractor shall protect against hardware, software and human error. The Contractor shall maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file back-ups, and Disaster recovery.

K.37. *Back-Up Requirements*. The Contractor shall maintain full and complete back-up copies of data and software in accordance with the timelines described in Section K.13. The Contractor shall maintain a back-up log to verify the back-ups were successfully run and a back-up status report shall be provided to the Agency upon request. The Contractor shall store its data in an off-site location approved by the Agency. Upon the Contract end date or termination date, all the Agency related data shall be returned to the Agency.

K.38. *Data Exchange*. All data shared by the Contractor with the Agency shall use the format specified by the Agency including use of valid values that will be accepted by each code field.

K.39. *Member Enrollment Data*.

a) *Member Enrollment Data Exchange.* The Contractor shall receive HIPAA-compliant 834 Enrollment files from the Agency in the manner, timeframe and frequency determined by the Agency. The Contractor shall load Enrolled Member data for use in eligibility verification, Claims processing, and other functions that rely on Enrolled Member data. The Contractor shall report inability to retrieve or load eligibility data for any reason to the sending trading partner and the Agency on the same business day as transmission. Error reporting standards and formats will be defined by the Agency. Extraction, transformation and load (ETL) processes used by the Contractor shall be documented in detail and approved by the Agency. The Contractor shall not modify Enrolled Member identifiers, eligibility categories, or other Enrolled Member data elements without written approval from the Agency.

b) *Reconciliation Process*. The Contractor shall reconcile Enrolled Member eligibility data and Capitation Payments for each eligible Enrolled Member. The Contractor shall reconcile its eligibility and capitation records monthly. If the Contractor discovers a discrepancy in eligibility or capitation, the Contractor shall provide notification in a manner specified by the Agency. The Contractor shall return any capitation or Overpayments to the Agency within sixty (60) Days of discovering the discrepancy via procedures determined by the Agency. If the Contractor receives either Enrollment information or capitation for an Enrolled Member, the Contractor is financially responsible for the Enrolled Member unless the Contractor has not received capitation for that Enrolled Member ninety (90) Days following notification to the Agency that a capitation was not received. Nothing in this section prohibits the Contractor from recovering payments to Providers, in accordance with Agency policy, for services rendered to Enrolled Members determined to be ineligible or for whom the Contractor has not received capitation.

K.40. *Provider Network Data*. The Contractor shall submit Provider Network information via electronic file to the Agency in the timeframe and manner defined by the Agency. The Contractor shall keep Provider Enrollment and Disenrollment information up to date.

K.41. *Claims Processing.*

a) *Claims Processing Capability*. The Contractor shall process and pay Provider Claims for services rendered to the Contractor's Enrolled Members. The Contractor shall have a Claims processing system for both in- and Out-of-Network Providers capable of processing all Claims types. The Contractor shall accept Claims submitted via standard EDI transactions directly from Providers, or through their intermediary, and must have the capacity to process paper Claims. The Contractor shall submit to Iowa Medicaid a daily file of pre-adjudicated Claims received on the previous day. The Contractor shall electronically accept and adjudicate Claims and accurately support payment of Claims for Enrolled Members' periods of eligibility. The Contractor shall also provide electronic remittance advice and to transfer Claims payment electronically. The Contractor shall process as many Claims as possible electronically. The Contractor shall track electronic versus paper Claim submissions over time to measure success in increasing electronic submissions. The Contractor shall accurately price specific procedures or encounters (according to the agreement between the Provider(s) and the Contractor) and to maintain detailed records of remittances to Providers. The Contractor shall update Provider reimbursement rates in its Claims processing system and adjudicate Claims using the new rates no later than thirty (30) Days from notification by the Agency, or as otherwise directed by the Agency. Except as otherwise specified in law, or as otherwise directed by the Agency, rate updates shall be implemented prospectively. The Contractor shall develop, implement, and adhere to policies and procedures, subject to Agency review and approval, to monitor Claims adjudication accuracy and shall submit its policies and procedures to the Agency for review and approval within fifteen (15) Days of Contract execution. The Out-of-Network Provider filing limit for submission of Claims to the Contractor is twelve (12) months from the date of service. This conforms with the filing limit under the Medicaid State Plan (42 C.F.R. § 447.45(d)(4)). The in-Network Provider filing limit is established in the Contractor's Provider agreements as described in Section E.1 and shall be no more than one hundred and eighty (180) Days from the date of service.

b) *Claims Disputes*. Contractor shall develop, implement, and adhere to written policies and procedures for registering and responding to Claim disputes, including a process for Out-of-Network Providers, and document such in its PPM.
c) *Compliance with State and Federal Claims Processing Regulations*. The Contractor shall comply with the requirements related to Claims forms as set forth in Iowa Admin. Code r. 441-80.2. Any Claims forms or payment methodology developed by the Contractor for use by Providers shall be approved by the Agency and shall be in such a format as to assure the submission of encounter data as required under the Contract. The Contactor shall also comply with any applicable federal regulations, including HIPAA regulations related to transactions and code sets and confidentiality and submission requirements for PHI. Contractor shall require each physician providing services to Enrolled Members to have a standard unique health identifier in compliance with 42 U.S.C. § 1396u-2(d)(4). The Contractor shall require that all Providers that submit Claims to the Contractor have a national Provider identifier (NPI) number unless otherwise directed to the Agency; this requirement shall be consistent with 45 C.F.R. § 162.410.
d) *Out-of-Network Claims*. The Contractor shall not require Out-of-Network Providers to establish a Contractor-specific Provider number in order to receive payment for Claims submitted.
e) *Coordination among Contractors*. Contractors shall collaborate to provide consistent practices, such as on-line billing, for Claims submission to simplify Claims submission and ease administrative burdens for Providers in working with multiple Contractors. In addition, the Contractor shall obtain Agency approval for strategies to handle Medicare crossover Claims to help reduce the administrative burden on the Providers.
f) *Member Cost Sharing*. Additionally, some Enrolled Members, as described in Section F.8.06 may be subject to cost sharing. The Contractor shall reduce the payment it makes to a Provider, by the amount of the Enrolled Member's cost sharing obligation. The Contractor shall implement a mechanism, with Agency prior approval, to notify Providers of an Enrolled Member's financial participation or cost sharing requirement.
g) *Audit.* The Agency reserves the right to perform a random sample audit of all Claims, and the Contractor shall fully comply with the requirements of the audit and provide all requested documentation, including Provider Claims and encounter submissions in the form, manner and timeframe requested by the Agency.

K.42. *Encounter Claim Submission*. The Contractor shall obtain Agency approval of policies and procedures, to support encounter Claim reporting. The Contractor shall strictly adhere to the Agency-approved policies and procedures as well as standards defined by the Agency for items such as the file structure and content definitions. The Agency reserves the right to make revisions to these standards in a reasonable timeframe and manner and as required by law. The Agency will communicate these changes to the Contractor ninety (90) days prior to effective date.

K.43. *Definition of Uses of Encounter Claims*. The Contractor shall submit an encounter Claim to the Agency, or its Designee, for every service rendered to an Enrolled Member for which the Contractor either paid or denied reimbursement. The Contractor shall ensure encounter data provides reports of individual patient encounters with the Contractor's Provider Network. The Contractor shall ensure these Claims contain fee-for-service equivalent detail as to procedures, diagnoses, place of service, units of service, billed amounts, reimbursed amounts, and Providers' identification numbers. The Agency will use encounter data to calculate the Contractor's future capitation rates, with alternative data sources utilized as appropriate to meet actuarial and federal standards. Encounter Claims data may also be a source used by the Agency to calculate certain liquidated damages assessed to the Contractor.

K.44. *Reporting Format and Batch Submission Schedule*. The Contractor shall submit encounter Claims in an electronic format that adheres to the data Specifications set forth by the Agency and in any State or federally mandated electronic Claims submission standards. The Agency will have all of the remedies provided to it

under the Contract, including liquidated damages, for failure to comply with these requirements. All encounter data shall be submitted by the twentieth (20th) of the following month (i.e., subsequent to the month for which data are reflected). All corrections to the monthly encounter data submission shall be finalized within forty-five (45) Days from the date the initial error report for the month was sent to the Contractor or fifty-nine (59) Days from the date the initial encounter data were due. The error rate for encounter data shall not exceed one percent (1%). The source of the error can be identified by system edits and/or analysis of the encounter data. The Agency will notify the Contractor of changes made to calculate encounter data timeliness, accuracy, and Quality sixty (60) Days prior to implementation.

K.45. *Encounter Claims Policies*. Contractor shall develop written policies and procedures to address its submission of encounter Claims to the Agency, and document such in its PPM.

a) *Accuracy of Encounter Claims.* The Contractor shall implement policies and procedures to ensure that encounter Claims submissions are accurate. The Agency reserves the right to monitor encounter Claims for accuracy against Contractor internal criteria as well as State and Federal requirements. The Agency will regularly monitor the Contractor's accuracy by reviewing the Contractor's compliance with its internal policies and procedures for accurate encounter Claims submissions and by random sample audits of Claims. The Agency will establish a quarterly Encounter Utilization Monitoring report and review process during the second contract year. The Contractor shall submit timely and accurate reports in the format and timeframe designated by the Agency. The Contractor shall investigate root cause of report inaccuracies and submit a revised report in the timeframe designated by the Agency. The Contractor shall fully comply with requirements of these audits and provide all requested documentation, including, but not limited to, applicable Medical Records and Prior Authorizations. The Agency will require the Contractor to submit a Corrective Action Plan and will require non-compliance remedies for Contractor failure to comply with accuracy of these reporting requirements.
b) *Encounter Data Completeness.* The Contractor shall have in place a system for monitoring and reporting the completeness of Claims and encounter data received from Providers. For every service provided, Providers must submit corresponding Claim or encounter data with Claim detail identical to that required for fee-for-service Claims submissions. The Contractor shall also have in place a system for verifying and ensuring that Providers are not submitting Claims or encounter data for services that were not provided. The Contractor shall demonstrate its internal standards for measuring completeness, the results of any completeness studies, and any Corrective Action Plans developed to address areas of non-compliance. The Agency may require the Contractor to demonstrate, through report or audit, that this monitoring system is in place and that the Contractor is regularly monitoring the completeness of Claims and encounter data and ensuring that the Contractor is meeting the Agency completeness requirements.

K.46. *PA Tracking Requirements.* The Contractor shall track all Prior Authorization requests in its information system. All notes in the Contractor's Prior Authorization tracking system shall be signed by clinical staff and include the appropriate suffix (e.g., DDS, RDH, RN, etc.). For Prior Authorization approvals, the Contractor shall provide a Prior Authorization number to the requesting Provider and maintain a record of the following information, at a minimum, in the Contractor's information system: (i) name and title of caller or submitter, (ii) date and time of call, fax or online submission, (iii) Prior Authorization number, (iv) time to determination, from receipt and (v) approval/denial count.

K.47. *PA Denials*. For all denials of Prior Authorization requests, the Contractor shall maintain a record of the following information, at a minimum, in the Contractor's information system: (i) name and title of caller or submitter, (ii) date and time of call or submission, (iii) clinical synopsis inclusive of timeframe of illness or condition, diagnosis and treatment plan; and (iv) clinical guidelines or other rational supporting the denial (i.e. insufficient documentation).

K.48. *Application Programming Interface (API).* The Contractor shall implement an Application Programming Interface (API) that meets the criteria specified at 42 CFR 431.60 and include(s):

a) Data concerning adjudicated Claims, including Claims data for payment decisions that may be Appealed, were Appealed, or are in the process of Appeal, and provider remittances and beneficiary cost-sharing pertaining to such Claims, no later than one (1) business day after a Claim is processed;
b) Encounter data, including encounter data from any Network Providers the Contractor is compensating on the basis of Capitation Payments and adjudicated Claims and encounter data from any subcontractors no later than one (1) business day after receiving the data from Providers;
c) Clinical data, including laboratory results, if the Contractor maintains any such data, no later than one (1) business day after the data is received by the Agency; and
d) Implementation and maintenance of a publicly accessible standards-based API as described in 42 CFR 431.70, which must include all of the provider directory information specified in 42 CFR 438.10(h)(1) and (2).

See: 42 CFR 438.242(b)(5); 42 CFR 438.242(b)(6); 42 CFR 457.1233(d)(2); 42 CFR 457.1233(d)(3). {From CMSC K.1.09 - K.1.10}.

K.49. *Education and Outreach.* The Contractor shall institute a system that integrates information about Enrolled Members in order to facilitate positive Enrolled Member outcomes through education and outreach. The system shall have the ability to track the results of the Initial Oral Health Risk Screening, use of the Oral Health Equity Self-Assessment Tool, Enrolled Member outcomes, and have the ability to share information with the Enrolled Member, his or her authorized representatives, and all relevant treatment providers, including, but not limited to Primary Care Providers and Specialists. The Contractor shall submit regular reporting regarding the selection criteria, strategies, and outcomes of education and outreach programs as prescribed in the reporting template.

L. State Obligations

L.1 Enrolled Member and Potential Enrolled Member Information

L.1.01. *Prevalent Languages.* This Contract specifies the Prevalent non-English languages spoken by Enrolled Members and Potential Enrolled Members in the State and each Contractor service area, identified by the Agency, and provides that information to the Contractor. The Prevalent languages are: English and Spanish. See: 42 C.F.R. § 438.10(d)(1); 42 C.F.R. § 457.1207. {From CMSC L.1.01}.

L.1.02. *Moral or Religious Objections.* If the Contractor does not cover counseling or referral services because of moral or religious objections and chooses not to furnish information on how and where to obtain such services, the Agency will provide that information to Potential Enrolled Members. See: 42 C.F.R. § 438.10(e)(2)(v)(C); 42 C.F.R. § 457.1207. {From CMSC L.1.02}.

L.2 Contract Sanctions and Terminations

L.2.01. *Offsets – Premiums or Excess Amounts.* If the Agency imposes a civil monetary penalty on the Contractor for charging premiums or charges in excess of the amounts permitted under Medicaid, the Agency will deduct the amount of the overcharge from the penalty and return it to the affected Enrolled Member. See: 42 C.F.R. § 438.704(c); 42 C.F.R. § 457.1270. {From CMSC L.2.01}.

L.2.02. *Temporary Management – Enrollee Right to Terminate.* If the Agency imposes temporary management because a Contractor has repeatedly failed to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 C.F.R. § 438, the Agency will notify affected Enrolled Members of their right to terminate enrollment without cause. See: 42 C.F.R. § 438.706(b); 42 C.F.R. § 457.1270. {From CMSC L.2.02}.

L.2.03. *Timely Notice of Intermediate Sanctions – Basis.* The Agency will provide Contractor with timely written notice before imposing any intermediate sanction (other than required temporary management) that explains the basis and nature of the sanction. See: 42 C.F.R. § 438.710(a)(1). {From CMSC L.2.03}.

L.2.04. *Timely Notice of Intermediate Sanctions – Appeal Rights.* The Agency will provide Contractor with timely written notice before imposing any intermediate sanction (other than required temporary management) that explains any Appeal rights the Agency elects to provide. See: 42 C.F.R. § 438.710(a)(2); 42 C.F.R. § 457.1270. {From CMSC L.2.04}.

L.2.05. *Sanctions Hearings.* The Agency:

a) will provide the Contractor with a pre-termination hearing before terminating the Contract.
b) must give the Contractor a written notice of its intent to terminate and the reason for termination.
c) must provide the Contractor with the time and place of the pre-termination hearing.
d) must provide the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract.
e) must provide the effective date for Contract termination following an affirming decision.
f) must give the Enrolled Members of the Contractor notice of the termination following an affirming decision.
g) must inform Enrolled Members of their options for receiving Medicaid services following the effective date of termination following an affirming decision.

See: 42 C.F.R. § 438.710(b); 42 C.F.R. § 438.710(b)(2)(i) - (iii); 42 C.F.R. § 438.10; 42 C.F.R. § 457.1270. {From CMSC L.2.05 - L.2.11}.

L.2.06. *Notice to Enrolled Members.* After Contractor is notified that the Agency intends to terminate the Contract, the Agency may:

a) Give the Contractor's Enrolled Members notice of the Agency's intent to terminate the Contract.
b) Allow Enrolled Members to disenroll immediately without cause.

See: Section 1932(e)(4) of the Social Security Act; 42 C.F.R. § 438.722(a) - (b); 42 C.F.R. § 457.1270. {From CMSC L.2.12 - L.2.13}.

L.3 Payment

L.3.01. *Payment for Services & GME Only.* The Agency must ensure that no payment is made to a Network Provider other than by the Contractor for services covered under the Contract, except when these payments are specifically required to be made by the State in Title XIX of the Social Security Act, in 42 C.F.R., or when the Agency makes direct payments to Network Providers for graduate medical education costs approved under the State Plan. See: 42 C.F.R. § 438.60. {From CMSC L.3.01}.

L.3.02. *Supplemental IHCP Payments.* When the amount the IHCP receives from a Contractor is less than the amount the IHCP would have received under FFS or the applicable encounter rate published annually in the Federal Register by the IHS, the Agency will make a supplemental payment to the IHCP to make up the difference between the amount the Contractor pays and the amount the IHCP would have received under FFS or the applicable encounter rate. See: 42 C.F.R. § 438.14(c)(3); 42 C.F.R. § 457.1209. {From CMSC L.3.02}.

L.4 Identifying Special Healthcare Needs or Who Needs LTSS

L.4.01. *Identifying Persons with Special Health Care Needs.* The Agency, the Enrollment Broker, or the Contractor will identify persons with special health care needs as defined by the Agency. The 834 and LTSS file and any other mechanisms identified by the Agency will convey the identity of those persons with special health care needs. See: 42 C.F.R. § 438.208(c)(1); 42 C.F.R. § 457.1230(c). {From CMSC L.4.01}.

L.4.02. *Reserved.* N/A.

L.5 Data Collection

L.5.01. *Member Data.* The Agency will collect the following information from the Contractor to improve the performance of its managed care program:

a) Enrollment and Disenrollment data from Contractor.
b) Enrolled Member Grievance and Appeal logs from Contractor.

See: 42 C.F.R. § 438.66(c)(1) - (2).

L.5.02. *Provider Data.* The Agency will collect Provider complaint and Appeal logs from Contractor to improve the performance of its managed care program. See: 42 C.F.R. § 438.66(c)(3).

L.5.03. *Survey Data.* The Agency will collect the following information to improve the performance of its managed care program:

a) The results of any Enrolled Member satisfaction survey conducted by the Contractor and/or the Agency.
b) The results of any Provider satisfaction survey conducted by the Contractor and/or the Agency.

See: 42 C.F.R. § 438.66(c)(5).

L.5.04. *Quality Data.* The Agency will collect the following information to improve the performance of its managed care program:

a) Performance on required Quality measures from the Contractor.
b) Medical management committee reports and minutes from the Contractor.
c) The Contractor's annual Quality improvement plan.

See: 42 C.F.R. § 438.66(c)(6) - (8).

L.5.05. *Performance Data.* The Agency will collect the following information to improve the performance of its managed care program:

a) Audited financial and encounter data from the Contractor.
b) The MLR summary reports from the Contractor.
c) Customer service performance data from the Contractor.

See: 42 C.F.R. § 438.66(c)(9) - (11); 42 C.F.R. § 438.8.

M. Termination

M.01. *Contractor's Termination Duties.* A Transition Period shall begin upon any of the following triggering events:

a) Contract termination;
b) Notice issued by either party of an intent to not extend this Contract for a subsequent extension period; or
c) If the Contract has no remaining extension periods, ninety (90) Days before the natural Contract termination date.

M.02. *Authority to Withhold.* The Agency retains authority to withhold the Contractor's final capitation and any other payments due Contractor until the Contractor has:

a) received the Agency approval of its Transition Plan; and
b) completed the activities set forth in its Transition Plan, as well as any additional activities requested by the Agency, to the satisfaction of the Agency.

The Agency retains sole discretion to determine whether Contractor has satisfactorily completed the Contractor's transition responsibilities pursuant to the Agency-approved Transition Plan.

M.03. *Transition Period Obligations.* During the Transition Period, the Contractor shall:

a) Cooperate in good faith with the Agency and its employees, agents and independent contractors during the Transition Period between the notification of termination and the substitution of any replacement service Provider.
b) Submit a written Transition Plan to the Agency for approval:
    1. In a timeframe identified by the Agency following a triggering event as set forth in Section M.01.
    2. In a timeframe identified by the Agency in any Notice of Termination.
    3. Within one hundred and eighty (180) Days before Contract expiration.
c) Revise the Transition Plan as necessary in order to obtain approval by the Agency.
d) Execute, adhere to, and provide the services set forth in the Agency-approved plan.
e) Obtain Agency prior approval for all changes to the plan.
f) Make any updates to maintain a current version of the plan.
g) Agree to comply with all duties and/or obligations, including Provider reimbursement, incurred prior to the actual termination date of the Contract.
h) Appoint a liaison for transition activities and provide for sufficient Claims payment staff, Member services staff, Care Coordination staff and Provider services staff until Enrolled Members can be fully assigned to a different Program Contractor.
i) Arrange for the orderly transfer of patient care and patient records to those Providers who will assume care for the Enrolled Member. For those Enrolled Members in a course of treatment for which a change of Providers could be harmful, the Contractor shall continue to provide services until that treatment is concluded or appropriate transfer of care can be arranged. The Contractor shall transfer all applicable clinical information on file, including but not limited to approved and outstanding Prior Authorization requests and a list of Enrolled Members in Care Coordination, to the Agency and/or the successor Program Contractor in the timeframe and manner required by the Agency.
j) Take whatever other actions are necessary in order to ensure the efficient and orderly transition of Enrolled Members from coverage under this Contract to coverage under any new arrangement developed by the Agency.
k) Work cooperatively with and supply program information to the Agency or any successor Program Contractors who receive Agency assignments of Enrolled Members. Both the program information and the working relationship among the Contractor and successor Program Contractors will be defined by the Agency.
l) Coordinate the continuation of care for Enrolled Members who are undergoing treatment for an acute condition.
m) Notify all Providers about the Contract termination or expiration and the process by which Enrolled Members will continue to receive dental care. The Contractor shall be responsible for all expenses associated with Provider notification. The Agency must approve all Provider notification materials in advance of distribution.
n) Remain financially responsible for and continue to serve or arrange for provision of services to Enrolled Members for up to forty-five (45) Days from the Contract termination date or until the Enrolled Members can be transferred to another Program Contractor, whichever is longer.
o) Remain financially responsible for all Claims with dates of service through the day of Contract termination or expiration, including those Claims submitted within established time limits after Contract termination or expiration.
p) Remain financially responsible for services rendered through the day of Contract termination or expiration and for which payment is denied by the Contractor and subsequently approved upon Appeal or State Fair Hearing.
q) Provide the Agency, or its designated entity, all pre-termination performance data, including but not limited to any Agency-identified survey tool and HEDIS.
r) Provide the Agency with all outstanding Encounter data issues and an action plan to correct the issues. The Agency reserves the right to withhold Capitation Payments or any other payments due the Contractor until the Contractor resolves the outstanding encounter data issues.

s) Submit encounter data to the Agency for all Claims incurred before the Contract termination or expiration date according to established timelines and procedures and for a period of at least fifteen (15) months after Contract termination or expiration.
t) Report any capitation or other Overpayments made by the Agency to the Contractor within thirty (30) Days of discovery and cooperate with investigations by the Agency or its Subcontractors into possible Overpayments made during the Contract term. The Contractor shall return any capitation or other Overpayments, including those discovered after Contract expiration, to the Agency within fourteen (14) Days of reporting the Overpayment to the Agency.

M.04. *Post-Transition Contract Obligations.* Termination or expiration of the Contract does not discharge the obligations of the Contractor with respect to services or items furnished before termination or expiration of the Contract. Termination or expiration of the Contract does not discharge the Agency's payment obligations to the Contractor or the Contractor's payment obligations to its Subcontractors and Providers. Upon any termination or expiration of this Contract, in accordance with the provisions in this Section, the Contractor shall:

a) Appoint a liaison for post-transition activities.
b) Provide the Agency, or its designated entity, all records related to the Contractor's activities undertaken pursuant to the Contract, in the format and within the timeframes set forth by the Agency, which shall be no later than thirty (30) Days of the request. Such records shall be provided at no expense to the Agency or its designated entity.
c) Participate in the External Quality Review, as required by 42 C.F.R. Part 438, Subpart E, for the final year of the Contract.
d) Maintain the financial requirements, as described in the Contract as of the Contractor's date of termination notice, fidelity bonds and insurance set forth in the Contract until the Agency provides the Contractor written notice that all continuing obligations of the Contract have been fulfilled.
e) Submit reports to the Agency every thirty (30) Days detailing the Contractor's progress in completing its continuing obligations under the Contract. The Contractor, upon completion of these continuing obligations, shall submit a final report to the Agency describing how the Contractor has completed its continuing obligations. The Agency will advise in writing whether the Agency agrees that the Contractor has fulfilled its continuing obligations. If the Agency finds that the final report does not evidence that the Contractor has fulfilled its continuing obligations, the Agency will require the Contractor to submit a revised final report. The Agency will notify the Contractor in writing once the Contractor has submitted a revised final report evidencing to the Agency's satisfaction that the Contractor has fulfilled its continuing obligations.
f) Remain responsible for resolving Enrolled Member Grievances and Appeals with respect to dates of service prior to the day of Contract expiration or termination, including Grievances and Appeals filed on or after the day of Contract termination or expiration but with dates of service prior to the day of Contract termination or expiration.
g) Maintain Claims processing functions as necessary for a minimum of twelve (12) months in order to complete adjudication of all Claims for services delivered prior to the Contract termination or end date, as well as any time period beyond twelve (12) months to the extent necessary to complete adjustments of all timely Claims.
h) Cooperate with audits conducted by the Agency, CMS, the Office of the Inspector General, and their Designees, as outlined in Contract Section J.1.02 and in accordance with 42 CFR 438.3(h).

N. Reporting

N.01. *General.* Performance monitoring and data analysis are critical components in assessing how well the Contractor is maintaining and improving the Quality of care delivered to Enrolled Members. Failure to meet performance targets shall subject the Contractor to the corrective actions as outlined in Special Contract Exhibits, Exhibit A for information on the pay-for-performance program. The Agency publishes a Reporting Manual to simplify Contractor's reporting obligations.

N.02. *Reporting Requirements.* The Contractor shall comply with all reporting requirements, including but not limited to those requirements found in the Reporting Manual, and shall submit the requested data completely and accurately within the requested timeframes and in the format identified by the Agency. The Agency reserves the right to require the Contractor to work with and submit data to third-party data warehouses or analytic vendors. The Contractor shall have policies, procedures and mechanisms in place to ensure that the financial and non-financial performance data submitted to the Agency is accurate.

N.03. *Implementation and Operational Reporting.* The Agency reserves the right to require more frequent reporting during the implementation and early operational timeframe following Contractor's entry into the Iowa Dental Wellness Plan and Hawki Dental programs, or as otherwise directed by the Agency, to: (i) monitor program implementation; (ii) permit adequate oversight and correction of problems as necessary; and (iii) ensure satisfactory levels of Member and Provider services.

N.04. *Other Reporting and Changes.* The Agency will provide at least thirty (30) Days' notice to the Contractor before changing or adding any reporting requirements for reports that are anticipated as routine or are intended to be included in the Reporting Manual. The Agency will provide reasonable notice in advance but may request ad hoc reports at any time. The Reporting Manual will detail reporting requirements and the full list of required reports.

N.05. *Audit Rights and Remedies.* The Agency reserves the right to audit the Contractor's self-reported data at any time. Contractor shall maintain all supporting data related to all reports submitted pursuant to the Reporting Manual or ad hoc reports. The Agency may require a Corrective Action Plan or other remedies as specified in Special Contract Exhibits, Exhibit A for Contractor non-compliance with these and other subsequent reporting requirements and performance standards.

N.06. *Meeting with the Agency.* The Agency may schedule meetings or conference calls with the Contractor upon receiving the performance data. Meetings or conference calls will be scheduled on days and times that are mutually agreed upon to by the Agency and the Contractor. When the Agency identifies potential performance issues, the Contractor shall formally respond in writing to these issues within the timeframe required by the Agency. If the Contractor fails to provide a formal, written response to the feedback or fails to respond within the timeframe established by the Agency, the Agency may consider the Contractor noncompliant in its performance reporting and may implement corrective actions.

SECTION 3: SPECIAL CONTRACT EXHIBITS

The Special Contract Exhibits in this section are a part of the Contract.

Exhibit A: Capitation Rate Information, MLR, Pay for Performance, Liquidated Damages, and Carved-Out Services

1. Capitation Rate Information
2. MLR for Rate Period
3. Payment for Performance Chart
4. Liquidated Damages
5. Carved-Out Services

Exhibit B: Glossary of Terms/Definitions

Exhibit C: General Access Standards

Exhibit D: Eligible Enrolled Members and Excluded Populations

Exhibit E: Covered Benefits

Exhibit F: Program-Specific Cost Sharing and Annual Benefit Maximum (ABM) Requirements

Exhibit A: Capitation Rate Information, MLR, Pay for Performance, Liquidated Damages, and Carved-Out Services

Section 1: Capitation Rate Information

Reserved.

Section 2: MLR for Rate Period

The MLR established for purposes of this rate period pursuant to Section D.4.03 is eighty-five percent (85.0%).

Section 3: SFY 2025 Payment for Performance Chart

The Agency has established a pay for performance program under which the Contractor may receive compensation if certain conditions are met. Eligibility for compensation under the pay for performance program is subject to the Contractor's complete and timely satisfaction of its obligations under the Contract.

The Agency may, at its option, reinstate the Contractor's eligibility for participation in the pay for performance program once the Contractor has properly cured all prior instances of non-compliance of its obligations under the Contract, and the Agency has satisfactory assurances of acceptable future performance.

During each measurement year, the Agency will withhold a portion of the approved Capitation Payments from Contractor. The amount withheld in this current rate period is two percent (2%) of the Capitation Payments made. Contractor may be eligible to receive some or all the withheld funds based on the Contractor's performance in the areas outlined in the tables immediately below.

The Agency has established a set of Pay for Performance measures for Contractors for the Iowa Dental Wellness Plan and Hawki Dental program. Final SFY 2025 capitation rates that will be established prior to the start of the Contract will be calculated in consideration of the Pay for Performance measures listed below.

Table A: SFY 2025 PAY FOR PERFORMANCE MEASURES

The Agency will provide a document with the full description of the guidelines and data definitions for the SFY 2025 Pay for Performance Measures.

Performance Standard 1	**Amount of Performance Withhold at Risk**
Dental Care Utilization	25%
Required Contractual Standard	
The Contractor shall meet or exceed the percentage of Enrolled Members who accessed dental care services within the contract year. Rates are reported for: 1) the Dental Wellness Plan Adult (DWP-A) population, 2) the Dental Wellness Plan Kids (DWP-K) population, and 3) the Hawki population.	
Standard Required to Receive Incentive Payment	

To receive forty percent (40%) of the total withhold for this measure:

1) The percent of unique DWP-A Enrolled Members with over six (6) months of coverage during the measurement State fiscal year that accessed dental care services shall meet or exceed twenty-five percent (25%).

To receive forty percent (40%) of the total withhold for this measure:

2) The percent of unique DWP-K Enrolled Members with over six (6) months of coverage during the measurement State fiscal year that accessed dental care services shall meet or exceed forty-five percent (45%).

To receive twenty percent (20%) of the total withhold for this measure:

3) The percent of unique Hawki Enrolled Members with over six (6) months of coverage during the measurement State fiscal year that accessed dental care services shall meet or exceed forty-five percent (45%).

Performance Standard 2	**Amount of Performance Withhold at Risk**
Preventive Care Utilization	20%

Required Contractual Standard

The Contractor shall increase the percentage of Enrolled Members who received preventive dental care during the measurement State fiscal year. Rates are reported for: 1) the Dental Wellness Plan Adult (DWP-A) population, 2) the Dental Wellness Plan Kids (DWP-K) population, and 3) the Hawki population.

Standard Required to Receive Incentive Payment

To receive forty percent (40%) of the total withhold for this measure:

1) The percent of unique DWP-A Enrolled Members with over six (6) months of coverage during the measurement State fiscal year that accessed any preventive care services shall meet or exceed fifteen percent (15%).

To receive forty percent (40%) of the total withhold for this measure:

2) The percent of unique DWP-K Enrolled Members with over six (6) months of coverage during the measurement State fiscal year that accessed any preventive care services shall meet or exceed fifty percent (50%).

To receive twenty percent (20%) of the total withhold for this measure:

3) The percent of unique Hawki Enrolled Members with over six (6) months of coverage during the measurement State fiscal year that accessed any preventive care services shall meet or exceed fifty percent (50%).

Performance Standard 3	**Amount of Performance Withhold at Risk**
Initial Oral Health Risk Screening	15%

Required Contractual Standard

The Contractor shall increase reporting of information related to health equity including social determinants of health among the Dental Wellness Plan Adult (DWP-A) population. One rate is reported for: 1) the DWP-A population. Exclude members for whom the PAHP has documentation that verifies that at least 3 unsuccessful attempts have been made to contact the member to schedule a Oral Health Risk assessment.

Standard Required to Receive Incentive Payment

The percent of unique new Enrolled Members in the DWP-A population, who have been assigned to the Contractor for a continuous period of at least ninety (90) Days during the measurement State fiscal year, that complete an Initial Oral Health Risk Screening using the Oral Health Equity Self-Assessment Tool shall meet or exceed seventy percent (70%).

Performance Standard 4	Amount of Performance Withhold at Risk
Encounter Data Reconciliation	20%

Required Contractual Standard

Encounter data shall be submitted by the twentieth (20th) of the month subsequent to the month for which data is reflected. All corrections to the monthly encounter data submission shall be finalized within forty-five (45) Days from the date the initial error report for the month was sent to the Contractor or fifty-nine (59) Days from the date the initial encounter data was due. The error rate for the encounter data shall not exceed one percent (1%). For every service provided, providers must submit corresponding Claim or encounter data with Claim detail identical to that required for fee-for-service Claims submissions.

Standard Required to Receive Incentive Payment

Within ninety (90) days of the end of each quarter, the Contractor's accepted encounter data shall match the Contractor's submitted financial information within ninety-eight percent (98%) using reporting criteria set forth in the financial reporting template.

Performance Standard 5	Amount of Performance Withhold at Risk
Timely Claims Processing	20%

Required Contractual Standard

The Contractor shall pay Providers for covered medically necessary services rendered to the Contractor's Enrolled Members in accordance with the Contract. The Contractor shall pay or deny ninety percent (90%) of all Clean Claims within fourteen (14) calendar days of receipt, ninety-five percent (95%) of all Clean Claims within twenty-one (21) calendar days of receipt, and ninety-nine percent (99%) of all claims within ninety (90) calendar days of receipt. A "Clean Claim" is one in which all information required for processing is present. If a Claim is denied because more information was required to process the Claim, the Claim denial notice shall specifically describe all information and supporting documentation needed to evaluate the Claim for processing. As provided in 42 C.F.R. § 447.46(c)(2), the Contractor may, by mutual agreement, establish an alternative payment schedule with in-Network Providers. The alternative payment schedule shall be outlined in the Provider contract. In accordance with 42 C.F.R. § 447.45(d), the date of receipt of a Claim is the date the Contractor receives the Claim, as indicated by its date stamp on the Claim, and the date of payment is the date of the check or other form of payment.

Standard Required to Receive Incentive Payment

The Contractor will achieve a measure of ninety-six percent (96%) of all Clean Claims paid or denied within twenty-one (21) calendar days of receipt to receive fifty percent (50%) of the total withhold for this measure.

The Contractor will achieve a measure of ninety-seven percent (97%) of all Clean Claims paid or denied within twenty-one (21) calendar days of receipt to receive seventy-five percent (75%) of the total withhold for this measure.

The Contractor will achieve a measure of ninety-eight percent (98%) of all Clean Claims paid or denied within twenty-one (21) calendar days of receipt to receive one hundred (100%) of the total withhold for this measure.

Section 4: Liquidated Damages

#	Category	Topic	Requirement	Liquidated Damage
1	Systems	Timeliness	After the Operational Start Date, the Contractor's IS must meet all requirements in Section K. Health Information Systems and Enrolled Member Data.	$2,500 per Day, per requirement
2	Helplines	Helplines	The Contractor shall meet or exceed each performance requirement listed in Section A.27. Call Center Performance Metrics.	$1,000 per full percentage point below requirement, measured

				monthly (requirements a, b, d, f, g, and i) $1,000 per instance (requirements c, e, and h)
3	Claims	Timeliness	The Contractor shall pay or deny ninety percent (90%) of Clean Claims within fourteen (14) Days of receipt, ninety-five percent (95%) of Clean Claims within twenty-one (21) Days of the date of receipt, and/or ninety-nine percent (99%) of all Claims within ninety (90) Days of receipt as outlined in Sections D.5.01 and D.6.01. Measured monthly.	$7,500 per month of non-compliance
4	Encounter Data	Encounter Data	The Contractor shall comply with encounter data submission requirements as described in Sections K.42 through K.45. Examples of non-compliance included, but are not limited to: • MMIS file submission edits with an error rate greater than one percent (1%), measured per file submission • The initiation of a new encounter data quality measurement issue that exceeds one percent (1%) of encounters corresponding to the issue • Encounter data is not submitted by the twentieth (20^{th}) of the following month (i.e., subsequent to the month for which data are reflected) • Identification of new Claims in a previous encounter data quality measurement	$7,500 per incident of non-compliance
5	Grievance and Appeals	Appeals	The Contractor shall resolve one hundred percent (100%) of Appeals within thirty (30) calendar days of receipt, or within seventy-two (72) hours of receipt for expedited Appeals. Measured quarterly.	$1,000 per full percentage point below requirement
6	Grievance and Appeals	Grievances	The Contractor shall resolve one hundred percent (100%) of Grievances within thirty (30) calendar days of receipt, or within seventy-two (72) hours of receipt for expedited Grievances. Measured quarterly.	$1,000 per full percentage point below requirement
7	Prior Authorizations	Timeliness	The Contractor shall render a decision on ninety-nine percent (99%) of prior authorization requests within fourteen (14) Days of the request for service or within seventy-two (72) hours for expedited authorization decisions. Measured monthly. Requests for extensions approved in accordance with the Contract shall be removed from this timeliness measure.	$2,000 per full percentage point below requirement
8	Program Integrity	Fraud, Waste, and Abuse	The Contractor shall comply with Fraud and Abuse provisions as described in Section I.12 Required Fraud, waste, and Abuse Activities of this Contract.	$250 per Day, per requirement
9	Corrective Action Plans	General Requirements	The Contractor shall provide a timely and acceptable Corrective Action Plan and/or comply with the Corrective Action Plan timeline approved by the Agency.	$500 per Day the Contractor exceeds approved timeline to provide and/or comply
10	Readiness Review	Readiness Review	Contractor shall pass the Readiness Review at least thirty (30) Days prior to scheduled member Enrollment.	$5,000 per Day of non-compliance
11	Prior Authorizations and Claims	System	Any Prior Authorization or Claims payment system issue that was reported by the Contractor as corrected shall not reoccur within sixty (60) days of the reported correction.	$1,000 per Day until corrected

12	Credentialing	Provider Services	The Contractor shall complete credentialling of all Providers applying for Network Provider status as follows: eighty-five percent (85%) of Providers within thirty (30) Days, ninety-eight percent (98%) of Providers within forty-five (45) Days, and/or one hundred percent (100%) within sixty (60) Days as outlined in Section E.1.29. Provider Credentialing Performance Metric. Measured quarterly.	$1,000 per every half percentage point (.5%) below each requirement
13	Network Adequacy	Provider Directory	The Contractor shall update the Provider Directory to assure accurate and timely network Provider availability, including but not limited to, information on whether Network Providers will accept new Enrolled Members.	$1,000 per Day until an error in the Provider Directory is corrected. Measured beginning the day after the Contractor is informed of an error by the Agency and/or Network Provider
14	General Requirements	Timeliness and Accuracy	The Contractor shall provide timely and accurate deliverables in response to Agency inquiries within the timeframes set forth by the Agency, per Section A.22 State Inquiries & Requests for Information.	$1,000 per Day of non-compliance, per inquiry
15	Encounter Data	Accuracy	The Contractor shall not provide duplicate encounter submissions.	$5.00 per duplicate encounter submitted, measured monthly. Damage shall be capped at thirty-three hundredths of a percent (0.33%) of the Contractor's monthly capitation.

Section 5: Carved-Out Services

The Agency will exclude from the capitation rates the select services and treatments as set forth herein. Contractor shall continue to provide coverage for these services and treatments, and the Agency will reimburse the Contractor based on Contractor's invoice to the Agency for services or treatments paid. Contractor may only invoice for the lower of (1) actual cost to the Contractor or (2) the actual cost paid.

COVID 19 Vaccination Administration Carve-Out.

Per Informational Letter No. 2425-FFS-D-CVD, the Agency will exclude from the capitation rates the costs associated with COVID 19 vaccine administration services through September 30, 2024. Contractor shall provide coverage for COVID 19 vaccine administration services. The Agency will reimburse the Contractor on a retrospective basis for such Claims using the Medicare payment methodology and rates for the same services and consistent with CMS guidance and Agency policy as published in any and all provider informational letters (IL).

However, payments to Contractor under this provision shall be limited to the lower of (1) what Medicare would have paid for the same services for a Medicare eligible individual and consistent with all published ILs, or (2) the Contractor's actual out-of-pocket payments for such services. All invoices for reimbursement under this paragraph must be submitted no later than twelve (12) months from the date of service. All adjustments made to invoices shall be submitted to the Agency within ninety (90) days from the date of the invoice being adjusted and must be backed by Claim level detail sufficient to support the invoice.

Exhibit B: Glossary of Terms/Definitions

This glossary of definitions and abbreviations includes certain terms that may not be otherwise included in this Contract. These terms are included for additional context across the broader Iowa Medicaid landscape.

1915(c) HCBS Waiver: Refers to the seven (7) 1915(c) HCBS waivers operated by the Agency. Current waivers include: (i) AIDS/HIV; (ii) Brain Injury; (iii) Children's Mental Health; (iv) Elderly; (v) Health and Disability; (vi) Intellectual Disabilities; and (vii) Physical Disabilities. For purposes of clarification, this definition remains in effect even in the event of a change in waiver authority affecting these covered populations.

1915(i) State Plan HCBS: Refers to the State Plan HCBS program operated by the agency for adults and transition age youth that have been assessed to have functional limitations related to a psychiatric illness.

340B Program: The federal 340B Drug Pricing program managed by HRSA's Office of Pharmacy Affairs (OPA). The program allows certain designated facilities to purchase prescription medications at discounts, so that these facilities can offer some medications to their patients at reduced prices.

ABA: Applied Behavior Analysis.

ABP: Alternate Benefit Plan.

Abandonment Rate: Percentage of unanswered calls abandoned by the caller after thirty (30) seconds of the call entering the queue. (E.g., caller hangs up before speaking to anyone after waiting more than thirty (30) seconds in a queue.)

Abuse: 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 beneficiary practices that result in unnecessary cost to the Medicaid program. See: 42 C.F.R. § 438.2; 42 C.F.R. § 455.2. {From CMSC}.

Access: As used in 42 C.F.R. part 438 subpart E and pertaining to External Quality Review, the timely use of services to achieve optimal Outcomes, as evidenced by the Contractor successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 42 C.F.R. § 438.68 (Network adequacy standards) and § 438.206 (Availability of services). See: 42 C.F.R. § 438.320. {From CMSC}.

Actuary: An individual who meets the qualification standards established by the American Academy of Actuaries for an Actuary and follows the practice standards established by the Actuarial Standards Board. In 42 C.F.R. part 438, Actuary refers to an individual who is acting on behalf of the Agency when used in reference to the development and certification of capitation rates. See: 42 C.F.R. § 438.2. {From CMSC}.

Adverse Benefit Determination: Any of the following:

- 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.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service, but excluding a denial solely because the Claim does not meet the definition of a Clean Claim.
- The failure to provide services in a timely manner, as defined by the Agency.

- The failure of the Contractor to act within the timeframes provided in 42 C.F.R. § 438.408(b)(1) and (2) regarding the standard resolution of Grievances and Appeals.
- For a resident of a Rural area with only one (1) PAHP, the denial of an Enrolled Member's request to exercise their right, under 42 C.F.R. § 438.52(b)(2)(ii), to obtain services outside the network.
- The denial of an Enrolled Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrolled Member financial liabilities.

See: 42 C.F.R. § 438.400(b). {From CMSC}.

Agency: The Iowa Department of Health and Human Services.

Annual Benefit Maximum (ABM): A $1,000 maximum State Fiscal Year (July 1 to June 30) benefit limit that applies to every Dental Wellness Plan adult member, age twenty-one (21) and older, as well as the Hawki population. By program design, certain services are excluded from the ABM calculation including emergency dental services. ABM is determined using the Medicaid FFS rates, regardless of reimbursement rate to providers.

Annual Dollar Limit: A dollar limitation on the total amount of specified benefits that may be paid in a twelve (12) month period under the Contract. See: 42 C.F.R. § 438.900. {From CMSC}.

Appeal: A review by the Contractor of an Adverse Benefit Determination. See: 42 C.F.R. § 438.400(b). {From CMSC}.

ARRA: The American Recovery and Reinvestment Act.

BCCEDP: Breast and Cervical Cancer Early Detection Program.

Behavioral Health Services: Mental health and substance use disorder treatment services.

Benefits: The package of dental and oral Health Care Services that define the covered services available to Enrolled Members under the Contract.

BHIS: Behavioral and Health Intervention Services.

CAHPS: Consumer Assessment of Healthcare Providers and Systems.

Capitation Payment: A payment the Agency makes periodically to the Contractor on behalf of each beneficiary enrolled under the Contract and based on the actuarially sound capitation rate for the provision of services under the State Plan. The Agency makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment. See: 42 C.F.R. § 438.2. {From CMSC}.

Case Management: Provides service coordination and monitoring. Available as a Habilitation service when the individual is not enrolled in an Integrated Health Home and does not otherwise qualify for targeted case management.

Care Coordination: Care Coordination is the overall system of dental and oral health management encompassing, but not limited to: UM, disease management, continuity of care, care transition, Quality management and service verification.

Chronic Condition Health Home ("CCHH"): Integrated and coordinated care for individuals with one (1) chronic condition and the risk of developing another for all primary, acute, behavioral health, and long- term services and supports to treat the whole person.

Choice Counseling: The provision of information and services designed to assist beneficiaries in making Enrollment decisions; it includes answering questions and identifying factors to consider when choosing among Contractors. Choice Counseling does not include making recommendations for or against Enrollment into a specific Contractor. See: 42 C.F.R. § 438.2. {From CMSC}.

CCO: Consumer Choices Option.

CDAC: Consumer Directed Attendant Care.

COA: Certificate of Authority licensed by the Iowa Insurance Division.

Centers for Medicare and Medicaid Services (CMS): The agency within the U.S. Department of Health and Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program under Title XXI of the Social Security Act. This agency was formerly known as HCFA.

CHIP: Children's Health Insurance Program.

Claim: A formal request for payment for Benefits received or services rendered.

Clean Claim: A Claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the Claim. 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.

Client Participation: The amount a member is required to contribute to the cost of care provided in an institutional or home and community-based setting. Institutional settings subject to Client Participation include skilled nursing facilities, nursing facilities, intermediate care facilities for the intellectually disabled (ICF/ID) and residential care facilities. members in acute hospital care or eligible for Medicaid as a Qualified Medicare Beneficiary (QMB) are not subject to Client Participation. Client Participation is determined by the Agency when the member's income is higher than allowable thresholds. Client Participation is paid at the beginning of a coverage month. If an member is institutionalized, the facility makes arrangements with the member to collect Client Participation. Client Participation is not cost sharing subject to the requirements of 42 CFR § 447.50 through 42 CFR § 447.82.

CMH: Children's Mental Health.

CMHC: Community Mental Health Centers.

CMSC: The CMS State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval (also known as the CMS Checklist), available at: https://www.medicaid.gov/medicaid/downloads/mce-checklist-state-user-guide.pdf

Code of Federal Regulations (C.F.R.): The C.F.R. is the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal Government. It can be found at: www.ecfr.gov.

Cold-Call Marketing: Any unsolicited personal contact by the Contractor with a Potential Enrolled Member for the purpose of Marketing. See: 42 C.F.R. § 438.104(a). {From CMSC}.

Community-Based Case Management: Community-Based Case Management is a collaborative process of planning, facilitation, and advocacy for options and services to meet a Medicaid member's needs through communication and available resources to promote high Quality, cost-effective Outcomes. Qualified staff provides Community-Based Case Management services to assist members in gaining timely Access to the full range of needed services.

Comprehensive Risk Contract: A Risk Contract between the Agency and an MCO that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three (3) or more of the following services:

- Outpatient hospital services
- RHC services
- FQHC services
- Other laboratory and X-ray services
- NF services
- EPSDT services
- Family planning services
- Physician services
- Home health services.

See: 42 C.F.R. § 438.2. {From CMSC}.

Contractor: The entity identified on the first page of the Contract.

Co-Payment: A cost-sharing arrangement in which an Enrolled Member pays a specified charge for a specified service; also called a co-pay.

Corrective Action Plan (CAP): A plan designed to ameliorate an identified deficiency and prevent recurrence of that deficiency. The CAP outlines all steps, actions and timeframes necessary to address and resolve the deficiency.

CPT: Current Procedure Technology.

Credentialing: The Contractor's process for verifying and monitoring Providers' licensure, liability insurance coverage, liability Claims, criminal history and Drug Enforcement Administration (DEA) status.

Credibility Adjustment: An adjustment to the MLR for a partially credible Contractor to account for a difference between the actual and target MLRs that may be due to random statistical variation. See: 42 C.F.R. § 438.8(b). {From CMSC}.

Cultural Competence: The U.S. Department of Health and Human Services, Office of Minority Health defines cultural and linguistic competence as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups. "Competence" implies having the capacity to function effectively as a participant and an organization within the context of the cultural beliefs, behaviors, and needs presented by Enrolled Members and their communities. Cultural affiliations may include, but are not limited to race, preferred language, gender, disability, age, religion, deaf and hard of hearing, sexual orientation, homelessness, and geographic location.

Cumulative Financial Requirements: Financial requirements that determine whether or to what extent Benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums. (However,

Cumulative Financial Requirements do not include aggregate lifetime or annual dollar limits because these two (2) terms are excluded from the meaning of financial requirements.) See: 42 C.F.R. § 438.900. {From CMSC}.

Days: Calendar days unless otherwise specified.

Day Habilitation: Day habilitation services are services that assist or support the consumer in developing or maintaining life skills and community integration.

Dental Plan: see PAHP.

Dental Wellness Plan (DWP): Medicaid Dental Coverage that is not Hawki split into:

- DWP-Kids (DWP-K) those non-Hawki members eighteen (18) years and younger
- DWP-Adults (DWP-A) those non-Hawki members nineteen (19) years and older

Designee: An organization designated by the Agency to act on behalf of the Agency in the administration of the program under this Contract.

DHHS: United States Department of Health and Human Services.

DIA: The Iowa Department of Inspections and Appeals.

Disaster: An occurrence of any kind that severely inhibits the Contractor's ability to conduct daily business or severely affects the required performance, functionality, efficiency, accessibility, reliability or security of the Contractor's system. This may include natural Disasters, human error, computer virus or malfunctioning hardware or electrical supply.

Discharge Planning: The process, begun at admission, of determining an Enrolled Member's continued need for treatment services and of developing a plan to address ongoing needs.

Discrimination: Termination of Enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage Enrollment by beneficiaries whose medical condition or history indicates a probable need for substantial future medical services. See: 42 C.F.R. § 438.700(b)(3). {From CMSC}.

Disenrollment: The removal of an Enrolled Member from the Contractor's Enrollment either through loss of eligibility or some other cause.

Dispensing Fee: Payment provided for the costs incurred by a pharmacy to dispense a drug. The fee reflects the pharmacist's professional services and costs associated with ensuring that possession of the appropriate covered outpatient drug is transferred to a Medicaid member.

DRG: Diagnosis Related Group.

Drug Rebate: Payments provided by pharmaceutical manufacturers to State Medicaid programs under the terms of the manufacturers' agreements with the Department of Health and Human Services or with the individual state.

Drug Utilization Review (DUR): A Quality review of covered outpatient drugs that assures that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical Outcomes.

Drug Utilization Review (DUR) Commission: A Quality assurance body of ten (10) members that seeks to improve the Quality of pharmacy services and ensure rational, cost-effective medication therapy for Medicaid Members in Iowa.

Dual Eligible: A Member enrolled in both Medicaid and Medicare.

Durable Medical Equipment (DME): Durable medical equipment. DME is equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefits: Benefits defined in section 1905(r) of the Act, and applying to individuals under the age of twenty-one (21), including: screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan. See: Section 1905(r) of the Social Security Act. {From CMSC}.

EBP: Evidence Based Practice.

EDI: Electronic Data Interchange.

Electronic Visit Verification (EVV) System: An electronic system into which Providers can check-in at the beginning and check-out at the end of each period of service delivery to monitor Member receipt of HBCS and which may also be utilized for submission of Claims.

Emergency Communication: An urgent or emergent situation that requires immediate communication by the Managed Care Plan to Providers and Enrolled Members to ensure their health and safety. These situations include but may not be limited to extreme weather events, natural disasters, violence, terrorism, or other mass casualty events.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

See: 42 C.F.R. § 438.114(a). {From CMSC}.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services that a member receives in an emergency room.

Emergency Services: Covered inpatient and outpatient services that are as follows:

- Furnished by a Provider that is qualified to furnish these services under Title XIX of the Social Security Act.
- Needed to evaluate, treat, or stabilize an Emergency Medical Condition.

See: 42 C.F.R. § 438.114(a). {From CMSC}.

Enrolled Member: See *Enrolled Member.*

Enrolled Member: A person who has been determined eligible by the Agency for Medicaid or Hawki and who is currently enrolled with the Contractor. See: 42 C.F.R. § 438.2. {From CMSC}.

Enrolled Member Encounter Data: The information relating to the receipt of any item(s) or service(s) by an Enrolled Member under the Contract that is subject to the requirements of 42 C.F.R. § 438.242 and 42 C.F.R. § 438.818. See: 42 C.F.R. § 438.2. {From CMSC}.

Enrollment: The process by which a Member becomes an Enrolled Member of the Contractor.

Enrollment Activities: Activities such as distributing, collecting, and processing Enrollment materials and taking Enrollments by phone, in person, or through electronic methods of communication. See: 42 C.F.R. § 438.810(a). {From CMSC}.

Enrollment Broker: An individual or entity that performs Choice Counseling or Enrollment Activities, or both. See: 42 C.F.R. § 438.810(a). {From CMSC}.

EOB: Explanation of Benefits

ETL: Extraction, Transformation, and Load

Excluded Services: Services that are not covered on the members identified plan.

Expedited Grievances: If an Enrolled Member requests to switch plans to stay with their established provider, because their provider is leaving the Contractor's network for any reason than the MCP must “expedite” the grievance. This is the only scenario where using expedited grievances is required.

External Quality Review: As used in 42 C.F.R. part 438 subpart E, the analysis and evaluation by an External Quality Review Organization (EQRO), of aggregated information on Quality, timeliness, and Access to the Health Care Services that the Contractor (described in 42 C.F.R. § 438.310(c)(2)), furnishes to Enrolled Members. See: 42 C.F.R. § 438.320. {From CMSC}.

External Quality Review Organization (EQRO): As used in 42 C.F.R. part 438 subpart E, an organization that meets the competence and independence requirements set forth in 42 C.F.R. § 438.354, and performs External Quality Review, other External Quality Review-related activities as set forth in 42 C.F.R. § 438.358, or both. See: 42 C.F.R. § 438.320. {From CMSC}.

*FBR***:** SSI Federal Benefit Rate.

Federally Qualified HMO: An HMO that CMS has determined is a qualified HMO under section 1310(d) of the Public Health Service (PHS) Act. See: 42 C.F.R. § 438.2. {From CMSC}.

FFS: Fee-for-Service.

Financial Relationship: As used in 42 C.F.R. part 438 subpart E:

- A direct or indirect ownership or investment interest (including an option or nonvested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means, and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest; or
- A compensation arrangement with an entity.

See: 42 C.F.R. § 438.320. {From CMSC}.

Financial Requirements: Deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits. See: 42 C.F.R. § 438.900. {From CMSC}.

FMAP: Family Medical Assistance Program.

FQHC: Federally Qualified Health Center.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes Fraud under applicable Federal or state law. See: 42 C.F.R. § 438.2; 42 C.F.R. § 455.2. {From CMSC}.

Grievance: 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 Enrolled Member's rights regardless of whether remedial action is requested. Grievance includes an Enrolled Member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. See: 42 C.F.R. § 438.400(b). {From CMSC}.

Grievance and Appeal System: The processes the Contractor implements to handle Appeals of an Adverse Benefit Determination and Grievances, as well as the processes to collect and track information about them. [42 C.F.R. § 438.400(b)] {From CMSC}.

Habilitation Services and Devices: Per 441 IAC 78.27(249A) Habilitation services are to assist members who have functional deficits typically seen in persons with a chronic mental illness. These home and community-based services assist in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.

Hawki Program: Healthy and Well Kids in Iowa, the Iowa program to provide health care coverage for uninsured children of eligible families as authorized by Title XXI of the federal Social Security Act.

HCFA: Health Care Financing Administration.

Health Care Services: As used in 42 C.F.R. part 438 subpart E, all Medicaid services provided by the Contractor in any setting, including but not limited to medical care, behavioral health care, and LTSS. For the purposes of this Contact, Health Care Services primarily refers to dental and oral health care services. See: 42 C.F.R. § 438.320. {From CMSC}.

Healthcare Effectiveness Data and Information Set (HEDIS): A set of Performance Measures developed by the NCQA. The measures were designed to help health care purchasers understand the value of health purchases and measure plan performance.

Health Insurance: Financial coverage to cover a portion of the cost of a policyholder's medical and/or dental bills. May be a public coverage program such as Medicare, Medicaid, MCO's, CHIP, Indian Health Services. May be Private Healthcare such as provided by an employer or purchased in the market.

HIPP: Health Insurance Premium Payment Program.

HIT: Health Information Technology.

HMO: Health Maintenance Organization licensed by the Iowa Insurance Division.

Home-Based Habilitation: Habilitation Services means the 1915(i) State Plan Home and Community Based Services. Habilitation services are provided to maintain persons with functional deficits typically associated with chronic mental illness in their own homes and communities.

Home and Community-Based Services (HCBS): Services that are provided as an alternative to long-term care institutional services in a NF or an ICF/ID or to delay or prevent placement in a NF.

Home Health Care: Home health care is a wide range of health care services that can be given in a member's home for an illness or an injury.

Hospice Services: Services to provide comfort and support for members in the last stages of a terminal illness, and their families.

Hospitalization: Medically necessary care determined to require a hospital stay.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

HRSA: Health Resources Services Administration.

Integrated Health Homes (IHH): Integrated and coordinated care for individuals with serious mental illness or serious emotional disturbance for all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

Incentive Arrangement: Any payment mechanism under which the Contractor may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the Contract. See: 42 C.F.R. § 438.6. {From CMSC}.

Indian: Any individual defined at 25 U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12. This means the individual:

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

See: 42 C.F.R. § 438.14(a). {From CMSC}.

Indian Health Care Provider (IHCP): A health care program operated by the IHS or by an I/T/U as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). See: 42 C.F.R. § 438.14(a). {From CMSC}.

Informational Letter (IL): Iowa Medicaid publishes provider bulletins called Informational Letters that are necessary to clarify and explain new and existing program and policy.

Iowa Health and Wellness Plan (IHAWP): The Iowa Health and Wellness Plan covers Iowans, ages nineteen (19) to sixty-four (64), with incomes up to and including one hundred and thirty-three percent (133%) of the Federal Poverty Level (FPL). The plan provides a comprehensive benefit package and is part of Iowa's implementation of the Affordable Care Act or Medicaid expansion.

Iowa Health Information Network (IHIN): Iowa's Health Information Exchange.

Iowa Insurance Division (IID): The state regulator which supervises all insurance business transacted in the state of Iowa.

Iowa Medicaid: The division of Health and Human Services (HHS) that administers the Iowa Medicaid Program.

IVR: Interactive Voice Response.

Large Print: Printed in a conspicuously visible font size as defined by the HHS Office of Civil Rights at 45 C.F.R. § 92.8(f)(1). See: 42 C.F.R. § 438.10(d)(2). {From CMSC}.

Limited English Proficient or *Limited English Proficiency (LEP):* Potential Enrolled Members and Enrolled Members 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. See: 42 C.F.R. § 438.10(a). {From CMSC}.

LSO: Limited Service Organization licensed by the Iowa Insurance Division.

Long-Term Services and Supports (LTSS): Services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a Provider-owned or controlled residential setting, a NF, or other institutional setting. See: 42 C.F.R. § 438.2. {From CMSC}.

LTSS Residential Provider: A residential provider who provides services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses, including, but not limited to, (i) NFs; (ii) ICF/IDs; (iii) 1915(i); (iv) 1915(c); and (iii) Residential Community-based neurobehavioral rehabilitation (CNRS) providers.

M-CHIP: Refers to Medicaid CHIP, or Medicaid expansion. M-CHIP provides coverage to children ages six (6) to eighteen (18) whose family income is between one hundred and twenty two percent (122%) and one hundred and sixty seven percent (167%) of the Federal Poverty Level (FPL), and infants whose family income is between two hundred and forty percent (240%) and three hundred and seventy five percent (375%) of the FPL.

Managed Care Organization (MCO): An entity that has, or is seeking to qualify for, a Comprehensive Risk Contract under 42 C.F.R. part 438, and that is— (1) A Federally qualified HMO that meets the advance directives requirements of 42 C.F.R. part 489, subpart I; or (2) Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions: (i) Makes the services it provides to its members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity; (ii) Meets the solvency standards of 42 C.F.R. § 438.116. See: 42 C.F.R. § 438.2. {From CMSC}.

Managed Care Plan (MCP): A term used when the contract section applies to both the Managed Care Organization and the Pre-Paid Ambulatory Health Plan.

Mandatory Enrollment: Enrollment where one (1) or more groups of beneficiaries as enumerated in section 1905(a) of the Social Security Act must enroll with the Contractor to receive covered Medicaid Benefits. See: 42 C.F.R. § 438.54(b)(2). {From CMSC}.

Marketing: Any communication, from the Contractor to a Medicaid beneficiary who is not enrolled with the Contractor, that can reasonably be interpreted as intended to influence the beneficiary to enroll with the Contractor, or either to not enroll in or to disenroll from another Contractor's Medicaid product. Marketing does not include communication to a Medicaid beneficiary from the issuer of a QHP, as defined in 45 C.F.R. § 155.20, about the QHP. See: 42 C.F.R. § 438.104(a). {From CMSC}.

Marketing Materials: Materials that—

- Are produced in any medium, by or on behalf of the Contractor; and
- Can reasonably be interpreted as intended to market the Contractor to Potential Enrolled Members.

See: 42 C.F.R. § 438.104(a). {From CMSC}.

MCO, PIHP, PAHP, PCCM, or PCCM entity: The acronyms include any of the entity's employees, Network Providers, agents, or contractors. See: 42 C.F.R. § 438.104(a). {From CMSC}.

MED. Medicare Exclusion Database.

Medicaid: A means tested federal-State entitlement program enacted in 1965 by Title XIX of the Social Security Act. Medicaid offers federal matching funds to states for costs incurred in paying health care Providers for serving eligible individuals.

Medicaid Expansion: See Iowa Health and Wellness Plan (IHAWP) and/or M-CHIP

Medical Loss Ratio (MLR) Reporting Year: A period of twelve (12) months consistent with the rating period selected by the Agency. See: 42 C.F.R. § 438.8(b). {From CMSC}.

Medical Records: All medical, dental, oral, behavioral health, and long-term care histories; records, reports and summaries; diagnoses; prognoses; record of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical, dental, oral, behavioral health, and long-term care documentation in written or electronic format; and analyses of such information.

Medical/Surgical Benefits: Benefits for items or services for medical conditions or surgical procedures, as defined by the Agency and in accordance with applicable Federal and State law, but do not include mental health or substance use disorder Benefits. Any condition defined by the Agency as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or State guidelines). Medical/Surgical Benefits include LTSS services. See: 42 C.F.R. § 438.900. {From CMSC}.

Medically Accepted Indication: Any use for a covered outpatient drug which is approved under the federal Food, Drug, and Cosmetic Act, or the use of which is supported by one (1) or more citations included or approved for inclusion in any of the compendia described in section 1927(g)(1)(B)(i) of the Social Security Act.

Medically Exempt: Includes individuals with disabling mental disorders (including adults with serious mental illness), individuals with chronic substance use disorders, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform one (1) or more activities of daily living, or individuals with a disability determination based on Social Security criteria. The phrase "Medically Exempt" as used in this Contract is intended to have the same meaning as the term "Medically Frail" as defined in 42 C.F.R. § 440.315(f).

Medically Necessary Services: Those Covered Services that are, under the terms and conditions of the Contract, determined through Contractor UM to be:

- Appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the Enrolled Member;
- Provided for the diagnosis or direct care and treatment of the condition of Enrolled Member enabling the Enrolled Member to make reasonable progress in treatment;
- Within standards of professional practice and given at the appropriate time and in the appropriate setting;
- Not primarily for the convenience of the Enrolled Member, the Enrolled Member's physician or other Provider; and
- The most appropriate level of Covered Services, which can safely be provided.

Medicare: A nationwide federally administered Health Insurance program that covers the cost of Hospitalization, medical care and some related services. Medicare has two (2) parts: Part A (also called the supplemental medical insurance program) covers inpatient costs; Part B covers outpatient costs. Part C is Medicare Advantage. Part D is optional coverage for prescription drugs.

Member: A Medicaid recipient or a recipient of services provided under the State Children's Health Insurance Program operated by the Agency who is subject to Mandatory Enrollment or is currently enrolled in the Contractor's coverage under the Contract for the program.

Member Months: The number of months an Enrolled Member or a group of Enrolled Members is covered by the Contractor over a specified time period, such as a year. See: 42 C.F.R. § 438.8(b). {From CMSC}.

MFCU: Medicaid Fraud Control Unit. A division within the Iowa Department of Inspections & Appeals whose primary goal is to prevent abuse of taxpayer resources through professional investigation of criminal activity. MFCU staffs experienced criminal investigators, auditors, and attorneys to achieve this goal.

MHDS: Mental Health and Disability Services.

MHPAEA: Mental Health Parity and Addiction Equity Act.

MMIS: The Agency's Medicaid Management Information System, a mechanized Claims processing and information retrieval system that all Medicaid programs are required to have and must be approved by the Secretary of DHHS. This system pays Claims for Medicaid services and includes information on all Medicaid Providers and Enrolled Members.

Money Follows the Person Rebalancing Demonstration (MFP): A federal grant that will assist Iowa in transitioning individuals from a NF or ICF/ID into the community and in rebalancing long-term care expenditures.

NAIC: National Association of Insurance Commissioners.

Natural Supports: Services and supports identified as wanted or needed by the consumer and provided by persons not for pay (e.g. family, friends, neighbors, coworkers and others in the community) and organizations or entities that serve the general public.

NCQA: National Committee for Quality Assurance.

Network or *Provider Network:* A group of participating health care Providers (both individual and group practitioners) linked through contractual arrangements to the Contractor to supply a range of dental health care services.

Network Adequacy: Refers to the Network of dental health care Providers for the program that is sufficient in numbers and types of Providers to ensure that all services are accessible to Enrolled Members without unreasonable delay. Adequacy is determined by a number of factors, including, but not limited to, Provider/Enrolled Member ratios, geographic accessibility and travel distance, waiting times for appointments, and hours of agency operations.

Network Provider: Any Provider, group of Providers, or entity that has a Network Provider agreement with the Contractor and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the Agency's Contract with the Contractor. A Network Provider is not a Subcontractor by virtue of the Network Provider agreement. See: 42 C.F.R. § 438.2. {From CMSC}.

NF: Nursing Facility.

NMHPA: The Newborn and Mothers Health Protection Act.

Non-Claims Costs: Those expenses for administrative services that are not:

- Incurred Claims;
- Expenditures on activities that improve health care Quality; or
- Licensing and regulatory fees, or
- Federal and State taxes.

See: 42 C.F.R. § 438.8(b). {From CMSC}.

Non-Emergent Use of Emergency Room: Illnesses or injuries that are generally not life-threatening and do not need immediate treatment at an Emergency Department.

Non-Participating Provider: A provider that is enrolled with Iowa Medicaid, is credentialed, but not contracted, with a managed care plan.

Notice: Notice means a written statement of the action the Contractor has taken or intends to take, the reasons for the action, the Enrolled Member's right to file an Appeal and request a fair hearing with the Agency, and the procedures for exercising that right.

NPPES: National Plan and Provider Enumeration System.

OIG: Office of Inspector General.

Other Disclosing Entity: Any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Social Security Act. This includes:

- Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, RHC, or HMO that participates in Medicare (title XVIII);
- Any Medicare intermediary or carrier; and
- Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it Claims payment under any plan or program established under title V or title XX of the Social Security Act.

See: 42 C.F.R. § 455.101. {From CMSC}.

Out-of-Network Provider: Any Provider that is not directly or indirectly employed by or does not have a Provider agreement with the Contractor or any of its Subcontractors pursuant to the Contract between the Agency and the Contractor.

Outcomes: As used in 42 C.F.R. part 438 subpart E, changes in patient health, functional status, satisfaction or goal achievement that result from health care or supportive services. See: 42 C.F.R. § 438.320. {From CMSC}.

Overpayment: Any payment made to a Network Provider by the Contractor to which the Network Provider is not entitled to under Title XIX of the Social Security Act or any payment to the Contractor by the Agency to which the Contractor is not entitled to under Title XIX of the Social Security Act. See: 42 C.F.R. § 438.2. {From CMSC}.

PACE: Program for All Inclusive Care for the Elderly.

Participating Provider: A provider that is enrolled with Iowa Medicaid and is credentialed and contracted with a managed care plan.

PASRR: Preadmission Screening and Resident Review.

Pass-Through Payment: Any amount required by the Agency to be added to the contracted payment rates, and considered in calculating the actuarially sound capitation rate, between the Contractor and hospitals, physicians, or nursing facilities that is not for the following purposes: A specific service or benefit provided to a specific Enrolled Member covered under the Contract; a Provider payment methodology permitted under paragraphs (c)(1)(i) through (iii) of 42 C.F.R. § 438.6 for services and Enrolled Members covered under the Contract; a subcapitated payment arrangement for a specific set of services and Enrolled Members covered under the Contract; graduate medical education payments; or FQHC or RHC wrap around payments. See: 42 C.F.R. § 438.6. {From CMSC}.

Performance Improvement Projects (PIPs): Projects to improve specific Quality Performance Measures through ongoing measurements and interventions that result in significant improvement, sustained over time, with favorable effects on health Outcomes and Enrolled Member satisfaction.

Performance Measures: Performance Measures are specific, operationally defined performance indicators that utilize data to track performance, Quality of care, and to identify opportunities for improvement in care and services.

Person-Centered Planning Process: A process led by the member, where possible, and includes the member's representative in a participatory role, as needed and as defined by the member, unless State law confers decision-making authority to the legal representative. In addition to being led by the member receiving services and supports, the Person-Centered Planning Process:

- Includes people chosen by the member;

- Provides necessary information and support to ensure that the member directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- Is timely and occurs at times and locations of convenience to the member;
- Reflects cultural considerations of the member and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are LEP, consistent with 42 C.F.R. § 435.905(b);
- Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;
- Providers of HCBS for the member, or those who have an interest in or are employed by a Provider of HCBS for the member must not provide Case Management or develop the Person-Centered Service Plan, except when the Agency demonstrates that the only willing and qualified entity to provide Case Management and/or develop Person-Centered Service Plans in a geographic area also provides HCBS. In these cases, the Agency must devise conflict of interest protections including separation of entity and Provider functions within Provider entities, which must be approved by CMS. Members must be provided with a clear and accessible alternative dispute resolution process;
- Offers informed choices to the member regarding the services and supports they receive and from whom;
- Includes a method for the member to request updates to the plan as needed;
- Records the alternative home and community-based settings that were considered by the member.

See: 42 C.F.R. § 441.301(c)(1). {From CMSC}.

Person-Centered Service Plan: A person-centered plan must reflect the services and supports that are important for the member to meet the needs identified through an assessment of functional need, as well as what is important to the member with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the member, and the scope of services and supports available under the State's 1915(c) HCBS Waiver, the written plan must:

- Reflect that the setting in which the member resides is chosen by the member. The Agency must ensure that the setting chosen by the member is integrated in, and supports full Access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of Access as individuals not receiving Medicaid HCBS;
- Reflect the member's strengths and preferences;
- Reflect clinical and support needs as identified through an assessment of functional need;
- Include individually identified goals and desired outcomes;
- Reflect the services and supports (paid and unpaid) that will assist the member to achieve identified goals, and the Providers of those services and supports, including Natural Supports. Natural Supports are unpaid supports that are provided voluntarily to the member in lieu of 1915(c) HCBS Waiver services and supports;
- Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
- Be understandable to the member receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to members with disabilities and persons who are LEP, consistent with 42 C.F.R. § 435.905(b) of this chapter;
- Identify the individual and/or entity responsible for monitoring the plan;
- Be finalized and agreed to, with the informed consent of the member in writing, and signed by all individuals and Providers responsible for its implementation;
- Be distributed to the member and other people involved in the plan;
- Include those services, the purpose or control of which the member elects to self-direct;
- Prevent the provision of unnecessary or inappropriate services and supports;

- Document that any modification of the additional conditions, under paragraph (c)(4)(vi)(A) through (D) of 42 C.F.R. § 431.301, must be supported by a specific assessed need and justified in the Person-Centered Service Plan.

See: 42 C.F.R. § 431.301(c)(2). {From CMSC}.

Pharmaceutical and Therapeutics (P&T) Committee: A committee of nine (9) members appointed by the Governor that is charged with developing and providing ongoing review of the PDL pursuant to Iowa Code section 249A.20A.

Pharmacy Benefit Manager (PBM): An entity responsible for the provision and administration of pharmacy services.

Physician Services: Health care services a licensed medical physician provides or coordinates.

Physician/Provider Administered Drugs: Drugs other than vaccines covered under section 1927(k)(2) of the Social Security Act that are typically furnished incident to a physician's/provider's services.

- Physician/Provider Administered Drugs are administered by a medical professional in a physician's or other qualified medical provider's office or other outpatient clinical setting.
- Physician/Provider Administered Drugs are incident to a physician's or other qualified medical provider's services that are separately billed to Medicaid or its Designee.
- Reimbursement for Physician/Provider Administered Drugs is allowed only if the drug qualifies for rebate in accordance with 42 USC 1396r-8.

Plan: An individual or group plan that provides, or pays the cost of, medical care.

PMIC: Psychiatric Medical Institutions for Children.

Policies and Procedures Manual (PPM): The document to be released by the Agency detailing the policies and procedures of the program.

POS: Point of Sale.

Post-Stabilization Care Services: Covered services, related to an Emergency Medical Condition that are provided after an Enrolled Member is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 C.F.R. § 438.114(e), to improve or resolve the Enrolled Member's condition. See: 42 C.F.R. § 438.114(a). {From CMSC}.

Potential Enrolled Member: A Medicaid beneficiary who is subject to Mandatory Enrollment or may voluntarily elect to enroll with the Contractor but is not yet an Enrolled Member of the Contractor. See: 42 C.F.R. § 438.2. {From CMSC}.

PPACA: The Patient Protection and Affordable Care Act.

PPS: Prospective Payment System.

Preauthorization: To ensure that services are medically necessary, Iowa Medicaid Medical Services conducts a pre-review and/or a pre-procedure review program for the Medicaid program. (IAC 441 – 79.11, 78.4 (1-9) Approval by Iowa Medicaid medical services will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by the department.

Preferred Drug: A drug on the PDL that provides medical equivalency to the Medicaid member in a cost-effective manner (by virtue of OBRA '90 and Supplemental Rebate) and does not require a Prior Authorization unless conditions are applied. A Preferred Drug is designated "P" on the PDL.

Preferred Drug List (PDL): A list comprised of drugs recommended to the Iowa Department of Health and Human Services by the Iowa Medicaid P&T Committee that have been identified as being therapeutically equivalent within a drug class and that provide cost benefit to the Medicaid program.

Premium: A Health Insurance premium is the amount that policy holders pay for health coverage.

Prepaid Ambulatory Health Plan (PAHP): An entity that—

- Provides services to Enrolled Members under contract with the Agency, and on the basis of Capitation Payments, or other payment arrangements that do not use State Plan payment rates.
- Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its Enrolled Members; and
- Does not have a Comprehensive Risk Contract.

See: 42 C.F.R. § 438.2. {From CMSC}.

Prepaid Inpatient Health Plan (PIHP): An entity that—

- Provides services to members under contract with the Agency, and on the basis of Capitation Payments, or other payment arrangements that do not use State Plan payment rates.
- Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its members; and
- Does not have a Comprehensive Risk Contract.

See: 42 C.F.R. § 438.2. {From CMSC}.

Prescription Drug Coverage: Preferred drugs by Medicaid Plans. Prescription records are required for all drugs as specified in Iowa pharmacy and drug laws, including Iowa Code sections 124.308, 126, 155A.27, and 155A.29. For Medicaid purposes, prescriptions are required for nonprescription drugs and are subject to the same provisions. This includes the record-keeping requirements on refills. Maintain prescriptions on file in such a manner that they will be readily available for audit by the Department. Prior Authorization may be required. Prescribers should review the therapy of their Medicaid patients for utilization of nonpreferred drugs and wherever medically appropriate, change patients to preferred drugs. New therapy should be initiated on a preferred drug unless a nonpreferred drug is medically necessary. A member receives the prescription when prescribed by a legally qualified practitioner (which includes physician, dentist, podiatrist, physician assistant, therapeutically certified optometrist, or advanced registered nurse practitioner). (IAC 79.1(7)c (2)).

Prevalent: A non-English language determined to be spoken by a significant number or percentage of Potential Enrolled Members and Enrolled Members that are LEP. Per Iowa's 1915(b) waiver, this threshold percentage is five percent (5%). See: 42 C.F.R. § 438.10(a). {From CMSC}.

Prevocational Services: Prevocational services means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings

Primary Care: All Health Care Services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, OB/GYN, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them. See: 42 C.F.R. § 438.2. {From CMSC}.

Primary Care Provider (PCP): A Primary Care physician, dentist, or other licensed health practitioners practicing in accordance with State law who is responsible for providing preventive and primary dental and/or oral health care to patients; for initiating referrals for Specialist care; and for maintaining the continuity of patient care.

Primary Care Services: Health care and laboratory services customarily furnished by, or through, the Enrolled Member's PCP for diagnosis and treatment of acute and chronic illnesses, disease prevention and screening, dental health maintenance, and dental health promotion, either by the PCP or through appropriate referral to specialists and/or ancillary Providers.

Prior Authorization (PA): The process of obtaining prior approval as to the appropriateness of a service or medication; Prior Authorization does not guarantee coverage.

Private Insurance: Does not include a QHP, as defined in 45 C.F.R. § 155.20. See: 42 C.F.R. § 438.104(a). {From CMSC}.

Professional Standards/Industry Standards: The generally accepted requirements followed by the members of an industry and the ethical or legal duty of a professional to exercise the level of care, diligence, and skill prescribed in the code of practice of their profession, or as other professionals in the same discipline would in the same or similar circumstances.

Program: The Iowa Dental Wellness Plan and Hawki Dental programs provided through this Contract.

Program Contractor(s): The vendors selected to operate the Program, including the Contractor and the other awarded entity(s).

Program Integrity (Pl): Program Integrity (Pl) is charged with reducing fraud, waste and abuse in the Iowa Medicaid program.

Prospective Drug Utilization Review (Pro-DUR): A process in which a request for a drug product for a particular patient is screened for potential drug therapy problems before the product is dispensed.

Protected Health Information (PHI): Individually-identifiable health information that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 C.F.R. parts 160 and 164.

Provider: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services. See: 42 C.F.R. § 438.2. {From CMSC}.

Provider-Preventable Conditions: Situations in which Medicaid payment is prohibited for services that should have been avoidable as defined in 42 C.F.R. § 447.26.

Psychosocial Necessity: The clinical, rehabilitative, or supportive mental health services that meet all of the following conditions: (i) are appropriate and necessary to the symptoms, diagnoses or treatment of a mental health diagnosis; (ii) are provided for the diagnosis or direct care and treatment of a mental disorder; (iii) are within standards of good practice for mental health treatment; (iv) are required to meet the mental health needs of the member and not primarily for the convenience of the member, the Provider, or the contractor; and (v) are the most appropriate type of service which would reasonably meet the needs of the member in the least costly manner after consideration of: (a) the member's clinical history including the impact of previous treatment and service interventions; (b) services being provided concurrently by other delivery systems; (c) the potential for

services/supports to avert the need for more intensive treatment; (d) the potential for services/supports to allow the member to maintain functioning improvement attained through previous treatment; (e) unique circumstances which may impact the accessibility or appropriateness of particular services for an individual member (e.g., availability of transportation, lack of Natural Supports including a place to live); and (f) the member's choice of Provider or treatment location.

QHP: Qualified Health Plan

Quality: As used in 42 C.F.R. part 438 subpart E and pertaining to External Quality Review, the degree to which the Contractor increases the likelihood of desired Outcomes of its Enrolled Members through:

- Its structural and operational characteristics.
- The provision of services that are consistent with current professional, evidenced-based-knowledge.
- Interventions for performance improvement.

See: 42 C.F.R. § 438.320. {From CMSC}.

RAC. Recovery Audit Contractor.

Rating Period: A period of twelve (12) months selected by the Agency for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by 42 C.F.R. § 438.7(a). See: 42 C.F.R. § 438.2. {From CMSC}.

Readily Accessible: Electronic information and services that comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions. See: 42 C.F.R. § 438.10(a). {From CMSC}.

Readiness Review: The process whereby the Agency assesses the Contractor's ability to fulfill the requirements of the Contract. Such review may include, but is not limited to, review of proper licensure, operational protocols, Contractor standards, and systems. The review may be completed as a desk review, on-site review, or combination of the two, and may include interviews with pertinent personnel so that the Agency can make an informed assessment of the Contractor's ability and readiness to render services.

Recommended Drug List (RDL): A voluntary list of drugs recommended to the Department of Health and Human Services by the Iowa Medicaid P&T Committee that informs prescribers of cost-effective alternatives that do not require a Prior Authorization.

Rehabilitation Services and Devices: All services determined to be medically necessary and reasonable for the member to improve health status. All services must meet a significant need of the member that cannot be met by a significant other, a friend, or medical staff; must meet accepted standards of medical practice by prior authorization. All services must be specific and effective treatment for a member's medical or disabling condition. A licensed skilled therapist must complete a plan of treatment every thirty (30) days and indicate the type of service required.

Reporting Manual: The document to be distributed by the Agency detailing the reporting requirements for the Program.

Reprocessed Claim: The adjustment of certain already-processed Claims until the Claim is correct or no further changes are required. The re-processing process includes all activities identified to pay or deny the Claim after its initial adjudication through the Claims payment system. This includes payment of the Claim once adjustments have been completed.

Retrospective Drug Utilization Review (Retro-DUR): The process in which patient drug utilization is periodically reviewed to identify patterns of Fraud, Abuse, gross overuse, or inappropriate or unnecessary care.

RHC: Rural Health Clinic.

Risk Contract: A contract between the Agency and Contractor under which the Contractor—

- Assumes 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 Contract.

See: 42 C.F.R. § 438.2. {From CMSC}.

Risk Corridor: A risk sharing mechanism in which the Agency and the Contractor may share in profits and losses under the Contract outside of a predetermined threshold amount. See: 42 C.F.R. § 438.6. {From CMSC}.

Routine Care: Medical care which is not urgent or emergent in nature and can wait for a regularly scheduled physician appointment without risk of permanent damage to the patient's life or health status. The condition requiring Routine Care is not likely to substantially worsen without immediate clinical intervention.

Rural: Any area that is not designated as a Metropolitan Statistical Area (MSA).

SAM: System for Award Management.

Sanctioned Individual: In accordance with section 1128(b)(8) of the Social Security Act, a Sanctioned Individual is a person who:

- Has a direct or indirect ownership or control interest of five percent (5%) or more in the entity, and:
  - Has had a conviction of relating to Fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient Abuse, or felony healthcare Fraud; or
  - Has been assessed a civil monetary penalty under section 1128A or 1129 of the Social Security Act; or
  - Has been excluded from participation under a program under title XVIII or under a state health care program
- Has an ownership or control interest (as defined in section 1124(a)(3) of the Social Security Act) in the entity, and:
  - Has had a conviction of relating to Fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient Abuse, or felony healthcare Fraud; or
  - Has been assessed a civil monetary penalty under section 1128A or 1129 of the Social Security Act; or
  - Has been excluded from participation under a program under title XVIII or under a state health care program
- Is an officer, director, agent, or managing employee of the Contractor, and:
  - Has had a conviction of relating to Fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient Abuse, or felony healthcare Fraud; or
  - Has been assessed a civil monetary penalty under section 1128A or 1129 of the Social Security Act; or
  - Has been excluded from participation under a program under title XVIII or under a state health care program
- No longer has direct or indirect ownership or control interest of five percent (5%) or more in the Contractor or no longer has an ownership or control interest defined under section 1124(a)(3) of the

Social Security Act, because of a transfer of ownership or control interest, in anticipation of or following a conviction, assessment, or exclusion against the person, to an immediate family member or a member of the household of the person who continues to maintain an ownership or control interest who:

- Has had a conviction of relating to Fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient Abuse, or felony healthcare Fraud; or
- Has been assessed a civil monetary penalty under section 1128A or 1129 of the Social Security Act; or
- Has been excluded from participation under a program under title XVIII or under a state health care program.

See: Section 1128(b)(8) of the Social Security Act. {From CMSC}.

Second Opinion: Subsequent to an initial medical opinion, a Second Opinion is an opportunity or requirement to obtain a clinical evaluation by a Provider other than the one originally recommending a proposed health service, to assess the clinical necessity and appropriateness of the initial proposed health service.

SED: Severe Emotional Disturbance.

Service Authorization: A managed care Enrolled Member's request for the provision of a service. See: 42 C.F.R. § 431.201. {From CMSC}.

Service Level (SL): In relation to call centers, service level is defined as the percentage of calls answered within a predefined amount of time.

SIM: State Innovation Model.

Single Case Agreement: A single case agreement (SCA) is defined as a contract between an out-of-network (not enrolled with Iowa Medicaid) health care provider and the Managed Care Plan (MCP).

SIU: Special Investigations Unit.

Skilled Nursing Care: Medicare Benefit Manual Policy 30.3 Direct Skilled Nursing Services to Patients. Skilled nursing services are services provided when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse are required.

Specialist: A licensed general dentist, who is certified or trained in a specific field of dentistry, including oral surgery, prosthodontia, pediatrics, periodontology, orthodontia, and endodontia.

SRC: State Resource Centers.

SSA: Social Security Administration.

SSI: Supplemental Security Income.

State: The State of Iowa, including, but not limited to, any entity or agency of the State, such as the Iowa Department of Health and Human Services, the MFCU, the Division of Insurance, and the Office of the Attorney General. It also refers to the Single State Agency as specified in 42 CFR § 431.10.

State Fair Hearing: The process set forth in 42 C.F.R. part 431, subpart E. See: 42 C.F.R. § 438.400(b). {From CMSC}.

State Plan: An agreement between the State and the federal government describing how the State administers its Medicaid and CHIP programs.

Subcontractor: A Third Party who contracts with the Contractor or another Subcontractor to perform a portion of the duties in the Contract. A Network Provider is not a Subcontractor by virtue of the Network Provider agreement with the Contractor See: 42 C.F.R. § 438.2.

Substance Use Disorder Benefits: Benefits for items or services for substance use disorders, as defined by the Agency and in accordance with applicable Federal and State law. Any disorder defined by the Agency as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or State guidelines). Substance use disorder Benefits include LTSS services. See: 42 C.F.R. § 438.900. {From CMSC}.

Targeted Case Management (TCM): Individual Community-Based Case Management services targeted to persons with chronic mental illness, mental retardation or developmental disabilities as defined in Iowa Code § 225C.20 with standards set forth in the Iowa Admin. Code ch. 441- 24 and ch. 441-90.

Third Party: An individual, entity, or program, excluding Medicaid, that is or may be liable to pay all or a part of the expenditures for medical assistance provided by a Medicaid payer to the recipient. A Third Party includes, but is not limited to

- a third-party administrator;
- a pharmacy benefits manager;
- a health insurer;
- a self-insured plan;
- a group health plan, as defined in s. 607(1) of the Employee Retirement Income Security Act of 1974;2
- a service benefit plan;
- a managed care organization;
- liability insurance, including self-insurance;
- no-fault insurance;
- workers' compensation laws or plans; or
- other parties that by law, contract, or agreement are legally responsible for payment of a Claim for a health care item or service.

TPL: Third Party Liability.

Treatment Limitations: Include limits on Benefits based on the frequency of treatment, number of visits, Days of coverage, Days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment Limitations include both QTLs, which are expressed numerically (such as fifty (50) outpatient visits per year), and NQTLs, which otherwise limit the scope or duration of Benefits for treatment under a plan or coverage. (See 42 C.F.R. § 438.910(d)(2) for an illustrative list of NQTLs.) A permanent exclusion of all Benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition. See: 42 C.F.R. § 438.900. {From CMSC}.

UAT: User Acceptance Testing.

Urban: A Metropolitan Statistical Area (MSA) as defined by the federal Executive Office of Management and Budget.

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

Usual and Customary Standards for the Community: The standard utilized by the Agency to review the Contractor's compliance with Network adequacy standards where Provider availability is insufficient to meet the Contract's required time and distance standards. The Agency reviews the availability of Medicaid-enrolled Providers in a geographic area to determine if the Usual and Customary Standards for the Community has been met.

Utilization Management (UM): The process of managing costs and use of services through effective planning and decision-making to assure that services provided are appropriate and cost-effective; it is composed of the following elements: (i) deciding who will be served; (ii) assessing service needs and identifying desired Outcomes; (iii) deciding what services to provide; (iv) selecting service Providers and determining costs; and (v) implementing, monitoring, changing and terminating services.

Utilization Review: An element of UM, it is the evaluation of the medical necessity, appropriateness, and efficiency of the use of Health Care Services, procedures, facilities, and practitioners. It involves a set of techniques used by or on behalf of purchasers of health care Benefits to manage the cost of health care before its provision by influencing patient-care decision making through case-by-case assessments of the appropriateness of care based on Professional Standards/ Industry Standards. Utilization Review is done at the individual Enrolled Member level as well as a system level.

Validation: As used in 42 C.F.R. part 438 subpart E, the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis. See: 42 C.F.R. § 438.320. {From CMSC}.

Value Added Services (VAS): Optional benefits provided by the Contractor outside of the standard Medicaid benefit package. Contractors use value added services as an incentive to attract members to their plan. Historically, dental value-added services have been in the form of gift cards toward dental hygiene items.

Value Based Purchasing (VBP): Linking Provider payment to improved performance by health care Providers is called VBP. This form of payment holds health care Providers accountable for both the cost and Quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing Providers, in a way consistent with overarching goals announced by U.S. Department of Health and Human Services on January 26, 2015.

Warm Transfer: A telecommunications mechanism in which the person answering the call facilitates transfer to a Third Party, announces the caller and issue and remains engaged as necessary to provide assistance.

Withhold Arrangement: Any payment mechanism under which a portion of a capitation rate is withheld from the Contractor and a portion of or all of the withheld amount will be paid to the Contractor for meeting targets specified in the Contract. The targets for a Withhold Arrangement are distinct from general operational requirements under the Contract. Arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a liquidated damages and not a Withhold Arrangement. See: 42 C.F.R. § 438.6. {From CMSC}.

Exhibit C: General Access Standards

In general, the Contractor shall provide available, accessible, and adequate numbers of service locations, service sites, professional, allied, and specialty providers for the provision of covered services. At a minimum, this shall include the standards described in this Special Contract Exhibit. For areas of the state where Provider availability is insufficient to meet these standards, for example in health professional shortage areas and medically underserved areas, the Access standards shall meet the Usual and Customary Standards for the Community. Exceptions to the requirements contained herein shall be justified and documented to the Agency on the basis of community standards. All other services not specified herein shall meet the Usual and Customary Standards for the Community.

A. Primary Care Physician/Dentist Access Standards

a) *Time and Distance*: thirty (30) minutes or thirty (30) miles from the personal residences of Enrolled Members.

b) *Appointment Times*: Not to exceed 6 six to eight 8 weeks from the date of a patient's request for a routine appointment, within forty-eight (48) hours for persistent symptoms and urgent within one (1) day.

B. Specialty Care Access Standards

a) *Specialty Network*: The Contractor shall contract with a sufficient number of specialists with the applicable range of expertise to ensure that the needs of Enrolled Members are met within the Contractor's Provider Network. The Contractor shall also have a system to refer Enrolled Members to, and pay for, non-Network Providers when medically necessary. The Contractor shall also pay for non-Network Providers when an Enrolled Member has medical and/or dental needs that would be adversely affected by a change in service Providers. All non-Network Providers referred to and reimbursed shall have the necessary qualifications or certifications to provide the medically necessary service. At minimum, the Contractor shall have Provider agreements with Providers practicing the following specialties: oral surgery, orthodontia, prosthodontia, periodontia, endodontia, and pediatric specialties. The Contractor shall analyze the clinical needs of the Enrolled Membership to identify additional specialty Provider types to enroll.

b) *Time and Distance:*

1. Sixty (60) minutes or sixty (60) miles from the personal residence of Enrolled Members for at least seventy-five percent (75%) of Enrolled Members.

2. Ninety (90) minutes or ninety (90) miles from the personal residence of Enrolled Members for ALL Enrolled Members.

c) *Appointment Times:* Not to exceed thirty (30) Days for Routine Care or one (1) day for urgent care.

C. Emergency and Post-Stabilization Services Access Standards

a) *Emergency Care*: All emergency care is immediate, at the nearest facility available, regardless of whether the facility or Provider is under contract with the Contractor.

b) *Post-Stabilization Services*: Required by the Contractor, to assure members receive dental treatment when presenting with emergency dental and/or medical needs that require dental services to eradicate. Post-stabilization services will be available to the Enrolled Member in a timely manner to prevent re-Hospitalization or presenting at the emergency room and shall be coordinated by the Contractor, for the member, upon notification from the member, MCO, hospital, physician, or dentist who referred the member.

Exhibit D: Eligible Enrolled Members and Excluded Populations

Table D.01: Eligible Enrolled Members

POPULATION	DESCRIPTION
American Indian/Alaskan Native	Individuals who are identified as American Indian or Alaskan Native may voluntarily opt-in to the Program but will not be mandatorily assigned.
Children Under Nineteen (19)	Children ages one (1) to eighteen (18) eligible in accordance with 42 C.F.R. § 435.118 with income at or below one hundred and sixty-seven percent (167%) FPL.
Children in Foster Care, Subsidized Adoptions or Guardianship	Children in foster care, subsidized adoption, or subsidized guardianship if the Agency is wholly or partially responsible for their support.
Former Foster Children	An individual under age twenty-six (26) who was in foster care under the responsibility of the State and was enrolled in Medicaid when they turned eighteen (18) or aged out of the foster care system.
Hawki (Medical and Dental)	The State's separate Children's Health Insurance (CHIP) program. Children under age nineteen (19) with no other Health Insurance and income at or below three hundred and two percent (302%) FPL. Premium requirements apply.
Hawki (Dental Only)	The State's separate Children's Health Insurance (CHIP) program. Children under age nineteen (19) that otherwise meet the eligibility requirements for the Hawki program, except the child is covered by Health Insurance through an individual or group health plan, but no other dental insurance, and income at or below three hundred and two percent (302%) FPL. Premium requirements apply.
Home and Community-Based Services	Individuals eligible for one (1) of the following seven (7) 1915(c) HCBS Waivers: • AIDS/HIV • Brain Injury • CMH • Elderly • Health and Disability • Intellectual Disabilities • Physical Disability Individuals eligible for the 1915(i) Habilitation program.
Independent Foster Care Adolescents	Individuals under age twenty-one (21) who were in State-sponsored foster care on their eighteenth (18th) birthday with income under two hundred and fifty-four percent (254%) FPL.
Infants under Age One (1)	Infants under one (1) year of age eligible in accordance with 42 C.F.R. § 435.118 with income at or below three hundred and seventy-five percent (375%) FPL.
Institutionalized	Individuals who reside in a medical institution (a hospital, NF, psychiatric institution, or ICF/ID) for a full calendar month. Must meet all eligibility requirements for SSI, except that monthly income may be such that they would be ineligible to receive cash assistance through SSI. Income falls below three hundred percent (300%) of the FBR.

POPULATION	DESCRIPTION
Iowa Health and Wellness Plan	Individuals eligible in accordance with the State's Iowa Health and Wellness Plan 1115 waiver. Includes individuals who do not have access to cost-effective Employee Sponsored Insurance (ESI) coverage with income not exceeding one hundred percent (100%) FPL for Iowa Wellness Plan, not exceeding one hundred and thirty-three percent (133%) for Iowa Marketplace Choice, and for Medically Exempt Iowans with income not exceeding one hundred and thirty-three percent (133%) FPL.
Kids with Special Needs	Children under nineteen (19) who are considered disabled based on SSI disability criteria and have gross family income at or below three hundred percent (300%) FPL.
Medicaid for Employed People with Disabilities (MEPD)	Individuals under age sixty-five (65) who are considered disabled, working, and have net family income of less than two hundred and fifty percent (250%) FPL. A premium payment is required for individuals with income over one hundred and fifty percent (150%) FPL. Resource limits apply.
Non-IV-E Adoption Assistance	Individuals eligible in accordance with 42 C.F.R. § 435.227. Child under age twenty-one (21) with a special need for whom there is a non-IV-E adoption assistance agreement in effect.
Parents and Other Caretaker Relatives	Individuals eligible in accordance with 42 C.F.R. § 435.110. A parent or caretaker relative of a dependent child(ren) under age eighteen (18) with income at or below the State's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI equivalent standard.
Pregnant Women	Individuals eligible in accordance with 42 C.F.R. § 435.116. A woman who is pregnant with income at or below three hundred and seventy-five percent (375%) FPL.
Reasonable Classifications of Individuals under Age Twenty-one (21)	Individuals eligible in accordance with 42 C.F.R. § 435.222 and the State Plan. Includes children under age twenty-one (21) placed in licensed foster care for whom non-IV-E foster care maintenance or adoption assistance payments are made.
SSI Recipients	Individuals receiving SSI. Also includes aged, blind and disabled individuals who are ineligible for SSI because of rules that don't apply to Medicaid or would be eligible for SSI if certain conditions were met.
State Supplementary Assistance	Individuals who receive State Supplementary Assistance, a State program that makes a cash assistance payment to certain SSI beneficiaries and people that are not eligible for SSI due to income slightly exceeding the SSI standard.
Transitional Medical Assistance	Persons and families canceled from the family medical assistance program (FMAP) due to the increased earnings of a specified relative of a dependent child. To receive transitional Medicaid coverage, an FMAP family must have received FMAP during at least three (3) of the six (6) months immediately preceding the month in which ineligibility occurred.

Table D.02: Excluded Populations & Services

Non-qualified aliens receiving time-limited coverage of certain Emergency Medical Conditions.
Beneficiaries who have a Medicaid eligibility period that is retroactive.

Persons eligible for the PACE who voluntarily elect PACE coverage.
Persons enrolled in HIPP.
Persons deemed Medically Needy.
Persons incarcerated and ineligible for full Medicaid Benefits.
Persons presumed eligible for services (i.e. Presumptive Eligibility).
Persons residing in the Iowa Veteran's Home.
Effective July 1, 2017, beneficiaries who are eligible only for the Family Planning Waiver.
Persons eligible only for the Medicare Savings Program.
Alaskan Native and American Indian populations shall be enrolled voluntarily.

Exhibit E: Covered Benefits

The Contractor shall provide medically necessary covered Benefits as described in the Contract. Medicaid covered dental services can be found in this Exhibit and are outlined in Iowa Admin. Code ch. 441-78, Iowa Admin. Code ch. 441-86, within the State Plan, and all CMS approved waivers.

The Iowa Medicaid program's benefit for children and adolescents is known as Early and Periodic Screening, Diagnostic and Treatment services, or EPSDT. EPSDT provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children, and adolescents under age twenty-one (21), as specified in Section 1905(r) of the Social Security Act (the Act) and as described in Section F.6.25.

Section I: Dental Wellness Plan

Dental Wellness Plan – Covered Dental Services: Available at this link or its successor.

Dental Wellness Plan – ABM Excluded Services: Available at this link or its successor.

Dental Wellness Plan – Additional Orthodontia Detail: Contractor shall follow the Agency's Orthodontic Administrative Guide (updated July 1, 2022), or its successor, for adjudication of orthodontia services.

Section II: Hawki

The following is a list of services that are payable under the Iowa Hawki Dental Plan.

Code	Diagnostic and Treatment Services
D0120	Periodic oral evaluation
D0140	Limited oral evaluation - problem focused
D0145	Oral evaluation for a child under 3 years of age and counseling with primary caregiver
D0150	Comprehensive oral evaluation
D0160	Detailed and extensive oral evaluation - problem focused, by report
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)
D0171	Re-evaluation - post-operative office visit
D0180	Comprehensive periodontal evaluation - new or established patient
D0190	Screening of a patient – only to be used by non-dentist providers
D0210	Intraoral – complete series (including bitewings)
D0220	Intraoral - periapical first film
D0230	Intraoral - periapical - each additional film
D0240	Intraoral – occlusal film
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector
D0251	Extra-oral posterior dental radiographic image
D0270	Bitewing - single film
D0272	Bitewings - two films
D0273	Bitewings - three films
D0274	Bitewings – four films

D0330	Panoramic film
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis
D0460	Pulp vitality test
Code	**Preventive Services**
D1110	Prophylaxis – Adult
D1120	Prophylaxis – Child
D1206	Topical fluoride varnish
D1208	Topical fluoride application; excluding varnish
D1351	Sealant - per tooth - unrestored permanent premolars and molars
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth
D1353	Sealant repair – per tooth – previously sealed permanent premolars and molars
D1354	Interim caries arresting medicament application
D1510	Space maintainer – fixed – unilateral
D1516	Space maintainer - fixed - bilateral, maxillary
D1517	Space maintainer - fixed - bilateral, mandibular
D1520	Space maintainer - removable – unilateral
D1526	Space maintainer - removable - bilateral, maxillary
D1527	Space maintainer - removable – bilateral, mandibular
D1551	Maxillary – recement or rebond bilateral space maintainer
D1552	Mandibular recement or rebond bilateral space maintainer
D1553	Per quadrant – recement or rebond unilateral space maintainer
D1556	Per quadrant – removal of fixed unilateral space maintainer
D1557	Maxillary – removal of fixed bilateral space maintainer
D1558	Mandibular – removal of fixed bilateral space maintainer
D1575	Distal shoe space maintainer – fixed, unilateral – per quadrant
D1701	Pfizer-BioNTech Covid-19 vaccine administration - first dose
D1702	Pfizer-BioNTech Covid-19 vaccine administration - second dose
D1703	Moderna Covid-19 vaccine administration - first dose
D1704	Moderna Covid-19 vaccine administration - second dose
D1705	AstraZeneca Covid-19 vaccine administration - first dose
D1706	AstraZeneca Covid-19 vaccine administration - second dose
D1707	Janssen Covid-19 vaccine administration
D1708	Pfizer-BioNTech Covid-19 vaccine administration-third dose
D1709	Pfizer-BioNTech Covid-19 vaccine administration-booster dose
D1710	Moderna Covid-19 vaccine administration-third dose
D1711	Moderna Covid-19 vaccine administration-booster dose
D1712	Janssen Covid-19 vaccine administration-booster dose
D1713	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric-first dose
D1714	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric-second dose

D1999	Unspecified preventive procedure, by report; Used for a procedure that is not adequately described by a code. Describe the procedure.
Code	**Restorative**
D2140	Amalgam - one surface, primary or permanent
D2150	Amalgam - two surfaces, primary or permanent
D2160	Amalgam - three surfaces, primary or permanent
D2161	Amalgam - four or more surfaces, primary or permanent
D2330	Resin-based composite - one surface, anterior
D2331	Resin-based composite - two surfaces, anterior
D2332	Resin-based composite - three surfaces, anterior
D2335	Resin-based composite - four or more surfaces (anterior)
D2390	Resin-based composite crown, anterior; Full resin-based composite coverage of tooth.
D2391	Resin-based composite - one surface, posterior
D2392	Resin-based composite - two surfaces, posterior
D2393	Resin-based composite - three surfaces, posterior
D2394	Resin-based composite - four or more surfaces, posterior
D2710	Crown - resin-based composite (indirect)
D2712	Crown - 3/4 resin-based composite (indirect); This procedure does not include facial veneers.
D2720	Crown - resin with high noble metal
D2721	Crown - resin with predominantly base metal
D2722	Crown - resin with noble metal
D2740	Crown - porcelain/ceramic
D2750	Crown - porcelain fused to high noble metal
D2751	Crown - porcelain fused to predominately base metal
D2752	Crown - porcelain fused to noble metal
D2753	Crown - porcelain fused to titanium and titanium alloys
D2780	Crown - 3/4 cast high noble metal
D2781	Crown - 3/4 cast predominately base metal
D2782	Crown - 3/4 cast noble metal
D2783	Crown - 3/4 porcelain/ceramic; This procedure does not include facial veneers.
D2790	Crown - full cast high noble metal
D2791	Crown - full cast predominately base metal
D2792	Crown - full cast noble metal
D2910	Re-cement or re-bond inlay, only, veneer or partial coverage restoration
D2920	Re-cement or re-bond crown
D2921	Reattachment of tooth fragment, incisal edge or cusp
D2928	Prefabricated porcelain/ceramic crown - permanent tooth
D2929	Prefabricated porcelain/ceramic crown – primary tooth
D2930	Prefabricated stainless-steel crown – primary tooth
D2931	Prefabricated stainless-steel crown – permanent tooth

D2932	Prefabricated resin crown
D2933	Prefabricated stainless steel crown with resin window
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth
D2940	Protective restoration
D2950	Core buildup, including any pins
D2951	Pin retention – per tooth, in addition to restoration
D2952	Post and core in addition to crown, indirectly fabricated; Post and core are custom fabricated as a single unit.
D2953	Each additional indirectly fabricated post - same tooth; To be used with D2952.
D2954	Prefabricated post and core, in addition to crown
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework
D2976	Band stabilization - per tooth
D2980	Crown repair necessitated by restorative material failure
D2999	Unspecified restorative procedure, by report; Used for a procedure that is not adequately described by a code. Describe the procedure.
Code	**Endodontic Services**
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament
D3221	Pulpal Debridement
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development
D3310	Anterior root canal (excluding final restoration)
D3320	Bicuspid root canal (excluding final restoration)
D3330	Molar root canal (excluding final restoration)
D3331	Treatment of root canal obstruction; non-surgical access
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth
D3333	Internal root repair of perforation defects
D3346	Retreatment of previous root canal therapy-anterior
D3347	Retreatment of previous root canal therapy-bicuspid
D3348	Retreatment of previous root canal therapy-molar
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3352	Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)
D3353	Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)
D3410	Apicoectomy/periradicular surgery - anterior
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)
D3425	Apicoectomy/periradicular surgery - molar (first root)
D3426	Apicoectomy/periradicular surgery (each additional root)
D3430	Retrograde filling - per root
D3450	Root amputation - per root

D3470	Intentional reimplantation (including necessary splinting)
D3471	Surgical repair of root resorption – anterior
D3472	Surgical repair of root resorption – pre-molar
D3473	Surgical repair of root resorption – molar
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar
D3910	Surgical procedure for isolation of tooth with rubber dam
D3921	Decoronation or submergence of an erupted tooth
D3999	Unspecified endodontic procedure, by report
Code	**Periodontal Services**
D4210	Gingivectomy or gingivoplasty – four or more teeth
D4211	Gingivectomy or gingivoplasty – one to three teeth
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth
D4240	Gingival flap procedure, four or more teeth
D4241	Gingival flap procedure, one to three teeth
D4245	Apically positioned flap
D4249	Clinical crown lengthening-hard tissue
D4260	Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant
D4261	Osseous surgery (including flap entry and closure) – one to three teeth
D4263	Bone replacement graft - retained natural tooth - first site in quadrant
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site
D4268	Surgical revision procedure, per tooth
D4270	Pedicle soft tissue graft procedure
D4273	Subepithelial connective tissue graft procedures (including donor site surgery)
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft
D4276	Combined connective tissue and pedicle graft, per tooth
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each addl.
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each addl.
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each addl.
D4341	Periodontal scaling and root planning – four or more teeth per quadrant
D4342	Periodontal scaling and root planning – one to three teeth per quadrant

D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis
D4910	Periodontal maintenance
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)
D4921	Gingival irrigation with a medicinal agent - per quadrant
D4999	Unspecified periodontal procedure, by report; Used for a procedure that is not adequately described by a code. Describe the procedure.
Code	**Prosthodontic Services**
D5110	Complete denture - maxillary
D5120	Complete denture - mandibular
D5130	Immediate denture - maxillary
D5140	Immediate denture - mandibular
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)
D5213	Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)
D5214	Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)
D5410	Adjust complete denture – maxillary
D5411	Adjust complete denture - mandibular
D5421	Adjust partial denture – maxillary
D5422	Adjust partial denture - mandibular
D5511	Repair broken complete denture base, mandibular
D5512	Repair broken complete denture base, maxillary
D5520	Replace missing or broken teeth – complete denture (each tooth)
D5611	Repair resin partial denture base, mandibular
D5612	Repair resin partial denture base, maxillary
D5621	Repair cast partial framework, mandibular
D5622	Repair cast partial framework, maxillary
D5630	Repair or replace broken retentive/clasping materials – per tooth
D5640	Replace broken teeth – per tooth
D5650	Add tooth to existing partial denture
D5660	Add clasp to existing partial denture – per tooth
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)
D5710	Rebase complete maxillary denture
D5711	Rebase complete mandibular denture
D5720	Rebase maxillary partial denture

D5721	Rebase mandibular partial denture
D5730	Reline complete maxillary denture (direct)
D5731	Reline complete mandibular denture (direct)
D5740	Reline maxillary partial denture (direct)
D5741	Reline mandibular partial denture (direct)
D5750	Reline complete maxillary denture (indirect)
D5751	Reline complete mandibular denture (indirect)
D5760	Reline maxillary partial denture (indirect)
D5761	Reline mandibular partial denture (laboratory)
D5765	Soft liner for complete or partial removable denture – indirect
D5850	Tissue conditioning (maxillary)
D5851	Tissue conditioning (mandibular)
D5862	Precision attachment
D6065	Implant supported porcelain/ceramic crown
D6241	Pontic - porcelain fused to predominately base metal
D6242	Pontic - porcelain fused to noble metal
D6243	Pontic, porcelain fused to titanium and titanium alloys
D6245	Pontic - porcelain/ceramic
D6545	Retainer - cast metal for resin bonded fixed prosthesis
D6740	Crown - porcelain/ceramic
D6750	Crown - porcelain fused to high noble metal
D6751	Crown - porcelain fused to predominately base metal
D6752	Crown - porcelain fused to noble metal
D6753	Retainer crown – porcelain fused to titanium and titanium alloys
D6780	Crown - 3/4 cast high noble metal
D6781	Retainer crown - 3/4 cast predominantly base metal
D6782	Retainer crown - 3/4 cast noble metal
D6783	Retainer crown - 3/4 porcelain/ceramic
D6784	Retainer Crown ¾ - titanium and titanium alloys
D6790	Crown - full cast high noble metal
D6791	Crown - full cast predominately base metal
D6792	Crown - full cast noble metal
D6920	Connector bar
D6930	Re-cement or re-bond fixed partial denture
D6940	Stress breaker
D6950	Precision attachment
D6930	Recement or re-bond fixed partial denture
D6980	Fixed partial denture repair, by report
Code	**Oral Surgery**
D7111	Extraction, coronal remnants – primary tooth

D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220	Removal of impacted tooth - soft tissue
D7230	Removal of impacted tooth – partially bony
D7240	Removal of impacted tooth - completely bony
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications
D7250	Removal of residual tooth roots (cutting procedures)
D7241	Removal of impacted tooth - completely bony with unusual surgical complications
D7250	Surgical removal of residual tooth roots (cutting procedure)
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280	Surgical access of an unerupted tooth
D7282	Mobilization of erupted or malpositioned tooth to aid eruption
D7283	Placement of device to facilitate eruption of impacted tooth
D7284	Excisional biopsy of minor salivary glands
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)
D7286	Incisional biopsy of oral tissue – soft
D7287	Exfoliative cytological sample collection
D7288	Brush biopsy - transepithelial sample collection
D7291	Transeptal fiberotomy/supra crestal fiberotomy, by report
D7310	Alveoloplasty in conjunction with extractions - per quadrant
D7311	Alveoloplasty in conjunction with extractions-1-3 teeth or tooth spaces, per quadrant
D7320	Alveoloplasty not in conjunction with extractions - per quadrant
D7321	Alveoloplasty not in conjunction with extractions-1-3 three teeth or tooth spaces, per quad
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
D7471	Removal of exostosis
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis
D7485	Reduction of osseous tuberosity
D7509	Marsupialization of odontogenic cyst
D7510	Incision and drainage of abscess - intraoral soft tissue
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)
D7530	Removal of foreign body
D7910	Suture of recent small wounds up to 5 cm.
D7911	Complicated sutures up to 5 cm.
D7912	Complicated suture - greater than 5 cm
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site
D7961	Buccal / labial frenectomy (frenulectomey)

D7962	Lingual frenectomy (frenulectomy)
D7963	Frenuloplasty
D7970	Excision of hyperplastic tissue - per arch
D7971	Excision of pericoronal gingiva
D7999	unspecified oral surgery procedure, by report
Code	**Orthodontics**
D8020	Limited orthodontic treatment of the transitional dentition
D8070	Comprehensive orthodontic treatment of the transitional dentition
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8210	Removable appliance therapy
D8220	Fixed appliance therapy
D8660	Pre-orthodontic treatment examination to monitor growth and development
D8680	Orthodontic retention
D8701	Repair of fixed retainer, includes reattachment - maxillary
D8702	Repair of fixed retainer, includes reattachment - mandibular
D8703	Replacement of lost or broken retainer - maxillary
D8704	Replacement of lost or broken retainer - mandibular
D8999	Unspecified orthodontic procedure, by report
Code	**Adjunctive General Services**
D9110	Palliative treatment of dental pain – minor procedure
D9222	Deep sedation/general anesthesia – first 15 minutes
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician
D9995	Teledentistry - synchronous
D9996	Teledentistry - asynchronous
D9999	Unspecified adjunctive procedure, by report; Used for a procedure that is not adequately described by a code. Describe the procedure.

Exhibit F: Program-Specific Cost Sharing and Annual Benefit Maximum (ABM) Requirements

Section I: Annual Benefit Maximum (ABM) - Overview

DWP Enrolled Members aged twenty-one (21) years and over and Hawki Enrolled Members are limited to an Annual Benefit Maximum (ABM) of $1,000 per State fiscal year (July 1 - June 30). ABM is determined using the Medicaid FFS rates, regardless of reimbursement rate to providers.

Section II: Annual Benefit Maximum (ABM) – Dental Wellness Plan

The DWP ABM does not apply to preventive, diagnostic, emergency, anesthesia in conjunction with oral surgery approved codes, and fabrication of removable denture services. A list of excluded ABM services can be found Exhibit E. If a member reaches the $1,000 ABM and receives additional services that are not excluded services from the ABM, the DWP member is responsible for payment of services. If the member's ABM is met, services that meet medically necessity can still be received through an exception to policy.

DWP Enrolled Members under aged twenty-one (21) years do not have an ABM as part of their dental package and are limited to cost-sharing requirements established by federal EPSDT guidance.

Section III: Annual Benefit Maximum (ABM) – Hawki

The Hawki dental ABM applies to all covered services a member receives, except medically necessary orthodontia services and services considered emergent. If the member's ABM is met, services that meet medically necessity can still be received through an exception to policy.

Section III: Emergency Dental Services Beyond the Annual Benefit Maximum

Regardless of whether an Enrolled Member has reached their ABM under this Contract, the Contractor is required to cover Emergency and Post-Stabilization Services as outlined in Section F.1.

Treatment of Emergency Dental Conditions beyond the Annual Benefit Maximum may be covered by in-network and out-of-network providers.

Section IV: Federally Qualified Health Center (FQHC) and Annual Benefit Maximum

Contractor shall pay FQHC's the full encounter rate for Enrolled Members who have not reached their full Annual Benefit Maximum (ABM). Once the ABM has been reached fully, all future encounter payments submitted by the FQHC would be denied for exceeding the ABM, save for medically necessary services and services provided to treat an Emergency Dental Condition as outlined above.

Special Contract Amendment – SFY2025 Rates

MCNA - DWP
SFY25 Rate Sheet
Rates Effective July 1, 2024 - June 30, 2025

	Withhold Summary			
Rate Cell	**SFY25 Rate**	**Withhold %**	**Withhold PMPM**	**SFY25 Rate Net Withhold**
Children 0-1	$ 3.89	2.0%	$ 0.08	$ 3.81
Children 2-5	$ 17.36	2.0%	$ 0.35	$ 17.01
Children 6-18	$ 18.31	2.0%	$ 0.37	$ 17.94
Community and LTSS Disabled	$ 13.63	2.0%	$ 0.27	$ 13.36
Community and LTSS Elderly	$ 6.40	2.0%	$ 0.13	$ 6.27
Community Duals <65	$ 12.37	2.0%	$ 0.25	$ 12.12
Pregnant Women	$ 5.55	2.0%	$ 0.11	$ 5.44
TANF 19-34 F	$ 12.84	2.0%	$ 0.26	$ 12.58
TANF 19-34 M	$ 8.39	2.0%	$ 0.17	$ 8.22
TANF 35-49 F	$ 13.38	2.0%	$ 0.27	$ 13.11
TANF 35-49 M	$ 9.27	2.0%	$ 0.19	$ 9.08
TANF 50+	$ 13.31	2.0%	$ 0.27	$ 13.04
Wellness Plan 19-34 F	$ 9.50	2.0%	$ 0.19	$ 9.31
Wellness Plan 19-34 M	$ 6.56	2.0%	$ 0.13	$ 6.43
Wellness Plan 35-49 F	$ 11.75	2.0%	$ 0.24	$ 11.51
Wellness Plan 35-49 M	$ 8.19	2.0%	$ 0.16	$ 8.03
Wellness Plan 50+	$ 10.73	2.0%	$ 0.21	$ 10.52

MED-25-011 MCNA Ins NEW full

Final Audit Report 2024-06-27

Created:	2024-06-27
By:	Laura Myers (lmyers@dhs.state.ia.us)
Status:	Signed
Transaction ID:	CBJCHBCAABAAOecpwfykgnDaZdb4Wc7BHD0soa2NkXwg

"MED-25-011 MCNA Ins NEW full" History

Document created by Laura Myers (lmyers@dhs.state.ia.us)
2024-06-27 - 6:43:25 PM GMT- IP address: 207.165.23.74

Document emailed to Kelly Garcia (kgarcia@dhs.state.ia.us) for signature
2024-06-27 - 6:45:25 PM GMT

Document e-signed by Kelly Garcia (kgarcia@dhs.state.ia.us)
Signature Date: 2024-06-27 - 9:43:04 PM GMT - Time Source: server- IP address: 207.165.23.112

Agreement completed.
2024-06-27 - 9:43:04 PM GMT