CONTRACT DECLARATIONS AND EXECUTION

Procurement Type/Number	Contract #
RFP #MED-26-001	MEDIOMC26002

Title of Contract
Iowa Health Link

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 Lucas State Office Building 321 E. 12th Street Des Moines, IA 50319-1002	**Agency Billing Contact Name / Address:** Carol Mau Lucas State Office Building Iowa Department of Health and Human Services 321 E. 12th Street Des Moines, IA 50319-1002 **Phone:** 515-587-8182
Agency Contract Manager (hereafter "Contract Manager") /Address ("Notice Address"): Carol Mau Lucas State Office Building Iowa Department of Health and Human Services 321 E. 12th Street Des Moines, IA 50319-1002 **Phone:** 515-587-8182 **E-Mail:** carol.mau@hhs.iowa.gov	**Agency Contract Owner (hereafter "Contract Owner") / Address:** Kera Oestreich Iowa Department of Health and Human Services Lucas State Office Building 321 E. 12th Street Des Moines, Iowa 50319-1002 **E-Mail:** kera.oestreich@hhs.iowa.gov

Contractor: (hereafter "Contractor")	
Legal Name: Iowa Total Care, Inc.	**Contractor's Principal Address:** 1080 Jordan Creek Parkway, Suite 400 South West Des Moines, Iowa 50266
Tax ID #: 46-4829006	**Organized under the laws of:** State of Iowa
Contractor's Contract Manager Name/Address ("Notice Address"): Mitch Wasden Plan President and Chief Executive Officer 1080 Jordan Creek Parkways, Suite 400 South West Des Moines, Iowa 50266 **Phone:** 515-412-6000 **E-Mail:** Mitch.Wasden@iowatotalcare.com	**Contractor's Billing Contact Name/Address:** Mitch Wasden Plan President and Chief Executive Officer 1080 Jordan Creek Parkways, Suite 400 South West Des Moines, Iowa 50266

Contract Information	
Start Date: 7/1/2025	**End Date of Base Term of Contract:** 6/30/2029
Possible Extension(s): This Contract may be extended for one (1) two-year term.	
Contractor a Business Associate? Yes	**Contract Warranty Period (hereafter "Warranty Period"):** The term of this Contract, including any extensions.
Contract Include Sharing SSA Data? No	**Contract Payments include Federal Funds?** Yes
Contractor subject to Iowa Code Chapter 8F? No	**Contract Contingent on Approval of Another Agency:** Yes **Which Agency?** CMS
Contractor a Qualified Service Organization? Yes	**ISPO Number:** DPSOR2024-05
Security & Privacy Office Data Confirmation Number: 17-7	**DoIT Number:** N/A

Contract Payments include Federal Funds? Yes **UEI #: CXEJB873WLN7** **The Name of the Pass-Through Entity:** Iowa Department of Health and Human Services	
ALN #: 93.778 Title XIX: The Medical Assistance Program	**Federal Awarding Agency Name:** Centers for Medicare and Medicaid Services (CMS)
ALN #: 93.767 Children's Health Insurance Program	**Federal Awarding Agency Name:** Centers for Medicare and Medicaid Services (CMS)

This Contract consists of the above information, the attached General Terms for Services Contracts, Special Terms, and all Special Contract Attachments.

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, Iowa Total Care, Inc.	**Agency, Iowa Department of Health and Human Services**
Signature of Authorized Representative:	Signature of Authorized Representative:
Printed Name: Mitch Wasden	Printed Name: Kelly Garcia
Title: CEO/Plan President – Iowa Total Care	Title: Director of Iowa Department of Health and Human Serivces
Date: March 31, 2025	Date: 4\16\2025

Table of Contents

SECTION 1: SPECIAL TERMS

1.1 Special Terms Definitions.
See Section 5 Special Contract Exhibits, Exhibit B: Glossary of Terms/Definitions.

1.2 Contract Purpose.
The purpose of the Contract is to deliver high-quality healthcare services for the Iowa Medicaid, Iowa Health and 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) Enrolled Members while leveraging the strength and success of current initiatives. The Program has been designed to emphasize Enrolled Member choice, Access, safety, independence, and responsibility. Contractors shall provide high quality healthcare services in the least restrictive manner appropriate to an Enrolled Member's health and functional status. Contractors shall be responsible for delivering covered Benefits, including physical health, behavioral health and Long Term Support Services (LTSS) in a highly coordinated manner. The Program is intended to integrate care and improve quality Outcomes and efficiencies across the healthcare delivery system, in turn decreasing costs through the reduction of unnecessary, inappropriate, and duplicative services.

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 2" of the Contract). Section 1.9 incorporates by reference the Agency's Contingent Terms for Services Contracts ("Section 3" of the Contract). Section 4 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 MCO 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.
See Section 4: Program Specific Statements
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 4. If there is a conflict between the provisions of this Section and the provisions of Section 4, Section 4 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 Inspection and Audit of Records and Access to Facilities. The Agency, Centers for Medicare & Medicaid Services, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of an MCO, PIHP, PAHP, PCCM or PCCM entity, or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the Contract period or from the date of completion of any audit, whichever is later. See 42 CFR Ch. IV, subchapter C, Pt. 438, Subpart A, 438.2 for definitions of the acronyms herein.

1.3.2.4 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.

1.3.2.5 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) or upon occurrence of a qualifying maternity delivery. The capitation payments include both per member per month capitation rates and maternity case rate payments, as further defined in this section. The capitation payments and any Case rate shall be payment in full for goods and services provided pursuant to this Contract. Retroactive adjustments to the capitation rates/payments 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 Exhibits, Exhibits A and G.

The parties anticipate Contractor to begin providing managed care services to its assigned Medicaid population on July 1, 2025. 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 managed care 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 enrollee 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, 2026. The MCO determines that it does not want to agree to continue with the managed care contract and provides Notice of Termination on January 1, 2026. Because the parties are currently performing under agreed rates that run through June 30, 2026, the first day of the ninety (90) day notice period is July 1, 2026 – the first day of the new rate period. The effective date of contract termination is September 30, 2026 – 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, 2027. The Agency and MCO 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, 2027. The first day of the ninety (90) day notice period is August 1,

2027. The last day of the notice period is October 31, 2027 – 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.

In addition to the monthly capitation payment made to Contractor, the Agency will also make a payment to Contractor when a Medicaid member assigned to the Contractor gives birth and the member is in the population designated in the Contract's then current rate sheet as subject to a payment for giving birth. The amount of this payment, commonly referred to as a "maternity case rate payment," shall be in an amount established as part of the capitation rate-setting process and included in the rate sheet applicable to the given Contract period. To receive payment the Contractor must:

1) Supply documentation of the birth in a form and format determined by the Agency in accordance with the specifications described in the MCO Interface Guide.
2) Attest that the Contractor paid the provider for the entire delivery. If the delivery was covered entirely by a third-party insurer the Agency will not reimburse the Contractor for the 'maternity case rate payment'.
3) Ensure that the delivery and payment to the provider are recorded in accepted encounter data.
4) Ensure that 'maternity case rate payment' is submitted in accordance with Section G.2.05 of the Contract.
    a. When an enrolled member disenrolls to another contractor during an inpatient stay, the contractor of record maintains financial responsibility. For example, delivery and newborn expenses that occur prior to July 1 will be the responsibility of the contractor of record on June 30.

Upon verification by the Agency of the birth, the Agency shall cause the maternity case rate payment to be made separately and apart from the usual capitation payment for contracted services. Contractor shall diligently monitor births in its assigned Medicaid population and claim a maternity case rate payment for each birth in the assigned Medicaid population for which a maternity case rate payment is available no later than sixty (60) Days following the date on which the Contractor was

made aware of the birth. The Agency shall have no obligation to pay a maternity case rate payment for a birth that occurred more than two hundred ten (210) Days prior to Contractor's claim for a maternity case rate payment.

The Agency shall periodically evaluate accepted encounter data for Health Link enrolled beneficiaries where the Agency paid the Contractor a 'maternity case rate payment'. If the evaluation identifies instances where the encounter data does not support the payment for the delivery event, the Agency may recoup the "maternity case rate payment".

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 select prescription drugs and treatments as set forth in Special Contract Exhibits, Exhibit A. Contractor shall continue to provide coverage for these pharmaceuticals and treatments, and the Agency will reimburse the Contractor based on Contractor's invoice to the Agency for Special Contract Exhibits, Exhibit A pharmaceuticals or treatments paid. Contractor may only invoice for the lower of (1) actual cost to the Contractor, (2) actual cost to Contractor's PBM, or (3) the actual cost paid for the drug. All such invoices must be submitted by Contractor within 12 months of the date of service, with the exception of coordination of benefits situations, in which Contractor shall invoice for these pharmaceuticals or 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 pharmaceutical or treatment, or the amount the Contractor actually paid for the pharmaceutical or 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 of these drugs. At minimum, Contractor's invoice must include claim level detail sufficient to support the invoices. The selected prescription drugs 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 prescription drug 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 Graduate Medical Education (GME) Payments and Other Supplemental Payments.
To the extent there are supplemental payments identified in the rate sheet and associated actuarial certification, Contractor shall pass these payments through to the identified providers as directed by the Agency. Such payments may include Graduate Medical Education, Ground Emergency Medical Transportation, the University of Iowa Average Commercial Rate supplemental payment, or any other such directed payments or pass-through payments as identified in the rates.

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, 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 and timeliness of Invoices before making payment. The Agency will not pay Invoicesthat are not considered timely as defined in this Contract. If the Contractor wishes for untimely Invoice (s) to be considered for payment, the Contractor may submit Invoice(s) in accordance with the instructions for the Long Appeal Board Process to the State Appeal Board for consideration. Instructions for this process may be found at:
http://www.dom.state.ia.us/appeals/general_claims.html.

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 State 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	$15 Million
	Product/Completed Operations Aggregate	$15 Million
	Personal Injury	$15 Million

	Each Occurrence	$5 Million
Automobile Liability (including any auto, hired autos, and non-owned autos)	Combined Single Limit	$1 Million
Excess Liability, Umbrella Form	Each Occurrence Aggregate	$5 Million $15 Million
Workers' Compensation and Employer Liability	As required by Iowa law	As Required by Iowa law
Property Damage	Each Occurrence Aggregate	$2 Million $5 Million
Professional Liability	Each Occurrence Aggregate	$5 Million $5 Million

Subcontractors 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 Product/Completed Operations Aggregate Personal Injury Each Occurrence	$2 Million $1 Million $1 Million $1 Million
Automobile Liability (including any auto, hired autos, and non-owned autos)	Combined Single Limit	$1 Million
Excess Liability, Umbrella Form	Each Occurrence Aggregate	$1 Million $1 Million
Workers' Compensation and Employer Liability	As required by Iowa law	As Required by Iowa law
Property Damage	Each Occurrence Aggregate	$1 Million $1 Million
Professional Liability	Each Occurrence Aggregate	$2 Million $2 Million

1.5 Data and Security.

If this Contract involves Confidential Information, the following terms apply:

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

- Provide certification of compliance with either of the following security frameworks: NIST SP 800-53, NIST Cybersecruity Framework, HITRUST, HIPAA/HITECH, COBIT, CSA STAR, ,

ISO 27001, SOC 2 Type II, CIS Controls orPCI-DSS prior to implementation of the system and again 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/inititiatives/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.

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 athttps://hhs.iowa.gov/inititiatives/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. The Contingent Terms for Service Contracts may be referred to as Section 3.

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

Contractor a Business Associate? Yes	**Contractor a Qualified Service Organization?** Yes

Contractor subject to Iowa Code Chapter 8F? No	**Contract Includes Software (modification, design, development, installation, or operation of software on behalf of the Agency)?** Yes
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 #:** CXEJB873WLN7 **The Name of the Pass-Through Entity:** Iowa Department of Health and Human Services	
ALN #: 93.778 **Grant Name:** Title XIX: The Medical Assistance Program	**Federal Awarding Agency Name:** Centers for Medicare and Medicaid Services (CMS)
ALN #: 93.767 **Grant Name:** Children's Health Insurance Program	**Federal Awarding Agency Name:** Centers for Medicare and Medicaid Services (CMS)

SECTION 2: GENERAL TERMS FOR SERVICES CONTRACTS

The version of the General Terms for Services Contracts Section posted to the Agency's website at https://hhs.iowa.gov/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.

SECTION 3: CONTINGENT TERMS FOR SERVICES CONTRACTS

The version of the Contingent Terms for Services Contracts posted to the Agency's website at https://hhs.iowa.gov/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.

SECTION 4: PROGRAM-SPECIFIC STATEMENTS

A. General

A.01. *Effects of the Federal Waiver.* The Contract is contingent upon continued federal approval of the State's § 1915(b) 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) in accordance with Iowa Admin. Code ch. 191-40. As a strategy to facilitate continuity of care for Enrolled Members who move between Medicaid and premium tax credit eligibility, the Contractor may, but is not required to be, a qualified health plan (QHP) issuer certified by the Iowa Health Insurance Exchange, as defined at 45 C.F.R. § 155.20.

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) behavioral and physical health; (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 Care Coordination and Community-Based Case Management services are based in Iowa at locations that will facilitate the delivery of in-person services 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) *Medical Director*: Shall be an Iowa-licensed physician in good standing. Shall ensure oversight of all clinical functions including, but not limited to, disease management and Care Coordination programs, the development of clinical care guidelines and UM. 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 Program.
    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 Program. 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) *Pharmacy Director/Coordinator:* Shall be an Iowa licensed pharmacist who oversees the pharmacy Benefits under the Contract. Shall have experience as a Medicaid Pharmacy Director or equivalent Medicaid pharmacy experience, inclusive of Drug Rebate. Shall ensure oversight and coordination of all Contractor and PBM pharmacy requirements including Drug Rebate. Shall attend the Agency Pharmaceutical & Therapeutics (P&T) Committee and Drug Utilization Review (DUR) Commission meetings.
    7) *Grievance & Appeals Manager*: Manages the Contractor's Grievance and Appeals process, ensuring compliance with processing timelines and policy and procedure adherence.
    8) *Quality Management Manager*: Shall be an Iowa licensed registered nurse, physician or physician's assistant or a Certified Professional in Healthcare Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or Certified in Health Care Quality and Management (HCQM) by the American Board of Quality Assurance and

Utilization Review Physicians. The QM Manager shall oversee the Contractor's Quality Management and Improvement program and ensure compliance with Quality management requirements and Quality improvement initiatives.

9) *Utilization Management Manager*: Shall be an Iowa licensed registered nurse, physician or physician's assistant if required to make medical necessity determinations. This position manages all elements of the Contractor's UM program and staff under the supervision of the Medical Director. This includes but is not limited to functions related to Prior Authorization, medical necessity determinations, concurrent and retrospective reviews, and other clinical and medical management programs as described in the Contract.
10) *Behavioral Health Manager*: Shall be an Iowa licensed behavioral health professional such as a psychologist, psychiatrist, social worker, psychiatric nurse, marriage and family therapist or mental health counselor, with experience in both mental health and substance use disorder services. The Behavioral Health Manager shall ensure that the Contractor's behavioral health operations, which include the operations of any behavioral health Subcontractors, are in compliance with the terms of the Contract. The Behavioral Health Manager shall coordinate with all functional areas, including Quality management, UM, Network development and management, Provider relations, Member outreach and education, Member services, Contract compliance and reporting. If the Contractor subcontracts with a behavioral health organization (BHO) to provide Behavioral Health Services, the Behavioral Health Manager will continue to work closely with the Contractor's other managers to provide monitoring and oversight of the BHO and to ensure the BHO's compliance with the Contract.
11) *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.
12) *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.
13) *Information Systems (IS) Manager*: Serves as a liaison between the Contractor and the Agency, or its Designee, regarding Enrollee 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 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.
14) *Claims Administrator*: Shall ensure prompt and accurate Provider Claims processing in accordance with the terms of the Contract.
15) *Care Coordination Manager*: Shall ensure oversight of the Contractor's Care Coordination and Community-Based Case Management programs. The Care Coordination Manager shall, at a minimum, be a registered nurse or other medical professional with extensive experience in providing Care Coordination to a variety of populations. The individual will be shall oversee Care Coordination and Community-Based Case Management teams, care plan development and care plan implementation.

16) *Program Integrity Manager and Special Investigations Unit (SIU) Staffing.* Shall ensure oversight of the Contractor's SIU activity. The Contractor shall ensure that the qualifications of the Program Integrity Manager are equal to those of the Agency Program Integrity Director. 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 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 IME 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.

17) *LTSS Manager:* Shall ensure oversight of the Contractor's implementation of the State's community based and facility programs. The LTSS Manager shall, at minimum, have at least five (5) years of experience in LTSS policy and have a comprehensive understanding of CMS rules and regulations. The LTSS Manager shall oversee long-term care Provider reviews, Utilization Reviews, Enrolled Member satisfaction surveys, and Enrolled Member health and welfare.

18) *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, including but not limited to those described in SIM. 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 healthcare delivery system in Iowa.

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 & Concurrent Review Staff	Authorize requests for services and conduct inpatient concurrent review.
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.
Community-Based Case Managers	Ensure Enrolled Member needs are met, manages resources effectively, and ensure Enrolled Member's health, safety, and welfare are met. Assist the Enrolled Members in gaining Access to appropriate resources. Recommend staff have bachelor's degree in social work or related field or commensurate experience and experience with the Iowa Medicaid program.
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 (10th) 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 10th or the 15th 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 50% of local staff in each functional area of Contract performance within one hundred 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) in accordance with 42 C.F.R. § 422.128, training on the Contractor's policies and procedures on advance directives; (iii) initial and ongoing training on identifying and handling Quality of care concerns; (iv) cultural sensitivity training; (v) training on Fraud and Abuse and the False Claims Act as further described in Section I; (vi) HIPAA training; (vii) clinical protocol training for all clinical staff; (viii) training regarding interpretation and application of UM guidelines for all UM staff; (ix) assessment processes, person-centered planning and population specific training relevant to the enrolled populations for all care managers; (x) training and education to understand Abuse, neglect, exploitation and prevention including the detection, mandatory reporting, investigation and remediation procedures and requirements; and (xi) training specific to Iowa LTSS 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 50% of all work under the Contract in each functional area performed locally in Iowa, with less than 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 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) *Family Well Being and Protection.* This department has oversight of: Child Care; Child Protection and Services; and Early Intervention and Support.
c) *Iowa Department of Education*. The Contractor shall work closely with the Iowa Department of Education.
d) *Behavioral Health and Disability Services.* This department has oversight of: Community-Based Prevention, Services, and Integration for People with Disabilities; Performance, Innovation and Mental Health.
e) *Community Access.* This department has oversight of: Child Support Services; Eligibility; Wellness and Preventive Health.
f) *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 facility or Provider closure.
g) *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, (iii) Decategorization Boards; (iv) MHDS regions; (v) local public health entities; (vi) job training, placement and vocational service agencies; (vii) judicial districts; and (viii) the Iowa Department of Corrections. The Agency will work with the Contractor to prioritize community-based efforts to support the success of the Program.
h) *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.
i) *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.
j) *Iowa Insurance Division*. To the extent the Contractor participates in the Iowa individual health insurance market, the Contractor shall make a good faith effort to cooperate with and work with the Iowa Insurance Division, other Program Contractors, Subcontractors, State agencies and third-party representatives to provide statewide coverage in Iowa's individual health insurance market for the duration of the Contract.
k) *Estate Recovery*. Contractor must coordinate activities and cooperate with the Department's Estate Recovery contractor.
l) *Dental Pre-paid Ambulatory Health Plans (PAHPs)*. The dental PAHPs provide care for Enrolled Member's dental health. The Contractor shall cooperate and collaborate with the PAHPs 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 Program 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 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 State 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 State. 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 State.

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 State. The Contractor shall transfer this relevant knowledge during implementation to staff who will be responsible for implementing the Contract.

A.22. *Response to State 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 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 all e-mailed, voice mail, and other inquiries within two (2) business days of receipt.
g) The Contractor shall provide final resolution of 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. 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. *Participation in Hope and Opportunity in Many Environments (HOME) Project Design and Implementation Activities.*
As directed by the Agency, the Contractor shall:

a) Participate in MCO workgroups convened by the Agency related to the design and implementation of HOME;
b) Provide input and feedback to the MCO workgroups convened by the Agency related to Member and Provider materials, policy guidance, and specifications;
c) Educate the Contractor's staff, including but not limited to Member Services and Community-Based Case Managers, about HOME implementation;
d) Provide information about HOME implementation to Enrolled Members;
e) Develop HOME project-related Provider communications, trainings, and guidance per Sections E.01, E.04, E.1.03, E.1.04;
f) Perform provider education activities related to HOME implementation;
g) Perform Health Information System updates related to HOME implementation; and
h) Participate in Readiness Review activities related to HOME implementation, as further defined by the Agency.

All expenses related to this subsection are considered to be included in the capitation rates and shall be at no additional cost to the Agency.

B. Enrollment and Disenrollment

B.01. *Eligible for MCO Enrollment.* Persons eligible for enrollment with the Contractor are set forth in Special Contract Exhibit D. The State 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 State with information the Contractor believes indicates that the Enrolled Member's eligibility has changed.

B.02. *MCO Selection and Assignment.* Enrollment with an MCO 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 Medicare, facility placements, and 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 State-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 Enrollees.* 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 stereostypes. 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 1915(b) waiver entitled The Iowa High Quality Healthcare Initiative. See: 42 C.F.R. § 438.3(d)(2). {From CMSC B.3.01}.

B.4 Reenrollment

B.4.01. *Auto-Reenrollment.* Pursuant to Iowa Medicaid's 1915(b) waiver, the Agency automatically reenrolls in the same MCO 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, inclusive of LTSS Providers. 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 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 MCO must provide evidence to the State 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 MCO is required to have methods by which the State is assured that Disenrollment is not requested for another reason. The State 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. *Enrollee 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. *Enrollee Rights – Disenrollment Without Cause.* Enrolled Members have the right to disenroll from their Contractor without cause when the State imposes intermediate sanctions on the Contractor. See: 42 C.F.R. § 438.3(q)(5); 42 C.F.R. § 438.56(c)(2)(iv); 42 C.F.R. § 438.702(a)(4); 42 C.F.R. § 1201(m); 42 C.F.R. § 457.1212. {From CMSC B.5.11}.

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. *Enrollee 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. Under 42 C.F.R. § 438.56(d)(2)(iii), an example of "related services" is a cesarean section and a tubal ligation. 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. *Enrollee Disenrollment – LTSS Changes in Status.* Enrolled Members who use Managed LTSS may request Disenrollment if a Provider's change in status from an in-network to an Out-of-Network Provider with the Contractor would cause the Enrolled Member to have to change their residential, institutional, or employment supports Provider, and, as a result, the Enrolled Member would experience a disruption in their residence or employment. See: 42 C.F.R. § 438.56(d)(2)(iv); 42 C.F.R. § 457.1201(m); 42 C.F.R. § 457.1212. {From CMSC B.5.15}.

B.5.10. *Enrollee 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 State. 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 State), the Disenrollment is considered approved for the effective date that would have been established had the State 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 Enrollees in a manner and format that may be easily understood and is Readily Accessible by such Enrolled Members, authorized representatives, and Potential Enrollees. 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 Enrollees.* Contractor shall comply with all information request of the Agency or its contracted representatives that is required for the development of information for Potential Enrollees.

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 Member Helpline and the twenty-four (24) hour Nurse Call Line;
c) Description of how to complete a health risk screening, a process described in Section G.2;
d) If applicable, any cost-sharing information, including Client Participation responsibilities for 1915(c) HCBS Waiver Enrolled Members, 1915(i) program Enrolled Members, ICF/ID, and NF residents, and contact information where the Enrolled Member can ask questions regarding their cost-sharing obligations and consequences for failure to comply with cost sharing and Client Participation requirements;
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 health 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;
l) Contact information and description of the role of the Ombudsman; and
m) For Enrolled Members enrolled in a 1915(c) HCBS Waiver or 1915(i) State Plan, the Contractor shall also provide the following information:
    1. A description of the Community-Based Case Management's or Integrated Health Home (IHH) care coordinator's roles and responsibilities;
    2. Information on how to change Community-Based Case Management or IHH Care Coordination; and
    3. When applicable, information on the option to self-direct, a process described in Section F.12D, including but not limited to: (i) the roles and responsibilities of the Enrolled Member; (ii) the ability of the Enrolled Member to select a representative; (iii) the services that can and cannot be self-directed; (iv) the Enrolled Member's right to participate and voluntarily withdraw; (v) how to select the self-direction option; and (vi) who can and cannot be hired by the Enrolled Member to perform the services; and information on estate recovery.

C.1.04. *Health Education and Initiatives.* Contractor's communication initiatives shall include information on programs and how Enrolled Members can participate in activities to enhance the general health and well-being of Enrolled Members. The Contractor shall develop a strategy to participate in and interface with the Healthiest State Initiative. The Contractor shall obtain Agency approval of an approach to support the MHDS Redesign. The Contractor shall implement and adhere to the Agency-approved approach. Changes to this approach shall receive the Agency's prior approval.

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 Health Care Services and inform health care decision-making. 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 Health and 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). To maintain Enrolled Member confidentiality, EOBs shall not be sent on family planning services.

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. 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 Enrollees 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 healthcare services, the Member services helpline shall be used by all Enrolled Members, regardless of whether the Enrolled Member is calling about physical health, behavioral health and/or long-term care services. The Contractor shall not have separate numbers for Enrolled Members to call regarding behavioral health and/or long-term care services. 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 behavioral health and/or long-term care services.

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 two (2) business days. The Contractor shall have the ability to Warm Transfer Enrolled Members to outside entities, such as Provider offices, and internal Contractor departments, such as to care coordinators, 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 Health Care 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) health crises, including but not limited to, suicidal callers; (vii) balance billing issues; (viii) cost-sharing and Client Participation 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. *Nurse Call Line.* The Contractor shall operate a toll-free Nurse Call Line which provides nurse triage telephone services for Enrolled Members to receive medical advice twenty-four (24) hours a day/seven (7) days a week from trained medical professionals. The Nurse Call Line shall be well publicized and designed as a resource to Enrolled Members to help discourage inappropriate emergency room use. The Nurse Call Line shall have a system in place to communicate all issues with the Enrolled Member's health care Providers, as applicable. The Contractor shall have a written protocol specifying when a physician must be consulted in response to a call received. Calls requiring a medical decision shall be forwarded to the on-call physician, and a response to each call which requires a medical decision shall be provided by the physician within thirty (30) minutes.

C.1.18. *Redetermination Assistance*. The Contractor shall assist its Enrolled Members in the eligibility redetermination process. The Contractor shall conduct the following redetermination assistance activities: (i) conduct outreach calls or send letters to Enrolled Members reminding them to renew their eligibility; (ii) assist the Enrolled Member in understanding the redetermination process; and (iii) help the Enrolled Member obtain required documentation and collateral verification needed to process the application. In providing redetermination assistance, the Contractor shall not engage in any of the following activities: (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, these calls shall be referred to the Enrollment Broker; (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 shall:

a) Be available in alternative formats upon request of the Potential Enrollee or Enrolled Member at no cost.
b) Include taglines in the Prevalent non-English languages in the State, as well as Large Print, 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, as well as Large Print, explaining the availability of 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.1.06}.

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 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 Enrollee or Enrolled Member at no cost. See: 42 C.F.R. § 438.10(d)(3); 42 C.F.R. § 457.1207. {From CMSC C.1.07}.

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 State identifies as Prevalent. See: 42 C.F.R. § 438.10(d)(4); 42 C.F.R. § 457.1207. {From CMSC C.1.08}.

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.1.09 - C.1.11}.

C.1.25. *Easily Understood Standard.* Contractor shall provide all written materials for Potential Enrollees 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.1.12}.

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 Enrollees and Enrolled Members in a font size no smaller than twelve (12) point.
b) Make written materials for Potential Enrollees and Enrolled Members available in alternative formats in an appropriate manner that takes into consideration the special needs of Enrolled Members or Potential Enrollees with disabilities or Limited English Proficiency (LEP).
c) Make written materials for Potential Enrollees 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 Enrollees with disabilities or LEP.
d) Include on all written materials a Large Print tagline and information on how to request auxiliary aids and services, including materials in alternative formats.

See: 42 C.F.R. § 438.10(d)(6)(ii) - (iv); 42 C.F.R. § 457.1207. {From CMSC C.1.13 - C.1.16}.

C.2 Enrollee Handbook

C.2.01. *State-Developed Handbook.* Contractor shall use the State developed model Enrollee 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 Enrollee handbook, which serves as a summary of Benefits and coverage, and Member Identification (ID) card 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 Enrollee 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 Enrollee handbook developed by the State 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 State, 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 State.
d) About how transportation is provided for any Benefits carved out of the Contractor Contract and provided by the State.

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 Enrollee handbook developed by the State 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 State 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 Enrollee handbook developed by the State 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 Enrollee handbook developed by the State 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 Enrollee handbook developed by the State that includes:

a) How emergency care is provided.

b) Information regarding what constitutes an Emergency 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 hospital or other setting 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 Enrollee handbook developed by the State that includes:

a) Any restrictions on the Enrolled Member's freedom of choice among Network Providers.
b) The extent to which, and how, Enrolled Members may obtain Benefits, including family planning services and supplies from Out-of-Network Providers.

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. *Information Requirements – Family Planning.* Contractor shall utilize the model Enrollee handbook developed by the State that includes an explanation that the Contractor cannot require an Enrolled Member to obtain a referral before choosing a family planning Provider. See: 42 C.F.R. § 438.10(g)(2)(vii); 42 C.F.R. § 457.1207. {From CMSC C.2.20}.

C.2.11. *Information Requirements – Cost Sharing.* Contractor shall utilize the model Enrollee handbook developed by the State 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 – Enrollee Rights and Responsibilities.* Contractor shall utilize the model Enrollee handbook developed by the State 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 Enrollee handbook developed by the State 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 Enrollee handbook developed by the State 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 Enrollee handbook developed by the State that includes Grievance, Appeal,

and fair hearing procedures and timeframes in a State-developed or State-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 – Enrollee Rights Regarding Grievances & Appeals.* Contractor shall utilize the model Enrollee handbook developed by the State 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 State 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. *Information Requirements – Advance Directives.* Contractor shall utilize the model Enrollee handbook developed by the State that includes how to exercise an advance directive. See: 42 C.F.R. § 438.10(g)(2)(xii); 42 C.F.R. § 438.3(j); 42 C.F.R. § 457.1207. {From CMSC C.2.37}.

C.2.18. *Information Requirements – Auxiliary Aids.* Contractor shall utilize the model Enrollee handbook developed by the State 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 medical 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 State.

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 State, in the information specified in the Enrollee handbook at least 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 Enrollee handbook and notices that describe the transition of care policies for Enrolled Members and Potential Enrollees. See: 42 C.F.R. § 438.62(b)(3); 42 C.F.R. § 438.1216. {From CMSC C.2.46}.

C.3 Enrollee Handbook Dissemination

C.3.01. *Dissemination of Enrollee 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 (physicians, including specialists; hospitals; pharmacies; behavioral health Providers; and LTSS Providers, as appropriate), 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) 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.
h) 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 MCO 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 Formulary

C.5.01. *Information about Covered Drugs.* Contractor shall provide:

a) Information in electronic or paper form about which generic and name brand medications are covered.
b) Information in electronic or paper form about what tier each medication is on.
c) Formulary drug lists on the Contractor's website in a machine-readable file and format as specified by the Secretary.

See: 42 C.F.R. § 438.10(i)(1) - (3); 42 C.F.R. § 457.1207. {From CMSC C.5.01 - C.5.03}.

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 the 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 and health Outcomes which are tailored to issues prevalent among Enrolled Membership as identified by the Contractor. The Contractor shall provide information concerning its physician 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 State 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 State. Contractor's materials shall not contain any assertion or statement (whether written or oral) that the recipient must enroll in 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 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. *Advance Directives Information.* Contractor shall provide adult Enrolled Members with written information on advance directives policies and include a description of applicable State law. See: 42 C.F.R. § 438.3(j)(3). {From CMSC C.8.07}.

C.8.05. *Changes in State Law – Advance Directives.* Contractor shall reflect changes in State law in its written advance directives information as soon as possible, but no later than ninety (90) Days after the effective date of the change. See: 42 C.F.R. § 438.3(j)(4). {From CMSC C.8.08}.

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 State-developed definition for the following terms: Appeal; durable medical equipment; Emergency Medical Condition; emergency medical transportation; emergency room care; Emergency Services; Grievance; habilitation services; home health care; hospice services; hospitalization; hospital outpatient care; physician services; prescription drug coverage; prescription drugs; Primary Care physician; PCP; 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 State-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 Enrollees 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 State 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.9 Sales and Transactions

C.9.01. *Reporting Obligation.* Contractor shall make any reports of transactions between the Contractor and parties in interest that are provided to the State, or other agencies available to Contractor Enrolled Members upon reasonable request. See: Section 1903(m)(4)(B) of the Social Security Act. {From CMSC C.9.01}.

C.10 State Member Communication Approval.

C.10.01. *Agency Approval of Enrollee 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 State'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 State 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. MCO 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 health and well-being of Medicaid Enrollees. Value-Added Services may be actual Health Care Services, Benefits, or positive incentives that will promote healthy lifestyles and improved 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 services; (ii) medical equipment or devices not already covered under the Program to assist in prevention, wellness, or management of 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 PPM: (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 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 State 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. *Risk Adjustment.* The Agency will risk adjust each Contractor's rates, based on the relative morbidity of its Enrolled Members to the statewide population. The Agency reserves the right to change risk adjustment models and methodology. Total payments by the Agency will be risk score neutral, meaning Contractor's rates may be adjusted both up and down, according to the morbidity of their Enrolled Members relative to all Enrolled Members. Risk adjustment will be calculated separately for the LTSS benefit and the non-LTSS benefit.

D.1.05. *LTSS Benefit.* To financially incent contractors to deliver LTSS to Elderly and disabled populations in the least restrictive environment, the Agency will blend the Institutional (e.g. NF) and Home and Community-Based Services (HCBS) populations into one (1) rate cell per grouping of populations, encouraging management of the entry into institutions. Each Contractor's rates will be risk adjusted to reflect the Institutional versus HCBS mix of individuals enrolled with the Contractor at an initial point in time. The blending percentage will be updated on a regular basis, at least annually.

D.1.06. *Non-LTSS Benefit.* The Agency or their consultants will apply a system of assigning severity (risk) to the individuals enrolled using Claims or encounter data which may include diagnosis codes, services provided, or pharmacy data. The Agency will apply the risk score methodology prospectively and on an annual basis. Risk scoring will be normalized between program Contractors to ensure program-wide budget neutrality prior to their application to the capitation rates. The Agency reserves the right to modify the risk scoring methodology including the timing for assigning risk to individuals enrolled during the Contract.

After the first six (6) months, rates will be adjusted every twelve (12) months, based on Enrolled Member data from a recent, previous twelve (12) month period of complete data. The Agency reserves the right to adjust rates prospectively and/or retrospectively. Members enrolled for less than six (6) months will be risk adjusted according to each Contractor's average risk adjustment factor. Risk adjustment will not be calculated for the Dual Eligible rate cells or infants less than one (1) year of age.

D.1.07. *Delivery System and Payment Initiatives.* This Contract includes all delivery system and payment initiatives at the State'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). {From CMSC D.1.04}.

D.1.08. *IMD Restrictions.* The State will only make a monthly Capitation Payment to the Contractor for an Enrolled Member aged twenty-one (21) to sixty-four (64) receiving inpatient treatment in an Institution for Mental Diseases (IMD), as defined in 42 C.F.R. § 435.1010, so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services, and length of stay in the IMD is for a short term stay of no more than fifteen (15) Days during the period of the monthly Capitation Payment. See: 42 C.F.R. § 438.6(e). {From CMSC D.1.05}.

D.1.09. *Payment for services in IMD setting.* During the first fifteen (15) IMD Enrolled Member Days, the Enrolled Member will remain enrolled in the Plan, and the Plan will continue to provide Care Coordination services and reimburse all covered services for the Enrolled Member. Contractor may utilize other services to assist the Enrolled Member and is not required to utilize the IMD setting

except when constrained by court order. The Enrolled Member must be given the option to utilize other Medicaid services as opposed to the IMD setting except when constrained by court order. Contractor may cover services or settings for Enrolled Members that are in lieu of those covered under the State plan if:

1. The Agency determines that the alternative service or setting is a medically appropriate substitute for the covered service or setting under the State plan.
2. The Agency determines that the alternative service or setting is a cost-effective substitute for the covered service or setting under the State plan.
3. The Enrolled Member is not required by the Contractor to use the alternative service or setting.
4. The approved in lieu of services are authorized and identified in the Contract.
5. 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) - (v); 42 C.F.R. § 457.1201(e).

D.1.10. *Stays Exceeding Fifteen (15) Days.* For stays exceeding the fifteen (15) Days in a calendar month as allowed under this provision, the Enrolled Member will remain enrolled in the Plan and the Plan will continue to provide Care Coordination services and reimburse all covered services. The Plan must submit data related to IMD stays as outlined in the Reporting Manual.

D.1.11. *IMD Reimbursement.* When the Enrolled Member is served in an IMD for fifteen (15) days or less in a calendar month pursuant to Section D.1.09, the Contractor shall reimburse the IMD for the IMD Enrolled Member Days using the current weighted average inpatient hospitalization rate, and the Contractor shall be entitled to the full capitation payment attributable to the Enrolled Member for that month. For IMD stays that exceed the fifteen (15) Enrolled Member Days permitted under Section D.1.09, the Contractor will not reimburse the IMD for any of the IMD Enrolled Member Days in that month, and Contractor shall be entitled to retain only the capitation payment associated with Days the Enrolled Member did not spend in the IMD using an average daily value of monthly capitation paid for the Enrolled Member month.

D.1.12. *Mandatory Rates*. 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. At any time that a facility is undergoing a change of ownership, Contractor shall continue to pay the facility no less than then the approved rate. Pharmacy Providers shall be reimbursed in accordance with Section F.11.12.

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, Section 1 (Rate Sheets). The Agency has provided a sample set of Pay for Performance measures for the first year of the Contract for Contractors that may be selected under this RFP and are new to the Iowa Health Link program, and a separate set of Pay for Performance measures for incumbent Contractors that may be selected under this RFP. The Pay for Performance measures for Contractors that may be new to the program focus on operational and process metrics, such as measures related to timeliness and data accuracy, to ensure a successful implementation. It is expected that all Contractors will return to a common set of Pay for Performance

measures, which may differ from the measures for SFY 2026, beginning in State fiscal year 2027. See: Special Contract Exhibit A, Section 3 (Sample SFY 2026 Pay for Performance Charts).

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 less premium tax. Payment from the Agency to the Contractor will be adjusted for Premium tax.
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 State's 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 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 a 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 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-eight percent (88%) 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 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.

Amounts that must be deducted from incurred claims include the following:

a) Cost sharing and overpayment recoveries received from network providers.
b) Prescription drug rebates received and accrued.

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 enrollees 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 enrollees;
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 and licensing and regulatory fees.

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.

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 85 percent (85%) would be expected to experience a loss ratio less than 85 percent (85%) one (1) out of every four (4) years, or 25 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 1 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 88%.

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 88 percent (88%). 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 of 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 eighty (180) days of the end of the MLR reporting year or within thirty (30) days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

See: 42 C.F.R. § 438.8(k)(1)(xii) and 42 C.F.R. § 438.8(i)

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-eight percent (88%) 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 State 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 Enrollees 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 supplemental payments not at risk to the MCOs, 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-eight percent (88%) 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 Enrollee 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 Enrollee, 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) Supplemental Payments. Any reconciled supplemental/directed payments 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 State 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 87.95% does not meet the minimum Medical Loss Ratio requirements of 88%. 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.* The Coverage Year will initially be considered a fifteen (15) month period followed by subsequent twelve (12) month periods. 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, 2025 running through June 30, 2026. The Agency reserves the right to prospectively modify the terms of the risk corridor described though a contract amendment.

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) Amounts related to the Physician ACR payment, Hospital Directed Payments, GEMT payment, and GME payments.
c) Any unearned withhold amounts will not be included within the capitation revenue for purposes of the risk corridor calculation.

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 Agency/Agency's contracted actuaries based on encounter data and Contractor submitted financial 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 enrollees who are not eligible on the incurred date of service.
d) Administrative expenditures that are included in the pharmacy claims expenditures. These administrative expenditures will be removed from the pharmacy claims for purposes of the Risk Corridor calculation.
e) Adjusted medical expenditures will not include quality improvement expenses, case management expenses, or other administrative expenses.
f) Expenditures for value-added services.
g) Expenditures related to the Physician ACR payment, Hospital Directed Payments, GEMT payment, and GME.

The Agency reserves the right to audit claims expenditures. For purposes of the Risk Corridor, the State will limit the overall level of reimbursement to 103% of the Medicaid fee schedule and will sample the submitted encounter data to ensure compliance with the Medicaid fee schedule.

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 Risk Sharing Corridor is defined as follows:

Risk Corridor Minimum Percentage	Risk Corridor Maximum Percentage	Contractor Share	State / Federal Share
0.0%	87.7%	0.0%	100.0%
87.7%	90.7%*	100.0%	0.0%
90.7%*	93.7%	100.0%	0.0%
93.7%	93.7%+	0.0%	100.0%

**The target MLR of 90.7% is based on the weighted average of total non-medical load amounts built into the SFY25 rates using the SFY23 enrollment distribution.*

The actual target used for the final reconciliation will vary slightly based on the actual population distribution for the MCO during the SFY25 contract period.

To the extent the target MLR varies from 90.7% using the actual MCO enrollment mix during the contract period, the risk corridor bands will still be +/- 3.0% from the revised target MLR.

D.4.33. *Timelines.* Within two hundred 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 enrollees, 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.

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 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 thirty (30) Days of the date of receipt; and paying 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 State 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 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 thirty (30) Days of the date of receipt; paying 95% of all Clean Claims within forty-five (45) Days of the date of receipt; and paying 99% of all 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. The obligation for timely payment shall be met at both an aggregate and provider type level (*e.g.*, hospital, home health, waiver, nursing facility, 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 90% of all clean identified adjustments including Reprocessed Claims within thirty (30) business days of receipt and 99% of all 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 Payment Obligations.* Contractor shall make Pass-Through Payments as defined at 42 C.F.R. § 438.6(a) to Network Providers, which can only include hospitals, physicians, or nursing facilities. The contract must include the following:

a) The amount of the Pass-Through Payments included in the rates and the schedule of payments to the Network Providers.
b) The amount of the Pass-Through Payments noted in the Contract must be consistent with the amount calculated in the rate certification and comply with requirements outlined in 42 CFR 438.6(d).

See: 42 C.F.R. § 438.6(d). {From CMSC D.7.01}.

D.7.02. *Phase-Out of Pass-Through Payments – Physicians and Nursing Facilities.* Pass-Through Payments to physicians and nursing facilities may still be up to the amount calculated in the rate certification through rating periods for contracts beginning on or after July 1, 2021. For rating periods for contracts beginning on or after July 1, 2022, the Agency will not require Pass-Through Payments for physicians or nursing facilities under the Contract. See: 42 C.F.R. § 438.6(d)(5). {From CMSC D.7.02}.

D.7.03. *Phase-Out of Pass-Through Payments – Hospitals.* Pass-Through Payments to hospitals will be reduced, per the schedule at 42 C.F.R. § 438.6(d)(3), by at least 10% from the base amount, as defined at 42 C.F.R. § 438.6(a) and calculated at 42 C.F.R. § 438.6(d)(2), which was included under the Contract for rating periods beginning on or after July 1, 2017. Pass-Through Payments will not exceed a percentage of the base amount, beginning with 100% for rating periods for contracts beginning on or after July 1, 2017, and decreasing by 10% each successive year through rating periods for contracts beginning on or after July 1, 2026. Pass-Through Payments will not be included in contracts for rating periods beginning on or after July 1, 2027. See: 42 C.F.R. § 438.6(d)(3). {From CMSC D.7.03}.

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 and maintain and at all times comply 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 IME Units to identify specific training needs, to include but not limited to:

a) Statewide provider training;
b) Specialized populations;
c) Specialized provider trainings responding to urgent and emergent Enrolled Member needs;
d) Policy and procedure changes;
e) Presumptive eligibility and qualified entity training;
f) Trends and issues of interest to or impacting providers;
g) Enrollment issues; and
h) Increase provider participation in the Iowa Medicaid and Hawki Programs.

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 Emergency Medical Conditions.
b) Make arrangements with or referrals to, a sufficient number of 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 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. The Agency may waive the right to review and approve Provider communications.

Information that includes the State'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 State 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, 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 and long-term care insurance 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 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 twenty (120) days but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one (1) one hundred twenty (120) day period without enrollment of the provider, and notify affected enrollees. (See: 42 C.F.R. § 438.602(b)(2); 42 C.F.R. § 457.1285.)

E.1.07. *HCBS Providers.* In addition to the general Provider agreement requirements listed in Section E.1.06, the Contractor shall also include, at minimum, the following requirements in all Provider agreements with HCBS Providers:

a) Require the HCBS Provider to provide at least thirty (30) Days advance notice to the Contractor when the Provider is no longer willing or able to provide services to an Enrolled Member and to cooperate with the Enrolled Member's care coordinator to facilitate a seamless transition to alternate Providers;
b) Require that in the event that a HCBS Provider change is initiated for an Enrolled Member, regardless of any other provision in the Provider agreement, the transferring HCBS Provider continue to provide services to the Enrolled Member in accordance with the Enrolled

Member's plan of care until the Enrolled Member has been transitioned to a new Provider, as determined by the Contractor, or as otherwise directed by the Contractor, which may exceed thirty (30) Days from the date of notice to the Contractor

E.1.08. *Nursing Facility Provider Agreements.* In addition to the general Provider agreement requirements listed in Section E.1.06, the Contractor shall also include, at minimum, the following requirements in all Provider agreements with nursing facilities:

a) Require the NF to promptly notify the Contractor of an Enrolled Member's admission or request for admission to the NF as soon as the facility has knowledge of such admission or request for admission;
b) Require the NF to notify the Contractor immediately if the NF is considering discharging an Enrolled Member and to consult with the Enrolled Member's care coordinator;
c) Require the NF to notify the Enrolled Member and/or the Enrolled Member's representative (if applicable) in writing prior to discharge in accordance with State and Federal requirements;
d) Specify the NF's responsibilities regarding Client Participation as described in Section F.8.12;
e) Require the NF to notify the Contractor of any change in an Enrolled Member's medical or functional condition that could impact the Enrolled Member's level of care eligibility for the currently authorized level of NF services;
f) Require the NF to comply with federal PASRR requirements to provide or arrange to provide specialized services and all applicable Iowa law governing admission, transfer, and discharge policies; and
g) Provide that if the NF is involuntarily decertified by the State or CMS, the Provider agreement shall automatically be terminated in accordance with federal requirements.

E.1.09. *Physician Extenders.* Contractor shall ensure compliance with 42 C.F.R. § 441.22 by including nurse practitioners in Contractor's Provider panel and making nurse practitioner services available to Enrolled Members.

E.1.10. *Behavioral Health Providers.* The Contractor shall develop a network of appropriately credentialed behavioral health Providers to assure the availability of services for both adults and children and to meet the general Access requirements described in Special Contract Exhibit C.

E.1.11. *Essential Hospital Services.* The Contractor shall demonstrate sufficient Access to essential hospital services to serve the expected enrollment and to meet, at minimum, the Access and availability requirements set forth in Special Contract Exhibit C.

E.1.12. *Physician Specialists.* The Contractor shall establish and maintain a network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical and behavioral health needs of its Enrolled Members without excessive travel requirements. This means that, at a minimum: (i) the Contractor has signed Provider agreements with Providers of the specialty types listed in Special Contract Exhibit C who accept new Enrolled Members and are available on at least a referral basis; and (ii) the Contractor is in compliance with the Access and availability requirements set forth in Special Contract Exhibit C.

E.1.13. *Health Homes.* The Contractor shall administer and fund the State's Health Home services within the approved Chronic Condition Health Home and Integrated Health Home State Plan Amendments. The Contractor shall provide oversight that includes but not limited to documentation reviews and provider self-assessment reviews to ensure that Health Home Providers are meeting all of the requirements of the Health Home State Plan Amendments, Health Home Manual and Administrative Rules. The Contractor shall provide guidance to Health Home Providers to ensure the requirements of the Health Home State Plan Amendments, Health Home Manual and Administrative Rules are being met. The Contractor shall be responsible for any identified deficiencies. In

accordance with federal requirements, the Contractor shall ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) HCBS waivers, other forms of community-based case management, or value-based purchasing arrangements.

E.1.14. *Federally Qualified Health Centers and Rural Health Clinics.* The Contractor shall offer to contract with all FQHCs and RHCs located in Iowa. The Contractor may establish Quality standards that FQHCs and RHCs shall meet to be offered network participation for the Agency review and approval. The Contractor shall reimburse all FQHCs and RHCs the PPS rate in effect on the date of service for each encounter. The Contractor shall not enter into alternative reimbursement arrangements without prior approval from the State.

E.1.15. *Family Planning Clinics.* The Contractor shall make a reasonable and good faith attempt to contract with all local family planning clinics that are enrolled as such with Iowa Medicaid.

E.1.16. *Maternal and Child Health Centers.* The Contractor shall make a reasonable and good faith attempt to contract with all maternal and child health centers funded by Title V moneys.

E.1.17. *Urgent Care Clinics.* Contractor shall develop strategies, policies, and procedures describing how it intends to utilize urgent care clinics in the delivery of care to Enrolled Members, and document such in the PPM.

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, and document such in the PPM.

E.1.19. *Community-Based Residential Alternatives.* For community-based residential alternatives, the Contractor shall demonstrate good faith efforts to develop the capacity to have a travel distance of no more than 60 miles between an Enrolled Member's community-based residential alternative placement and the Enrolled Member's residence before entering the facility.

E.1.20. *Access to Medical 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. *Family Planning Provider Network.* Contractor shall demonstrate that its network includes sufficient family planning Providers to ensure timely Access to covered services. See: 42 C.F.R. § 438.206(b)(7); 42 C.F.R. § 457.1230(a). {From CMSC E.1.05}.

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 State'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 family planning, 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 Enrollees 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 State, in a format specified by the State, to demonstrate that it offers an appropriate range of preventive, Primary Care, specialty services, and LTSS 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 State, in a format specified by the State, to demonstrate that it maintains a network of Providers 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) on an annual basis, 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) 85% within thirty (30) Days; (ii) 98% within forty-five (45) Days; and (iii) 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 IA Health Link program the audit will occur on the third year of the contract. Failure to comply with the audit or the 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 State'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. In addition, the Contractor shall ensure that all required criminal history record checks and child and dependent adult abuse background checks are conducted for LTSS Providers who are not employees of a Provider agency or licensed/accredited by a board that conducts background checks. This includes but is not limited to, the Contractor ensuring criminal history checks and child and dependent adult background checks are conducted for non-agency affiliated self-direction service Providers such as CDAC and CCO employees. Each of the State's 1915(c) HCBS waivers and 1915(i) State Plan HCBS Habilitation program, delineate the minimum Provider qualifications for each covered service. The Contractor shall ensure all HCBS Providers meet these qualifications in accordance with Iowa Admin. Code Ch. 441-77.

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

E.3.08. *Substance Use Disorder Providers.* The Contractor shall ensure that substance use disorder treatment services provided to Enrolled Members are provided by programs licensed by IDPH in accordance with Iowa Code chapter 125 or by hospital-based substance use disorder treatment programs licensed and accredited in accordance with Iowa Code § 125.13.2(a). The Contractor shall accept counselor certification as specified in Iowa Admin. Code r. 441-155.21(8) as an acceptable credential for practitioners employed by a licensed substance use disorder treatment program.

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 State. 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 IA Health Link managed care entity.

E.3.17. *MH/SUD/LTSS Provider Enrollment – First Two (2) Years.* As permitted by law, for the first two (2) years following Contractor's entry into the IA Health Link marketplace, the Contractor shall give all of the following Providers, who are currently enrolled as Agency Providers, the opportunity to be part of its Provider Network: (i) CMHCs; (ii) 1915(i) HCBS Habilitation Services Providers; (iii) nursing facilities; (iv) ICF/IDs; (v) health homes; (vi) 1915(c) HCBS Waiver Providers, with the exception of case managers and care coordinators; and (vii) substance use disorder treatment programs. The Contractor shall document at least three (3) attempts to offer a reasonable rate as part of the contracting process.

E.3.18. *Other Providers.* For the first six (6) months from Contractor's entry into the IA Health Link marketplace and for all Provider types not described in Section E.3.17, the Contractor shall give Providers, who are currently enrolled as Agency Providers, the opportunity to be part of its network. The Contractor may use national or multi-state contracts for Durable Medical Equipment or Medical Supplies.

E.3.19. *Written Notice Obligation.* Notwithstanding the requirements set forth in Sections E.3.17 and 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 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 State 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 Enrollees or are comparable to Medicaid FFS, if the Provider serves only Medicaid and/or CHIP Enrolled Members.
c) The Contractor shall make services available twenty-four (24) hours a day, seven (7) Days a week, when medically necessary.
d) The Contractor shall establish mechanisms to ensure that its Network Providers comply with the timely Access requirements.
e) The Contractor shall monitor Network Providers regularly to determine compliance with the timely Access requirements.
f) 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. *Time & Distance – Provider Type Requirement.* Contractor shall adhere to the time and distance standards developed by the State 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 (if applicable).
m) Any additional Provider types when it promotes the objectives of the Medicaid and CHIP programs for the Provider type to be subject to time and distance Access 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.5.33}.

E.5.04. *Time & Distance – LTSS.* Contractor shall adhere to the time and distance standards for LTSS Provider types in which an Enrolled Member must travel to the Provider to receive services. See: 42 C.F.R. § 438.68(b)(2)(i); 42 C.F.R. § 457.1218. {From CMSC E.5.34 - E.5.35}.

E.5.05. *Network Adequacy – LTSS.* Contractor shall adhere to network adequacy standards other than time and distance standards for LTSS Provider types that travel to the Enrolled Member to deliver services. See: 42 C.F.R. § 438.68(b)(2)(ii); 42 C.F.R. § 457.1218. {From CMSC E.5.36}.

E.5.06. *Provider Type – Geographic Area Requirement.* Contractor shall meet relevant State network adequacy standards 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) OB/GYN Providers.
d) Adult behavioral health (mental health and substance use disorder) Providers.
e) Pediatric behavioral health (mental health and substance use disorder [MH/SUD]) Providers.
f) Adult specialist Providers.
g) Pediatric specialist Providers.
h) Hospitals.
i) Pharmacies.
j) Pediatric dental Providers (if applicable).
k) Any additional Provider types when it promotes the objectives of the Medicaid Program as determined by CMS.

For relevant time and distance standards, see Special Contract Exhibit C, “General Access Standards.” See: 42 C.F.R. § 438.68(b)(3); 42 C.F.R. § 438.68(b)(1)(i) - (viii); 42 C.F.R. § 457.1218. {From CMSC E.5.37 - E.5.47}.

E.5.07. *LTSS Geographic Adequacy.* Contractor shall meet relevant State network adequacy standards in all geographic areas in which the Contractor operates for LTSS services. See: 42 C.F.R. § 438.68(b)(3); 42 C.F.R. § 438.68(b)(2)(i); 42 C.F.R. § 457.1218. {From CMSC E.5.48}.

E.5.08. *Exceptions.* The State-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.5.49}.

E.6 Provider Notification of Grievance and Appeals Rights

E.6.01. *Enrollee 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.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 Physician Incentive Plan

E.8.01. *Restriction on Reducing or Limiting Services.* Contractor may only operate a physician incentive plan if no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician 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.* The Contractor must have at least 40% of the population defined by the Agency in a value-based purchasing (VBP) arrangement with the healthcare delivery system by the end of the first year of any managed care contract. By the end of the second year, the Contractor shall have 50% VBP enrollment. Thereafter, the Contractor shall maintain or exceed 50% VBP enrollment. The VBP arrangement shall recognize population 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 health through delivery system reform under VBP means that Providers need a clear understanding of the specific lives 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 PCP. This PCP information shall be immediately reported by the Contractor for use in system wide coordination enhancements as specified by the Agency. The Contractor shall also require that all contracted hospitals report admission and discharge information to support this exchange and coordination. Contractor shall use an Agency-approved tool, to provide a consistent, real-time notification platform for hospitals to uniformly report inpatient and ED events for Enrolled Members to the Contractor and care teams participating in VBP agreements. 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 managed care 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.* While the Contractor is required to reimburse Providers for the screening examination, the Contractor is not required to reimburse Providers for non-Emergency Services rendered in an emergency room for treatment of conditions that do not meet the prudent layperson standard. The Contractor may not deny or pay less than the allowed amount for the CPT code on the Claim without a medical 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 Medical 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 medical training. The Contractor shall not impose restrictions on coverage of Emergency Services more restrictive than those permitted by the prudent layperson standard.

F.1.03. *Obligation to Pay for Screening.* If an emergency screening examination leads to a clinical determination that an actual Emergency Medical Condition exists, the Contractor shall pay for both the services involved in the 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 clinical emergency is stabilized.

F.1.04. *Non-Contracted Provider Payment Obligation.* Emergency services shall be available twenty-four (24) hours a day, seven (7) days a week. 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 an 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 treatment obtained when a representative of the Contractor instructs the Enrolled Member to seek Emergency Services.

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 an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.
b) Refuse to cover Emergency Services based on the emergency room Provider, 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.1.08 - F.1.09}.

F.1.07. *Restriction on Holding Patient Liable.* Contractor may not hold an Enrolled Member who has an 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.1.10}.

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.1.11 - F.1.12}.

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 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.1.13 - F.1.17}.

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, LTSS, and Behavioral Health 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 Enrollee 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.1.18}.

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 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.1.19 - F.1.22}.

F.2 Family Planning

F.2.01. *Prohibition on Restricting Free Choice.* Contractor shall not restrict the Enrolled Member's free choice of family planning services and supplies Providers. See: Section 1902(a)(23) of the Social Security Act; 42 C.F.R. § 431.51(b)(2). {From CMSC F.2.01}.

F.2.02. *Self-Referral Obligation.* Enrolled Members shall be permitted to self-refer to any Agency Medicaid Provider for the provision of family planning services, including those not in the Contractor's network.

F.3 Abortions

F.3.01. *Covered Abortions.* Abortions in the following situations are covered Medicaid Benefits:

a) If the pregnancy is the result of an act of rape or incest. If the pregnancy is the result of a rape which is reported within forty-five days of the incident to a law enforcement agency or to a public or private health agency which may include a family physician. 653 IAC 13.17(2) and 13.17(4)(a) and the HHS Provider Manual set forth additional requirements for health care providers.

b) If the pregnancy is the result of a rape which is reported within one hundred forty days of the incident to a law enforcement agency or to a public or private health agency which may include a family physician. 653 IAC 13.17(2) and 13.17(4)(a) and the HHS Provider Manual set forth additional requirements for health care providers.

c) If the pregnancy was ended as the result of a "spontaneous abortion" or miscarriage, and not all of the products of conception are expelled.

d) If the attending physician certifies that the fetus has a fetal abnormality that in the physician's reasonable medical judgment is incompatible with life. 653 IAC 13.17(4)(b) and the HHS Provider Manual set forth additional requirements for health care providers.

e) If the pregnancy must be ended as a result of a medical emergency. A medical emergency is a situation in which an abortion is performed to preserve the life of the pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy, but not including psychological conditions, emotional conditions, familial conditions, or the woman's age; or when continuation of the pregnancy will create a serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman.

See: 42 C.F.R. § 441.202; Consolidated Appropriations Act of 2008. {From CMSC F.3.01}; Iowa Code 146, 146A, 146B, 146C, 146D, 146E.

F.4 Delivery Network

F.4.01. *Women's Health Specialist.* If a female Enrolled Member's designated Primary Care physician is not a women's health specialist, Contractor shall provide the Enrolled Member with direct Access to a women's health specialist within the Provider Network for covered routine and preventive women's Health Care Services. See: 42 C.F.R. § 438.206(b)(2); 42 C.F.R. § 457.1230(a). {From CMSC F.4.01}.

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 and Client Participation as further described in Section F.8.

F.4.09. *MH/SUD Obligations.* Contractor shall use processes, strategies, evidentiary standards, or other factors in determining Access to Out-of-Network Providers for mental health or substance use disorder Benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining Access to Out-of-Network Providers for Medical/Surgical Benefits in the same classification. See: 42 C.F.R. § 438.910(d)(3); 42 C.F.R. § 457.1201(l); 42 C.F.R. § 457.496(d)(5). {From CMSC F.4.05}.

F.4.10. *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. 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 denying or reducing 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), or the CHIP State Plan, as applicable, such as medical necessity. 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 documenting Access to board certified consultants 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 physical health or behavioral health care professional who has appropriate clinical expertise in treating the Enrolled Member's condition or disease, or in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services.

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 IA Health Link program or following open enrollment, the Contractor shall honor existing authorizations for covered Benefits for a minimum of 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. LTSS, residential services and certain services rendered to dual diagnosis populations, which are addressed in F.13.28, are excluded from this 90-Day period. 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 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. *UM – Family Planning.* Contractor may place appropriate limits on a service for utilization control, provided family planning services are provided in a manner that protects and enables the Enrolled Member's freedom to choose the method of family planning to be used. See: 42 C.F.R. § 438.210(a)(4)(ii)(C); 42 C.F.R. § 457.1230(d). {From CMSC F.6.09}.

F.6.14. *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. The Contractor shall work collaboratively with MHDS regions.

F.6.15. *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. Members enrolled in the Iowa Health and Wellness Plan, who have not been identified as Medically Exempt, as described in this Section F.6, are eligible for the Alternative Benefit Plan Benefits outlined in the State Plan and approved waivers. Members enrolled in the Iowa Health and Wellness Plan, who have been identified as Medically Exempt, as described in this Section F.6, are eligible for services defined as the State/territory's approved Medicaid State Plan and will have the option to change coverage to the Alternative Benefit Plan known as the Iowa Wellness Plan.

F.6.16. *Hawki Enrollees.* 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.6.17. *Iowa Health and Wellness Plan Benefits.* The Contractor shall ensure that individuals eligible for the Iowa Health and Wellness Plan receive Iowa Wellness Plan Benefits, which is the Secretary Approved Alternative Benefit Plan (ABP) coverage option under Section 1937 of the Social Security Act. Iowa Wellness Plan coverage is described in the State Plan and summarized in Special Contract Exhibit E, Table E.02. The Contractor shall ensure the delivery of services to Iowa Health and Wellness Plan Enrolled Members in accordance with the ABP, with the exception of Medically Exempt Enrolled Members.

F.6.18. *Medically Exempt.* Individuals who are identified as Medically Exempt by the Agency shall have a choice between the Iowa Wellness Plan and regular Medicaid State Plan Benefits, as described in Iowa Admin. Code ch. 441-78, which offers more comprehensive coverage. Medically Exempt is the term used by Iowa to define the Federal definition of "medically frail." Consistent with 42 C.F.R. § 440.315(f), an individual shall be considered Medically Exempt if the Member has one (1)

or more of the following: (i) a disabling mental disorder, including adults with serious mental illness; (ii) chronic substance use disorder; (iii) serious and complex medical condition; (iv) a physical, intellectual or developmental disability that significantly impairs his or her ability to perform one (1) or more activities of daily living; or (v) a disability determination based on SSA criteria. Table 2 below provides more detailed definitions of the categories of exempt individuals. "Activities of daily living" as used in Table 2 may include: (i) bathing and showering; (ii) bowel and bladder management; (iii) dressing; (iv) eating; (v) feeding; (vi) functional mobility; (vii) personal device care; (viii) personal hygiene and grooming; and (ix) toilet hygiene.

Table 2: Medically Exempt Definition

Category	Definition
Individuals with Disabling Mental Disorder	The Enrolled Member has a diagnosis of at least one (1) of the following: • Psychotic disorder • Schizophrenia • Schizoaffective disorder • Major depression • Bipolar disorder • Delusional disorder • Obsessive-compulsive disorder • Or Enrolled Member is identified to have a chronic behavioral health condition and the Global Assessment Functioning (GAF) score is fifty (50) or less
Individuals with Chronic Substance Use Disorders	• The Enrolled Member has a diagnosis of substance use disorder, AND • The Enrolled Member meets the Severe Substance Use Disorder level on the DSM-V Severity Scale by meeting six (6) or more diagnostic criteria, OR • The Enrolled Member's current condition meets the Medically-Monitored or Medically-Managed Intensive Inpatient criteria of the ASAM criteria ("DSM-V" means the 5th edition of the *Diagnostic and Statically Manual of Mental Disorders* published by the American Psychiatric Association. "ASAM criteria" means the 2013 edition of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions* published by the American Society of Addition Medicine.)
Individuals with Serious and Complex Medical Conditions	• The individual meets criteria for Hospice services, OR • The individual has a serious and complex medical condition AND • The condition significantly impairs the ability to perform one (1) or more activities of daily living. (Examples of serious and complex medical conditions include but are not limited to: acquired brain injury, epilepsy, cerebral palsy and ventilator dependency.)
Individuals with a Physical Disability	• The individual has a physical disability AND

Category	Definition
	• The condition significantly impairs the ability to perform one (1) or more activities of daily living. (Examples of physical disabilities include but are not limited to: multiple sclerosis, quadriplegia, and paraplegia.)
Individuals with an Intellectual or Developmental Disability	The individual has an intellectual or developmental disability as defined in Iowa Admin. Code r. 441-24.1. This definition means a severe, chronic disability that: • Is attributable to a mental or physical impairment or combination of mental and physical impairments; • Is manifested before the age of twenty-two (22); • Is likely to continue indefinitely; • Results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; • Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated; and • The condition significantly impairs the ability to perform one (1) or more activities of daily living. (Developmental disabilities include but are not limited to: autism, epilepsy, cerebral palsy, and mental retardation.)
Individuals with a Disability Determination	Any individual with a current disability designation by the SSA.

F.6.19. *Identification of Medically Exempt Members*. Medically Exempt individuals are identified through: (i) a Medically Exempt Member survey, and (ii) Medically Exempt attestation and referral form. During the Medicaid application process, an individual determined eligible for the Iowa Health and Wellness Plan indicating they have limitations in their activities of daily living or receive Social Security income, will receive a Medically Exempt Member Survey. The Agency maintains responsibility for scoring the Enrolled Member survey and determining if, based on the survey, the Enrolled Member is Medically Exempt. The attestation and referral form is made available on the IME website and can be completed by Providers, employees of the Agency, Designees from the mental health region or the Iowa Department of Corrections. The Agency retains responsibility for determining if based on the attestation and referral form an Enrolled Member is Medically Exempt. The Agency will communicate the findings from the Enrolled Member survey and attestation and referral form to the Contractor.

F.6.20. *Benefits for Medically Exempt Members.* The Agency will communicate the findings from the Enrolled Member survey and attestation and referral form described above to the Contractor and the Contractor shall provide State Plan versus Alternative Benefit Plan Benefits to Medically Exempt Enrolled Members. Individuals who qualify as Medically Exempt will be defaulted by the State to enrollment in the Medicaid State Plan. However, these individuals have the opportunity to opt-out of

Medicaid State Plan coverage and receive coverage on the Iowa Wellness Plan. The Contractor shall enroll a Medically Exempt Enrolled Member in the Iowa Wellness Plan Benefits in the event the Enrolled Member opts-out of State Plan coverage.

F.6.21. *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.6.22. *Integrated Care.* In delivering services under the Contract, the Contractor shall develop, implement, and adhere to strategies to integrate the delivery of care across the healthcare delivery system including but not limited to, physical health, behavioral health, oral health, and long-term care services.

F.6.23. *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.6.24. *EPSDT Services*: The Contractor shall provide EPSDT services to all Enrolled Members under twenty-one (21) years of age in accordance with law.

a) *Screening, Diagnosis and Treatment.* The Contractor shall implement strategies to ensure the completion of health 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.
b) *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 medical and peer review records, shall be available for inspection by State or Federal personnel or their representatives. The Contractor shall record health screenings and examination related activities and shall report those findings in an Agency approved format at the Agency established frequency.
c) *Outreach.* The Contractor shall implement outreach, monitoring, and evaluation strategies for EPSDT. The Contractor shall develop Provider and Enrolled Member education activities that increase beneficiary awareness of and Access to EPSDT services.

F.6.25. *Prior Authorization - EPSDT.* The Contractor shall not require Prior Authorization or PCP (if applicable) referral for the provision of EPSDT screening services.

F.6.26. *Newborn and Mothers Health Protection*. The Contractor shall meet the requirements of the Newborn and Mothers Health Protection Act (NMHPA) of 1996. The Contractor shall not limit Benefits for postpartum hospital stays to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section, unless the attending Provider, in consultation with the mother makes the decision to discharge the mother or the newborn child before that time. The Contractor shall not require a Provider to obtain Prior Authorization for stays up to the forty-eight (48) or ninety-six (96) hour periods.

F.6.27. *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.6.28. *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.6.29. *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.6.30. *Living Setting of Enrollee's Choice.* Contractor shall cover services related to the opportunity for an Enrolled Member receiving LTSS to have Access to the Benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice under the auspices of Medically Necessary Services. See: 42 C.F.R. § 438.210(a)(5)(ii)(D). {From CMSC F.6.14}.

F.6.31. *Mental Health Parity.* Contractor may cover, in addition to services covered under the State Plan, any services necessary for compliance with the requirements for parity in mental health and substance use disorder (MH/SUD) Benefits in 42 C.F.R. part 438, subpart K and 42 C.F.R. section 457.496 (as appropriate to the Enrolled Member), and the Contract identifies the types and amount, duration and scope of services consistent with the analysis of parity compliance conducted by either the State or the MCO. See: 42 C.F.R. § 438.3(e)(1)(ii); 42 C.F.R. § 457.1201(e). {From CMSC F.6.15}.

F.6.32. 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.
f) The approved in lieu of services meet the requirements outlined in SMDL 23-001, including the in lieu of services cost percentage limits (e.g., 1.5% of the total capitation or no more than 5.0% with enhanced qualifications.

See: 42 C.F.R. § 438.3(e)(2)(i) - (v); 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 State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.

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 and Client Participation.* The Contractor and all Providers and Subcontractors shall not require any cost sharing or Client Participation responsibilities for covered services except to the extent that cost sharing or Client Participation responsibilities are required for those services in accordance with law and as described in Section F.8. Further, the Contractor and all Providers and Subcontractors shall not charge Enrolled Members for missed appointments.

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; (iv) mechanisms for making payments for required charges; and (v) a list of Preferred Drugs or a mechanism to access such a list, if drug copayments are applied by the Contractor.

F.8.04. *Healthy Behaviors Program.* In accordance with the terms of the State's 1115 waiver, the State will submit a protocol for CMS review and approval for the Healthy Behaviors Program standards. This includes the selected healthy behaviors to be met by an individual to be deemed compliant with healthy behaviors to have their premium responsibility waived. The Contractor shall comply with the protocols approved by CMS, and any updates thereto, and implement policies and procedures to ensure compliance.

F.8.05. *Healthy Behaviors.* Once an Iowa Health and Wellness Plan Member is enrolled with the Contractor, the Contractor shall establish mechanisms to: (i) track Enrolled Member completion of the healthy behaviors and (ii) educate Enrolled Members on the importance and benefits of healthy behavior completion

F.8.06. *Copayments.* The Contactor shall impose copayments for Iowa Health and Wellness Plan participants in accordance with the State's 1115 waiver and Hawki Enrolled Members in accordance with the State's CHIP State Plan. For all other enrolled populations, the Contractor may elect, but is not required, to impose copayments as outlined in the State Plan. If the Contractor elects to impose copayments it shall ensure compliance with the requirements outlined in this section. In addition, Contractor shall notify the Agency if it elects to impose any of the State Plan cost sharing.

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:

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;
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 age eighteen (18); (ii) pregnancy-related services, including those defined at 42 C.F.R. §§ 440.210(a)(2) and 440.250(p) and counseling for cessation of tobacco use; (iii) Provider preventable services as defined at 42 C.F.R. § 447.26(b); (iv) Emergency Services, and (v) family planning services and supplies described in section 1905(a)(4)(C) of the Social Security Act.

F.8.09. *Nonemergency Use of Emergency Room (ER).* The Contractor shall impose an $8 copayment for Iowa Health and Wellness Plan Enrolled Member's nonemergency use of an ER and a $25 copayment for Hawki Enrolled Member's non-emergency use of an ER. A copayment shall not be imposed on Hawki Enrolled Members whose family income is less than 181% of the federal poverty level or Iowa Health and Wellness Plan Enrolled Members whose family income is at or below 50% of the federal poverty level. To impose cost-sharing for non-emergency use of the ER, the hospital providing the care must first conduct an appropriate medical screening pursuant to 42 C.F.R. § 489.24 to determine the individual does not need Emergency Services. The Contractor shall instruct its Provider Network of the ER services Co-Payment policy and procedure, such as the hospital's notification responsibilities, outlined below, and the circumstances under which the hospital must waive or return the Co-Payment. Before providing non-emergency treatment and imposing cost-sharing for such services on an individual, the hospital must:

a) Inform the individual of the amount of their cost sharing obligation for non-Emergency Services provided in the emergency department;
b) Provide the individual with the name and location of an available and accessible alternative non-Emergency Services Provider. If geographical or other circumstances prevent the hospital from meeting this requirement, cost-sharing may not be imposed;
c) Determine that the alternative Provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount. The assessment of Access to timely services shall be based on the medical needs of the Enrolled Member; and
d) Provide a referral to coordinate scheduling for treatment by the alternative Provider.

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. *Client Participation.* Some Enrolled Members have a Client Participation (formerly known as "patient liability"), which must be met before Medicaid reimbursement for services is available. This includes Enrolled Members with income above the Agency-defined threshold and eligible for Medicaid on the following bases: (i) Enrolled Members in an institutional setting; and (ii) Enrolled Members in a 1915(c) HCBS Waiver. The Agency has sole responsibility for determining the Client Participation amount and will notify the Contractor of Client Participation via the LTSS file. The Contractor shall develop, implement, and adhere to policies and procedures subject to Agency review and approval, to identify the Provider to which Client Participation shall be paid by Enrolled Members enrolled in LTSS. The Contractor shall implement mechanisms to communicate the Client Participation amount to Providers and shall delegate the collection of Client Participation to Providers. The Contractor shall pay Providers net of the applicable Client Participation amount.

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 Nonpayment

F.9.01. *Organ Transplants.* Contractor shall not pay for organ transplants unless the State Plan provides, and the Contractor follows, written standards that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high-Quality care to Enrolled Members. See: Section 1903(i) of the Social Security Act, final sentence; section 1903(i)(1) of the Social Security Act. {From CMSC F.9.01}.

F.9.02. *Excluded Providers.* Contractor shall not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):

a) Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act.
b) Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) or the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable Notice has been furnished to the person).
c) Furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of Fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments.
d) With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.
e) With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the State Plan.

See: Section 1903(i) of the Social Security Act, final sentence; section 1903(i)(2)(A) - (C) of the Social Security Act; section 1903(i)(16) - (17) of the Social Security Act. {From CMSC F.9.02 - F.9.06}.

F.10 Federally Qualified Health Center (FQHC) Payments

F.10.01. *Generally.* If Contractor enters into a contract for the provision of services with a FQHC or a RHC, the Contractor shall provide payment that is not less than the level and amount of payment which the Contractor would make for the services if the services were furnished by a Provider that is not a FQHC or RHC. See: Section 1903(m)(2)(A)(ix) of the Social Security Act. {From CMSC F.10.01}.

F.11 Outpatient Prescription Drugs

F.11.01. *Prescription Drug Coverage.* Prescription drugs shall be covered and reimbursed by the Contractor. In accordance with 42 C.F.R. § 438.3(s), the Contractor shall administer pharmacy Benefits in compliance with the following requirements and in conformance with federal regulatory requirements as if such regulatory requirements applied directly to the Contractor.

F.11.02. *Pharmacy Network.* The Contractor shall provide a pharmacy network that complies with Special Contract Exhibit C requirements and at a minimum includes pharmacies licensed with the Iowa Board of Pharmacy.

F.11.03. *Mail Order Pharmacy.* Contractor agrees that although they may offer mail order pharmacy as an option to beneficiaries, they or their PBM are not allowed to require or incentivize the use of Mail Order Pharmacy.

F.11.04. *Coverage of Outpatient Prescription Drugs.* Contractor shall provide coverage of outpatient prescription drugs as defined in section 1927(k)(2) of the Social Security Act, in alignment with standards for such coverage imposed by section 1927 of the Social Security Act. See: 42 C.F.R. § 438.3(s)(1). {From CMSC F.11.01}.

F.11.05. *Coverage of All Classes of Drugs.* The Contractor shall provide coverage for all classes of drugs including over the counter, to the extent and manner they are covered by the Medicaid Fee For Service (FFS) pharmacy benefit. The Medicaid FFS pharmacy benefit includes outpatient drugs self-administered by the Enrolled Member or those administered in the home. Medicaid is required to

cover all medications that are rebated by the pharmaceutical manufacturer, in accordance with Section 1927 of the Social Security Act, with the exception of drugs subject to restriction as outlined in Section 1927 (d)(2) of the Act.

F.11.06. *Restricting Coverage.* The Medicaid FFS excludes or restricts coverage consistent with Section 1927(d)(2) of the Social Security Act, as indicated in Iowa Admin. Code r. 441-78.2(4)b. The Contractor is required to enforce the rebate requirement, including Physician/Provider administered drugs and to provide coverage for the same categories in the excluded/restricted classes, to the same extent they are covered by FFS. Over-the-counter drugs for Enrolled Members in a NF, PMIC, or ICF/ID shall be included in the per diem rate.

F.11.07. *Pharmacy Benefit Manager (PBM).* The Contractor shall use a PBM to process prescription Claims online through a real-time, rules-based POS Claims processing system. The Contractor shall ensure that the PBM is directly available to the Agency staff. The Contractor must utilize a pass-through pricing model which means there is no difference in the PBM to pharmacy net payment amounts and MCO to PBM reported payment amounts. No additional direct or indirect remuneration fees, membership fees or similar fees from pharmacies or other contracted entities acting on behalf of pharmacies as a condition of claims payment or network inclusion may be imposed on a pharmacy as a condition of Claims payment or network inclusion. No additional retrospective remuneration models including fees related to brand effective rates (BERs) or generic effective rates (GERs) shall be permitted. The Contractor shall prohibit clawback business arrangements whereby the PBM reimburse network pharmacies an initial drug reimbursement amount and dispensing fee, and subsequently the PBM receives remuneration for a portion of that fee that is unreported to the Department and its actuary. However, nothing shall preclude the reprocessing of Claims due to Claims adjudication errors of the Contractor or its agent. The Contractor shall not require as a condition for participation in its pharmacy Network any limitations that would exclude independent retail pharmacies. The Contractor or its PBM shall not steer or require any Providers or Enrollees to use a specific pharmacy for regular prescriptions, refills, or specialty drugs. The Contractor's pharmacy Network under this Contract must be contracted and administered separately from the Contractor's or Subcontractor's commercial network.

A contracted entity or a subcontractor of a contracted entity shall not enforce a policy or contract term with a provider that requires the provider to contract for all products that are currently offered or that may be offered in the future by the contracted entity or subcontractor.

F.11.08. *PBM Approval.* The Contractor shall obtain Agency approval of the Contractor's PBM and submit all PBM ownership information to the Agency prior to approval. If the PBM is owned wholly or in part by a retail pharmacy Provider, chain drug store or pharmaceutical manufacturer, the Contractor shall submit a written description of the assurances and procedures that shall be put in place under the proposed PBM subcontract, such as an independent audit, to prevent patient steering, to ensure no conflicts of interest exist, and to ensure the confidentiality of proprietary information. The Contractor shall provide a plan documenting how it will monitor such Subcontractors and submit it to the Agency for review within fifteen (15) Days after Contract execution. The plan shall identify the steps to be taken and include a timeline with target dates. A final plan, incorporating any changes requested by the Agency, shall be submitted to the Agency within fifteen (15) Days of receiving Agency comments on the first submission of the plan. 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. These assurances and procedures shall be transmitted to the Agency for review and approval prior to the date pharmacy services begin. The payment model for the PBM's administrative fee shall be made available to the Agency.

F.11.09. *PBM Oversight.* The Contractor shall develop a plan for oversight of the PBM's performance, including Provider issues at a minimum, and submit the plan to the Agency for review within fifteen (15) Days after Contract execution. The plan shall identify the steps to be taken and include a timeline with target dates. A final plan, incorporating any changes requested by the Agency, shall be submitted to the Agency within fifteen (15) Days of receiving Agency comments on the first submission of the plan. 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.

F.11.10. *System Requirements.* The Contractor shall have an automated Claims and encounter processing system for pharmacy Claims that will support the requirements of this Contract and ensure the accurate and timely processing of Claims and encounters. The Contractor shall support electronic submission of Claims using the most current HIPAA compliant transaction standard. Pharmacy Claim edits shall include but are not limited to a minimum of eligibility, drug coverage, benefit limitations, prescriber and prospective/concurrent Drug Utilization Review edits. The system shall provide for an automated update to the National Drug Code file including all product, packaging, prescription, pricing and rebate information. The system shall provide online access to reference file information. The system shall maintain a history of the pricing schedules and other significant reference data. The drug file, including price, shall be updated at a minimum every seven (7) Days. Contractor may update the file more frequently. Audit Trails shall be maintained online for no less than six (6) years; additional history shall be retained for no less than ten (10) years. Contractor shall provide forty-eight (48) hour turnaround or better on request for access to information in machine readable form, that is between six (6) to ten (10) years old.

F.11.11. *Claim Entries.* The Contractor shall ensure that the National Drug Code (NDC) is listed on all Claims. This information shall be supplied by the Provider based on actual package utilized. Provisions shall be made to maintain permanent history by service date for those services identified as "once-in-a-lifetime."

F.11.12. *Reimbursement:* Contractor shall reimburse consistent with Iowa Admin. Code r. 441-79.1(8). Contractor shall reimburse pharmacy Providers at a professional Dispensing Fee as determined and approved by the Medicaid FFS cost of dispensing study performed every two (2) years.

F.11.13. *340B Drug Pricing Program, 340B Covered Entities: 340B Drug Pricing Program, 340B Covered Entities:* Contractor shall ensure that all 340B Covered Entities that use 340B Program drugs and serve Iowa Medicaid managed care Enrollees adhere to all Agency 340B Program policies and procedures including appropriate Claim level identifiers. This requirement applies to outpatient pharmacy Claims, Physician/Provider administered drugs, vaccines, diabetic supplies and exclusion of 340B contract pharmacies. See: IL 2243-MC (July 13, 2021).

a) The Contractor shall be required to meet the same timeframes for reimbursement, prior approval responses and clean claims for 340B claims as for non-340B claims.

b) The Contractor shall not apply a different timeframe for timely filing to 340B claims than non-340B claims, unless otherwise permitted by federal law.

c) The Contractor shall not apply restrictions to 340B claims or covered entities if not applied to non-340B claims or providers such as fees, chargebacks, claw backs, adjustments, or other assessments not already required or permitted by Iowa law or Administrative Code.

d) The Contractor shall not require any additional prior approvals, fraud checks, forms, or data reporting for 340B covered entities or 340B prescription drugs that is not required of non-340B providers or non-340B prescription drugs, unless otherwise required by federal law or approved by Iowa Medicaid as an amendment to this agreement.

F.11.14. *Drug Utilization Data Reporting.* Contractor shall report:

a) Drug utilization data that is necessary for the State to bill manufacturers for rebates no later than 45 Days after the end of each quarterly rebate period.
b) Drug utilization information that includes, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code (NDC) of each covered outpatient drug dispensed or covered by Contractor. For Physician/Provider administered drug Claims, Contractor shall include, at a minimum, in encounter data the HCPCS/CPT code and the number of code units and NDC for each encounter.

See: 42 C.F.R. § 438.3(s)(2); section 1927(b)(1)(A) of the Social Security Act. {From CMSC F.11.02 – F.11.03}.

F.11.15. *Physician/Provider Administered Drugs.* The Contractor shall provide coverage and reimbursement for Physician/Provider administered drugs (which means drugs that are not self-administered or those not administered in the home) to the same extent as the Medicaid FFS, including federal rebate requirements. Such drugs would typically be injected or infused. The billing information shall comply with all Medicaid FFS billing requirements including, but not limited to 340B billing, in accordance with guidelines provided by the Agency.

F.11.16. *Federal Drug Rebates.* The Contractor shall ensure compliance with the rebate requirements under Section 1927 of the Social Security Act. Contractor shall provide information on drugs administered/dispensed to individuals enrolled in the MCO. Specifically, Section 1927(b) of the Social Security Act, as amended by Section 2501(c) of PPACA, requires the Agency to provide utilization information for Contractor covered drugs in the quarterly rebate invoices to drug manufacturers and in quarterly utilization reports to the CMS. The Contractor shall submit all outpatient prescription drug encounters and Physician/Provider administered drug encounters, with the exception of inpatient hospital drug encounters to the Agency or its Designee pursuant to the requirements of this Contract. The Agency or its Designee will submit these encounters for federal Drug Rebates from manufacturers.

F.11.17. *Supplemental Rebates.* The Agency participates in the federal supplemental Drug Rebate program. Other than reimbursement by the Agency, Contractor and its Subcontractors including their PBM(s) are prohibited from obtaining anything of value, including but not limited to rebates, credits, discounts, and fees, in relation to prescription drugs. This provision excludes the Hawki program.

F.11.18. *Drug Encounter Claims Submission.* Contractor shall submit pharmacy encounter data in compliance with the Iowa Medicaid Encounter Companion Guide, inclusive of all fields listed in the guide. The Contractor shall submit a Claim-level detail file once a week of drug encounters to the Agency or its Designee, unless otherwise approved. The Contractor shall provide this reporting to the Agency in the manner and timeframe prescribed by the Agency, including, but not limited to, the submission of complete and accurate drug encounter data rebate file and required Attestation Form to the Agency or its Designee. The detail must provide the basis for comparing the actual amount paid to pharmacies to the amount that the PBM charged the Contractor for the transaction. The Contractor shall comply with spread pricing prohibition and if pass through pricing is used for PBM contracting, any administrative fee the PBM charges the Contractor, cannot be sent as part of the encounter claim pricing. The Contractor shall comply with all file layout requirements including, but not limited to, format and naming conventions and submission of Provider paid amount. A complete listing of Claim fields required will be determined by the Agency. The Contractor shall ensure that its pharmacy Claims process recognizes Claims from 340B pharmacies for products purchased through the 340B Program at the Claim level utilizing the NCPDP field designed for this purpose. The Contractor shall ensure that the Physician/Provider administered drug Claims process recognizes Claims from 340B Providers at the Claim level.

See: CMS CIB 050519 and 42 C.F.R. § 438.8(e)(2)(v)(A) and 42 CFR 438.8(k)(3)

F.11.19. *Drug Rebate Quality Assurance Process.* Contractor shall implement and at all times comply with a pre- and post-payment Quality Assurance processes to optimize Medicaid Drug Rebate Program invoicing and collection. Contractor shall develop policies and procedures and document the same in the PPM to ensure compliance with all federal rebate obligations.

F.11.20. *Drug Rebate Dispute Resolution .*
Participating drug manufacturers in the Medicaid Drug Rebate Program (MDRP) are invoiced quarterly for utilization of their drug products per CMS regulations and guidelines.
When a labeler remits payment to the state, they may dispute certain claims if they have identified an error that needs corrected. The contractor is responsible for resolving all pharmacy and medical drug disputes submitted by drug manufacturers for the contractor's claims.
The process indicated in the 'Drug Dispute Workflow' document must be followed including any subsequent revisions. Excluding months when there are no drug disputes, the Contractor will receive a monthly file of disputes that must be worked in a timely manner.
Upon initial receipt, the contractor has a maximum of sixty (60) days to accurately resolve all drug rebate disputes and submit a completed file to the secure system specified by the state. The Contractor must also submit the corrected pharmacy claims on a weekly encounter data file and the corrected medical drug claims on a monthly encounter data file.

In addition to the administrative sanctions of this contract, failure of the Contractor to submit corrected claims on the encounter data files and/or upload a completed monthly file within the required timelines provided shall result in a monthly offset to the capitation payment equal to the value of the provider reimbursement amount on the disputed claims.

F.11.21. *Excluded Drug Encounter Submissions.* The Contractor shall review all claims excluded from Drug Rebate invoicing exclusions and

a) Develop a review process to ensure all exclusions are appropriate and claims payable,
b) Develop Corrective Action Plan for Claims paid with errors/issues, and
c) Make programming changes, where applicable, to prevent issues in the future.

Contractor shall be responsible for uncorrected invalid rebate exclusions. A report is produced by the Agency and provided to the Contractor no later than sixty (60) Days following the close of the invoicing quarter. Post-payment Claim review and timely correction is solely the responsibility of the Contractor.

F.11.22. *340B Exclusions.* Contractor shall establish procedures to report all utilization data for covered outpatient drugs, specifically identifying drugs subject to discounts under the 340B drug pricing program so as to prevent duplicate discounts on such drugs. See: 42 C.F.R. § 438.3(s)(3). {From CMSC F.11.04}.

F.11.23. *Drug Utilization Review (DUR) Program.* Contractor shall operate a DUR program that includes prospective drug review, retrospective drug review , and an educational program as required at 42 C.F.R. part 456, subpart K. See: 42 C.F.R. § 438.3(s)(4). {From CMSC F.11.05}.

F.11.24. *Agency DUR:* Contractor shall contribute to and participate in the Agency's DUR Board (Commission) meetings and activities and shall adhere to DUR oversight conducted on the Medicaid FFS population and initiatives recommended. Contractor's participation in the Agency's DUR Board activities satisfies all contractual DUR requirements, and Contractor need not have its own DUR board or commission for purposes of this Contract. No DUR initiatives can be implemented without review and recommendation from the Agency's DUR Board. Contractor may not go beyond the DUR Board/Commission's mandates.

F.11.25. *Prospective DUR (proDUR):* The Contractor shall implement all Medicaid FFS proDUR edits through its POS pharmacy Claims processing system and/or vendor.

F.11.26. *Retrospective DUR (Retro-DUR):* The Contractor shall participate and collaborate with the Agency's DUR Board (Commission) activities related to all aspects of Retro-DUR including but not limited to providing Claims data, conducting the activity, following up (re-evaluation), and providing all associated reporting.

F.11.27. *Educational Component:* The Contractor shall participate and collaborate with the Agency's DUR Board (Commission) activities related to the educational program/interventions for prescribers and pharmacists as recommended by the DUR Board (Commission) including but not limited to providing Claims data, conducting the activity, following up (re-evaluation) and providing all associated reporting.

F.11.28. *DUR Reporting:* The Contractor shall provide all reporting as deemed necessary to perform the federal and State required DUR functions, including but not limited to, the CMS Drug Utilization Review Annual Report, Quarterly Agency DUR Program Report, Prevalence and associated reporting for each DUR meeting, and SUPPORT Act reporting, in the format and timeline as directed by the Agency through the State regulatory process.

F.11.29. *DUR Commission:* Contractor shall collaborate with the Agency on all federally required activities as well as development and review of Prior Authorization criteria and Pro-DUR Review edits, which will be forwarded for review and approval by the DUR Board (Commission) and Agency staff. The Agency will provide the Contractor with an MCO DUR Commission Guideline document, which details additional specifics regarding process.

F.11.30. *CMS Annual DUR Reporting.* Contractor shall provide a detailed description of its Drug Utilization Review program activities to the State on an annual basis. See: 42 C.F.R. § 438.3(s)(5). {From CMSC F.11.06}.

F.11.31. *Utilization Management Programs.* Contractor may develop programs under this Contract to ensure appropriate utilization. These programs shall be reviewed and approved by the Agency in advance of implementation.

F.11.32. *Utilization Management Program Reporting:* The Contractor shall provide reports on UM programs quarterly and in a format as directed by the Agency.

F.11.33. *PA Programs.* Contractor shall conduct a Prior Authorization program that complies with the requirements of section 1927(d)(5) of the Social Security Act, as if such requirements applied to the Contractor instead of the Agency. See: 42 C.F.R. § 438.3(s)(6); Section 1927(d)(5) of the Social Security Act. {From CMSC F.11.07}.

F.11.34. *PA response time:* Contractor shall ensure that zero Prior Authorization responses exceed twenty-four (24) hours.

F.11.35. *SUPPORT Act Requirements.* Consistent with section 1902(oo)(1)(A)(ii) of the Social Security Act, as added by the SUPPORT for Patients and Communities Act, Contractor shall have in place, for individuals eligible for medical assistance under the State Plan (or waiver of the State Plan) who are enrolled with the entity, subject to the exemptions for individuals noted in the Act,

a) Safety edit on Days' supply, early refills, duplicate fills, and quantity limitations on opioids and a Claims review automated process that indicates fills of opioids in excess of limitations identified by the State;
b) Safety edits on the maximum daily morphine equivalent for treatment of pain and a Claims review automated process that indicates when an individual is prescribed the morphine milligram equivalent for such treatment in excess of any limitation that may be identified by the State;
c) A claims review automated process that monitors when an individual is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics;
d) A program to monitor and manage the appropriate use of antipsychotic medications by all children including foster children enrolled under the State Plan;
e) Fraud and Abuse identification processes that identifies potential Fraud or Abuse of controlled substances by beneficiaries, health care Providers, and pharmacies;
f) Implementation of retrospective reviews on opioid prescriptions exceeding above limitations on an ongoing basis.

All of the above SUPPORT Act requirements are satisfied by Contractor's compliance with the obligation to adhere to the Agency's DUR Board recommendations as implemented by the Agency.

F.11.36. *Preferred Drug List (PDL) and Recommended Drug List (RDL).* Iowa law permits the Agency to restrict access to prescription drugs through the use of a PDL with PA. Iowa Admin. Code r. 441-78.2(4)(a). The Contractor will follow and enforce the PDL under the Medicaid FFS Pharmacy benefit with PA criteria, including all utilization edits. Pursuant to Iowa Code § 249A.20A, drugs prescribed for the treatment of human immunodeficiency virus or acquired immune deficiency syndrome, transplantation and cancer are excluded from inclusion on the PDL. The Agency developed the RDL for these drug categories. The Contractor shall utilize the RDL, which is a voluntary list of drugs recommended to the Agency by the Iowa Medicaid P&T Committee to inform prescribers of the most cost-effective drugs in those categories. Contractor shall enforce any Medicaid FFS PA criteria, including all utilization edits on the RDL drugs or categories.

F.11.37. *Pharmacy Prior Authorization (PA).* Consistent with all applicable laws, the Contractor shall use a PA program to ensure the appropriate use of medications. For any drugs that require PA, the Contractor shall operate and maintain a fully functional PA system to support both automated and manual PA determinations and responses, at minimum, capable of:

a) Examining up to twenty-four (24) months of administrative data; for example, patient-specific pharmacy, medical and encounter Claims from both FFS and MCOs and applying evidence-based guidelines to determine prescribing appropriateness (administrative data includes but is not limited to pharmacy, hospitalizations, length of stay, emergency department utilization, eligibility, paid/denied clams, Provider, etc.).
b) Gathering and applying appropriate decision criteria needed to make a decision.
c) Integrating with the POS Claims processor and all corresponding processing applications and providing an automated decision during the POS transaction with the vendor's POS system in accordance with National Council for Prescription Drug Programs (NCPDP) mandated response times with 95% of electronic PA system transactions completing in less than one (1) second.
d) Submitting PA requests electronically in HIPAA compliant transaction formats using the most current standard.
e) Providing a detailed reporting package.
f) Generating and distributing PA Denial letters to Enrolled Members and applicable healthcare Providers; and PA Approval letters to applicable healthcare Providers.
g) Communicating the decision clearly and quickly to the healthcare Provider.
h) Updating internal records in adjudication/Claims systems and call tracking systems in conjunction with Claims adjudication.

i) Implementing revisions to the PDL and PA programs consistent with FFS and by the effective date of such revisions.
j) Providing the capability to utilize a prescriber's specialty code in rendering an automated Prior Authorization determination.

F.11.38. *Provider Portal*. The Contractor shall provide the Provider community with the ability to automate the Prior Authorization process through a HIPAA-compliant, Web-based Provider portal which shall, at minimum, shall be capable of:
a) Minimizing the burden on the Provider community while driving appropriate utilization;
b) Supplying access to electronic health records to healthcare Providers via a secure login process;
c) Electronically and securely submitting pharmacy PA requests for automated and manual review by examining up to twenty-four (24) months of administrative data; for example, patient-specific pharmacy, medical and encounter Claims and applying evidence-based guidelines to determine prescribing appropriateness (administrative data includes but is not limited to pharmacy, hospitalizations, length of stay, emergency department utilization, eligibility, paid/Denied Claims, Provider, etc.);
d) Providing authorized users with access to an Enrolled Member's:
    1. Patient profile information;
    2. Prescriber information;
    3. PA history;
    4. PA questions;
    5. Approval and Denial outcomes; and
    6. Ability to attach applicable medical record data to PA submissions.

F.12 Long-Term Services and Supports (LTSS)
F.12.01. *Contractor Service Obligations.* The Contractor shall deliver LTSS to all Enrolled Members meeting the eligibility criteria and authorized to be served by these programs. The Contractor shall provide for: (i) assessment of needs-based eligibility; (ii) service plan review and authorization; (iii) Claims payment; (iv) Provider recruitment; (v) Provider agreement execution; (vi) rate setting; and (vii) providing training and technical assistance to Providers.

F.12.02. Contractor shall establish and maintain an Enrolled Member advisory committee. See: 42 C.F.R. § 438.110(a). {From CMSC F.13.01}.

F.12.03. *LTSS Member Stakeholder Engagement.* Contractor shall develop a comprehensive Enrolled Member and stakeholder education and engagement strategy to ensure understanding of the program and to promote a collaborative effort to enhance the delivery of high-Quality services to Enrolled Members. Representatives from the MCO will participate in HHS-sponsored outreach and education activities as requested by the Agency. Contractor shall document its strategy in the PPM.

F.12.04. *LTSS Stakeholder Advisory Board.* The Contractor shall convene a Stakeholder Advisory Board in accordance with the following requirements of 42 C.F.R. § 438.110. Contractor shall establish and maintain a stakeholder advisory board within ninety (90) Days of the effective date of the Contract. The purpose of the Stakeholder Advisory Board is to serve as a forum for Enrolled Members or their representatives and Providers to advise the Contractor. The Stakeholder Advisory Board shall provide input on issues such as: (i) service delivery; (ii) Quality of care; (iii) Enrolled Member rights and responsibilities; (iv) resolution of Grievances and Appeals; (v) operational issues; (vi) program monitoring and evaluation; (vii) Enrolled Member and Provider education; and (viii) priority issues identified by Enrolled Members.

F.12.05. *LTSS Stakeholder Advisory Board Composition.* The Stakeholder Advisory Board shall be comprised of Enrolled Members' representatives of the different populations enrolled in the program, family members and Providers. The Stakeholder Advisory Board shall have an equitable representation of its Enrolled Members in terms of race, gender, special populations and Iowa geographic areas. At least 51% of the Stakeholder Advisory Board shall be comprised of Enrolled Members and/or their representatives (e.g., family members or caregivers), including Enrolled Members receiving LTSS. Provider membership shall be representative of the different services covered under the Contract, including, but not limited to LTSS Primary Care and behavioral health Providers.

F.12.06. *Advisory Board Documentation.* The Contractor shall maintain written documentation of all attempts to invite and include Enrolled Members in the Stakeholder Advisory Board meetings. Additionally, the Contractor shall maintain meeting minutes, which shall be made available to the Agency upon request. The Contractor shall report to the Agency on participation rates, engagement strategies and outcomes of the committee process in the timeframe and manner prescribed by the Agency in the Reporting Manual.

F.12.07. *Facilitating Member Participation.* The Contractor shall implement strategies to facilitate Enrolled Member participation in the Stakeholder Advisory Board meetings, including but not limited to alternative means of remote participation such as video or conference call and through the provision of transportation, interpretation services, and personal care assistance.

F.12.08. *Meeting Frequency.* The Contractor shall convene the Stakeholder Advisory Board, at minimum, on a quarterly basis and in regions throughout the state. The Contractor shall advise the Agency of all meetings at least 15 Days in advance of the meeting.

F.12.09. *Meeting Outcomes.* The Contractor shall utilize feedback obtained from the Stakeholder Advisory Board in the development and implementation of process improvement strategies and to inform policy and procedure development and modification. Issues raised by stakeholders shall be incorporated into the Contractor's Quality assessment and performance improvement program, and into other Contractor operational planning and management activities as indicated by the nature of the input.

F.12.10. The Member advisory committee shall include at least a reasonably representative sample of the LTSS populations, or other individuals representing those Enrolled Members, covered under the Contract. See: 42 C.F.R. § 438.110(b). {From CMSC F.13.02}.

F.12.11. *LTSS Service Provision*. LTSS service provision is described below.

F.12.12. *LTSS in General.* 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. The Contractor shall support and enhance person-centered care. When Enrolled Members reside in nursing facilities or ICF/IDs, those facilities are primarily responsible for the care and treatment of those individuals, and for addressing health and safety needs. Enrolled Members residing in these facilities receive additional Care Coordination and Quality oversight from the Contractor. When Enrolled Members with health and long-term care needs live in their own homes or other community-based residential settings, the Contractor, in accordance with 42 C.F.R. § 438.208(c)(3)(i) – (v), shall, with the Enrolled Member's participation and in consultation with the Enrolled Member's Provider(s) develop a person-centered care plan to address the Enrolled Member's care and treatment needs, providing assurances for health and safety, and proactively address potential risks related to Enrolled Members' desires to live as independently as possible. For Enrolled Members who require individualized, enhanced staffing patterns to support

them in a less-restrictive setting, the Contractor shall not reduce the enhanced staffing arbitrarily without supporting documentation including Provider service documentation and reassessment of the Enrolled Member's needs.

F.12.13. *Identification of Members Needing LTSS.* Contractor shall develop, implement, and adhere to policies and procedures for ongoing identification of Enrolled Members who may be eligible for LTSS, which includes, at minimum the following processes: (i) processing referrals from an Enrolled Member's Provider(s); (ii) processing Enrolled Member self-referrals; (iii) incorporating hospital admission notifications; and (iv) ongoing review of Claims data. Contractor shall document its policies and procedures in its PPM.

F.12.14. *Coverage of Long Term Services and Supports (LTSS).* The Contractor shall not reduce, modify or terminate LTSS services in the absence of a current needs assessment that supports the reduction, modification or termination. Identification of duplication of services, use of like State Plan services in place of LTSS, or other efforts to address over-utilization and under-utilization shall be documented by the Contractor as part of the service planning process. The Contractor shall ensure Enrolled Members receiving LTSS will be permitted to see all current Providers on their approved service plan, when they initially enroll with the Contractor, even on a non-network basis, until an updated service plan is completed, either agreed upon by the Enrolled Member or resolved through the Appeals or fair hearing process, and implemented. The Contractor shall extend the authorization of LTSS from a non-contracted Provider as necessary to ensure continuity of care pending the Provider's contracting with the Contractor, or the Enrolled Member's transition to a contract Provider. The Contractor shall facilitate a seamless transition to new services and/or Providers, as applicable, in the plan of care developed by the Contractor without any disruption in services.

F.12.15. *Residential Services*

a) *Year One Operations.* During the first year following Contractor's entry into the IA Health Link marketplace, the Contractor shall permit Enrolled Members using an LTSS Residential Provider at the time of enrollment with the Contractor to continue to receive care from the residential Provider being utilized at the time of enrollment for up to one (1) year, even on a non-network basis.
b) *Ongoing Operations.* At all other times not set forth in Section F.12.15(a), the Contractor shall not transition Enrolled Members using LTSS Residential Providers to another residential Provider unless the following conditions are met: (i) the Enrolled Member or their representative specifically requests to transition; (ii) the Enrolled Member or their representative provides written consent to transition based on Quality or other concerns raised by the Contractor, which shall not include the residential Provider's rate of reimbursement; (iii) the residential Provider has chosen not to contract with the Contractor; or (iv) the residential Provider chooses to not serve the Enrolled Member at the reimbursement rate offered. If the residential Provider is a non-contract Provider, the Contractor may: (i) authorize continuation of the services pending contracting with the Provider; (ii) authorize continuation of the services, for at least thirty (30) Days pending facilitation of the Enrolled Member's transition to a contracted Provider, subject to the Enrolled Member's agreement with such transition; or (iii) continue to reimburse services from the non-contract Provider. If an Enrolled Member is transitioned to a contract Provider, the Contractor shall extend the authorization of services with the non-contracted Provider beyond the minimum thirty (30) day requirement as necessary to ensure continuity of care and the Enrolled Member's seamless transition to a new Provider. The Contractor shall permit an Enrolled Member to remain with their residential Provider for at least one (1) year or with their inpatient psychiatric Provider, regardless of network status, as long as the services continue to be medically necessary. If, for whatever reason, an Enrolled Member can no longer be served by their residential Provider the Contractor shall find and make available to the Enrolled Member an alternative residential

Provider who can meet the Enrolled Member's needs. The Contractor shall ensure a seamless transition to new services and/or Providers, as applicable, in the plan of care developed by the Enrolled Member's IDT without any disruption in services.

F.12.16. *Transitions Between Facilities or Community Settings.* The Contractor shall not transition LTSS community-based residents to a facility, other residence, or more restrictive setting unless: (i) the Enrolled Member or their representative specifically requests to transition; (ii) the Enrolled Member or their representative provides written consent to transition based on Quality or other concerns raised by the Contractor, which shall not include the residential Provider's rate of reimbursement; or (iii) the Provider has chosen not to contract with the Contractor and all efforts have been exhausted to secure an alternative Provider. The Contractor shall establish contractual terms with its Providers that protect an individual from involuntary discharge without a minimum thirty (30) day notice and an acceptable transition plan to avoid placement in an inappropriate or more restrictive setting. The Contractor shall ensure a seamless transition whenever an Enrolled Member transitions without any disruption in services.

F.12.17. *Admissions Alternatives.* If an Enrolled Member is unable to be placed in the LTSS residential settings of their choice, the Contractor shall meet with the Enrolled Member and/or the designated/legal representative to provide options counseling to discuss: (i) the reasons why placement is not possible; (ii) available options; and (iii) identification of an alternative facility or community-based residential setting. When the Contractor is facilitating an Enrolled Member's admission to an NF, the Contractor shall ensure that all PASRR requirements have been met prior to the Enrolled Member's admission to a NF. The Contractor shall ensure that Enrolled Members have the option to receive HCBS in more than one (1) residential setting appropriate to their needs and shall educate Enrolled Members on the available settings.

F.12.18. *Implementation Transition of Services.* In addition to the continuity of care requirements described in Section G.2, the Contractor shall implement a comprehensive strategy to ensure a seamless transition of services. Contractor shall have a strategy and timeline to ensure that all Enrolled Members receiving LTSS will receive an in-person visit from appropriate Contractor staff and an updated needs assessment and service plan at a minimum on an annual basis and more often as the Enrolled Member's needs dictate. Services may not be reduced, modified or terminated in the absence of an up-to-date assessment of needs that supports the reduction, modification or termination. Contractor shall document its strategy in the PPM.

F.12A Long-Term Care Facilities (ICF/ID, NF, SNF and NF/MI)

F.12A.01. *LTSS Successful Transition after Long-Term Institutional Stay.* In accordance with the Agency's Community Integration plan, Contractor shall demonstrate an ongoing increase in the number of Enrolled Members successfully returning to the community following a long-term institutional stay.

F.12A.02. *LTSS Supports Minimizing Institutional Length of Stay.* Contractor shall demonstrate an ongoing increase in the number of eligible Enrolled Members successfully discharged to the community within one hundred twenty (120) Days of admission.

F.12A.03. *LTSS Admission to an Institution from the Community*. In accordance with the Agency's Community Integration plan, Contractor shall demonstrate an ongoing decrease in the number of institutional facility admissions by eligible Enrolled Members.

F.12A.04. *Preadmission Screening and Resident Review*. Prior to admission to an NF and any time there is a significant change in status, Enrolled Members will receive a pre-admission screening and resident review (PASRR), to include a PASRR level I screening and as applicable, a level II PASRR

evaluation. Consistent with 42 C.F.R. § 483.20, the Agency's designee performs all PASRR evaluations. The Contractor shall work with Agency or its designee responsible for implementing the PASRR process and for oversight to ensure that PASRR screenings are conducted prior to admission or when there is a significant change in the Enrolled Member's status. The Contractor shall be responsible for ensuring that Enrolled Members receive specialized services identified by the PASRR process.

F.12A.05. *LOCs for SNF, NF & ICF/ID Residents.* The Agency will perform initial level of care assessments for SNF, NF or ICF/ID enrollment for individuals who are enrolled with the Contractor and are applying for initial Medicaid LTSS eligibility, as follows:

a) Skilled Nursing Facilities:
    1. A prior authorization is required prior to admission for a skilled nursing facility stay and the prior authorization must be uploaded to the Agency identified database within five (5) days upon the prior authorization approval.
    2. Prior authorization reassessments are to be performed by the Contractor. The Contractor shall submit the prior authorization reassessment to the Agency approved database within five (5) days of the completed assessment.
b) Nursing Facilities
    1. The Agency will perform initial level of care assessments for NF enrollment for individuals who are enrolled with the Contractor and are applying for initial Medicaid LTSS eligibility.
    2. Continued stay reviews must be completed annually and are to be performed by the Contractor. The Contractor shall submit the level of care/support needs assessment to the Agency approved database within five (5) days of the completed assessment.
c) ICF/ID
    1. The Agency will perform initial level of care assessments for ICF/ID enrollment for individuals who are enrolled with the Contractor and are applying for initial Medicaid LTSS eligibility.
    2. For all members enrolled with a Managed Care Organization, the MCO shall review the Member's need for continued care in an ICF/ID at least annually .

The Agency will retain all authority for determining Medicaid categorical, financial, and level of care eligibility and enrolling Members into a Medicaid eligibility category. The Agency will notify the Contractor when an Enrolled Member has been enrolled in SNF, NF or ICF/ID eligibility category and any applicable Client Participation amounts.

F.12A.06. *LTSS Facilities; Case Management Requirements.* Contractor shall obtain Agency approval of strategies for monitoring services for Enrolled Members in LTSS facilities. Community Based Case management must meet the requirements contained in Section F.12C of this Contract.

The Contractor shall ensure the provision of care for Enrolled Members, which includes coordinating with LTSS facilities. The Contractor shall initiate and lead transitional care coordination to Enrolled Members residing in a facility to ensure transition into the community where appropriate. Transitional care activities include but are not limited to the Contractor's development and implementation of a transitional care plan and securing placement with a Provider that is able to meet the Enrolled Member's needs. The Contractor shall implement strategies, as approved by the Agency, to monitor transition and ensure that services and supports are made available to ensure transition success.

The Contractor shall develop, implement, and adhere to targeted strategies to improve the health, functional and Quality of life Outcomes of Enrolled Members residing in an LTSS facility. The Contractor shall develop, implement, and adhere to policies and procedures, subject to Agency review and approval, to escalate and report concerns regarding LTSS facility Quality. The Contractor shall provide all Enrolled Members residing in LTSS facilities options counseling and transition

activities, including but not limited to those Enrolled Members identified through quarterly screening of MDS Section Q, Participation in Assessment and Goal Setting. Contractor shall provide Enrolled Members any necessary information regarding the waiver application process if the Enrolled Member wishes to return to the community. Contractor shall identify a single point of contact for each Enrolled Member.

F.12A.07. *Diversion Strategies.* Contractor shall develop a comprehensive institutional diversion program. The Contractor's program shall target and address the needs of groups needing institutional diversion, including but not limited to: (i) Enrolled Members waiting placement in an NF, ICF/ID or other institutional setting; (ii) Enrolled Members who may be on an HCBS waiver waitlist; (iii) Enrolled Members who have a change in circumstance or deterioration in health or functioning and request LTSS facility placements; (iv) waiver Enrollees admitted to a hospital or inpatient rehabilitation program; (v) individuals in a NF for a short-term stay; and (vi) incarcerated Enrolled Members. Contractor shall document its program in its PPM.

F.12A.08. *Community Transition Activities.* In accordance with the Agency's Community Integration plan, Contractor shall develop strategies to identify Enrolled Members who desire to transition from a LTSS facility setting to community integrated settings. In addition to the MFP Grant activities, the Contractor shall include strategies to identify Enrolled Members who have the ability or desire to transition from an LTSS facility setting to the community. Contractor shall document its strategies in its PPM.

The provider shall complete the MDS, per 42 C.F.R. § 483.112, on Enrolled Members and shall otherwise report transition outcomes related to Enrolled Member transitions to the community from facility settings. The transition assessment shall include, at minimum, an assessment of the Enrolled Member's desire and ability to transition to the community as well as an identification of risks. The Contractor shall develop a transition plan and engage the Enrolled Member and representatives of the Enrolled Member's choosing in the transition plan development process. The transition plan shall address all transition needs and services necessary to safely transition the Enrolled Member to the community including but not limited to: (i) physical and behavioral health needs; (ii) selection of Providers in the community; (iii) housing needs; (iv) financial needs; (v) interpersonal skills; and (vi) safety. The transition plan shall also identify any barriers to a safe transition and strategies to overcome those barriers. If as part of the transition plan the Enrolled Member enrolls in a 1915(c) HCBS Waiver, or 1915(i) state plan HCBS Habilitation program, the needs assessment and service plan requirements described in Iowa Admin. Code chs. 441-78, 441-83 and 441-90

The State currently operates an MFP grant, which provides opportunities for individuals in Iowa to move out of ICF/IDs and nursing facilities and into their own homes in the community of their choice. The Contractor shall implement Agency-approved strategies to coordinate care with the MFP transition specialist prior to and during the demonstration year to prevent duplication and fragmentation of care. The Contractor maintains primary responsibility for holistic care management while the MFP transitional specialist coordinates facility to community services transition. Contractor shall document strategies in its PPM. If the MFP grant is no longer authorized by CMS, the Contractor shall assist with the development and implementation of the sustainability plan, subject to the Agency's approval.

F.12A.09. *Monitoring of Community Transition Activities.* The Contractor shall monitor all aspects of the transition process and take immediate action to address any issues that arise. The Contractor shall monitor hospitalizations and LTSS facility readmissions for Enrolled Members who transition to the community to identify issues and implement strategies to improve Outcomes. The Contractor shall conduct face-to-face visits with the Enrolled Member, at minimum: (i) within two (2) Days of the transition to the community; (ii) every two (2) weeks for the first two (2) months from discharge; and

(iii) once per month for the first year after transition. More frequent contact shall occur based on an individualized assessment of the Enrolled Member's needs and risk factors.

F.12A.10. *State Resource Centers.* SRCs provide intensive intermediate care facility services for individuals with intellectual disabilities. SRCs are included in coverage by the Contractor. The Contractor shall administer and manage coverage of the SRCs consistent with the following:

a) All admissions to SRCs shall be consistent with the requirements of any and all applicable Consent Decrees and Iowa Code § 222.13.
b) Application to the SRC for care, treatment, or evaluation by an SRC shall only be made through Contractor's LTSS Manager.
c) Collectively, all MCOs shall reduce its number of Enrolled Members residing at the SRCs by no less than the target number of beds outlined by the Agency each State fiscal year. Contractor shall show a continual reduction of bed utilization at the SRCs.
d) The Contractor shall lead efforts with the SRCs to identify, develop, and coordinate community transition plans for residents.
e) The Contractor shall fund transition activities, including but not limited to training staff at the new placement, staff visits, and staffing for overnight visits during the transition period. For purposes of this provision, the transition period means no less than six (6) months post-transition.
f) The Contractor shall fund diversion referral activities to appropriately divert referrals from SRC placement to available services in the community.
g) The Contractor shall fund all placements mandated by the court pursuant to Iowa law.

F.12B 1915(c) and 1915(i) Home and Community-Based Services

F.12B.01. *Overview.* The State currently operates 1915(c) and 1915(i) HCBS programs. The Contractor shall deliver the HCBS services to all Enrolled Members meeting the eligibility criteria and authorized to be served by these programs. The Contractor shall provide: (i) screening of Enrolled Members who appear to be eligible; (ii) timely completion of the initial and annual comprehensive functional assessment for needs-based eligibility and level of care; (iii) monitoring of Enrolled Members on the HCBS wait list; (iv) completion of a Social History; (v) annual redetermination of needs-based eligibility and level of care; (vi) service plan review, services monitoring, and authorization; (vii) Claims payment; (viii) network capacity; (ix) Provider agreement execution; (x) rate setting; and (xi) Provider training and technical assistance.

F.12B.02. *HCBS Settings.* Contractor shall provide LTSS services in a setting that complies with the 42 C.F.R. § 441.301(c)(4) requirements for home and community-based settings. See: 42 C.F.R. § 438.3(o); sections 1915(c), 1915(i), and 1915(k) of the Social Security Act; 42 C.F.R. § 441.301(c)(4); 42 C.F.R. § 401.725; 42 C.F.R. § 401.710(a)(1)-(2) {From CMSC F.13.03}

F.12B.03. *Waiting List*. In the event there is a waiting list for a 1915(c) Waiver, at the time of application, the Contractor shall advise the Enrolled Member there is a waiting list and that they may choose to receive other non-waiver support services because 1915(c) Waiver enrollment is not immediately available. The Contractor shall provide regular outreach to ensure that Enrolled Members are receiving all necessary services and supports to address all health and safety needs while on the wait list.

Enrolled Members are awarded waiver slots by the Agency. When an Enrolled Member is in a facility and qualifies for a reserved capacity slot, the Agency will work with the Contractor for slot release. Contractor shall ensure that each Enrolled Member has obtained supporting documentation necessary to support eligibility for the particular waiver.

The Contractor shall ensure that the number of Enrolled Members assigned to LTSS is managed in such a way that ensures maximum Access, especially for HCBS community integrated services, while controlling overall LTSS costs. Achieving these goals requires that the Agency and the Contractor jointly manage Access to LTSS. To that end, the Contractor shall provide the Agency with LTSS utilization information at regularly specified intervals in a specified form. The Agency will convene regular joint LTSS Access meetings with all Contractors. The purpose of the meetings will be to collaboratively and effectively manage Access to LTSS. Except as specified below, the Contractor shall not add Enrolled Members to LTSS without the Agency authorization resulting from joint LTSS Access meetings. Enrollee rights and protections apply to ILOS, including short-term IMD stays. These include the right to choose not to receive ILOS, retention of the right to state plan services or settings, the right to informed decisions about health care and to receive information on available treatment options and alternatives, and the right to not have state plan-covered services or settings denied because an ILOS was offered. This also applies to section D.1.09 Payment for services in IMD setting. §§ 438.3(e)(2)(i) – (v), 438.10(g), 457.1201(e) and 457.1207.

a) In Lieu of Services (ILOS) for members on waiting lists the Contractor may offer the following ILOS to individuals on a 1915(c) HCBS waiting list whose name has been placed on a waiting list and who are at risk of hospitalization or imminent institutionalization or in need of ILOS to return to a community living environment where no other resources are available. The determination of ILOS shall be based on the Agency approved standardized assessment tool conducted by the Contractor to assess Medical Necessity for the following services:

1. Pre-tenancy and tenancy sustaining services: these are services that include tenant rights, education, and eviction prevention.
    a. Exclusions and limitations: may NOT include room and board, rental assistance, deposits.
2. Housing transition navigation services: these services encompass tenant rights, eviction prevention, and education. They are designed to support members experiencing homelessness or at risk of homelessness in securing housing.
    a. Exclusions and limitations: may NOT include room and board, rental assistance, deposits.
3. Case management: these services include outreach and education including linkage and referral to community resources and non-Medicaid supports, physical health, behavioral health, and transportation coordination.
    a. Exclusions and limitations: none.
4. Respite care services: these are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.
    a. Exclusions and limitations: up to 120 hours of respite care per year. Must have a primary live-in caregiver who has primary responsibility for caregiving activities.
5. Personal care services: these services are a range of human assistance provided to persons with disabilities and chronic conditions of all ages to enable them to accomplish tasks that they would normally do for themselves if they did not have a disability. Such assistance most often relates to performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs), which includes assistance with daily activities such as eating, bathing, dressing, toileting, transferring, personal hygiene, light housework, medication management, etc.
    a. Exclusions and limitations:
        i. Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/ID or IMD, part of the individualized plan of treatment. Only available when no Home Health Agency (HHA) agency or In Home Health Related Care (IHHRC) is available and cannot be

combined with HHA services or IHHRC. Documentation of denial of HHA services or IHHRC is required. Must have a need for physical assistance with eating, bathing, personal hygiene, and medication administration.

ii. These services include up to 52 hours per year for eating, bathing dressing and personal hygiene. Assistance may take the form of hands-on assistance or as cueing so that the person performs the task by him/herself.

6. Medically Tailored Meals (MTM): these services include up to 2 meals a day delivered in the home or private residence for up to six months. Medically tailored or nutritionally appropriate food prescriptions delivered in various forms such as nutrition vouchers and food boxes, for up to 6 months. The covered population includes any currently enrolled 1915(c) waiver member that have been discharged from an inpatient hospital, skilled nursing facility, or rehab facility and have mobility needs, no family support to assist with food access and/or be at risk for readmission due to nutritional issues (no age requirement).
    a. Exclusions and limitations:
        i. Medically Tailored Meals Home delivered including prep; per meal (2 meals/day delivered to home).
        ii. Standard home delivered meals will not exceed 2 meals per day for seven days or 60 meals per month.
        iii. Monthly documentation of member's receipt of meals is to be submitted by vendor and is to be on file with the Managed Care Organization. State may request this documentation from the MCO at any time during the State ILOS review process.
        iv. Medically tailored or nutritionally appropriate food prescriptions delivered in various forms such as nutrition vouchers and food boxes, for up to 6 months.
7. Assistive Services/Devices: these services mean practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. Assistive devices include but are not limited to: long-reach brush, extra-long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup, sipper lid.
    a. Exclusions and limitations:
        i. Must require physician letter specifically stating member's dx and why their health would require them to be in a NF without the assistive device and how this helps the member to remain in their home. Item must be least costly to meet member's need.
        ii. Assistive Devices shall include medically necessary items for personal use by a member, supporting the member's health and safety, up to $124.81 per item, not to exceed $500 per year.
8. Home modifications: these are physical modifications to the member's home that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home. Medically necessary home modifications and remediation services may include accessibility ramps, handrails, grab bars, repairing or improving ventilation systems, and mold/pest remediation.
    a. Exclusions and limitations:
        i. Must require physician letter specifically stating member's dx and why their health would require them to be in a NF without the modification and how this helps the member to remain in their home. Item must be least costly to meet member's need.
        ii. Must also have a PT/OT evaluation for physical modification.

iii. Member must own their own home or have written approval from landlord if renting home.
iv. Can also not duplicate or substitute any DME through State Plan Medicaid or any other funding source.
v. Annual limit of $4,000 for Home Modification.
vi. Three (3) bids, physician order, follow protocols like HVM and specialized medical equipment (SME).

9. Vehicle Modifications: these servicesmay include ramps, lifts, wheelchair securement systems or other modifications that increase the waiver applicant's ability to be transported safely and securely and remain in their own home.
    a. Exclusions and limitations:
        i. Must require physician letter specifically stating member's dx and why their health would require them to be in a NF without the modification and how this helps the member to remain in their home.
        ii. Service must be least costly to meet member's need.
        iii. Member must own their own vehicle or have written approval from vehicle owner.
        iv. Annual limit of $5,000 for vehicle modifications
        v. 3 bids, physician order, follow protocols like HVM and SME.
10. Intermittent Supported Community Living Services (SCL): these services include supported community living services are provided within the member's home and community, according to the individualized member need. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.
    a. Exclusions and limitations:
        i. Activities do not include those associated with vocational services, academics, day care, or medical services.
        ii. Monthly limit of $1,202/mo. (30 hrs./mo. @ $10.02/15 min. unit).
11. Supported Employment Services: supported employment means the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state's minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce in a job that meets personal goals of the member. Includes Individual Supported Employment and Long-Term Job Coaching.
    a. Exclusions and limitations:
        i. Monthly limit of $2,200/mo. (45 hrs./mo.) to obtain and maintain employment.
12. Personal emergency response system (PERS): the personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.
    a. Exclusions and limitations:
        i. Cannot duplicate or substitute any other funding mechanism such as Medicare benefits, Veteran's benefits, etc.
        ii. Must have fall risk or wandering concerns. Cannot be for caregiver convenience and cannot be for members who are not left alone.
13. Specialized medical equipment: specialized medical equipment and supplies include: devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; devices, controls, or appliances that

enable the participant to perceive, control, or communicate with the environment in which they live; items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; such other durable and non-durable medical equipment not available under the state plan that is necessary to address participant functional limitations; and, necessary medical supplies not available under the state plan.

a. Exclusions and limitations:
    i. Specialized medical equipment shall include medically necessary items for personal use by a member, supporting the member's health and safety, up to $3,000 per year. These items may include:
        1. Electronic aids and organizers
        2. Medicine dispensing devices
        3. Communication devices
        4. Bath aids
        5. Environmental control units
        6. Repair and maintenance of items purchased through the waiver specialized medical equipment can be covered when it is:
            a. Not available under the state plan.
            b. Not funded by educational or vocational rehabilitation programs.
            c. Not provided by voluntary means.
            d. Necessary for the member's health and safety, as documented by a health care professional.

14. Adult Day Care: these services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. Components of the service include health-related care, social services, and other related support services.
    a. Exclusions and limitations:
        i. Max 23 days per month if no other services are being utilized.
        ii. Only allowable when a member has a need to be supervised 24/7 and primary
        caregiver is required to work.
        iii. Transportation is allowed to and from the Adult Day Care center as a component of the service.

15. Non-medical Transportation: These services include assisting the member to conduct personal business essential to the health and welfare of the member. Non-Medical Transportation are services offered to member on a waitlist to enable those members on the waitlist to gain access to community services, activities, and resources.
    a. Exclusions and limitations:
        i. Whenever possible, natural supports (family, neighbors, or friends) or community agencies which can provide this service without charge are utilized. This service does not include transportation to medical services.

b) The ILOS notated in this section are limited to less than 1.5% of the total capitation (including directed payments and pass-through payments).

F.12B.04. *Authorization of Admission for NF/ICFID.* The above expectations in Section F.12B.02 notwithstanding, the Contractor shall authorize all admissions of Enrolled Members that meet level of care requirements to NFs and ICFs/ID that have a contract in good standing with the Contractor.

F.12B.05. *Comprehensive Assessments.* Upon notification from the Agency of availability of an open 1915 (c) waiver slot, the Contractor shall conduct a comprehensive assessment, in accordance with 42 C.F.R. § 438.208(c)(2), as described, using a tool and process prior approved by the Agency, for the waitlisted Enrolled Member unless otherwise directed by the Agency per Section F.12B.23. The Contractor shall refer individuals who are identified as potentially eligible for LTSS to the Agency or its designee for level of care determination, if applicable.

F.12B.06. *HCBS Level of Care and Needs-based Assessments.* Contractor shall perform level of care and needs-based assessments for their Enrolled Members unless otherwise directed by the Agency per Section F.12B.23. The Agency has designated the tools that will be used to determine the level of care and comprehensively assessed supports needed for individuals wishing to Access HCBS. The intention of the multi-purpose evaluation is to provide uniformity and streamline the documents completed to determine the appropriate level of care or needs-based eligibility and outline the assessed needs of the individual. The tool is also used to evaluate the Enrolled Members strengths, needs, and level of supports needed to maintain health and safety while residing in the community. The tools currently designated by the Agency are contained in the approved 1915 (c) Waiver Applications and 1915(i) SPA. The Contractor shall not revise or add to the tools without express approval from the Agency.

F.12B.07. *Initial Level of Care Assessments.* The Agency is responsible for performing initial level of care assessments for 1915(c) HCBS Waiver and needs-based eligibility assessments for 1915(i) Habilitation Enrolled Members who are applying for initial Medicaid LTSS eligibility. Contractor shall provide Enrolled Members any necessary information regarding the waiver application process.

F.12B.08. *Initial Assessment and Annual Reassessment.* The Contractor shall perform level of care and needs-based eligibility assessments for Enrolled Members potentially eligible for 1915(c) and 1915(i) HCBS programs includes an assessment of the Enrolled Member's ability to have their needs met safely and effectively in the community and at a reasonable cost to the Agency unless otherwise directed by the Agency per Section F.12B.23. If an Enrolled Member's needs exceed limits established in Iowa Administrative Code or the approved 1915(c) waivers, the Contractor has discretion to authorize services that exceed those limits. If required, the Contractor can submit an exception to policy to the Agency to exceed limits outlined in the Iowa Administrative Code. If an Enrolled Member does not appear to meet enrollment criteria, the Contractor shall comply with the requirements related to the appearance of ineligibility. The Contractor will establish Agency-approved timelines that will promptly assess the Enrolled Member's needs and ensure Enrolled Member safety.

F.12B.09. *Submission of Level of Care.* Once the assessment is completed, the Contractor shall submit the level of care or needs-based eligibility assessment to the Agency. This level of care or needs based assessment shall be uploaded to the Agency database within five (5) days of the date the assessment was completed. The Agency will retain all authority for determining Medicaid categorical, financial and level of care eligibility and enrolling Members into a Medicaid eligibility category. The Agency will notify the Contractor when an Enrolled Member has been enrolled in a 1915(c) HCBS Waiver eligibility category or 1915(i) HCBS program and any applicable Client Participation amounts.

F.12B.10. *Assessment Requirements.* The Contractor shall administer all HCBS level of care and needs-based eligibility assessments in accordance with the following requirements:

a) Enrolled Members shall have the ability to have others present of their choosing;
b) Enrolled Members and chosen team members shall receive notice to schedule no less than fourteen (14) Days prior to current assessment end date;

c) Enrolled Members and chosen team members shall receive a copy of the completed assessment within three (3) business days of the assessment;
d) Enrolled Members and chosen team members shall receive information related to the assessment results in a manner that is meaningful to the team;
e) Assessments shall be conflict-free and firewalled from case management and UM functions;
f) Assessors shall be trained either by the organization that developed the assessment tool or by an individual directly trained by the organization that developed the assessment tool;
g) Assessors shall be trained in appropriate administration of the identified assessment tool in line with best practice for the tool administered;
h) Assessors shall actively participate in the inter-rater reliability oversight and monitoring activities to ensure fidelity in the assessment process;
i) Where applicable, assessment results shall be drawn using a valid sample size to evaluate the inter-rater reliability of the assessment administration; and
j) Any assessment determined to be inappropriately derived during evaluation shall be re-administered within thirty (30) Days of findings.

F.12B.11. *Timeliness of Level of Care and Needs-Based Eligibility Assessments.* Reassessments shall be completed within twelve (12) months of the previous assessment or more frequently as warranted by a significant change in an Enrolled Member's needs or situation. The Agency also reserves the right to audit the application of level of care criteria to ensure the accurate and appropriate application of criteria.

F.12B.12. *Assessment Policies and Procedures.* Contractor shall develop policies and procedures:
a) Identifying a timeline in which all needs assessments shall be completed: (i) upon initial enrollment with the Contractor; and (ii) when the Contractor becomes aware of a change in the Enrolled Member's circumstances which necessitates a new assessment;
b) Providing that reassessments shall be conducted, at least every twelve (12) months; and
c) Identifying a mechanism for completing needs assessments in an appropriate and timely manner. Contractor shall document such policies and procedures in its PPM.

F.12B.13. *Level of Care and Needs-Based Eligibility Changes.* The Contractor shall submit documentation to the Agency, in the timeframes described in Section F.12B.12 and in the format determined by the Agency, for all reassessments that indicate change in the Enrolled Member's 1915(c) level of care or needs-based eligibility for the 1915(i) HCBS programs. The Agency or its Designee shall have final review and approval authority for any reassessments that indicate a change. The Contractor shall comply with the findings of the Agency or its Designee in these cases. If the level of care reassessment or needs-based eligibility reassessment indicates no change in level of care or needs-based eligibility, the Enrolled Member is approved to continue participation in the 1915(i) or 1915(c) HCBS program at the already established level of care for the particular waiver. The Contractor shall maintain the ability to track and report on level of care or needs-based eligibility reassessment data, including but not limited to, the date the reassessment was completed.

F.12B.14. *Service Plan Development.* The Contractor shall provide service plan development for each HCBS Enrolled Member. Contractor shall include how it will ensure that all components of the service plan process will meet contractual requirements, as well as State and Federal regulations and policies, including 42 C.F.R. § 438.208(c)(3)(i)-(v). Contractor shall document any policies and procedures in its PPM.

F.12B.15. *Frequency for Service Planning.* The Contractor shall ensure service plans are completed within 30 days of notification by the Agency of level of care or needs-based eligibility approval, and that the service plan is approved prior to the provision of HCBS services. The Contractor shall ensure completed service plans are uploaded to the Agency designated database and distributed to

the member and other people responsible for implementation of the plan within thirty (30) days of the date the IDT meeting was held. The Contractor shall ensure service plans are reviewed and revised: (i) at least every 365 days; or (ii) when there is significant change in the Enrolled Member's circumstance or needs; or (iii) at the request of the Enrolled Member.

F.12B.16. *Person-Centered Planning Process*. The Contractor shall ensure that the HCBS service plan is established through a Person-Centered Service Planning process that is led by the Enrolled Member or representative. The Enrolled Member's representative shall have a participatory role, as needed and as defined by the Enrolled Member. The Contractor shall establish a team for the Enrolled Member that shall include the case manager, Enrolled Member, family, Providers, IHH Care Coordination staff, and others as appropriate and desired by the Enrolled Member. The Contractor shall implement the level of services and supports as identified by the interdisciplinary team's assessment of the Enrolled Member's needs and as documented in the Enrolled Member's comprehensive person-centered service plan. The Contractor shall ensure that the comprehensive person-centered service plan identifies an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or when the Enrolled Member's needs change. The Contractor shall ensure compliance with the Person-Centered Planning Process. *See* Iowa Admin. Code chs. 441-78, and 441-90; 42 C.F.R. § 441.301 and § 441.725.

F.12B.17. *Service Plan Content.* In accordance with 42 C.F.R. § 441.301 and § 441.725, Iowa Admin. Code ch. 441-90, Iowa Admin. Code ch. 441-83, and Iowa Admin. Code ch. 441-78, the Contractor shall ensure the service plan reflects the services and supports that are important for the Enrolled Member to meet the needs identified through the needs assessment, as well as what is important to the Enrolled Member with regard to preferences for the delivery of such services and supports. The service plan shall reflect the Enrolled Member's needs and preferences and how those needs will be met by a combination of covered services and available community supports. The Person-Centered Service Planning process shall be holistic in addressing the full array of medical and non-medical services and supports regardless of funder to ensure the maximum degree of integration and the best possible health Outcomes and participant satisfaction.

F.12B.18. *Emergency Plan Requirements*. The Contractor shall ensure the service plan has an emergency plan documented that identifies the supports available to the Enrolled Member in situations for which no approved service plan exists and that, if not addressed, may result in injury or harm to the Enrolled Member or other persons or in significant amounts of property damage. Emergency plans shall include, at minimum: (i) the Enrolled Member's risk assessment and the health and safety issues identified by the Enrolled Member's team; (ii) the emergency backup support and crisis response system; and (iii) emergency, backup staff designated by Providers for applicable services.

F.12B.19. *Refusal to Sign*. Contractor shall develop, implement, and adhere to policies and procedures describing measures to be taken by the Contractor to address instances when an Enrolled Member refuses to sign a service plan, including an escalation process that includes a review of the reasons for the Enrolled Member's refusal as well as actions take to resolve any disagreements with the service plan. Contractor shall document such procedures in its PPM.

F.12B.20. *Monitoring Receipt of Services*. After the initiation of services identified in the Enrolled Member's service plan, the Contractor shall implement strategies to monitor the provision of services, at both residential and vocational settings, to confirm services have been initiated and are being provided on an ongoing basis as authorized in the service plan and are meeting the Enrolled Member's identified needs. At minimum, the CBCM or the care coordinator shall contact 1915(c) and 1915(i) HCBS Enrolled Members within five (5) business days of scheduled initiation of services to

confirm that services are being provided and that Enrolled Member's needs are being met. This initial contact may be conducted via phone.

The Contractor shall: (1) develop monitoring strategies to meet this requirement; (2) develop, implement, and adhere to policies and procedures for identifying, responding to, and resolving service gaps; and (3) develop, implement, and adhere to policies and procedures for ensuring that the service plan, emergency plan, and back-up plans are implemented and functioning effectively. The Contractor shall document its policies and procedures in its PPM.

The Contractor shall develop policies and processes for identifying changes to an Enrolled Member's risk and for addressing any changes, including, but not limited to an update to the Enrolled Member's risk assessment and person-centered service plan.

F.12B.21. *Disenrollment.* There are certain conditions that must be met for an individual to be eligible for a 1915(c) HCBS Waiver or 1915(i) State Plan HCBS. The Contractor shall track the information described in this section and notify the Agency, in the manner prescribed by the Agency, at any time a member appears to be ineligible. This notice obligation includes any appearance of ineligibility under Iowa Admin. Code ch. 441-83 or Iowa Admin. Code ch. 441-78.27. The Agency shall have sole authority for determining if the Member will continue to be eligible under the 1915(c) HCBS Waiver or 1915(i) State Plan HCBS program, and the Contractor shall comply with the Agency's determination.

F.12B.22. *Minimum Service Requirements.* Contractor shall notify the Agency if an HCBS waiver Enrolled Member is non-compliant with utilization of at minimum one (1) unit of service per calendar quarter or non-compliant with Contractor's contractual oversight obligations.

F.12.B.23 *Transitioning Comprehensive Assessment, HCBS Level of Care, and Needs-based Assessment functions for Enrolled Members in 1915(c) HCBS Waiver(s).*
Effective January 1, 2025, the Contractor will not be required to complete Comprehensive Assessments, HCBS Level of Care, and Needs-Based Assessments for the Intellectual Disability HCBS Waiver, and effective July 1, 2025 for all of the remaining 1915 (c) HCBS Waivers and Habilitation. The Contractor will be responsible for the following:

a) Communicating changes regarding the assessment process to Enrolled Members.
b) Collaborating with the Agency's assessment contractor which includes communication strategies about assessment needs and a plan for sending and receiving assessment data, and the proposed effective date. [1]

F.12C Community Based Case Management

F.12C.01. *Community-Based Case Management Requirements.* The Contractor shall provide for the delivery of Community-Based Case Management (CBCM) to all community-based LTSS Enrolled Members, including all of the activities described in this section the approved 1915(c) waiver applications, 1915(i) SPA , the case management manual and the Iowa Administrative Code for Enrolled Members who are receiving services under the 1915(c) and 1915(i) HCBS programs. Enrolled Members enrolled in 1915(i) Habilitation and 1915(c) CMH Waiver may receive Care Coordination via the IHH in lieu of CBCM with the Contractor acting as the lead entity.

Unless enrolled in an IHH, the Contractor shall assign to each Enrolled Member receiving home and community-based LTSS a community-based case manager who is the Enrolled Member's main point of contact with the Contractor and their service delivery system. The Contractor shall establish

[1] MED-20-001 Amendment 22

mechanisms to ensure ease of Access and a reasonable level of responsiveness for each Enrolled Member to their community-based case manager during regular business hours. The Contractor shall provide for after-hours contact for Enrolled Members receiving CBCM. Community-based case manager staff shall have knowledge of community alternatives for the LTSS population, and the full range of LTSS resources as well as specialized knowledge of the conditions and functional limitations of the target populations served by the Contractor, and of the individual Enrolled Members to whom they are assigned. The Contractor shall also ensure that additional requirements are met including Section F.12B applicable to Enrolled Members receiving 1915(c) and 1915(i) HCBS programs.

The Contractor shall ensure CBCM is provided in a conflict free manner that administratively separates the final approval of 1915(c) and 1915(i) HCBS program plans of care from the approval of funding amount determined by the Contractor. CBCM efforts made by the Contractor, or its designee, shall avoid duplication of other coordination efforts provided within the Enrolled Members' systems of care.

F.12C.02. *Community-Based Case Manager Qualifications.* Contractor shall submit the required qualifications, experience and training of community-based case managers to the Agency for approval. Community-based case managers serving Enrolled Members that have chosen self direction through the Consumer Choices Option shall have specific experience with self-direction and additional training regarding self-direction. The Agency reserves the right to require the Contractor to hire additional community-based case managers if it is determined, at the sole discretion of the Agency, the Contractor has insufficient CBCM staff to perform its obligations under the Contract. The Agency reserves the right to establish CBCM to Enrolled Member ratios.

The Contractor shall ensure that all case managers serving LTSS populations that are hired on or after July 1, 2024 complete the Agency-identified initial training curriculum on the Agency's Learning Management System (LMS) platform within six (6) months of hire. The Contractor shall also ensure that all case managers serving LTSS populations complete the Agency-identified refresher curriculum by December 31, 2024 as well as on an annual basis within 365 calendar days since the most recent completion date of the initial or refresher curriculum. The Contractor shall be responsible for ensuring that training is also provided on designated topics within the Agency-identified curriculum that are not provided by the Agency. The Contractor shall submit all training content to the agency for prior approval. The Contractor must maintain documentation of staff names and completion dates of all Agency-identified training for LTSS case managers that will be available to the Agency upon request.

F.12C.03. *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 also coordinate with stakeholders funding non-Medicaid covered services and supports to the Enrolled Member that are important to the Enrolled Member's health, safety and well-being and/or impact an Enrolled Member's ability to reside in the community. 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 provide to service Providers information regarding the role of the community-based case manager and request that Providers notify a community-based case manager, as expeditiously as warranted by the Enrolled Member's circumstances, of any significant changes in the Enrolled Member's condition or care, hospitalizations, or recommendations for additional services. The Contractor shall ensure adequate and timely communication and sharing of

records with other managed care 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.12C.04. *Internal Contractor Communications.* The Contractor shall implement strategies to ensure there is internal communication among its departments to ensure community-based case managers are made aware of issues relevant to the Enrolled Members on their assigned caseload. This will include ensuring that community-based case managers have timely access to Medicaid and LTSS eligibility changes and updates.

F.12C.05. *Changes in Community-Based Case Managers*. The Contractor shall permit Enrolled Members to change to a different community-based case manager if the Enrolled Member desires and there is an alternative community-based case manager available. Such availability may take into consideration the Contractor's need to efficiently deliver CBCM in accordance with the requirements of the Contract. In order to ensure Quality and continuity of care, the Contractor shall make efforts to minimize the number of changes in an Enrolled Member's community-based case manager. Examples of when a Contractor initiated change in community-based case managers may be appropriate include, but are not limited, to when the community-based case manager: (i) is no longer employed by the Contractor; (ii) has a conflict of interest and cannot serve the Enrolled Member; (iii) is on temporary leave from employment; or (iv) has caseloads that must be adjusted due to the size or intensity of the individual community-based case manager's caseload.

Contractor shall develop, implement, and adhere to policies and procedures regarding Notice to Enrolled Members of community-based case manager changes initiated by either the Contractor or the Enrolled Member, including advance Notice of planned community-based case manager changes initiated by the Contractor. The Contractor shall ensure continuity of care when community-based case manager changes are made, whether initiated by the Enrolled Member or the Contractor. The Contractor shall demonstrate use of best practices by encouraging newly assigned community-based case managers to attend a face-to-face transition visit with the Enrolled Member and the out-going community-based case manager when possible. Contractor shall document its policies and procedures in its PPM.

Contractor shall develop, implement, and adhere to policies and procedures to provide seamless, effective case management transition for the Enrolled Members from Fee-for-Service to managed care, and from one MCO to another. Contractor shall document and update its policies and procedures as needed and required in its PPM.

F.12C.06. *Discharge Planning.* Contractor shall develop, implement, and adhere to policies and procedures to ensure that community-based case managers are actively involved in Discharge Planning when an LTSS Enrolled Member is hospitalized or otherwise served outside of the home. The Contractor shall define circumstances that require that hospitalized Enrolled Members receive an in-person visit to complete a needs reassessment and an update to the Enrolled Member's plan of care. Contractor shall document its policies and procedures in its PPM.

F.12C.07. *In-Person Requirements.* The Contractor shall ensure that each in-person visit by a community-based case manager to an Enrolled Member includes observations and documentation of the following: (i) the Enrolled Member's physical condition including observations of the Enrolled Member's skin, weight changes and any visible injuries; (ii) the Enrolled Member's physical environment; (iii) the Enrolled Member's satisfaction with services and care; (iv) the Enrolled Member's upcoming appointments; (v) the Enrolled Member's mood and emotional well-being; (vi) the Enrolled Member's falls and any resulting injuries; (vii) a statement by the Enrolled Member regarding any concerns, questions, gaps in services, or unmet needs; and (viii) a statement from the

Enrolled Member's representative or caregiver regarding any concerns or questions (if representative/caregiver is available).

F.12C.08. *Frequency of Community-Based Case Manager and Care Coordination Contact*. The Contractor shall ensure that case management contacts occur as frequently as necessary and that contacts are conducted and documented consistent with the following:

a. Community-based case managers must have at least one (1) face-to-face contact per month with Enrolled Members for the first three (3) months when Enrolled Members first become eligible for the Habilitation or HCBS waiver program and the Contractor's CBCM case management. This requirement applies when a case management-eligible member newly enrolls with the Contractor or when an existing member first becomes eligible for the Contractor's case management services.
b. After the first three (3) months of case management services with the Contractor, the community-based case manager shall consult the Enrolled Member, their authorized representative and their care team to identify the appropriate frequency of community-based case manager and member communication.

Following the first three (3) months of case management services, community-based case managers shall have:

a. At least one, in-home, face-to-face contact every other month with Enrolled Members who have a diagnosis of intellectual and/or developmental disability and every three (3) months for all other community-based LTSS members.
b. At least one contact per month with the member or the member's authorized representative. This contact may be face-to-face or by telephone. Written communication does not constitute a contact unless there are extenuating circumstances outlined in the Enrolled Member's person-centered service plan.

F.12C.09. *Identification and Response to Problems and Issues.* The Contractor shall identify, document, and immediately remediate problems and issues including but not limited to safety concerns, service gaps, changes in needs or circumstances, and complaints or concerns regarding the Quality of care rendered by Providers, workers, or CBCM staff.

F.12C.10. *Community-Based Case Management Monitoring.* The Contractor shall develop a comprehensive program for monitoring, on an ongoing basis, the effectiveness of its CBCM processes. The Contractor shall include a description of that program, along with its policies and procedures, in its PPM. The Contractor shall: (i) immediately remediate all individual findings identified through its monitoring process; (ii) track and trend such findings and remediation to identify systemic issues of marginal performance and/or non-compliance; (iii) implement strategies to improve CBCM processes and resolve areas of non-compliance or Enrolled Member dissatisfaction; and (iv) measure the success of such strategies in addressing identified issues. At a minimum, the Contractor shall monitor the following:

a) CBCM tools and protocols are consistently and objectively applied and Outcomes are continuously measured to determine effectiveness and appropriateness of processes;
b) Level of care and reassessments occur at least every three-hundred and sixty-five (365) days;
c) Comprehensive needs-based assessments and reassessments, as applicable, occur at least every three-hundred and sixty-five (365) days; and in compliance with the Contract;
d) Care plans are developed in accordance with 42 C.F.R. § 438.208(c)(3)(i)-(v), 42 CFR 441.300-441.310, and 42 CFR 441.700 – 441.745 for HCBS Waivers and State Plan HCBS by a person trained in person-centered planning using a person-centered process and plan.

e) Care plans are to occur at least every three-hundred and sixty-five (365) days and are led by the Enrolled Member with provider consultation in compliance with the Contract.[2]
f) Care plans reflect needs identified in the comprehensive needs assessment and reassessment process;
g) Care plans address all of the Enrolled Member's needs;
h) Services are delivered as described in the care plan and authorized by the Contractor;
i) Services and providers are appropriate to address the Enrolled Member's needs, and in accordance with 42 C.F.R. § 438.208(c)(4), Contractor allows Enrolled Members with special health care needs determined through an assessment in accordance with 42 C.F.R. § 438.208(c)(2) to need a course of treatment or regular care monitoring to directly Access a specialist as appropriate for the Enrollee's condition and identified needs;
j) Services are delivered in a timely manner;
k) Service utilization is appropriate;
l) Service gaps are identified and addressed;
m) Minimum community-based case manager contacts are conducted;
n) Case management training and reporting requirements are facilitated in accordance with the Reporting Manual and other Agency guidance.
o) Community-Based Case Manager-to-Member ratios do not exceed a statewide average of 45 members to a single CBCM. No single CBCM may exceed 50 members. If there are extenuating circumstances which lead to a CBCM exceeding 45 members, Contractor must alert the agency in writing. The Contractor must provide a plan to reduce the amount of members assigned for each CBCM exceeding 45 members. These ratios shall be met by January 1, 2025.
p) Service limits are monitored and appropriate action is taken if an Enrolled Member is nearing or exceeds needs-based service limits outlined in the service plan. Appropriate action includes assessment of whether the service plan requires revision to allocate additional units of waiver services or if other non-waiver resources are available to meet the Enrolled Member's needs in the community.
q) A critical incident or involuntary discharge must result in an audit of case management activities and development of a remediation plan to include CBCM training where appropriate.

F.12D Consumer Choices Option

F.12D.01. *Self-Direction (Consumer Choices Option).* The Contractor shall offer 1915(c) HCBS Waiver Enrolled Members the option to self-direct waiver services, except for those Members enrolled in the CMH Waiver consistent with all applicable rules and regulations. In Iowa Medicaid, the self-direction option is referred to as the Consumer Choices Option (CCO).

F.12D.02. *CCO General Responsibilities.* The Contractor shall ensure that the Enrolled Member and/or the Enrolled Member's representative fully participate in developing and administering the CCO and that sufficient supports are made available to assist Enrolled Members who require assistance. The Contractor shall obtain Agency approval for a strategy to implement the following components of the CCO: (i) identifying resources, including natural and informal supports that may assist in meeting the Enrolled Member's needs; (ii) developing a budget to address the needs of the Enrolled Member; (iii) conducting employer-related activities such as assisting an Enrolled Member in identifying a designated representative if needed, finding and hiring CCO providers, and completing all Documentation required to pay CCO providers; (iv) identifying and resolving issues related to the implementation of the budget; (v) assisting the Enrolled Member with Quality assurance activities to ensure implementation of the Enrolled Member's budget and utilization of the authorized budget; (vi) recognizing and reporting critical incidents related to self-directed services as further described in Section G.5.13; (vii) facilitating resolution of any disputes regarding payment to CCO providers for

services rendered; and (viii) monitoring the Quality of services provided. The Contractor shall implement and adhere to the Agency approved plan for CCO. Any changes to this plan shall receive Agency approval prior to implementation.

F.12D.03. *CCO Self-Assessment.* During the service planning process, the Contractor shall advise Enrolled Members of their option to self-direct services. Members expressing an interest in the CCO shall be required to complete a self-assessment, using a tool developed by the Contractor and prior approved by the Agency. The self-assessment is intended to determine an Enrolled Member's ability to make decisions regarding the Enrolled Member's health services and knowledge of available resources to access for assistance. If the self-assessment results reveal that the Enrolled Member is unable to self-direct services, but the Enrolled Member is still interested in electing the option, the Enrolled Member will be required to appoint a representative to assume the self-direction responsibilities on the Enrolled Member's behalf.

F.12D.04. *CCO Documentation.* The Contractor shall ensure all Enrolled Members who elect to self-direct sign an informed consent contract. The language for informed consent contracts is subject to the Agency review and approval in accordance with Section C.10.01. All Enrolled Members choosing the self-direction option shall also sign an individual risk agreement that permits the participant to acknowledge and accept certain responsibilities for addressing risks.

F.12D.05. *CCO - Use of Representatives.* Services may be self-directed by an Enrolled Member, or a representative selected by the Enrolled Member. The representative may be either a legal representative or non-legal representative freely chosen by an adult Enrolled Member. The Enrolled Member and the representative must sign a consent form designating who they have chosen as their representative and what responsibilities the representative will have. The choice of representative shall be documented in the Enrolled Member's file and provided to the Enrolled Member and the Enrolled Member's representative. At a minimum, the representative's responsibilities include ensuring decisions made do not jeopardize the health and welfare of the Enrolled Member and ensuring decisions made do not financially exploit the Enrolled Member. The Contractor shall implement Quality assurance processes, including but not limited to, Enrolled Member interviews, to determine if a representative is working in the best interest of the Enrolled Member.

F.12D.06. *CCO - Support Brokers.* Contractor shall develop a strategy, policies and procedures to implement Support Broker functions. In developing its strategy, policies, and procedures, the Contractor shall ensure that Support Broker functions are not duplicative of care coordinator activities and functions. The Contractor shall ensure ongoing enrollment, training and oversight of the Support Brokers. Contractor shall document such strategy, policies and procedures in its PPM.

F.12D.07. *CCO - Financial Management Services.* The Contractor shall contract with an entity or entities for Financial Management Services (FMS) to assist Enrolled Members who elect the Consumer Choices Option.

F.12D.08. *CCO - Back-Up Plan.* The Support Broker shall assist the Enrolled Member or representative in developing a back-up plan for self-directed Benefits that adequately identifies how the Enrolled Member or representative will address situations when a scheduled CCO provider is not available or fails to show up as scheduled. The Contractor shall maintain a copy of the back-up plan in the Enrolled Member's file. The adequacy of the back-up plan shall be assessed at least annually and any time there are changes in services or CCO providers.

F.12D.09. *CCO - Budget.* The Support Broker and Enrolled Member shall work collaboratively to develop a CCO individual monthly budget for the self-directed services. The budget shall be based on the Enrolled Member's assessed services in the Enrolled Member's service plan authorized by the

Contractor that have been converted to a CCO budget amount using the Agency's CCO rate setting process.

F.12D.10. *CCO Payment.* The Enrolled Member or their representative shall review and approve timesheets of their CCO employees and providers to determine accuracy and appropriateness.

F.12D.11. *CCO - Services Pending Implementation of Self-Directed Services.* The Contractor shall ensure provision of all 1915(c) HCBS Waiver services to Enrolled Members who elect the CCO with Contractor Network Providers until all necessary requirements have been fulfilled in order to implement the self-direction of services. If the Enrolled Member elects not to receive services using Contractor Network Providers, until all necessary requirements have been fulfilled to implement the self-direction of services, the Contractor shall document this decision and provide face-to-face visits with a Contractor community based case manager at the frequency determined necessary to ensure the Enrolled Member's needs are met.

F.12D.12. *CCO - Provider Qualifications and Employment Agreement.* The Contractor's FMS solution, as described in this Section F.12D, shall verify that potential CCO employees and providers meet all applicable qualifications prior to delivering services, including, but not limited to, compliance with criminal record checks and adult and child abuse registry information. Enrolled Members shall have an employment agreement or vendor agreement, as appropriate, with each of their CCO providers. The template for this agreement shall be reviewed and approved by the Agency. Employment agreements shall be updated any time there is a change in any of the terms or conditions specified in the agreement. A copy of each employment agreement shall be provided to the Enrolled Member and/or representative and also maintained in the Enrolled Member file. CCO employees and providers under the CCO are not required to be Network Providers with the Contractor. The Contractor shall not require CCO employees and providers to sign a Provider agreement with the Contractor.

F.12D.13. *CCO Training.* The Contractor shall require that all Enrolled Members or representatives participate in a training program prior to assuming self-direction. The Contractor shall also provide ongoing Enrolled Member or representative training upon request and/or if it is determined an Enrolled Member needs additional training. At minimum, the self-direction training programs shall address the following: (i) understanding the role of Enrolled Members and/or representatives in self-direction; (ii) understanding the role of and choosing an independent support broker; (iii) developing the CCO budget; (iv) selecting and terminating CCO employees and providers; (v) being an employer and managing employees; (vi) conducting administrative tasks such as staff evaluations and approval of time sheets; (vii) scheduling CCO employees and providers; and (viii) back-up planning.

F.12D.14. *CCO Monitoring.* The Contractor shall monitor the Quality of service delivery and the health, safety and welfare of Enrolled Members participating in the CCO. The Contractor shall also monitor implementation of the back-up plan as described in this Section F.12D. The Contractor shall monitor the Enrolled Member's participation in CCO to determine the success and viability of the Enrolled Member continuing self-direction. If problems are identified, a self-assessment shall be completed to determine what additional supports, if any, could be made available to assist the Enrolled Member.

F.12D.15. *CCO - Disenrollment from Self-Direction.* The Contractor shall ensure Enrolled Members have the option to voluntarily discontinue the self-direction option at any time. The Contractor shall develop a new service plan with the Enrolled Member if the Enrolled Member voluntarily discontinues the self-direction option. The Contractor may only initiate involuntarily termination of an Enrolled Member's use of the self-direction option if: (i) there is evidence of Medicaid Fraud or misuse of funds; or (ii) if the Contractor determines there is a risk to the Enrolled Member's health or safety by

continued self-direction of services. Under these conditions, the Contractor shall submit a request to the Agency for review and approval to involuntarily terminate the Enrolled Member from self-direction. Such requests shall be submitted in the format required by the Agency and with sufficient documentation regarding the rationale for termination. Upon the Agency approval of Disenrollment from self-direction, the Contractor shall notify the Enrolled Member regarding the termination in accordance with the Agency policy and procedures. The Contractor shall facilitate a seamless transition from the CCO to traditional waiver services to ensure there are no interruptions or gaps in service delivery.

F.12D.16. *Self-Direction Performance Metric.* The Agency will establish a baseline rate and the Contractor shall demonstrate an ongoing increase in self-directed services.

F.13 Mental Health and Substance Use Disorders Benefits & MH/SUD Parity

F.13.01. *No Aggregate Lifetime or Annual Dollar Limits.* If Contractor does not include an aggregate lifetime or Annual Dollar Limit on any Medical/Surgical Benefits or includes an aggregate lifetime or Annual Dollar Limit that applies to less than one-third of all Medical/Surgical Benefits provided to Enrolled Members through a contract with the State, it may not impose an aggregate lifetime or Annual Dollar Limit, respectively, on mental health or substance use disorder Benefits. See: 42 C.F.R. § 438.905(b); 42 C.F.R. § 457.1201(l); 42 C.F.R. § 457.496(c)(1). {From CMSC F.12.01}.

F.13.02. *Aggregate Lifetime or Annual Dollar Limit Obligations.* If Contractor includes an aggregate lifetime or Annual Dollar Limit on at least two-thirds of all Medical/Surgical Benefits provided to Enrolled Members through a contract with the State, it must either apply the aggregate lifetime or Annual Dollar Limit both to the Medical/Surgical Benefits to which the limit would otherwise apply and to mental health or substance use disorder Benefits in a manner that does not distinguish between the Medical/Surgical Benefits and mental health or substance use disorder Benefits; or not include an aggregate lifetime or Annual Dollar Limit on mental health or substance use disorder Benefits that is more restrictive than the aggregate lifetime or Annual Dollar Limit, respectively, on Medical/Surgical Benefits. See: 42 C.F.R. § 438.905(c); 42 C.F.R. § 457.1201(l); 42 C.F.R. § 457.496. {From CMSC F.12.02}.

F.13.03. *Aggregate Lifetime Limits or Annual Dollar Amounts.* If Contractor includes an aggregate lifetime limit or annual dollar amount that applies to one-third or more but less than two-thirds of all Medical/Surgical Benefits provided to Enrolled Members through a contract with the State, it must either impose no aggregate lifetime or Annual Dollar Limit on mental health or substance use disorder Benefits; or impose an aggregate lifetime or Annual Dollar Limit on mental health or substance use disorder Benefits that is no more restrictive than an average limit calculated for Medical/Surgical Benefits in accordance with 42 C.F.R. § 438.905(e)(ii). See: 42 C.F.R. § 438.905(e); 42 C.F.R. § 457.1201(l); 42 C.F.R. 457.496(c)(4). {From CMSC F.12.03}.

F.13.04. *Financial Restrictions.* Contractor must not apply any financial requirement or treatment limitation to mental health or substance use disorder Benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all Medical/Surgical Benefits in the same classification furnished to Enrolled Members (whether or not the Benefits are furnished by the same managed care plan). See: 42 C.F.R. § 438.910(b)(1); 42 C.F.R. § 457.1201(l); 42 C.F.R. § 457.496(d)(2)(i). {From CMSC F.12.04}.

F.13.05. *Classification of Enrollees.* If an Enrolled Member with Contractor is provided mental health or substance use disorder Benefits in any classification of Benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or substance use disorder Benefits must be provided to the Contractor Enrolled Member in every classification in which Medical/Surgical Benefits are provided.

See: 42 C.F.R. § 438.910(b)(2); 42 C.F.R. § 457.1201(l); 42 C.F.R. § 457.496(d)(2)(ii). {From CMSC F.12.05}.

F.13.06. *Cumulative Financial Requirements.* Contractor may not apply any Cumulative Financial Requirements for mental health or substance use disorder Benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for Medical/Surgical Benefits in the same classification. See: 42 C.F.R. § 438.910(c)(3); 42 C.F.R. § 457.1201(l); 42 C.F.R. § 457.496(d)(e)(iii). {From CMSC F.12.06}.

F.13.07. *NQTLs in MH/SUD.* Contractor may not impose Non-Quantitative Treatment Limitations (NQTLs) for mental health or substance use disorder Benefits in any classification unless, under the policies and procedures of the Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder Benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for Medical/Surgical Benefits in the classification. See: 42 C.F.R. § 438.910(d); 42 C.F.R. § 457.1201(l); 42 C.F.R. § 457.496(d)(4). {From CMSC F.12.07}.

F.13.08. *Mental Health Parity Compliance.* The Contractor shall comply with all necessary documentation and reporting required from the Contractor to the Agency to establish and demonstrate compliance with 42 C.F.R. part 438, subpart K and 42 C.F.R. § 457.1201(l) and 42 C.F.R. § 457.496 regarding parity in mental health and substance use disorder Benefits. See: 61 Fed. Reg. 18413, 18414-15 and 18417 (March 30, 2016). {From CMSC F.12.08}.

F.13.09. *Mental Health Parity.* In accordance with 42 C.F.R. § 438.3(n), Contractor shall deliver services in compliance with the requirements of 42 C.F.R. part 438, subpart K insofar as those requirements are applicable. This includes, but is not limited to: (i) ensuring medical management techniques applied to mental health or substance use disorder Benefits are comparable to and applied no more stringently than the medical management techniques that are applied to medical and surgical Benefits; (ii) ensuring compliance with MHPAEA for any Benefits offered by the Contractor to Enrolled Members beyond those specified in Iowa's Medicaid State Plan; (iii) making the criteria for medical necessity determinations for mental health or substance use disorder Benefits available to any current or Potential Enrollee, or contracting Provider upon request; (iv) providing the reason for any denial of reimbursement or payment with respect to mental health or substance use disorder Benefits to Enrolled Members, including the applicable medical necessity criteria applied to that Enrolled Member as required by 42 C.F.R. § 438.404(b)(2); and (v) providing out-of-network coverage for mental health or substance use disorder Benefits when made available for medical and surgical Benefits.

F.13.10. *Service Delivery Principles.* The Contractor shall adhere to the following principles related to the delivery of Behavioral Health Services and BHIS: (i) the Contractor shall allow each Enrolled Member to choose their behavioral health professional(s); (ii) the Contractor shall establish policies that support the involvement of the Enrolled Member and those significant in the Enrolled Member's life in decisions about services provided to meet the Enrolled Member's behavioral health needs; (iii) the Contractor shall establish and promote strategies to engage Enrolled Members regardless of histories of inconsistent involvement in treatment; (iv) services for adult Enrolled Members who have a serious mental illness and Enrolled Members who are children with an SED shall focus on helping the Enrolled Member to maintain their home environment, education/employment and on promoting their recovery; (v) mental health services for children are most appropriately directed toward helping a child and the child's family to develop and maintain a stable and safe family environment for the child; (vi) in the delivery of services and supports, the Contractor is encouraged to explore the use of emerging technology (e.g., telehealth) as a way to expand Access to services and extend the reach

of mental health and substance use disorder service professionals, particularly into Rural and underserved areas of the State; (vii) the Contractor shall work with all Providers and other entities serving an Enrolled Member to coordinate services for the purpose of eliminating both gaps in service and duplication of services.

F.13.11. *Olmstead Obligations.* 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. The Contractor shall support and enhance person-centered care.

F.13.12. *Enhanced Staffing.* For Enrolled Members who require individualized, enhanced staffing patterns to support them in a less-restrictive setting, the Contractor shall not deny or reduce the enhanced staffing or the funding required to support them without Provider service documentation supporting the reduction or denial.

F.13.13. *Mental Health and Disability Services System for Adults and Children.* The Contractor shall obtain Agency approval on a plan to collaborate with the MHDS Regions as well as a designed point of contact to increase Access to services that support adults with a serious and persistent mental illness and children with a serious emotional disturbance. The Contractor shall implement and adhere to the Agency-approved approach. Changes to this approach shall receive the Agency's prior approval.

F.13.14. *Rehabilitation, Recovery and Strengths-Based Approach to Services*. The Contractor shall provide a recovery-oriented system that supports person-centered approaches to service delivery. Recovery-oriented care identifies and builds upon each individual's assets, strengths, and areas of health and competence to support the individual in achieving a sense of mastery over mental illness and/or addiction while regaining the Enrolled Member's life and a meaningful, constructive sense of membership in the broader community. The Contractor shall provide the following core activities as part of its effort to provide recovery-oriented system of services to Enrolled Members:

a) identification and implementation of evidence-based practices in service delivery;
b) identification and implementation of the preferences of individuals and families in the design of services and supports;
c) facilitation of the development of consumer-operated programs and use of peer support, including consumer/family teams for persons of all ages and behavioral health conditions;
d) facilitation of the utilization of Natural Supports;
e) facilitation of the development of resources to support self-management and relapse prevention skills; and
f) activities to support the development and maintenance of healthy social networks and skills, employment, school performance or retirement activities.

F.13.15. *Active Engagement Strategy for Families*. The Contractor shall engage families to actively participate in treatment planning and development of successful interventions. The Contractor shall develop protocols for team meetings in which families' opinions are respected, their strengths are explored and validated, and families are given opportunities to choose the course of care for their loved one.

F.13.16. *Individual Service Coordination and Treatment Planning Requirements.* The Contractor shall work with Providers to emphasize the importance of exploring Enrolled Member strengths in the process of service planning and including the Enrolled Member in the design of the Enrolled Member's person-centered, wellness-oriented treatment plan that meet all applicable Iowa Administrative Code obligations including a crisis plan or relapse management plan that addresses the Enrolled Member's self-identified triggers.

a) The Contractor shall ensure the provision of care for Enrolled Members, which includes coordinating with inpatient mental health and substance use disorder treatment facilities including but not limited to PMICS, MHIs, subacute mental health facilities, psychiatric hospitals, and substance use disorder treatment facilities. The Contractor shall initiate and lead transitional care coordination to Enrolled Members residing in a facility to ensure transition into the community where appropriate. Transitional care activities include but are not limited to the Contractor's development and implementation of a transitional care plan and securing placement and services with community providers that are able to meet the Enrolled Member's needs. The Contractor shall implement strategies, as approved by the Agency, to monitor transition and ensure that services and supports are made available to ensure transition success.

b) Monitoring of Community Transition Activities. The Contractor shall monitor all aspects of the transition process and take immediate action to address any issues that arise. The Contractor shall monitor hospitalizations and MH/SUD facility readmissions for Enrolled Members who transition to the community to identify issues and implement strategies to improve Outcomes. The Contractor shall conduct face-to-face visits with the Enrolled Member, at minimum: (i) within two (2) Days of the transition to the community; (ii) every two (2) weeks for the first two (2) months from discharge; and (iii) once per month for the first year after transition. More frequent contact shall occur based on an individualized assessment of the Enrolled Member's needs and risk factors.

c) MH/SUD Facilities; Case Management Requirements. Contractor shall obtain Agency approval of strategies for monitoring services for Enrolled Members in MH/SUD facilities. Community Based Case management must meet the requirements contained in Section F.12C of this Contract.

d) Discharge Planning. Contractor shall develop, implement, and adhere to policies and procedures to ensure that community-based case managers are actively involved in Discharge Planning when an Enrolled Member is hospitalized, receiving inpatient mental health or substance use disorder treatment or otherwise served outside of the home. The Contractor shall define circumstances that require that hospitalized/ inpatient Enrolled Members receive an in-person visit to complete a needs reassessment and an update to the Enrolled Member's plan of care. Contractor shall document its policies and procedures in its PPM.

F.13.17. *Scope of Covered Mental Health Services*. The Contractor shall deliver Behavioral Health Services and BHIS in accordance with the scope of covered services and as outlined in Iowa Code, Iowa Administrative Code, the Iowa Medicaid State Plan, and all CMS approved waivers. Limitations apply to Iowa Health and Wellness Plan Enrolled Members who have not been determined Medically Exempt. Mental health services shall be provided to meet the individual's medical necessity unless as dictated in Section F.13.24.

F.13.18. *Scope of Covered Substance Use Disorder Services.* The Contractor shall ensure, arrange, monitor and reimburse the substance use disorder treatment services as described in Iowa Code, Iowa Administrative Code, the Iowa Medicaid State Plan, and all CMS approved waivers. All services shall be provided as part of substance use disorder treatment according to the American Society of Addiction Medicine ("ASAM") level of care criteria. Limitations apply to Iowa Health and Wellness Plan Enrolled Members who have not been determined Medically Exempt.

F.13.19. *Iowa Health and Wellness Plan.* Enrolled Members who are enrolled in the Iowa Health and Wellness Plan, with the exception of Medically Exempt Enrolled Members, are eligible for the services under the Iowa Wellness Plan Alternative Benefit Plan State Plan Amendment as required by Section F.6.20.

F.13.20. *Peer Support/Peer Recovery Services.* The Contractor shall support the development and implementation of certified peer support/recovery programs and services as required by Iowa Admin. Code ch. 441-25 to empower Enrolled Members to take an active role in their recovery from mental illness and substance use disorder to return to active roles in their community. Certified peer specialists shall work to establish recovery self-help groups, peer support/recovery, Recovery/Wellness Centers where Enrolled Members can learn coping skills for all aspects of life, including employment skills, and warm line counseling to assist Enrolled Members in distress. Such services may give recovering persons volunteer or employment opportunities through which they support their own recovery by supporting others in their recovery efforts.

F.13.21. *Integrated Mental Health Services and Supports*. The Contractor shall integrate informal support services provided by family members, friends and community-based support services into Enrolled Member's behavioral health treatment plans, especially for those who can benefit from services and supports designed to assist Enrolled Member remain in or return to their home. Integrated services and supports are specifically tailored to an individual Enrolled Member's needs at a particular point in time and are not a set menu of services offered by the Contractor. The Contractor shall integrate these services into the Enrolled Member's treatment plan and may provide reimbursement for such services if the Contractor deems it necessary. In the design and authorization of integrated mental health services and supports, the Contractor shall plan jointly with Enrolled Members, family members, decategorization projects, and representatives of other service delivery systems. The concept of integrating services and supports does not require the Contractor to assume clinical oversight or financial responsibility for services regularly funded through other funding streams. Rather, it allows the Contractor flexibility to provide Enrolled Members unique services to address the Enrolled Members' mental health needs to augment and complement those provided through other funders and systems. As one component of integrated mental health services and supports, the Contractor shall encourage the involvement of natural support systems, including providing compensation, if appropriate, to support their involvement. The Contractor shall also draw upon self-help systems when appropriate. The Contractor shall work with consumer and family advocacy organizations, Providers, other funders, and appropriate groups and individuals to help promote the understanding and acceptance of integrated mental health services and supports. The Contractor shall obtain Agency approval of a strategy to integrate services. The Contractor shall implement and adhere to the Agency-approved strategy.

F.13.22. *Prevention and Early Intervention*. The Contractor shall have a network of service Providers that screen Enrolled Members for risk factors and early signs of mental health or substance use disorder symptoms and implement evidenced-based early interventions to remediate them. The intention of this approach is to prevent further deterioration of function and to avoid the need for more intensive services in the future.

F.13.23. *Court-Ordered Mental Health Services*. The Contractor shall provide all covered and required mental health services ordered for Enrolled Members through a court action pursuant to Iowa Code chapters 125, 229, and 232.51 for a period of at least three (3) Days, regardless of medical necessity. Notwithstanding this provision, the Contractor may only end funding of court ordered services under Iowa Code chapters 125, 229, and 232.51 after giving the Provider and the Agency and, as appropriate, the Juvenile Court Officer twenty-four (24) hour written notice of the Contractor's offer of adequate, available, and accessible mental health services and supports that can meet the Enrolled Member's needs in a lower level of care. The Contractor shall fund all placements mandated by the court pursuant to Iowa Code chapter 812 (not competent to stand trial) or Iowa Rule of Criminal Procedure 2.22 (not guilty by reason of insanity) for Enrolled Members except as limited by F.13.25.

F.13.24. *Court-Ordered Substance Use Disorder Services*. The Contractor shall provide all substance use disorder services ordered for Enrolled Members through a court action, for a period of three (3) Days regardless of medical necessity, when: (i) except for evaluations, the services ordered by the court meet the ASAM Criteria after the initial three (3) Days, or (ii) the court offers treatment with a substance use disorder licensed program. The Contractor shall work with the courts to examine the appropriateness of court-ordered placements and identify specific appropriate alternatives for the courts to consider. The Contractor has the right to establish policies that require Providers of court-ordered substance use disorder services to provide notification and documentation of court-ordered treatment.

F.13.25. *Services at a State Mental Health Institute*. The Contractor shall authorize payment for inpatient treatment at State mental health institutes and other institutions for mental disease based on the Enrolled Member's age. The Contractor shall authorize and pay for all inpatient treatment for Enrolled Members twenty-one (21) years of age and under or sixty-five (65) years of age and older at State mental health institutes that falls within the Agency-approved Contractor's UM Guidelines. If the Enrolled Member is a resident of inpatient treatment on their twenty-first (21st) birthday, the Contractor shall authorize and pay for treatment until their twenty-second (22nd) birthday if medically necessary. The Contractor also shall implement policies to assure reimbursement for up to five (5) Days, regardless of whether the Contractor's UM Guidelines are met, when an Enrolled Member age twenty-one (21) and under or age sixty-five (65) and older is court-ordered for an inpatient mental health evaluation at a State mental health institute. If an Enrolled Member's clinical condition falls within the Contractor's UM Guidelines for inpatient care, inpatient services shall be authorized as long as Guidelines are met. The Contractor may establish policies to limit reimbursement to no more than one (1) evaluation per inpatient episode.

F.13.26. *Evidence-Based Coverage.* The Contractor shall develop, maintain and at least annually review and update a compendium of evidence-based mental health practices, and shall periodically advise the Agency regarding how to modify covered services to be consistent with established evidence-based practices (EBPs). At minimum, the Contractor shall provide assurances to the fidelity of the EBPs developed and align its EBPs to the MHDS regional EBPs required in Iowa Admin. Code r. 441-25.5.

F.13.27. *Services for Children with Serious Behavioral Health Conditions*. The Contractor shall implement a screening protocol and comprehensive treatment approach to be used by its Provider Network for serious, behavioral health conditions for children. These protocols require Agency approval and shall be developed using Industry Standards for the detection of behavioral health conditions, which, if untreated, may cause serious disruption in a child's development and success in the community. The Contractor shall work with Providers to help the family to identify informal and natural community supports that can help stabilize a child's behavioral health symptoms as an integral component of Discharge Planning. The Contractor shall work with Providers to develop a crisis plan that helps the family to identify triggers and timely interventions to reduce the risk to the child and family and offer family-identified supports and interventions. The Contractor shall work collaboratively with child welfare and juvenile justice Providers and systems to develop effective trainings, interventions and supports for child welfare and juvenile justice Providers and systems to respond effectively to needs of children with behavioral health issues. Services may include telephonic consultations provided by a child psychiatry team or with the Contractor, emergency stabilization response to crisis situations, on-site mental health counseling, follow-up with a child's family, identification and mobilization of community resources, and referral to IHH services and community mental health agencies.

F.13.28. *Dual Diagnosis – Continuity of Care.* Even if the Provider is not in-network with the Contractor, the Contractor shall permit Enrolled Members with a dual diagnosis of a behavioral health

condition and developmental disorder to remain with their Providers of all outpatient behavioral health services for a minimum of three (3) months as long as the services continue to be medically necessary. The Contractor may shorten this transition time frame only when the Provider of services is no longer available to serve the Enrolled Member or when a change in Providers is requested in writing by the Enrolled Member or the Enrolled Member's representative.

F.13.29. *Mental Health, SUD and Physical Health Integration.* Contractor shall ensure the coordination of physical health, substance use disorder, and mental health care among all Providers treating the Enrolled Member. The Contractor shall ensure the coordination of services for individuals with multiple diagnoses of mental illness, substance use disorder, and physical illness. The Contractor shall have policies and procedures to facilitate the reciprocal exchange of Enrolled Member approved health information between physical health, substance use disorder, and mental health Providers to ensure the provision of integrated Enrolled Member care. The Contractor shall evaluate and monitor the effectiveness of its policies and procedures regarding physical health, substance use disorder, and mental health coordination and develop, implement, and adhere to mechanisms to improve coordination and continuity of care based on monitoring Outcomes. Additionally, integration shall occur when Enrolled Members are also receiving LTSS.

F.14 Advance Directives

F.14.01. *Written Policies & Procedures.* Contractor shall maintain written policies and procedures on advance directives for all adults receiving medical care by or through the Contractor. See: 42 C.F.R. § 438.3(j)(1) and (2); 42 C.F.R. § 422.128(a); 42 C.F.R. § 422.128(b); 42 C.F.R. § 489.102(a). {From CMSC F.14.01}.

F.14.02. *Prohibition on Conditioning Care.* Contractor shall not condition the provision of care or otherwise discriminating against an individual based on whether or not the individual has executed an advance directive. See: 42 C.F.R. § 438.3(j)(1) and (2); 42 C.F.R. § 422.128(b)(1)(ii)(F); 42 C.F.R. § 489.102(a)(3). {From CMSC F.14.02}.

F.14.03. *Education of Staff.* Contractors shall educate staff concerning their policies and procedures on advance directives. See: 42 C.F.R. § 438.3(j)(1) and (2); 42 C.F.R. § 422.128(b)(1)(ii)(H); 42 C.F.R. § 489.102(a)(5). {From CMSC F.14.03}.

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 Enrollee 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 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, including but not limited to a drug that is not on the State's PDL or FFS fee schedule but is approved by the FDA. 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 HHS Director's own initiative or upon request. Exceptions to Medicaid policy are only specifically granted by the HHS 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 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 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). 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. During the PHE, additional expansion of telehealth services is allowed. Telehealth services post-PHE will be as the Agency prescribes. As additional information develops, the Agency will provide guidance to the Contractor and Providers via Informational Letters.

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.2.0f1 - 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. *Obligation to Establish Procedures.* Contractor shall implement procedures to coordinate the services the Contractor furnishes to the Enrolled Member between settings of care, including appropriate Discharge Planning for short-term and long-term hospital and institutional stays. See: 42 C.F.R. § 438.208(b)(2)(i); 42 C.F.R. § 457.1230(c). {From CMSC G.2.04}.

G.2.04. *Reserved.*

G.2.05. *Transitions during Inpatient Stays.* The Contractor shall provide Care Coordination after the Enrolled Member has disenrolled from the Contractor whenever the Enrolled Member Disenrollment occurs during an inpatient stay. Acute inpatient hospital services for Enrolled Members who are hospitalized at the time of Disenrollment from the Contractor shall be paid by the Contractor until the Enrolled Member is discharged from acute care or for sixty (60) Days after Disenrollment, whichever is less, unless the Enrolled Member is no longer eligible for Medicaid. Services other than inpatient hospital services (e.g., physician services) shall be paid by the new Program Contractor as of the effective date of Disenrollment. When Enrolled Member Disenrollment to another Program Contractor occurs during an inpatient stay, the Contractor shall notify the new Program Contractor of the inpatient status of the Enrolled Member. The Contractor shall also notify the inpatient hospital of the change in Program Contractor enrollment but advise the hospital that the Program Contractor maintains financial responsibility.

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 Health Risk Screening.* The Contractor shall obtain Agency approval for a plan to conduct initial health risk screenings for: (i) new Enrolled Members, within ninety (90) Days of enrollment for the purpose of assessing need for any special health care or Care Coordination services; (ii) Enrolled Members who have not been enrolled in the prior twelve (12) months; and (iii) Enrolled Members for whom there is a reasonable belief they are pregnant. During the initial health risk screening process, Enrolled Members shall be offered assistance in arranging an initial visit with

their PCP (as applicable) for a baseline medical 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.

G.2.11. *Health Risk Screening Tool.* The Contractor shall obtain Agency approval of a health risk screening tool. At minimum, information collected shall assess the Enrolled Member's physical, behavioral, social, functional and psychological status and needs. The tool shall determine the need for Care Coordination, Behavioral Health Services, or any other health or community services. The tool shall also comply with NCQA standard for 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 managed care entities. In addition, the 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 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 health screening.

G.2.13. *Completion of Initial Health Risk Screening.* Contractor shall complete an initial health risk screening no later than ninety (90) Days after Member enrollment with the Contractor. Each quarter, at least 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 health risk screening within ninety (90) Days. For any Enrolled Member who does not obtain an initial health risk screening, the Contractor shall document at least three (3) attempts to conduct the screening.

G.2.14. *Subsequent Screenings.* The Contractor shall also conduct a subsequent health screening, using the tool reviewed and approved by the Agency, if an Enrolled Member's health care status is determined to have changed since the original screening, or every twelve (12) months, whichever is sooner. Subsequent screenings shall include standardized questions that tie to social determinants of health. Such evidence may be available through methods such as Claims review or Provider notification.

G.2.15. *Subsequent Health Risk Screening Performance Measure.* Each quarter, at least 70% of the Contractor's Enrolled Members who are due for subsequent health risk screening, who have been assigned to the Contractor for a continuous period of at least twelve (12) months, shall complete an initial health risk screening within twelve (12) months of the last initial or comprehensive health risk screening or last health risk screening attempt. For any Enrolled Member who does not obtain a subsequent health risk screening, the Contractor shall document at least three (3) attempts to conduct the screening. Demonstrated good faith efforts of these three (3) attempts which result in the unsuccessful completion of an Enrolled Member's Health Risk Screening will be excluded from the 70% threshold calculation.

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. *Comprehensive Health Risk Assessment*. The initial health screening described in Section G.2.10 shall be followed by a comprehensive health risk assessment by a health care professional when an Enrolled Member is identified in the initial screening process as having a special health care need, or when there is a need to follow-up on problem areas identified in the initial screening.

G.2.18. *Timeline for Completion*. The Contractor shall obtain Agency approval for the timeframe in which all comprehensive health risk assessments shall be completed for all Enrolled Members. The Contractor shall implement and adhere to the Agency-approved timeline. Changes to this timeline must receive the Agency's prior approval.

G.2.19. *Risk Stratification*. The Contractor shall utilize risk stratification levels, subject to the Agency review and approval, to determine the intensity and frequency of follow-up care that is required for each Enrolled Member participating in the Care Coordination program.

G.2.20. *Member Identification*. In addition to identifying Enrolled Members eligible for the Care Coordination program through the initial health risk screening and comprehensive health risk assessment, the Contractor shall utilize, at minimum: (i) industry standard predictive modeling; (ii) Claims review; (iii) Enrolled Member and caregiver requests; and (iv) physician 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 a special health care need. Minimum requirements for the Contractor's Care Coordination program include: (i) catastrophic case management; (ii) disease management; (iii) programs to target Enrolled Members underusing, overusing and/or abusing services; (iv) Discharge Planning; and (v) transition planning.

G.2.22. *Care Plan Development.* Enrolled Members identified by the Contractor through the health risk assessment as having a potential special healthcare need shall have a care plan developed. Care plans shall be updated, at minimum, annually. The Contractor shall develop the care plan for all Enrolled Members eligible for the Care Coordination program. The care plan shall be individualized and person-centered based on the findings of the health risk screening, health risk assessment, available Medical Records, and other sources needed to ensure that care for Enrolled Members is adequately coordinated and appropriately managed. The care plan shall: (i) establish prioritized, measurable goals and actions with defined outcomes; (ii) facilitate seamless transitions between care settings; (iii) create a communication plan with Providers and Enrolled Members; and (iv) monitor whether the Enrolled Member is receiving the recommended care.

G.2.23. *Involved Parties.* When developing the care plan, in addition to working with a multidisciplinary team of qualified health care professionals including specialists caring for the Enrolled Member, the Contractor shall ensure that there is a mechanism for Enrolled Members, their families and/or advocates and caregivers, or others chosen by the Enrolled Member, to be actively involved in the care plan development. Care plans shall be conducted jointly with other caseworkers for Enrolled Members who are accessing multiple services concurrently or consecutively. The Contractor shall provide an integrated care plan which avoids duplication and/or fragmentation of services.

G.2.24. *Care Plan Requirements.* The care plan shall reflect cultural considerations of the Enrolled Member. In addition, the care plan development process shall be conducted in plain language and be accessible to Enrolled Members who have disabilities and/or have LEP. The care plan shall be approved by the Contractor in accordance with applicable Quality measures and Utilization Review standards. For Enrolled Members determined to need a course of treatment or regular monitoring, the Contractor shall have direct Access to a specialist as appropriate for the Enrolled Member's condition and identified needs. The Contractor shall ensure that the care plan is provided to the

Enrolled Member's PCP (if applicable) or other significant Providers. The Contractor shall also provide the Enrolled Member the opportunity to review the care plan as requested.

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 health risk screening, comprehensive health risk assessment, the care plan, 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, including, but not limited to: (i) behavioral health Providers; (ii) PCPs; and (iii) specialists. The Contractor shall submit regular reporting regarding the selection criteria, strategies & Outcomes of Care Coordination programs as prescribed in the Reporting Manual.

G.2.26. *Care Plan and Case Notes Audit.* The Agency reserves the right to conduct an audit, or to utilize a Subcontractor to conduct an audit, of all Contractor care plan and case notes including those under the 1915(c) HCBS Waiver and 1915(i) Habilitation services to determine Contractor compliance with: (i) timely completion; (ii) care plan addressing the Enrolled Member's assessed health and safety risks, and personal goals; (iii) Enrolled Member signature on the care plan; (iv) all Providers are listed on the care plan; (v) all funding sources are listed on the care plan; (vi) plan for supports available to the Enrolled Member in the event of an emergency are documented; (vii) provision of services as delineated in the care plan; (viii) discussion of advanced directives with Enrolled Members; (ix) percentage of new Enrolled Members starting ongoing services within the required timeframe; (x) Enrolled Member and/or guardian participation in care plan development; and (xi) number and percentage of in-person visits that were on time, late or missed.

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. *Reassessments.* The Contractor shall develop a process for reviewing and updating the care plans with Enrolled Members on an as-needed basis, but no less often than annually. In addition, Enrolled Members may move between stratified levels of care groups over time as their needs change; therefore, the Contractor shall develop a protocol for re-evaluating Enrolled Members periodically to determine if their present care levels are adequate. The Contractor shall also identify triggers that would immediately move the Enrolled Member to a more assistive level of service. Additionally, any Enrolled Member or Provider can request a reassessment at any time.

G.2.29. *Information Sharing Obligation.* Contractor shall share with the State 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 State 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. The Contractor must demonstrate the following components are implemented to ensure continuity of care during transitions:

a) The Enrolled Member has Access to services consistently through the process of transition.
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 year following Contractor's entry into the IA Health Link marketplace, with the exception of LTSS, residential services and certain services rendered to dual diagnosis populations, which are addressed in Section F.13.28, 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 IA Health Link marketplace, with the exception of LTSS, residential services and certain services rendered to dual diagnosis populations, which are addressed in Section F.13.28, 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. *LTSS Obligations.* Contractor shall implement mechanisms to comprehensively assess each Medicaid and/or CHIP Enrolled Member (as appropriate) identified as needing LTSS 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.7.02}.

G.2.39. *LTSS Service Coordination.* Contractor's assessment mechanisms shall use appropriate Providers or individuals meeting LTSS service coordination requirements of the State or the Contractor as appropriate. See: 42 C.F.R. § 438.208(c)(2); 42 C.F.R. § 457.1230(c) {From CMSC G.7.03}.

G.2.40. *LTSS Treatment Plans.* Contractor shall produce a treatment or service plan for Enrolled Members who require LTSS. See: 42 C.F.R. § 438.208(c)(3); 42 C.F.R. § 457.1230(c). {From CMSC G.7.04}.

G.2.41. *Special Needs Treatment Plans.* Contractor shall produce a treatment or service plan for Enrolled Members with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring treatment or service plan. See: 42 C.F.R. § 438.208(c)(3); 42 C.F.R. § 457.1230(c). {From CMSC G.7.05}.

G.2.42. *LTSS Plan Obligations.* For Enrolled Members who require LTSS:

a) Contractor shall include a treatment or service plan developed by an individual meeting LTSS services coordination requirements with Enrolled Member participation, and in consultation with any Providers caring for the Enrolled Member.
b) Contractor's treatment or service plan shall be developed by a person trained in person-centered planning using a person- centered process and plan as defined in 42 C.F.R. § 441.301(c)(1) and (2).

c) Contractor's treatment or service plan shall be approved by the Contractor in a timely manner, if this approval is required by the Contractor.
d) Contractor's treatment or service plan shall be developed in accordance with any applicable State Quality assurance and Utilization Review standards
e) Contractor's treatment or service plan shall be reviewed and revised upon reassessment of functional need, at least every twelve (12) months, or when the Enrolled Member's circumstances or needs change significantly, or at the request of the Enrolled Member.

See: 42 C.F.R. § 438.208(c)(3)(i) - (v); 42 C.F.R. § 441.301(c)(1) - (3); 42 C.F.R. § 457.1230(c). {From CMSC G.7.06 - G.7.10}.

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

a) Contractor's treatment or service plan shall be approved by the Contractor in a timely manner, if this approval is required by the Contractor.
b) Contractor's treatment or service plan shall be developed in accordance with any applicable State Quality assurance and Utilization Review standards.
c) Contractor's treatment or service plan shall be reviewed and revised upon reassessment of functional need, at least every twelve (12) months, or when the Enrolled Member's circumstances or needs change significantly, or at the request of the Enrolled Member.

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 care needs determined through an 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. *Dual Eligible Special Needs Plan Coordination.* Contractor shall coordinate with all Dual Eligible Special Needs Plans with which the Agency has contracted by coordinating the delivery of all benefits covered by both Medicare and the Iowa Medicaid Program consistent with the coordination obligations set forth in the D-SNP agreements entered into between the Agency and the individual D-SNP Health Plans.

The Contractor shall take all required steps to obtain Centers for Medicare & Medicaid Services (CMS) approval to operate a statewide Dual Eligible Special Needs Plan (D-SNP) that will start January 1, 2027. The Contractor seeking D-SNP status for the first time shall be aware of this general timeline as it intersects with the Health Link program.

The Contractor is responsible for monitoring State and CMS information regarding dates of submission for D-SNP related documentation. The State and CMS continue to develop the timeline regarding D-SNP submission applications and associated documents, therefore, the deadlines for such documents are subject to change. The State and/or CMS may provide specific due dates to the Contractor.

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 including a designated senior physician and shall involve a designated behavioral health care practitioner in the implementation of behavioral health aspects of the program and a designated long-term care professional in the implementation of the

long-term care aspects of the program. 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 medical, behavioral health and/or long-term care 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 up-dated as appropriate.

G.3.03. *Program Elements.* The UM program shall provide for methods of assuring the appropriateness of inpatient care, analyzing emergency department utilization and diversion efforts, monitoring patient data related to length of stay and re-admissions related to hospitalizations and 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. In addition, the UM program shall include distinct policies and procedures regarding LTSS.

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 for any new managed care entity entering the IA Health Link marketplace.

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 emergency room services and other Health Care Services, identify aberrant Provider practice patterns (especially related to emergency room, inpatient services and drug utilization), 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 care transitions, Discharge Planning and appropriate follow up care including but not limited to home health, Durable Medical Equipment, behavioral health, substance use disorder treatment and Long Term Services and Supports.

G.3.05. *UM Committee.* The Contractor shall have a UM committee directed by the Contractor's Medical Director. The committee is responsible for: (i) monitoring Providers' requests for rendering Health Care Services to its Enrolled Members; (ii) monitoring the medical appropriateness and necessity of 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 a Network Provider or Contractor representative to respond within one (1) hour to all emergency room Providers twenty-four (24) hours-a-day, seven (7) days-a-week.

The Contractor's Medical Director shall participate in quarterly Clinical Advisory Committee (CAC) and monthly Iowa Medicaid Medical Director meetings to provide recommendations for clinical criteria to ensure clinical policies are implemented consistently. The Contractor's Medical Director shall communicate critical information from the CAC and Iowa Medicaid 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. 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 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 board certified consultants 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 physical health or behavioral health care professional who has appropriate clinical expertise in treating the Enrolled Member's condition or disease, or in the case of LTSS, an LTSS professional who has appropriate expertise in providing LTSS.

G.3.08. *Medical Necessity of Mental Health Services.* Psychosocial services are those mental health services, not including outpatient, inpatient and medication management services, designed to support an individual with a serious mental illness or child with an SED to successfully live and work in the community. The Contractor shall develop or adopt UM guidelines to interpret the Psychosocial Necessity of mental health services and supports. In the context of this requirement, Psychosocial Necessity is an expansion of the concept of medical necessity and shall mean clinical, rehabilitative or supportive mental health services that meet all 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 Enrolled Member and not primarily for the convenience of the Enrolled Member, the Provider, or the Contractor; and (v) are the most appropriate type of service which would reasonably meet the need of the Enrolled Member in the least costly manner.

The determination of Psychosocial Necessity shall be made after consideration of: (i) the Enrolled Member's clinical history including the impact of previous treatment and service interventions; (ii) services being provided concurrently by other delivery systems; (iii) the potential for services/supports

to avert the need for more intensive treatment; (iv) the potential for services/supports to allow the Enrolled Member to maintain functioning improvement attained through previous treatment; (v) unique circumstances which may impact the accessibility or appropriateness of particular services for an individual Enrolled Member (e.g., availability of transportation, lack of Natural Supports including a place to live); and (vi) the Enrolled Member's choice of Provider or treatment location. The guidelines for interpreting Psychosocial Necessity shall also meet the requirements of all Contractor practice guidelines as set forth in this Section G.

G.3.09. *Prior Authorization Requests*

a) *Use of Standard Forms.* Contractor shall utilize the universal Prior Authorization forms as set forth in IL 2147-MC-FFS.
b) *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 and Psychosocial Necessity; (iii) completing Provider and Member Appeals and expedited Appeals for Prior Authorization of service requests or determinations of medical necessity and Psychosocial 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 Psychosocial 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 and Psychosocial Necessity. Instances in which an Enrolled Member's health condition shall be deemed to require an expedited authorization decision by the Contractor shall include requests for home health services and LTSS services for Enrolled Members being discharged from a hospital or other inpatient setting when such services are needed to begin upon discharge.
c) *Pharmacy Prior Authorization.* PA requests shall be processed in accordance with 42 U.S.C. § 1396r-8(d)(5).
d) *Newborn and Mothers Health Protection.* The Contractor shall meet the requirements of the NMHPA. The Contractor shall not limit Benefits for postpartum hospital stays to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section, unless the attending Provider, in consultation with the mother makes the decision to discharge the mother or the newborn child before that time. The Contractor shall not require a Provider to obtain Prior Authorization for stays up to the forty-eight (48) or ninety-six (96) hour periods.
e) *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) *EPSDT.* The Contractor shall not require Prior Authorization or PCP (if applicable) referral for the provision of EPSDT screening services.
g) *Behavioral Health Services.* The Contractor shall not require a PCP referral for Enrolled Members to Access a behavioral health Provider.
h) *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 (e.g., RN, MD, RPh, 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. 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. *Additional LTSS Requirements.* Contractor shall authorize LTSS based on an Enrolled Member's current needs assessment and consistent with the Person-Centered Service Plan. See: 42 C.F.R. § 438.210(b)(2)(iii). {From CMSC G.3.04}.

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. *Parity.* Contractor's Prior Authorization requirements shall comply with the requirements for parity in MH/SUD Benefits in 42 C.F.R. § 438.910(d) and 42 C.F.R. § 457.496(d)(4)(i). See: 42 C.F.R. § 438.910(d); 42 C.F.R. § 457.496(d)(4)(i). {From CMSC G.3.06}.

G.3.17. *Notice – Timeframe.* For standard authorization decisions, Contractor shall provide Notice as expeditiously as the Enrolled Member's condition requires and within State-established timeframes that may not exceed 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.* 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. For outpatient prescription drug PA, 100% of authorization decisions shall be rendered within twenty-four (24) hours of the request. Requests for extensions approved in accordance with previous sections of the Contract shall be removed from this timeliness measure.

G.3.20. *Drug Authorizations.* For all covered outpatient drug authorization decisions, Contractor shall provide Notice as described in section 1927(d)(5)(A) of the Social Security Act. Under this section, Contractor may require as a condition of coverage or payment for a covered outpatient drug for which Federal Financial Participation (FFP) is available the approval of the drug before its dispensing for any Medically Accepted Indication only if the system providing for such approval provides response by telephone or other telecommunication device within twenty-four (24) hours of a request for Prior Authorization. See: 42 C.F.R. § 438.210(d)(3); 42 C.F.R. § 457.1230(d). {From CMSC G.3.09}.

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. 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 contracting health care professionals. 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 medical and Quality improvement staff. The Contractor shall use the result of its QM/QI activities to improve the Quality of physical health, behavioral health, and LTSS 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) Address physical health, behavioral health and LTSS services;
d) Reserved;
e) A process to monitor variation in practice patterns and identify outliers;
f) 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;
g) Analysis of the effectiveness of treatment services, employing both standard measures of symptom reduction/management, and measures of functional status;
h) Monitor the prescribing patterns of network prescribers to improve the Quality of Care Coordination services provided to Enrolled Members through strategies such as: (i) identifying medication utilization that deviates from current clinical practice guidelines; (ii) identifying Enrolled Members whose utilization of controlled substances warrants intervention; (iii) providing education, support and technical assistance to Providers; and (iv) monitor the prescribing patterns of psychotropic medication to children, including children in foster care;
i) Written policies and procedures for Quality improvement including methods, timelines and individuals responsible for completing each task;
j) 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;
k) Incorporation of clinical studies and use of HEDIS rate data, 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;
l) Implement utilization of and report using the survey tool identified by the Agency for Enrolled Members receiving HCBS services;
m) Submit a report on any Performance Measures required by CMS;
n) 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;
o) 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;
p) Procedures for a Provider pay-for-performance program;

q) Enrolled Member incentive programs aligned with the Healthiest State Initiative and other Quality Outcomes; and
r) 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 health services, and healthy behaviors. 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, Community-Based Case Management or Care Coordination program; (iii) making healthy lifestyle decisions such as quitting smoking or losing weight; (iv) encouraging responsible emergency room use; and (v) complying with Provider recommended drug maintenance programs.

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 medical, behavioral health, and LTSS 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 State 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 State 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 State 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. *LTSS Obligations.* Contractor's comprehensive QAPI program shall include mechanisms to assess the Quality and appropriateness of care furnished to Enrolled Members using LTSS, including:

a) An assessment of care between care settings; and
b) A comparison of services and supports received with those set forth in the Enrolled Member's treatment/service plan.

See: 42 C.F.R. § 438.330(b)(5)(i). {From CMSC G.5.06 - G.5.07}.

G.5.12. *Addressing Critical Incidents.* Contractor's comprehensive QAPI program shall include participation in efforts by the State to prevent, detect, and remediate critical incidents consistent with assuring beneficiary health and welfare that are based, at a minimum, on the requirements on the State for home and community-based waiver programs. See: 42 C.F.R. § 438.330(b)(5)(ii); 42 C.F.R. § 441.302; 42 C.F.R. § 441.730(a); 42 C.F.R. § 441.302(h). {From CMSC G.5.08}.

G.5.13. *QAPI Program in General.* The Contractor shall develop, implement, and adhere to a critical incident reporting and management system in accordance with the Agency requirements for reporting incidents for 1915(c) HCBS Waivers, 1915(i) Habilitation Program, PMICs, and all other incidents required for licensure of programs through the Department of Inspections and Appeals. The Contractor shall develop, implement, and adhere to policies and procedures, subject to Agency review and approval, to: (i) address and respond to incidents; (ii) report incidents to the appropriate entities per required timeframes; and (iii) track and analyze incidents. The Contractor shall use this information to identify both case-specific and systemic trends and patterns, identify opportunities for improvement and develop, implement, and adhere to appropriate strategies to reduce the occurrence of incidents and improve the Quality of care.

G.5.14. *Provider Requirements.* The Contractor shall require internal staff and Network Providers to: (i) report critical incidents; (ii) respond to critical incidents; (iii) document critical incidents; and (iv) to cooperate with any investigation conducted by the Contractor or outside agency.

G.5.15. *Training.* The Contractor shall provide staff and Provider training on critical incident policies and procedures at least annually.

G.5.16. *Corrective Action.* The Contactor shall take corrective action as needed to ensure Provider compliance with critical incident requirements.

G.5.17. *Monitoring.* The Contractor shall identify and track critical incidents and shall review and analyze critical incidents to identify and address Quality of care and/or health and safety issues. The Contractor shall regularly review the number and types of incidents and findings from investigations. This review shall be used to identify trends, patterns and areas for improvement. Based on these

findings, the Contractor shall develop, implement, and adhere to strategies to reduce the occurrence of critical incidents and improve the Quality of care delivered to Enrolled Members.

G.5.18. *Annual Measurement.* Contractor shall annually: measure and report to the State on its performance, using the standard measures required by the State; submit to the State data, specified by the State, which enables the State to calculate the Contractor's performance using the standard measures identified by the State 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 State 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 State'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 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 Quadruple Aim, including specific detail for the value-based purchasing requirements described in Section E.8.

G.5.28. *Quadruple Aim Strategy.* The Contractor shall obtain Agency approval of an approach to support Iowa's goal of delivery system transformation consistent with CMS's Triple Aim started under the SIM project. The Quadruple Aim consists of three (3) strategic goals to align the health care system. The goals are: 1) to improve population health; 2) to enhance the patient care experience; and 3) to reduce the per capita cost of care. This approach should include strategy to advance the amount of payment tied to Quality based on Health Care Payment Learning & Action Network (HCP-LAN) Alternative Payment Model (APM) Framework. 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 physician's 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 State'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 State 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 State 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. *Accreditation Obligation.* The Contractor shall attain and maintain accreditation from the NCQA or the Utilization Review Accreditation Commission (URAC). 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. Contractors providing services to LTSS services to Enrolled Members shall pursue NCQA LTSS Distinction for Health Plans or URAC Health Plan Accreditation with Long-Term Services and Supports. The Contractor shall report LTSS quality measures to the Agency in accordance with the Contractor's accreditation and the reporting requirements outlined in the Reporting Manual.

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, Client Participation, 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, copayment, and Client Participation responsibilities; and
d) Exceptions to policy regarding services outside of State Plan or waiver 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 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 State, 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 State. 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.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 State 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 § 447.45(b) of this chapter is not an adverse benefit determination. Therefore, this Contract also meets the requirement in 42 C. F.R. § 438.915(b) (in Subpart K, Parity in Mental Health and Substance Use Disorder Benefits), which requires the managed care plan to make available to the Enrolled Member the reason for any denial by the managed care plan of reimbursement or payment for services for mental health or substance use disorder Benefits to the Enrolled Member. {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 and not to 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. *Enrollee 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 State 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 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. *Oral Appeal Obligation.* Unless an expedited resolution is requested by the Enrolled Member, Contractor shall accept an oral filing of an Appeal. See: 42 C.F.R. § 438.402(c)(3)(ii); 42 C.F.R. § 457.1260. {From CMSC H.6.03}.

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.6.04}.

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.6.05}.

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.6.06}.

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 request within 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 request within 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.6.07}.

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.6.08}.

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.6.09}.

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.6.10}.

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.6.11}.

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 State 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 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 State 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 State 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 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 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 State 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 State 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 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 100% of Appeals within thirty (30) Days of receipt, or within seventy-two (72) hours of receipt for expedited Appeals. Further, 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 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. *Employment/Contracting Prohibitions – Debarment/Suspension.* 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 would (or is affiliated with a person/entity that would) provide those services through an individual or entity debarred, suspended, or excluded from participating in procurement activities under the 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)(ii); 42 C.F.R. § 438.610(a); 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.1.08}.

I.1.09. *Employment/Contracting Prohibitions – Excluded Individuals or Entities.* 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 would provide those services through an individual or entity excluded from participation in any Federal health care program under

section 1128 or 1128A of the Act. See: 42 C.F.R. § 438.808(a); 42 C.F.R. § 438.808(b)(3)(ii); 42 C.F.R. § 438.610(b); 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.1.09}.

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 State 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 State 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 State 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 State 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 State 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 State 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 State 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.6.02}
c) If the State 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 State may not renew or extend the existing agreement with the Contractor unless the Secretary provides to the State 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.6.03}.
d) If the State 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 State may not renew or extend the existing agreement with the Contractor unless the Secretary provides to the State 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.6.04}.

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 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.6.01}.

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 ensure that a reimbursed Consumer Choice Option Provider is not an excluded entity. The Contractor shall be responsible for checking the lists of Providers currently excluded by the State and the federal government every 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 State 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 State 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; 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 State 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 State at the following times:

a) When the Contractor submits a proposal in accordance with the State's procurement process.
b) When the Contractor executes a contract with the State.
c) When the State renews or extends the Contractor contract.
d) Within 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 State 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.6.07}.

I.3.04. *US Only.* The State 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.6.08}.

I.4 Reporting Transactions

I.4.01. *Reporting Transactions*. Contractor shall report to the State and, upon request, to the Secretary of the Department of Health & Human Services (DHHS), the Inspector General of the DHHS, and the Comptroller General a description of transactions between the Contractor and a party in interest (as defined in section 1318(b) of such Act), including the following transactions: (i) Any sale or exchange, or leasing of any property between the Contractor and such a party; (ii) Any furnishing for consideration of goods, services (including management services), or facilities between the Contractor and such a party, but not including salaries paid to employees for services provided in the normal course of their employment; (iii) Any lending of money or other extension of credit between the Contractor and such a party. See: Section 1903(m)(4)(A) of the Social Security Act; section 1318(b) of the Social Security Act. {From CMSC I.4.01}.

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 State 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 shall 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 Agreements.

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) 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.* The Contractor shall initiate administrative action and recover improper payments or overpayments related to claims paid by the Contractor within twenty-four (24) months from the date the claim was paid or from the date of any applicable reconciliation, whichever is later. Except for Overpayments identified under a Credible Allegation of Fraud, the Contractor shall confer with the Agency before pursuing Overpayment recoveries for Claims where more than twenty-four (24) months have passed since the claims were paid or adjudicated. The Contractor shall not subject these claims to repayment or offset against future claim reimbursements without prior consent from the Agency.

a) Payment Disputes- Request for Agency Review:

Should a provider ask the Agency to review the Contractor's post-payment activity once the provider has exhausted the Contractor's dispute or grievance process, the Contractor shall cooperate with the Agency by providing information that supports the recovery activity. If the Agency, in the review of information from the Provider and the Contractor, finds evidence of erroneous findings by the Contractor, the Agency will instruct the Contractor to amend or overturn the provider's dispute and reimburse the provider any funds that have been recovered.

The Contractor shall collaborate with the Agency in the creation of Standard Operating Procedures for this process. If the Contractor's decision is amended or overturned, the Agency may require the Contractor to waive timely filing requirements and allow the Provider to reprocess claims for payment.

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 State 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 (30) 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. *Agency-Identified Overpayments.* If the Agency discovers and identifies an improper payment or overpayment after twenty-four (24) months from the date the claim was paid, the Agency will recover the identified Overpayment from the Contractor, unless the improper payment or overpayment was the result of an Agency error. The Contractor shall not recover Overpayments for which it did not discover or issue a, overpayment finding to the Provider. The Contractor may dispute the Agency's notice of findings in accordance with the Payment Integrity Audit process.

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 Enrollee 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.6.05}.

I.11.02. *Agreements Pending Outcome of Screening.* Contractor shall execute Network Provider agreements with nursing facilities and ICF/IDs undergoing a change in ownership and pending the

screening and enrollment of the new owner for a period of one hundred twenty (120) Days. As to all other providers, Contractor may execute Network Provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to one hundred twenty (120) Days. In either circumstance, the Contractor must terminate a Network Provider immediately upon notification from the State that the Network Provider cannot be enrolled, or the expiration of one (1) one hundred twenty (120) day period without enrollment of the Provider, and notify affected Enrollees. See: 42 C.F.R. § 438.602(b)(2); 42 C.F.R. § 457.1285. {From CMSC L.6.06}.

I.11.03. *Notification of Enrollee 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 State and the Contractor, shall implement and maintain arrangements or procedures for prompt notification to the State 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 State and the Contractor, shall implement and maintain arrangements or procedures for notification to the State 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 or not 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.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 State 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. *Reviews & Audits.* The Contractor shall conduct regular review and audits of operations, including incorporation of Correct Coding Initiative editing in the Contractor's Claims adjudication process.

I.12.03. *Internal Controls.* The Contractor shall assess and strengthen internal controls to ensure Claims are submitted and paid properly.

I.12.04. *FCA Policies & Procedures.* Contractor or Subcontractor, to the extent that the Subcontractor is delegated responsibility by the Contractor for coverage of services and payment of Claims under the contract between the State and the Contractor, shall 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 and conduct on-site audits.

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 State 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.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, 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 State 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 MCO'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 State, 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. *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 State, 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 State, 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 State, 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. *Enrollee 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.2.03. *Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).* In the event that the Agency determines a need to share confidential client information from the Iowa WIC program, the Contractor agrees to not use, further disclose, or permit others to use or disclose the Iowa WIC Data received through this Contract except as directed by the Agency. The Contractor shall allow only those members of its workforce who have a legitimate business need for the Data to access the Data.

Records and data regarding participants, applicants, and vendor information for the Iowa WIC program are confidential (Iowa Code Section 22.7(2), 641 IAC 73.25(135), 7 CFR 246). Iowa HHS may disclose WIC program data to the Contractor as persons directly connected with the administration of the WIC Program determined by the State agency to have a need to know the information for WIC Program purposes (7 CFR 246.26 (d)(1)(ii)).

The Contractor shall maintain the confidentiality of and protect from unauthorized access, use, and disclosure all Iowa WIC Data shared through this Contract. Except as authorized through this Contract or as required by law, the User shall not disclose, release, sell, loan, or otherwise grant access to the Iowa WIC Data shared through this Contract, either during the period of this Agreement or hereafter.

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, such as Behavioral Health Services, 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 State 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 State 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); 42 C.F.R. § 438.230(c)(2). {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 State, 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 State. 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 State, 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 State, 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 State, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of Fraud or similar risk, the State, 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 State or the Contractor retains the TPL collections.
d) Shall identify how the State 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, including confidentiality of family planning services. In addition, the Contractor must follow all applicable provisions under 42 C.F.R. §§ 59.2 and 59.11 relating specifically to confidentiality of family planning services. In particular, if an Enrolled Member requests confidentiality related to any family planning services sought and/or received, and also requests such confidentiality extend to any notification to a policy holder of any third-party coverage to which the Enrolled Member is also covered, the Contractor may not provide any notifications to the policy holder, related to such family planning services sought and/or received by the Enrolled Member. 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 Medicare Part A and Part B crossover 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 and Part B 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. *Medically Necessary Services.* If Contractor fails to substantially provide Medically Necessary Services to an Enrolled Member that the Contractor is required to provide under law or under this Contract, the State may impose a civil monetary penalty of up to $25,000 for each failure to provide services. The State may also:

a) Appoint temporary management to the Contractor.
b) Grant Enrolled Members the right to disenroll without cause.
c) Suspend all new enrollments to the Contractor after the date the Secretary or the State notifies the Contractor of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.
d) Suspend payments for new enrollments to the Contractor until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

See: 42 C.F.R. § 438.700(b)(1); 42 C.F.R. § 438.702(a); 42 C.F.R. § 438.704(b)(1); sections 1903(m)(5)(A)(i); 1903(m)(5)(B); 1932(e)(1)(A)(i); 1932(e)(2)(A)(i) of the Social Security Act; 42 C.F.R. § 457.1270. {From CMSC J.5.01}.

J.5.02. *Impermissible Charges to Enrollees.* If the Contractor imposes premiums or charges on Enrolled Members that are in excess of those permitted in the Medicaid program, the State may impose a civil monetary of up to $25,000 or double the amount of the excess charges (whichever is greater). The State may also:

a) Appoint temporary management to the Contractor.
b) Grant Enrolled Members the right to disenroll without cause
c) Suspend all new enrollments to the Contractor after the date the Secretary or the State notifies the Contractor of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.
d) Suspend payments for new enrollments to the Contractor until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

See: 42 C.F.R. § 438.700(b)(2); 42 C.F.R. § 438.702(a); 42 C.F.R. § 438.704(c); sections 1903(m)(5)(A)(ii); 1903(m)(5)(B); 1932(e)(1)(A)(ii); 1932(e)(2)(A)(iii) of the Social Security Act; 42 C.F.R. § 457.1270. {From CMSC J.5.02}.

J.5.03. *Sanction for Discrimination.* If the Contractor discriminates among Enrolled Members on the basis of their health status or need for health services, the State may impose a civil monetary penalty of up to $100,000 for each determination of Discrimination. The State may impose a civil monetary penalty of up to $15,000 for each individual the Contractor did not enroll because of a discriminatory practice, up to the $100,000 maximum. The State may also:

a) Appoint temporary management to the Contractor.
b) Grant Enrolled Members the right to disenroll without cause.
c) Suspend all new enrollments to the Contractor after the date the Secretary or the State notifies the Contractor of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.
d) Suspend payments for new enrollments to the Contractor until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

See: 42 C.F.R. § 438.700(b)(3); 42 C.F.R. § 438.702(a); 42 C.F.R. § 438.704(b)(2) and (3); sections 1903(m)(5)(A)(iii); 1903(m)(5)(B); 1932(e)(1)(A)(iii); 1932(e)(2)(A)(ii) & (iv) of the Social Security Act; 42 C.F.R. § 457.1270. {From CMSC J.5.03}.

J.5.04. *Falsification of Information to State or CMS.* If the Contractor misrepresents or falsifies information that it furnishes to CMS or to the State, the State may impose a civil monetary penalty of up to $100,000 for each instance of misrepresentation. The State may also:

a) Appoint temporary management to the Contractor.
b) Grant Enrolled Members the right to disenroll without cause.
c) Suspend all new enrollments to the Contractor after the date the Secretary or the State notifies the Contractor of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.
d) Suspend payments for new enrollments to the Contractor until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

See: 42 C.F.R. § 438.700(b)(4); 42 C.F.R. § 438.702(a); 42 C.F.R. § 438.704(b)(2); sections 1932(e)(1)(iv); 1903(m)(5)(A)(iv)(I); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(I); 1932(e)(2)(A)(ii) of the Social Security Act; 42 C.F.R. § 457. 1270. {From CMSC J.5.04}.

J.5.05. *Falsification of Information to Enrollees.* If the Contractor misrepresents or falsifies information that it furnishes to an Enrolled Member, Potential Enrollee, or health care Provider, the State may impose a civil monetary penalty of up to $25,000 for each instance of misrepresentation. The State may also:

a) Appoint temporary management to the Contractor.
b) Grant Enrolled Members the right to disenroll without case.

c) Suspend all new enrollments to the Contractor after the date the Secretary or the State notifies the Contractor of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.
d) Suspend payments for new enrollments to the Contractor until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

See: 42 C.F.R. § 438.702(a); 42 C.F.R. § 438.700(b)(5); 42 C.F.R. § 438.704(b)(1); sections 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i) of the Social Security Act; 42 C.F.R. § 457.1270. {From CMSC J.5.05}.

J.5.06. *Medicare PIP Compliance.* If the Contractor fails to comply with the Medicare physician incentive plan requirements, the State may impose a civil monetary penalty of up to $25,000 for each failure to comply. The State may also:

a) Appoint temporary management to the Contractor.
b) Grant Enrolled Members the right to disenroll without case.
c) Suspend all new enrollments to the Contractor after the date the Secretary or the State notifies the Contractor of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.
d) Suspend payments for new enrollments to the Contractor until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

See: 42 C.F.R. § 438.700(b)(6); 42 C.F.R. § 438.702(a); 42 C.F.R. § 438.704(b)(1); sections 1903(m)(5)(A)(v); 1903(m)(5)(B); 1932(e)(1)(A)(v); 1932(e)(2)(A)(i) of the Social Security Act; 42 C.F.R. § 457.1270. {From CMSC J.5.06}.

J.5.07. *Distribution of Marketing Materials.* If the Contractor distributes Marketing Materials that have not been approved by the State or that contain false or misleading information, either directly or indirectly through any agent or independent contractor, the State may impose a civil monetary penalty of up to $25,000 for each distribution. See: 42 C.F.R. § 438.700(c); 42 C.F.R. § 438.704(b)(1); sections 1932(e)(1)(A); 1932(e)(2)(A)(i) of the Social Security Act; 42 C.F.R. § 457.1270. {From CMSC J.5.07}.

J.5.08. *Sanctions.* If the Contractor violates any other applicable requirements in sections 1903(m) or 1932 of the Social Security Act or any implementing regulations, the State may impose only the following sanctions:

a) Grant Enrolled Members the right to disenroll without cause.
b) Suspend all new enrollments to the Contractor after the date the Secretary or the State notifies the Contractor of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.
c) Suspend payments for all new enrollments to the Contractor until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

See: 42 C.F.R. § 438.700(d)(1); 42 C.F.R. § 438.702(a)(3) - (5); sections 1932(e)(2)(C); 1932(e)(2)(D); 1932(e)(2)(E) of the Social Security Act; 42 C.F.R. § 457.1270. {From CMSC J.5.08}.

J.5.09. *Additional State Sanctions.* The State 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. *Denial of Payment.* The State will deny payments for new Enrolled Members when, and for so long as, payment for those Enrolled Members is denied by CMS based on the State's recommendation, when:

a) The Contractor fails substantially to provide Medically Necessary Services that the Contractor is required to provide, under law or under this Contract, to an Enrolled Member covered under the Contract.

b) The Contractor imposes on Enrolled Members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
c) The Contractor acts to discriminate among Enrolled Members on the basis of their health status or need for Health Care Services.
d) The Contractor misrepresents or falsifies information that it furnishes to CMS or to the State.
e) The Contractor misrepresents or falsifies information that it furnishes to an Enrolled Member, Potential Enrollee, or health care Provider.
f) The Contractor fails to comply with the requirements for PIPs, as set forth (for Medicare) in 42 C.F.R. § 422.208 and 42 C.F.R. § 422.210.

See: 42 C.F.R. § 438.700(b)(1) - (6) 42 C.F.R. § 438.726(b); 42 C.F.R. § 438.730(e)(1)(i); section 1903(m)(5)(B)(ii) of the Social Security Act; 42 C.F.R. § 457.1270. {From CMSC J.5.11 - J.5.16}.

J.5.11. *Denial of Payment.* The State will deny payments for new Enrolled Members when, and for so long as, payment for those Enrolled Members is denied by CMS. CMS may deny payment to the State for new Enrolled Members if its determination is not timely contested by the Contractor. See: 42 C.F.R. § 438.726(b); 42 C.F.R. § 438.730(e)(1)(ii); 42 C.F.R. § 457.1270. {From CMSC J.5.17}.

J.5.12. *Limitation on Imposition of Temporary Management.* Under this Contract, temporary management may only be imposed when the State finds, through onsite surveys, Enrolled Member or other complaints, financial status, or any other source:

a) There is continued egregious behavior by the Contractor;
b) There is substantial risk to Enrolled Members' health; or
c) The sanction is necessary to ensure the health of the Contractor's Enrolled Members in one (1) of two (2) circumstances:
    1. While improvements are made to remedy violations that require sanctions; or
    2. Until there is an orderly termination or reorganization of the Contractor.

See: 42 C.F.R. § 438.706(a); section 1932(e)(2)(B)(i) of the Social Security Act; 42 C.F.R. § 457.1270. {From CMSC J.5.18}.

J.5.13. *Temporary Management.* The State must impose mandatory temporary management when the Contractor repeatedly fails to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 C.F.R. § 438. The State may not delay the imposition of temporary management to provide a hearing and may not terminate temporary management until it determines that the Contractor can ensure the sanctioned behavior will not reoccur. See: 42 C.F.R. § 438.706(b) - (d); section 1932(e)(2)(B)(ii) of the Social Security Act; 42 C.F.R. § 457.1270. {From CMSC J.5.19}.

J.5.14. *Right to Terminate Enrollment.* The State must grant Enrolled Members the right to terminate Contractor enrollment without cause when the Contractor repeatedly fails to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 C.F.R. § 438. See: 42 C.F.R. § 438.706(b) - (d); section 1932(e)(2)(B)(ii) of the Social Security Act; 42 C.F.R. § 457.1270. {From CMSC J.5.20}.

J.6 Termination

J.6.01. *Termination Right.* The State 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 State 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. *Enrollees 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 Enrollee Liability on Unpaid Claims.* Medicaid and CHIP Enrolled Members shall not held liable for covered services provided to the Enrolled Member, for which the State does not pay the Contractor, or for which the State 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 Enrollee 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 State 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. *State Licensing.* Contractor shall meet the State's solvency standards for private health maintenance organizations, or be licensed or certified by the State as a risk-bearing entity. See: Section 1903(m)(1) of the Social Security Act; 42 C.F.R. § 438.116(b). {From CMSC J.7.06}.

J.7.06. *Financial Stability.* Contractor shall be licensed and in good standing as an HMO in the State of Iowa and shall comply with all applicable insurance regulations. The Contractor shall comply with rules regarding deposit requirements at Iowa Admin. Code r. 191-40.12 and reporting requirements at Iowa Admin. Code r. 191-40.14. 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 reinsurance requirements at Iowa Admin. Code r. 191-40.17 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.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 the 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. *Non-Compliance with Prescription Drug Rebate File.* The Contractor shall comply with the required layouts for submitting pharmacy Claim extracts used to support federal Drug Rebate invoicing and collection. The frequency of file submissions and the content of the files supporting Drug Rebate invoicing and collection are defined by the Agency and pertain to all pharmacy Claim transactions and medical Claim transactions that contain Physician/Provider administered drugs as set forth in Section F.11. The Contractor shall provide this reporting to the Agency in the manner and timeframe prescribed by the Agency, including, but not limited to, through a rebate file to the Agency or its Designee. For any instance in which the Contractor fails to provide required files for Drug Rebate purposes in a timely, accurate or complete manner, the Contractor shall be responsible for interest, based on the interest calculation for late rebate payments methodology published by CMS, on delayed rebate money owed to the Agency. For example, if the Contractor fails to meet the Agency established deadline for submission of the Claim extracts and/or rebate file and the Drug Rebate contractor completes the quarterly Drug Rebate invoicing process without the Contractor's Claim information for the invoicing quarter, the Contractor shall reimburse the Agency for interest on the rebate amount later calculated by the Drug Rebate contractor, for the period of delay in collecting the rebate amount. Such reimbursement shall be due within thirty (30) Days of presentation of the interest calculation.

J.8.04. *Non-Compliance with Provider Network Requirements.* In addition to the 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 the 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 actual to enforce contractual obligations, or implement intermediate sanctions under Section J.5 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:* Under Section J.5, 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:* Under Section J.5, 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 Enrollee 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 Iowa Health Information Network (doing business as CyncHealth) is the statewide health information technology network that is the sole statewide network for Iowa as pursuant to Iowa Code chapter 135D. The Contractor shall be a full participant of the Iowa Health Information Network (IHIN) and obtain Agency approval of HIT initiatives and interfaces with IHIN. 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.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.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 State 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.03}.

K.05. *Health Information System – Encounter Data Compliance*. Contractor shall collect data on Enrolled Member and Provider characteristics as specified by the State and on all services furnished to Enrolled Members through an encounter data system or other methods as may be specified by the State. See: 42 C.F.R. § 438.242(b)(2); 42 C.F.R. § 457.1233(d). {From CMSC K.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.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.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.07}.

K.09. *Availability of Data.* Contractor shall make all collected data available to the State and upon request to CMS. See: 42 C.F.R. § 438.242(b)(4); 42 C.F.R. § 457.1233(d). {From CMSC K.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 State at a frequency and level of detail to be specified by CMS and the State, based on program administration, oversight, and program integrity needs.
c) Permit submission of all Enrolled Member encounter data that the State is required to report to CMS.
d) Comply with specifications for submitting encounter data to the State 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.09 - K.12}.

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 PBM or other Subcontractor of Contractor. Any administrative fee the PBM charges the Contractor cannot be sent as part of the encounter claiming pricing.

K.12. *Required Functions.* The Contractor shall perform the following 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 subsequent to a written agreement with a county or a county's representative to provide and update such information as well as to provide required consumer releases;
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) *Medication Management*. Maintain data to support medication management activities;
f) *Capitation Payment*. Maintain data documenting receipt and distribution of the Capitation Payment;
g) *Incurred Claims*. Maintain data on incurred but not yet reimbursed Claims;
h) *Claims Processing Timeliness*. Maintain data on the time required to process and mail Claims payment;
i) *Critical Incident Data*. Maintain critical incident data;
j) *Clinical Data*. Maintain clinical and functional Outcomes data and data to support Quality activities;
k) *Grievance and Appeals*. Maintain data on clinical reviews, Appeals, Grievances and complaints and their Outcomes;
l) *Utilization Management*. Maintain data on services requested, authorized, provided and denied;
m) *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.
n) *Service Referrals*. Maintain data on all service referrals
o) *Service Specific Information*. Maintain all data in such a manner as to be able to generate information specific to service type, including but not limited to: (i) Behavioral Health Services; (ii) LTSS; (iii) pharmacy; (iv) inpatient services; and (v) outpatient services; and
p) *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 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;
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 State 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 State 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 State 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 State 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 State 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 Enrollee.* 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 State 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 State 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. *Electronic Case Management System*. The Contractor shall develop and maintain an electronic Community-Based Case Management system that includes the functionality to ensure compliance with the State's 1915(c) HCBS Waiver and 1915(i) programs and law. This includes, but is not limited to, the ability to capture and track: (i) key dates and timeframes such as enrollment date, date of development of the care plan, date of care plan authorization, date of initial service delivery, date of level of care and needs reassessments and dates of care plan updates and the functionality to notify the community-based case manager or care coordinator of care plan, assessment and reassessment deadlines; (ii) the care plan; (iii) all referrals; (iv) level of care assessment and reassessments; (v) needs assessments and reassessments; (vi) service delivery against authorized services and Providers; (vii) actions taken by the community-based case manager or care coordinator to address service gaps; and (viii) case notes.

K.29. *Electronic Visit Verification System*. The Contractor shall participate in EVV planning activities and use the Contractor-proposed, Agency-approved EVV system that will be in place within a timeframe determined by the Agency to ensure compliance with state and federal regulations, including Section 12006 of the Cures Act (42 U.S.C. § 1396b(l)). Beginning on the dates required by the Agency, the Contractor shall require personal care providers and home health services to use the Contractor EVV system or another EVV system complying with Section 12006 of the Cures Act. The Contractor shall develop and describe what methodologies will be used to monitor member receipt and utilization of personal care, Home Health Services, and other services using the EVV system. All EVV data that originates in or passes through the Contractor EVV system will be provided to the Agency in a format and timeframe subject to Agency approval.

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 the diagnosis and functional assessment score;
b) *Level of Functioning.* Determination of and documentation of the levels of functioning;
c) *Services Authorized.* Documentation of clinical services requested, services authorized, services substituted, services provided; Documentation shall reflect the application of UM criteria;
d) *Services Denied*. Documentation of services not authorized, reasons for the non-authorization based on Iowa Administrative Code citations, and substitutions offered;
e) *Missed Appointments*. Documentation of missed appointments, and subsequent attempts to follow up with the Enrolled Member;
f) *Emergency Room*. Follow-up on Enrolled Members discharged from the emergency room without an admission for inpatient treatment or observation;
g) *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;
h) *Medication Management.* Documentation of the Enrolled Member's medication management done by the Contractor's clinical staff;
i) *Inpatient Data*. Documentation of assessment and determination of level at admission, continued service and discharge criteria;
j) *Joint Treatment Planning*. Name(s) of persons key to the treatment planning of Enrolled Members who Access multiple services; and
k) *Discharge Planning*. Documentation of the discharge plan for each Enrolled Member discharged from twenty-four (24) hour services reimbursed through the Contractor; this shall include the destination of the Enrolled Member upon discharge.

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 State or the State'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 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 Client Participation and Cost Sharing*. Some Enrolled Members, as described in Section F.8.12, including LTSS recipients who are receiving facility or community-based care, must contribute a predetermined Client Participation for the cost of services prior to Medicaid reimbursement. The Agency will notify the Contractor of an Enrolled Member's Client Participation amount. The Contractor will establish which Provider the Enrolled Member is to pay their Client Participation to on a monthly basis. The Provider will then bill the Enrolled Member for their portion of the set Client Participation amount. The Contractor shall process Claims in accordance with the participation amount and pay Providers net of the applicable Client Participation amount. In the event the sum of any applicable third-party payment and an Enrolled Member's Client Participation equals or exceeds the reimbursement amount established for services, the Contractor shall make no payment.

g) *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.

h) *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 will 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. Drug encounter data shall be submitted by the Contractor once a week for adjudicated Claims in support of the IME's Drug Rebate invoicing process identified in Section F.11. All encounter data including the drug encounter data shall be submitted by the twentieth (20^{th}) 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 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 State, 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., RN, MD, RPh, 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 State; and
d) Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one (1) business day after the effective date of any such information or updates to such information.

The Contractor shall implement and maintain 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}.

L. State Obligations

L.1 Enrollee and Potential Enrollee Information

L.1.01. *Prevalent Languages.* This Contract specifies the Prevalent non-English languages spoken by Enrolled Members and Potential Enrollees in the State and each managed care plan service area, identified by the State, 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 State will provide that information to Potential Enrollees. 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 State imposes a civil monetary penalty on the Contractor for charging premiums or charges in excess of the amounts permitted under Medicaid, the State 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 State imposes temporary management because an MCO 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 State 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 State 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 State will provide Contractor with timely written notice before imposing any intermediate sanction (other than required temporary management) that explains any Appeal rights the State 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 State:

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 State intends to terminate the Contract, the State may:

a) Give the Contractor's Enrolled Members notice of the State'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 State 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 State 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 managed care plan 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 State 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 State, the Enrollment Broker, or the Contractor will identify persons with special health care needs as defined by the State. The 834 and LTSS file and any other mechanisms identified by the State 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. *Identifying Persons Who Need LTSS.* The State, the Enrollment Broker, or the Contractor will identify persons who need LTSS as defined by the State. The 834 and LTSS file and any other mechanisms identified by the State 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.4.02}.

L.5 Data Collection

L.5.01. *Member Data.* The State 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). {From CMSC L.5.01 - L.5.02}.

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). {From CMSC L.5.03}.

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). {From CMSC L.5.04 - L.5.05}.

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). {From CMSC L.5.06 - L.5.08}.

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. {From CMSC L.5.09 - L.5.11}.

L.5.06. *LTSS Data.* The Agency will collect LTSS data from Contractor to improve the performance of its managed care program. See: 42 C.F.R. § 438.66(c)(12). {From CMSC L.5.12}.

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 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 managed care entity.
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 Community-Based Case Management or 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 medical 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 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) Be financially responsible for inpatient services for patients hospitalized on or before the day of Contract termination or expiration.
r) Provide the Agency, or its designated entity, all pre-termination performance data, including but not limited to any Agency-identified survey tool and HEDIS.
s) Provide the Agency, or its designated entity, in the format and within the timeframes set forth by the Agency, information on all Iowa Health and Wellness Plan Enrolled Members' completion of Healthy Behaviors Program requirements.
t) 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.
u) Provide the Agency with all outstanding Drug Rebate disputes with a manufacturer and an action plan to resolve the disputes. The Agency reserves the right to withhold Capitation Payments or any other payments due the Contractor until the Contractor resolves the outstanding Drug Rebate disputes.
v) 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
w) 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 IA Health Link marketplace, 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 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 5: SPECIAL CONTRACT EXHIBITS

Exhibit A: Capitation Rate Information, MLR, Pay for Performance, Liquidated Damages, and Excluded Pharmaceuticals

1. Capitation Rate Information
2. MLR for Rate Period
3. Sample Payment for Performance Chart
4. Liquidated Damages
5. Excluded Pharmaceuticals

Exhibit B: Glossary of Terms/Definitions

Exhibit C: General Access Standards

Exhibit D: Eligible Enrollees and Excluded Populations

Exhibit E: Covered Benefits

Exhibit F: NEMT Standards

Exhibit G: Pandemic-Related Contract Provisions

Exhibit H: State Directed Payments

Exhibit I: Memorandum of Understanding of State Directed Payments Between the Agency and the Iowa Hospital Association

Exhibit J: Managed Care Premium Tax

Exhibit A: Capitation Rate Information, MLR, Pay for Performance, Liquidated Damages, and Excluded Pharmaceuticals

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 88.0%.

Section 3: SFY 2026 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 withhold amount is based on the capitation rates less premium tax. Payment from the Agency to the Contractor will be adjusted for Premium tax.

The Agency has established a set of Pay for Performance measures for the first year of the Contract. It is expected that all Contractors will return to a common set of Pay for Performance measures, which may differ from the measures listed below, beginning in State fiscal year 2027. Final SFY 2026 capitation rates that will be established prior to the start of the Contract will be calculated in consideration of the particular Pay for Performance measures in Table A.

Final SFY26 Pay for Performance measures, for incumbent Contractors, will be determined by the Agency at a later date and will be provided via an amendment to this Contract. The agency will provide a document with the full description of the guidelines and data definitions for the final SFY 2026 Pay for Performance Mesuares.

Section 4: Liquidated Damages

#	Category	Topic	Requirement	Liquidated Damage
1	Systems	Timeliness	After the Operational Start Date, the Contractor's MMIS must meet all requirements in Section K. Health Information Systems and Enrollee Data	$5,000 per Day, per requirement
2	Pharmacy	Pharmacy	The Contractor shall adhere to the Medicaid PDL requirements listed in Section F.11.36	$500 for each incident per Member and per drug of

			Preferred Drug List (PDL) and Recommended Drug List (RDL).	non-compliance, not to exceed $10,000 per Day
3	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)
4	Claims	Timeliness	The Contractor shall pay or deny ninety percent (90%) of Clean Claims within thirty (30) Days of receipt, ninety-five percent (95%) of Clean Claims within forty-five (45) Days of the date of receipt, and/or ninety-nine percent (99%) of all Claims within ninety (90) Days of receipt as outlined in Section D.6.01. Measured monthly.	$10,000 per month of non-compliance
5	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, including drug encounter data, is not submitted by the 20th 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	$10,000 per incident of non-compliance
6	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
7	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
8	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, within seventy-two (72) hours for expedited authorization decisions, and within twenty-four (24) hours for outpatient	$5,000 per full percentage point below requirement

			prescription drugs prior authorizations. Measured monthly. Requests for extensions approved in accordance with the Contract shall be removed from this timeliness measure.	
9	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.	$500 per Day, per requirement
10	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.	$1,000 per day the Contractor exceeds approved timeline to provide and/or comply
11	Readiness Review	Readiness Review	Contractor shall pass the Readiness Review at least thirty (30) Days prior to scheduled member enrollment.	$10,000 per Day of non-compliance
12	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
13	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
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	Member Services	1915(c) and 1915(i) HCBS Waiver Assessment and Care Plan Development	Contractor shall complete a comprehensive assessment, develop a plan of care, and authorize and initiate all long-term care services specified in the plan of care for a 1915(c) and 1915(i) HCBS waiver enrollees within the timeframe outlined by the Agency.	$1,000 per occurrence
16	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: Excluded Pharmaceuticals

The Agency will exclude from the capitation rates the select prescription drugs and treatments as set forth herein. Prescription drugs or gene therapies that cost more than $1.5 million per individual dose or treatment will be excluded from capitation rates. All drugs and gene therapies must be approved by the U.S. Food and Drug Administration AND the manufacturer must have entered into, and have in effect, a National Drug Rebate Agreement with the Secretary of the Department of Health and Human Services. Contractor shall continue to provide coverage for these pharmaceuticals and treatments, and the Agency will reimburse the Contractor based on Contractor's invoice to the Agency for pharmaceuticals or treatments paid. Contractor may only invoice for the lower of (1) actual cost to the Contractor, (2) actual cost to Contractor's PBM, or (3) the actual cost paid for the drug. . The list of pharmaceuticals and treatments excluded from the capitation payments will be posted on the HHS website here Medicaid Contracts and Rates | Health & Human Services (iowa.gov) This list will be reviewed and updated, if necessary, at least once every 6 months.

Exhibit B: Glossary of Terms/Definitions

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.

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 State 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) MCO, 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 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 Health Care Services including: (i) physical health; (ii) behavioral health; (iii) pharmacy; and (iv) LTSS 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 State 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}.

Care Coordination: Care Coordination is the overall system of medical and psychosocial management encompassing, but not limited to: UM, disease management, Discharge Planning following restrictive levels of care, continuity of care, care transition, Quality management and service verification.

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.

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.

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 an Enrolled 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. Enrolled 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 Enrolled Member's income is higher than allowable thresholds. Client Participation is paid at the beginning of a coverage month. If an Enrolled Member is institutionalized, the facility makes arrangements with the Enrolled Member to collect Client Participation. The Contractor is responsible for establishing Client Participation collection activities in accordance with the terms of this Contract. 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 Enrollee 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 an Enrolled 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 Enrolled Members in gaining timely Access to the full range of needed services. For the purpose of this scope of work, TCM activities are to be conducted through Community-Based Case Management.

Comprehensive Risk Contract: A Risk Contract between the State and the Contractor 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}.

Day Habilitation: Day habilitation services are services that assist or support the consumer in developing or maintaining life skills and community integration.

Days: Calendar days unless otherwise specified.

Denied Claim: A Claim for which no payment is made to the Network Provider by the Contractor for any of several reasons, including but not limited to, the Claim is for non-covered services, the Provider or Enrolled Member is ineligible, the Claims is a duplicate of another transaction, or the Claim has failed to pass a significant requirement (or edit) in the Claims processing system.

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 Enrolled 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: 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 or stabilize an Emergency Medical Condition.

See: 42 C.F.R. § 438.114(a). {From CMSC}.

Enrolled Member: See *Enrollee.*

Enrollee: 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}.

Enrollee 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 the expedited grievance 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}.

Functional Family Therapy (FFT): An evidenced based family therapy that provides clinical assessment and treatment for the youth and their family to improve communication, problem solving, and conflict management in order to reduce problematic behavior of the youth.

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: 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.

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. 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.

HIPP: Health Insurance Premium Payment Program.
Health Insurance: Financial coverage to cover a portion of the cost of a policyholder's medical bills. May be a public coverage program such as Medicare, Medicaid, MCO's; CHIP, Indian Health Services. May be private health care such as provided by an employers or purchased in the market.

HIT: Health Information Technology.

HMO: Health Maintenance Organization licensed by the Iowa Insurance Division.

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 Based Habilitation: Home-based habilitation services are individualized supportive services provided in the member's home and community that assist the member to reside in the most integrated setting appropriate to the member's needs.

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 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.

IDPH: Iowa Department of Public Health.

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}.

In Lieu of Services (ILOS): a service or setting that is provided to an enrollee as a substitute for a covered service or setting under the State Plan in accordance with 42 C.F.R 438.3(e)(2). An ILOS can be used as an immediate or longer-term substitute for a covered service or setting under the State plan, or when the ILOS can be expected to reduce or prevent the future need to utilize the covered service or setting under the State Plan.

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 Information Network (IHIN): Iowa's Health Information Exchange.

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 Enrollees 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}.

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.

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 Enrolled 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 Enrollees.

See: 42 C.F.R. § 438.104(a). {From CMSC}.

MCO Interface Guide: The MCO Interface Guide is a resource that outlines all file transfers between MMIS and the MCOs. The document describes File Transfer Protocols and File Naming Conventions. Corresponding File Layouts for supplemental files, disenrollment files, and Companion Guides for 834, 820, and 837 files are available for MCO reference. These documents can be found in the MCO Resource Library on IMPA.

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.

Medical Loss Ratio (MLR) Reporting Year: A period of twelve (12) months consistent with the rating period selected by the State. See: 42 C.F.R. § 438.8(b). {From CMSC}.

Medical Records: All medical, 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, 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 State 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 State 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.

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.

Multi-Systemic Therapy (MST): An evidenced based intensive treatment process that focuses on diagnosed behavioral health disorders and on environmental systems (family, school, peer groups, culture, neighborhood, and community) that contribute to, or influences a youth's involvement, or potential involvement in the juvenile justice system.

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 Health Care Services.

Network Adequacy: Refers to the Network of 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 State'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-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}.

PA: Prior Authorization.

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 State 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 Enrolled Member, where possible, and includes the Enrolled Member's representative in a participatory role, as needed and as defined by the Enrolled Member, unless State law confers decision-making authority to the legal representative. In addition to being led by the Enrolled Member receiving services and supports, the Person-Centered Planning Process:

- Includes people chosen by the Enrolled Member;

- Provides necessary information and support to ensure that the Enrolled 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 Enrolled Member;
- Reflects cultural considerations of the Enrolled 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 Enrolled Member, or those who have an interest in or are employed by a Provider of HCBS for the Enrolled Member must not provide case management or develop the Person-Centered Service Plan, except when the State 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 State must devise conflict of interest protections including separation of entity and Provider functions within Provider entities, which must be approved by CMS. Enrolled Members must be provided with a clear and accessible alternative dispute resolution process;
- Offers informed choices to the Enrolled Member regarding the services and supports they receive and from whom;
- Includes a method for the Enrolled Member to request updates to the plan as needed;
- Records the alternative home and community-based settings that were considered by the Enrolled 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 Enrolled Member to meet the needs identified through an assessment of functional need, as well as what is important to the Enrolled Member with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the Enrolled 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 Enrolled Member resides is chosen by the Enrolled Member. The State must ensure that the setting chosen by the Enrolled Member is integrated in, and supports full Access of Enrolled 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 Enrolled 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 Enrolled 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 Enrolled 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 Enrolled 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 Enrolled 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 Enrolled Member in writing, and signed by all individuals and Providers responsible for its implementation;
- Be distributed to the Enrolled Member and other people involved in the plan;
- Include those services, the purpose or control of which the Enrolled 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/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.

Physician Services: Health care services a licensed medical physician provides or coordinates.

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 Enrollee: 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.

Preferred Drug: A drug on the PDL that provides medical equivalency to the Medicaid Enrolled 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 policyholders pay for health coverage.

Premium Tax: In accordance with Iowa Code §432.1B and 42 CFR § 433.68, an amount equal to a percentage of the premiums received and taxable under Iowa Code subsection 514B.31 and shall be paid as taxes to the director of the department of revenue for deposit in the Medicaid managed care organization premiums fund created in Iowa Code section 249A.13.

Prepaid Ambulatory Health Plan (PAHP): An entity that—

- Provides services to Enrolled Members under contract with the State, 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 Enrolled Members under contract with the State, 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 Enrolled Members; and
- Does not have a Comprehensive Risk Contract.

See: 42 C.F.R. § 438.2. {From CMSC}.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prevalent: A non-English language determined to be spoken by a significant number or percentage of Potential Enrollees and Enrolled Members that are LEP. Per Iowa's 1915(b) waiver, this threshold percentage is 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 or other licensed health practitioners practicing in accordance with State law who is responsible for providing preventive and primary 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, health maintenance, and health promotion, either by the PCP or through appropriate referral to specialists and/or ancillary Providers.

Prior Authorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency.

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 high-quality healthcare initiative.

Program Contractor(s): The vendors selected to operate the Program, including the Contractor and the other awarded entity(s).

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 Enrolled Member and not primarily for the convenience of the Enrolled Member, the Provider, or the Contractor; and (v) are the most appropriate type of service which would reasonably meet the needs of the Enrolled Member in the least costly manner after consideration of: (a) the Enrolled 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 Enrolled 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 Enrolled Member (e.g., availability of transportation, lack of Natural Supports including a place to live); and (f) the Enrolled 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 State 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 a 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 30 days and indicate the type of service provided.

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 State 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 State 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 5 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 5 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}.

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 physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

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 State and in accordance with applicable Federal and State law. Any disorder defined by the State 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}.

Supported Employment: Supported employment means the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state's minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals. Supported employment services can be provided through many different service models.

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.

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.

Telecommunications Device for the Deaf (TDD): means any telecommunication device for the deaf.

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 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. [3]

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 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 institutional facilities, service locations, service sites, professional, allied, and paramedical personnel for the provision of covered services, including all Emergency Services, on a twenty-four (24) hour-a-day, seven (7) day-a-week basis. 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 State 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 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 four (4) to six (6) 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 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: (i) allergy; (ii) cardiology; (iii) dermatology; (iv) endocrinology; (v) gastroenterology; (vi) general surgery; (vii) hematology; (viii) neonatology; (ix) nephrology (x) neurology;; (xi) neurology;; (xii) obstetrics and gynecology; (xiii) occupational therapy, (xiv) oncology; (xv) ophthalmology; (xvi) orthopedics; (xvii) otolaryngology; (xviii) pathology; (xix) physical therapy; (xx) pulmonology; (xxi) psychiatry; (xxii) radiology; (xxiii) reconstructive surgery; (xxiv) rheumatology; (xxv) speech therapy; (xxvi) urology; and (xxvii) 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 75% of non-dual Enrolled Members.

2. Ninety (90) minutes or ninety (90) miles from the personal residence of Enrolled Members for ALL non-dual Enrolled Members.

c) *Appointment Times:* Not to exceed thirty (30) Days for Routine Care or one (1) day for urgent care.

C. Hospital and Emergency Services Access Standards

a) *Hospitals:* Transport time shall be the usual and customary, not to exceed thirty (30) minutes or thirty (30) miles, except in Rural areas where Access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions shall be justified and documented to the State on the basis of community standards.

b) *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.

D. Long-Term Care Services Access Standards

a) *Network*:

1. *Institutional Providers:* All licensed and Medicaid certified Nursing Facilities and ICF/IDs shall be offered inclusion in the Contractor's Provider Network for two (2) years in accordance with Section E.3.17. Following the minimum period, the Contractor can evaluate each facilities' continued Network enrollment based on assessment of Quality and performance outcomes and consistent with Contractor requirements for coordination of care, approved by the State.
2. *HCBS Providers:* All certified, accredited, or approved HCBS Providers shall be offered inclusion in the Contractor's Provider Network for two (2) years in accordance with Section E.3.17. The Contractor shall contract with at least two (2) Providers per county for each covered HCBS in the benefit package for each 1915(c) HCBS Waiver. In the event a county has an insufficient number of Providers licensed, certified, or available, the Access standard shall be based on the community standard and shall be justified and documented to the State.

b) Time and Distance:

1. Transport distance to Providers shall be the usual and customary not to exceed thirty (30) minutes or thirty (30) miles for Enrolled Members in Urban areas and not to exceed sixty (60) minutes or sixty (60) miles for Enrolled Members in Rural areas except where community standards and Documentation shall apply.

E. Reserved

F. Behavioral Health Access Standards

a) Time and Distance:

1. *Outpatient services:* Thirty (30) minutes or thirty (30) miles from the personal residence of Enrolled Members except where community standards and documentation shall apply.
2. *Inpatient, residential, intensive outpatient and partial hospitalization:* Sixty (60) minutes or sixty (60) miles from the personal residence of Enrolled Members in Urban areas and ninety (90) minutes or ninety (90) miles from the personal residence of Enrolled Members in Rural areas using GeoAccess standards for Rural and Urban travel time.

b) Appointment Times: The Contractor shall require that Network Providers have procedures for the scheduling of Enrolled Members appointments in accordance with their scope of practice in response to the following occurrences:

1. *Emergency*: Enrolled Members with emergency needs shall be seen or referred to an appropriate provider, upon presentation at a service delivery site.
2. *Mobile Crisis*: Enrolled Members in need of mobile crisis services shall receive services within one (1) hour of presentation or request.
3. *Urgent*: Enrolled Members with urgent non-emergency needs shall be seen or referred to an appropriate provider within one (1) hour of presentation at a service delivery site or within twenty-four (24) hours of telephone contact with Provider or the Contractor.
4. *Persistent symptoms*: Enrolled Members with persistent symptoms shall be seen or referred to an appropriate Provider within forty-eight (48) hours or reporting symptoms.
5. *Routine*: Enrolled Members with need for routine services shall be seen or referred to an appropriate Provider within three (3) weeks of the request for an appointment.
6. *Substance Use Disorder & Pregnancy*: Enrolled Members who are pregnant women in need of routine substance use disorder services must be admitted within forty-eight (48) hours of seeking treatment.

7. *Intravenous drug use*: Members who are intravenous drug users must be admitted not later than fourteen (14) Days after making the request for admission, or one hundred and twenty (120) Days after the date of such request if no program has the capacity to admit the individual on the date of such request and if interim services are made available to the individual not later than forty-eight (48) hours after such request.

G. Other Services

a) *General Optometry Services*:
   1. *Time and Distance:* Transport time shall be the usual and customary, not to exceed thirty (30) minutes or thirty (30) miles, except in Rural areas where community standards and Documentation shall apply.
   2. *Appointment Times*: Usual and customary not to exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care.

b) *Lab and X-Ray Services*: The Contractor shall arrange for laboratory services only through laboratories with Clinical Laboratory Improvement Amendments (CLIA) certificates and in accordance with CLIA law.
   1. *Time and Distance*: Transport time shall be the usual and customary, not to exceed thirty (30) minutes or thirty (30) miles, except in Rural areas where community Access standards and Documentation will apply.
   2. *Appointment Times*: Usual and customary not to exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care.

c) *Pharmacies:* The Contractor shall provide at least two (2) pharmacy Providers within thirty (30) minutes or thirty (30) miles from an Enrolled Member's residence in each county.

Exhibit D: Eligible Enrollees and Excluded Populations

Table D.01: Eligible Enrollees

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.
Breast or Cervical Cancer	Individuals who have been screened and diagnosed with breast or cervical cancer through the BCCEDP or by any Provider or entity and BCCEDP has elected to include screening activities by that Provider or entity. Individual is found to need treatment for either breast or cervical cancer, does not otherwise have creditable coverage as defined in HIPAA and is not otherwise Medicaid eligible.
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 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	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 300% FPL. Premium requirements apply. For pregnant or postpartum women, the age limit may extend past the age of 19.
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 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 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 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 100% FPL for Iowa Wellness Plan, not exceeding 133% for Iowa Marketplace Choice, and for Medically Exempt Iowans with income not exceeding 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 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 250% FPL. A premium payment is required for individuals with income over 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 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 services are outlined in Iowa Admin. Code ch. 441-78, within the State Plan, and all CMS approved waivers.

Table E.01: Full Medicaid Covered Benefits & Limitations

SERVICE	LIMITATIONS
1915(C) SERVICES	The Contractor shall cover 1915(c) waiver services as authorized in accordance with the federal waiver.
1915(I) HABILITATION SERVICES	The Contractor shall cover 1915(i) State Plan services as authorized in accordance with the federal State Plan amendment.
ABORTIONS	Abortions in the following situations are covered Medicaid Benefits: a) If the pregnancy is the result of an act of rape or incest. If the pregnancy is the result of a rape which is reported within forty-five days of the incident to a law enforcement agency or to a public or private health agency which may include a family physician. 653 IAC 13.17(2) and 13.17(4)(a) and the HHS Provider Manual set forth additional requirements for health care providers. b) If the pregnancy is the result of a rape which is reported within one hundred forty days of the incident to a law enforcement agency or to a public or private health agency which may include a family physician. 653 IAC 13.17(2) and 13.17(4)(a) and the HHS Provider Manual set forth additional requirements for health care providers. c) If the pregnancy was ended as the result of a “spontaneous abortion” or miscarriage, and not all of the products of conception are expelled. d) If the attending physician certifies that the fetus has a fetal abnormality that in the physician’s reasonable medical judgment is incompatible with life. 653 IAC 13.17(4)(b) and the HHS Provider Manual set forth additional requirements for health care providers. e) If the pregnancy must be ended as a result of a medical emergency. A medical emergency is a situation in which an abortion is performed to preserve the life of the pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy, but not including psychological conditions, emotional conditions, familial conditions, or the woman’s age; or when continuation of the pregnancy will create a serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman.
ALLERGY TESTING AND INJECTIONS	Contractor to use UM guidelines established.
ANESTHESIA	Contractor to use UM guidelines established.
B3 SERVICES	Contractor to develop and implement UM guidelines for Intensive Psychiatric Rehabilitation, Community Support Services, Peer

	Support, Integrated Services and Supports, and Respite. Contractor shall use the American Society of Addiction Medicine (ASAM) Criteria as UM guidelines for substance use disorder residential treatment.
BARIATRIC SURGERY	Contractor to use UM guidelines established.
BHIS (INCLUDING ABA)	Contractor to use UM guidelines established.
BREAST RECONSTRUCTION	Contractor to use UM guidelines established.
BREAST REDUCTION	Contractor to use UM guidelines established.
CARDIAC REHABILITATION	Contractor to use UM guidelines established.
CHEMOTHERAPY	Contractor to use UM guidelines established.
CHIROPRACTIC CARE (THERAPEUTIC ADJUSTIVE MANIPULATION)	• X-ray- payment for documenting x-rays is limited to one (1) per condition. No payment shall be made for subsequent x-rays. • Chiropractic manipulative therapy eligible for reimbursement is specifically limited to the manual manipulation of the spine for the purpose of correcting a subluxation demonstrated by x-ray. There are three (3) categories based off the patient's condition / diagnosis. A diagnosis or combination of diagnoses within category i generally required short-term treatment of twelve (12) per twelve (12) month period. A diagnosis or combination of diagnoses with category ii generally required moderate-term treatment of eighteen (18) per twelve (12) month period. A diagnosis or combination of diagnoses within category iii generally required long-term treatment of twenty-four (24) per twelve (12) month period. For diagnostic combinations between categories, twenty-eight (28) treatments are generally required per twelve (12) month period.
COLORECTAL CANCER SCREENING	Contractor to use UM guidelines established.
CONGENITAL ABNORMALITIES CORRECTION	Contractor to use UM guidelines established.
DAIBETIES EQUIP AND SUPPLIES	Contractor to use UM guidelines established.
DIAGNOSTIC GENGETIC TESTING	Contractor to use UM guidelines established.
DIALYSIS	Contractor to use UM guidelines established.
DURABLE MEDICAL EQUIPMENT AND SUPPLIES	• Medical supplies are not to exceed a three (3) month supply. Diabetic supplies are covered as follows: blood glucose test or reagent strips six (6) units per month (one (1) unit equals fifty (50) strips); urine glucose test strips three (3) units per month (one (1) unit equals one hundred (100) strips), lancets four (4) units per month (one (1) unit equals one hundred (100) lancets), and needles five hundred (500) units per month (one (1) unit equals one (1) needle). Reusable insulin pens are allowed once every six (6) months. Diapers and disposable under pads are covered and can be provided in a ninety (90) day period. Diaper/brief one hundred eighty (180) per ninety (90) day supply, liner/shield/guard/pad four hundred fifty (450) per ninety (90) day supply, pull-on four hundred fifty (450) per

	ninety (90) day supply, disposable under pads six hundred (600) per ninety (90) day supply, reusable under pads forty-eight (48) per twelve (12) months. Maximum units can very when combinations of incontinence products are used. Hearing aid batteries are covered up to thirty (30) batteries per aid in a ninety (90) day period. Ostomy supplies and accessories are covered one (1) unit per day of regular wear or three (3) units per month of extended wear are allowed. Services are limited to Enrolled Members in a medical facility. No payment is made to medical suppliers for medical supplies or durable medical equipment for Enrolled Members receiving inpatient or outpatient care in a hospital. • No payment is made for medical supplies or durable medical equipment for Enrolled Members for whom the facility is receiving skilled nursing care payment, except for orthotic and prosthetic services, orthopedic shoes, and therapeutic shoes for diabetics. • No payment is made for durable medical equipment or supplies for Enrolled Members • In an intermediate care facility for intellectual disability or a facility receiving • NF payments, except for the following: • Catheter (indwelling foley) • Colostomy and ileostomy appliances • Colostomy and ileostomy care dressings, liquid adhesive, and adhesive • Tape • Diabetic supplies (disposable or retractable needles and syringes, • Test-tape, clinitest tablets, and clinistix) • Disposable catheterization trays or sets (sterile) • Disposable bladder irrigation trays or sets (sterile) • Disposable saline enemas (sodium phosphate type, for example) • Hearing aid batteries • Orthotic and prosthetic services, including augmentative communication • Devices • Orthopedic shoes • Repair of Enrolled Member-owned equipment • Oxygen services: Oxygen services for residents in an ICF/ID are included in the per diem and are not payable separately. • Assistive Technology.
EMERGENCY ROOM SERVICES	Contractor to use UM guidelines established.
EPSDT	Contractor to use UM guidelines established.
FAMILY PLANNING	Contractor to use UM guidelines established.
FOOT CARE	Contractor to use UM guidelines established.
GENERAL INPATIENT HOSPITAL CARE	Contractor to use UM guidelines established.

GENETIC COUNSELING	Contractor to use UM guidelines established.
GYNOCOLOGICAL EXAMS	Contractor to use UM guidelines established.
HEARING AIDS	Contractor to use UM guidelines established.
HEARING EXAMS	• Prior Authorization is required for replacement of a hearing aid less than four (4) years old, except when Enrolled Member is a child under twenty-one (21) years of age.
HOME HEALTH	• Skilled nursing is limited to five (5) visits per week. • Home health aide is limited to visits that do not exceed twenty-eight (28) hours per week • Occupational therapy is limited to physician-authorized visits within guidelines for restorative, maintenance or trial therapy • Physical therapy is limited to physician-authorized visits within guidelines defined for restorative, maintenance or trial therapy • Speech pathology is limited to physician-authorized visits within guidelines defined for restorative, maintenance or trial therapy
HOSPICE	Contractor to use UM guidelines established.
ICF/ID	Must meet level of care.
IMAGING/DIAGNOSTICS (MRI, CT, PET)	Contractor to use UM guidelines established.
IMMUNIZATIONS	Contractor to use UM guidelines established.
INFERTILITY DIAGNOSIS AND TREATMENT	Contractor to use UM guidelines established.
INHALATION THERAPY	Contractor to use UM guidelines established.
INPATIENT PHYSICIAN SERVICES	Contractor to use UM guidelines established.
INPATIENT SURGICAL SERVICES	Contractor to use UM guidelines established.
IV INFUSION SERVICES	Contractor to use UM guidelines established.
LAB TESTS	Contractor to use UM guidelines established.
MATERNITY AND PREGNANCY SERVICES	Contractor to use UM guidelines established.
MEDICAL TRANSPORTATION	Contractor to use UM guidelines established.
MENTAL HEALTH/BEHAVIORAL HEALTH OUTPATIENT TREATMENT	Contractor to use UM guidelines established.
MENTAL/BEHAVIORAL HEALTH INPATIENT TREATMENT	Contractor to use UM guidelines established.
MIDWIFE SERVICES	Contractor to use UM guidelines established.
NEMT	Contractor to use UM guidelines established. See standards in Special Contract Exhibit F.
NEWBORN CHILD COVERAGE	Contractor to use UM guidelines established.
NON-COSMETIC RECONSTRUCTIVE SURGERY	Contractor to use UM guidelines established.

NURSING FACILITY	Must meet level of care.
NURSING SERVICES	• Private duty nursing and personal care services are covered as a benefit under EPSDT as provided through a home health agency for up to sixteen (16) hours per day.
NUTRITIONAL COUNELING	Contractor to use UM guidelines established.
OCCUPATIONAL THERAPY	Contractor to use UM guidelines established.
ORTHOTICS	• Payment for orthopedic shoes and inserts and therapeutic shoes for Enrolled Members with diabetes are limited as follows: only two (2) pairs of depth shoes per Enrolled Member are allowed in a twelve (12) month period, three (3) pairs of inserts in addition to the non-customized removable inserts provided with depth shoes are allowed in a twelve (12) month period, only two (2) pairs of custom-molded shoes per Enrolled Member are allowed in a twelve (12) month period, two (2) additional pair of inserts for custom-molded shoes are allow in in a twelve (12) month period.
OUTPATIENT SURGERY	Contractor to use UM guidelines established.
PATHOLOGY	Contractor to use UM guidelines established.
PHARMACY	• Prior Authorization is required as specified in the PDL: http://www.iowamedicaidpdl.com/ • Reimbursement is only for drugs marketed by manufacturers with a signed rebate agreement. • Coverage of drugs in the following categories is excluded: (1) Drugs whose prescribed use is not for a Medically Accepted Indication as defined by Section 1927(k)(6) of the Social Security Act. (2) Drugs used for anorexia, weight gain, or weight loss. (3) Drugs used for cosmetic purposes or hair growth. (4) Otherwise covered outpatient drugs if the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or the manufacturer's designee. (5) Drugs described in Section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the C.F.R. (drugs identified through the Drug Efficacy Study Implementation (DESI) review)). (6) "Covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any "Part D eligible individual" as defined by 42 U.S.C. Section 1395w-101(a)(3)(A), including an Enrolled Member who is not enrolled in a Medicare Part D plan. (7) Drugs prescribed for fertility purposes, except when prescribed for a Medically Accepted Indication other than infertility (8) Drugs used for sexual or erectile dysfunction (9) Drugs for symptomatic relief of cough and colds, except listed nonprescription drugs • Only certain nonprescription (OTC) drugs and non-drugs are covered as listed in Iowa Admin. Code r. 441-78.2(5) and at http://www.iowamedicaidpdl.com/preferred_drug_lists • Quantity: up to a one (1) month supply at a time except contraceptives at three (3) month quantities. Some drugs are

	limited to an initial fifteen (15) day supply, list at: http://www.iowamedicaidpdl.com/billing_quantity_limits • Monthly quantity limits by drug list at: http://www.iowamedicaidpdl.com/billing_quantity_limits • Reimbursement consistent with Iowa Admin. Code r. 441-79.1(8).
PHYSICAL THERAPY	Contractor to use UM guidelines established.
PMIC	Contractor to use UM guidelines established.
PRIMARY CARE ILLNESS/INJURY PHYSICIAN SERVICES	Contractor to use UM guidelines established.
PROSTATE CANCER SCREEING	Contractor to use UM guidelines established.
PROSTETICS	Contractor to use UM guidelines established.
PULMONARY REHABILITATION	Contractor to use UM guidelines established.
RADIATION THERAPY	Contractor to use UM guidelines established.
SCREEING PAP TESTS	Contractor to use UM guidelines established.
SCREENING MAMMOGRAPHY	Contractor to use UM guidelines established.
SECOND SURGICAL OPTION	Contractor to use UM guidelines established.
SKILLED NURSING SERVICES	Contractor to use UM guidelines established.
SLEEP STUDIES	Contractor to use UM guidelines established.
SPECIALTY PHYSICIAN SERVICES	Contractor to use UM guidelines established.
SPEECH THERAPY	Contractor to use UM guidelines established.
SUBSTANCE USE DISORDER INPATIENT TREATMENT	Contractor shall use The ASAM Criteria as the UM guidelines for substance use disorder services.
SUBSTANCE USE DISORDER OUTPATIENT TREATMENT	Contractor shall use The ASAM Criteria as the UM guidelines for substance use disorder services.
TMJ TREATMENT	Contractor to use UM guidelines established.
TOBACCO CESSATION	Contractor to use UM guidelines established.
TOBACCO CESSATION FOR PREGNANT WOMEN	Contractor to use UM guidelines established.
TRANSPLANT - ORGAN AND TISSUE	Contractor to use UM guidelines established.
URGENT CARE CENTERS/FACILITIES EMERGENCY CLINICS (NON-HOSPITAL BASED)	Contractor to use UM guidelines established.
VISION CARE EXAMS	• Routine eye examinations are covered once in a twelve (12) month period.
VISION FRAMES AND LENSES	• Frame services are limited up to three (3) times for children up to one (1) year of age, up to four (4) times per year for children

	one (1) through three (3) years of age, one (1) frame every twelve (12) months for children four (4) to seven (7) years of age and once every twenty-four (24) months after eight (8) years of age. Safety frames are allowed for children through seven (7) years of age. • Single vision and multifocal lens services are limited up to three (3) times for children up to one (1) year of age, up to four (4) times per year for children one (1) to three (3) years of age, once every twelve (12) months for children four (4) to seven (7) years of age, once every twenty-four (24) months after eight (8) years of age. • Gas permeable contact lenses are limited as follow: up to sixteen (16) lenses for children up to one (1) year of age, up to eight (8) lenses every twelve (12) months for children one (1) to three (3) years of age, up to six (6) lenses every twelve (12) months for children four (4) to seven (7) years of age, two (2) lenses every twenty-four (24) months for Enrolled Members eight (8) years of age and over. • Replacement of glasses that have been lost or damaged beyond repair are covered for adults age twenty-one (21) and over is limited to once every twelve (12) months. Replacement for lost or damaged glasses for children less than twenty-one (21) years of age is not limited.
WALK-IN CENTER SERVICES	Contractor to use UM guidelines established.
X-RAYS	Contractor to use UM guidelines established.
**ALL OTHER SERVICES IN STATE PLAN OR APPLICABLE WAIVERS THAT ARE NOT LISTED ABOVE OR ARE ADDED IN THE FUTURE	Contractor to use UM guidelines established.

Table E.02: Iowa Wellness Plan Benefits Coverage List

Service Category	Covered	Duration, Scope, exclusions, and Limitations	Excluded Coding
1. Ambulatory Services			
Primary Care Illness/injury Physician Services	□		
Specialty Physician Visits	□		
Home Health Services	□	Not Covered: Private Duty Nursing/Personal Care	Not Covered: Procedure code S9122 or REV codes 570 or 571

Service Category	Covered	Duration, Scope, exclusions, and Limitations	Excluded Coding
Chiropractic Care therapeutic adjustive manipulative	☐		
Outpatient surgery	☐		
Second Surgical Opinion	☐		
Allergy Testing & Injections	☐		
Chemotherapy-Outpatient	☐		
IV Infusion Services	☐		
Radiation Therapy Outpatient	☐		
Dialysis	☐		
Anesthesia	☐		
Walk-in Centers	☐		
AIDS/HIV parity	☐		
Access to clinical trials	☐	Medical necessity will be determined on a case-by-case basis through the Prior Authorization process.	
TMJ	☐		
Genetic Counseling	☐	Prior Authorization required. Must be an appropriate candidate and outcome is expected to determine a covered course of treatment and not just informational.	
2. Emergency Services			
Emergency Room Services	☐		

Service Category	Covered	Duration, Scope, exclusions, and Limitations	Excluded Coding
Emergency Transportation- Ambulance and Air Ambulance	☐	Reviewed for medical necessity prior to payment.	
Urgent Care Centers/Facilities Emergency Clinics (non-hospital)	☐		
3. Hospitalization			
General Inpatient Hospital Care	☐		
Inpatient Physician Services	☐		
Inpatient Surgical Services	☐		
Non-Cosmetic Reconstructive Surgery	☐		
Transplant Organ and Tissue	☐	Covered- certain bone marrow/stem cell transfers from a living donor, heart, heart/lung, kidney, liver, lung, pancreas, pancreas/kidney, small bowel. Not Covered- transport of living donor, services/supplies related to	
Congenital Abnormalities Correction	☐		
Anesthesia	☐		
Hospice Care - Inpatient	☐		
Hospice Respite - Inpatient	☐	Limited to fifteen (15) Days per lifetime for inpatient respite care. Fifteen (15) Days per lifetime for outpatient hospice respite care. Hospice respite care must be used in increments of not more than five (5) Days at a time.	Revenue code for Hospice Respite: 655

Service Category	Covered	Duration, Scope, exclusions, and Limitations	Excluded Coding
Chemotherapy - Inpatient	☐		
Radiation Therapy - Inpatient	☐		
Breast Reconstruction	☐		
4. Maternity & Newborn Care			
Maternity/Pregnancy Services - Pre & Postnatal Care - Delivery & Inpatient maternity - Nutritional	☐	Enrolled Member is required to report pregnancy and eligibility for consideration of Benefits under the Medicaid State Plan.	
Tobacco Cessation for Pregnant Women	☐		
Midwife Services	☐		
Newborn child coverage	☐		
5. Mental Health Behavioral Health Substance Use Disorder			
Mental Health/Behavioral Health Inpatient Treatment	☐	Those with disabling mental disorders will be considered Medically Exempt and enrolled in the Medicaid State Plan. Residential treatment is not covered.	Not covered: Code H0019
Mental Health/Behavioral Health Outpatient Treatment	☐	Those with disabling mental disorders will be considered Medically Exempt and enrolled in the Medicaid State Plan.	
Substance Use Disorder Inpatient Treatment	☐	Enrolled Members with disabling substance use disorder will be considered Medically Exempt and enrolled in the Medicaid State Plan. Residential treatment is not covered.	Not covered: Code H0019

Service Category	Covered	Duration, Scope, exclusions, and Limitations	Excluded Coding
Substance Use Disorder Outpatient Treatment	☐	Enrolled Members with disabling substance use disorder will be considered Medically Exempt and enrolled in the Medicaid State Plan.	
6. Prescription Drugs			
Prescription Drugs	☐		
7. Rehabilitative and Habilitative Services and Devices			
Physical Therapy, Occupational Therapy, Speech Therapy	☐	Each therapy is limited to sixty (60) visits per year. Occupational only for upper extremities. Not covered- OT supplies, IP OT/PT in the absence of separate medical condition requiring hospitalization.	Each therapy is limited to sixty (60) per year: Therapy services must be billed with the GP, GO, or GN modifier. Refer to Medicare's guidance on billing of therapy services.
Inhalation therapy	☐	Limit of sixty (60) visits in a twelve (12) month period.	N/A
Medical and Surgical supplies	☐	Non-covered- elastic stockings or bandages including trusses, lumbar braces, garter belts and similar items that can be purchased without a prescription	
Durable Medical Equipment	☐	Non-covered items include: elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that are available for purchase without a	
Orthotics	☐		
Prosthetics	☐		
Cardiac Rehabilitation	☐		
Pulmonary Rehabilitation	☐		

Service Category	Covered	Duration, Scope, exclusions, and Limitations	Excluded Coding
Skilled Nursing Services	□	Covered in nursing facilities, skilled nursing facilities and hospital swing beds.	This service is limited to one hundred twenty (120) Days per year.
8. Laboratory Services			
Lab Tests	□		
X-Rays	□		
Imaging/Diagnostics MRI CT PET	□		
Sleep Studies	□	Treatment for snoring not covered. Claims must be for a diagnosis of sleep apnea.	Services 95800-95811 are covered but not with a diagnosis of 786.09.
Diagnostic Genetic Tests	□	Requires Prior Authorization	
Pathology	□		
9. Preventive Wellness Chronic Disease Management			
Preventive Care	□	Limited to ACA required preventive services.	
Nutritional Counseling	□	Max forty (40) units allowed for twelve (12) month period	
Nutritional Counseling	□	Max twenty (20) units allowed for twelve (12) month	
Counseling and Education Services	□	Not covered: Bereavement, family, or marriage counseling. Education other than diabetes.	N/A
Family Planning	□		

Service Category	Covered	Duration, Scope, exclusions, and Limitations	Excluded Coding
Vision Care Exams (Adult)	□	Codes only allowed once per year: 92002, 92004, 92012, 92014. This does not limit the medical exams for Enrolled Members. Medical exams should be coded properly for accurate Claim adjudication.	Not covered: V2020, V2025, V2100- V2115, V2118, V2121, V2199, V2200- V2221, V2299, V2300-V2315, V2318-V2321, V2399, V2410, V2430, V2499, V2500-V2503, V2510-V2513, V2520- V2523, V2530-V2531, V2599, V2600, V2610, V2615, V2700-V2799, 76512, 92015, 92310, 92314, 92325, 92326, 92340, 92341, 92342, 92370, 92390, 92391, V2399, V2410, V2430, V2499, V2500-V2503, V2510-V2513, V2520- V2523, V2530-V2531, V2599, V2600, V2610, V2615, V2700-V2799, 76512, 92015, 92310, 92314, 92325, 92326, 92340, 92341, 92342, 92370, 92390, 92391
Immunizations	□	Not covered- immunizations for travel	Not covered: 90476, 90477, 90581, 90585, 90586, 90665, 90690, 90691, 90692, 90693, 90717, 90725, 90727, 90735, 90738
Colorectal Cancer Screening	□		
Screening Mammography	□	One (1) per year 77057, 77052, G0202	

Service Category	Covered	Duration, Scope, exclusions, and Limitations	Excluded Coding
Hearing Exam (Adult)	☐	Limit of one (1) hearing exam per year. Codes only allowed once per year: 92551, 92552, 92553, 92555, 92556, 92557 92558, 92559, 92560, V5008	Not covered: V5010, V5014, V5030, V5040, V5050, V5060, V5070, V5080, V5090, V5120, V5130, V5140, V5150, V5160, V5170, V5180, V5190, V5200, V5210, V5220, V5230, V5266, V5267, V5298, V5299V5240, V5264, V5266, V5267, V5298, V5299
Diabetes - med necessary equip & supplies Education	☐		
Screening Pap tests	☐		
Gynecological exam	☐	One (1) per year	
Prostate cancer screening	☐	One (1) per year for men age fifty (50) to sixty-four (64) years	
Foot Care	☐	Must be related to medical condition, routine services are not covered.	
Tobacco Cessation	☐	Immunizations and medical eval for nicotine dependence	
10. Pediatric Services including oral & vision			
EPSDT Ages 19 and 20	☐	Covered for ages nineteen (19) to twenty (20)	
EPSDT - Multi-Systemic Therapy	☐	Covered up to age 20	
EPSDT - Family Functional Therapy	☐	Covered up to age 20	
Benefits Not Provided			
Acupuncture	**X**	Not covered	

Service Category	Covered	Duration, Scope, exclusions, and Limitations	Excluded Coding
Infertility Diagnosis and Treatment	X	Not covered- infertility treatment resulting from voluntary sterilization, relating to collection/purchase of donor semen or eggs, freezing of the same, surrogate services, infertility diagnosis and treatment, and tubal/vasectomy reversals, fertility drugs.	
Bariatric Surgery	X	Not covered.	Not covered: 00797, 43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774,43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888, S2083 DRGs:619, 620, 621
Residential Services	X		
Non-emergency Transportation Services	X	Covered only for Enrolled Members determined Medically Exempt.	Covered only for Enrolled Members determined Medically Exempt.
Tobacco Cessation	X	Not covered	
Breast Reduction	X		CPT codes 19318 or 19316, ICD proc codes: 85.31, 85.32, 85.6. Code 00402 not covered if billed with diagnosis 611.1.
Hearing Aid	X	Not covered	
Frames and lenses	X	Not covered	

Table E.03: Hawki Covered Benefits

Inpatient hospital services • Medical • Surgical • Intensive care unit • Mental health • Substance use disorder
Physician services • Surgical • Medical • Office visits • Newborn care • Well-baby • Well-child • Immunizations • Urgent care • Specialist care • Allergy testing and treatment • Mental health visits • Substance use disorder visits The Contractor shall use the Recommended Childhood Immunization Schedule approved by the Advisory Committee on Immunization Practices (ACIP), The American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), as the immunization schedule. The Contractor shall incorporate the "Recommendations for Preventive Pediatric Health Care" by the AAP as the schedule for preventive care for children and adolescents. In lieu of the above, the Contractor may use the most current version of the U.S. Preventive Task Force, “Guide to Clinical Preventive Services” as the immunization and preventive care schedule for children and adolescents.
Outpatient hospital services • Emergency room • Surgery • Lab • X-ray • Other services
Ambulance services
Physical therapy
Nursing care services (including skilled nursing facility services)
Speech therapy
Durable medical equipment
Home health care
Hospice services
Prescription drugs
Hearing services
Vision services (including corrective lenses)
Maternity and mental health services not inconsistent with 42 U.S.C.A § 1396u-2(b)(8)

Table E.04: Excluded Services

Dental Services provided outside of a hospital setting.
MFP grant services
School-based services provided by the Area Education Agencies, Local Education Agencies, and Infant & Toddler Providers

Exhibit F: NEMT Standards

Specialized Medical Vehicle Standards
All vehicles:

a. Must have current license and registration as required by law.
b. Must have proof of financial responsibility maintained on any vehicle used to transport Iowa Medicaid Enrolled Members as required by law. The Broker shall confirm compliance with applicable financial responsibility and/or insurance requirements, which may include Iowa Code chapter 321A, and Iowa Admin. Code r. 761-910.5(1).
c. Must be kept at all times in proper mechanical condition.
d. Must have adequately functioning heating and air-conditioning systems and shall maintain a temperature at all times that is comfortable to the Enrolled Member.
e. Must be equipped with operable passenger restraint devices, turn signals, lights, horn, brakes, a front and rear windshield, windows, and mirrors.
f. Must pass a safety inspection, if required by state or federal law.
g. Must carry equipment for two-way emergency communication (two-way radio or cell phone acceptable).

Mileage Reimbursement and Volunteer Vehicle Standards (Applicable to Volunteers as well).
All vehicles:

a. Must currently be licensed and registered as required by law.
b. Must have proof of financial responsibility maintained on any vehicle used to transport Iowa Medicaid Enrolled Members as required by law. The Broker shall confirm compliance with applicable financial responsibility and/or insurance requirements, which may include Iowa Code chapter 321A, and Iowa Admin. Code r. 761-910.5(1).
c. Must be kept at all times in proper mechanical condition.
d. Must be equipped with operable passenger restraint devices, turn signals, lights, horn, brakes, a front and rear windshield, windows, and mirrors.
e. Must pass a safety inspection, if required by state or federal law.

Common Carrier Vehicle Standards
All vehicles:

a. Must have current license and registration as required by law.
b. Must have proof of financial responsibility maintained on any vehicle used to transport Iowa Medicaid Enrolled Members as required by law. The Broker shall confirm compliance with applicable financial responsibility and/or insurance requirements, which may include Iowa Code chapter 321A, and Iowa Admin. Code r. 761-910.5(1).
c. Must be kept at all times in proper physical and mechanical condition.
d. Must have adequately functioning heating and air-conditioning systems and shall maintain a temperature at all times that is comfortable to the Enrolled Member.
e. Must be equipped with operable passenger restraint devices, turn signals, lights, horn, brakes, a front and rear windshield, windows, and mirrors.
f. Must pass a safety inspection, if required to do so by state or federal law.
g. Must carry equipment for two-way emergency communication (two-way radio or cell phone acceptable).

Exhibit G:*Reserved*

Exhibit H: State Directed Payments

H.1 UIHC Physician ACR Payments - Description of Arrangement

University of Iowa Physician Average Commercial Rate (ACR) payments were the pass-through payments incorporated into the historical capitation rates. After the originally developed SFY19 rates were certified, the State worked with CMS to develop an approvable alternative minimum fee schedule for physician and professional services at qualifying Iowa State-Owned or Operated Professional Services Practices, in accordance with 42 CFR 438.6. Beginning with the SFY22 capitation rate period the state directed payments were not included in the monthly capitation rates. State directed payments were paid through a separate payment term on a quarterly basis.

The methodology used to calculate the initial estimate for this arrangement is described below and is consistent with the information submitted by the State in the 438.6 pre-print approved by CMS for SFY25.

The additional payment made to these qualifying physicians under the minimum fee schedule provide support for contracting and maintain access for Medicaid beneficiaries to the applicable physicians and the MCOs. Under this arrangement, in accordance with 42 CFR 438.6, a supplemental payment for covered physician services will be made for the services provided by a faculty or staff member of a qualifying Iowa State-Owned or Operated Professional Services Practice to reflect the reimbursement of the approved minimum fee schedule. Currently, only physicians affiliated with the University of Iowa meet this definition. Base reimbursement for these services is Iowa Medicaid reimbursement, which based on the historical mix of services for the applicable providers, is approximately 84.09% of Medicare (as of SFY24). The supplemental (directed) payment brings the final reimbursement to an Average Commercial Rate level, which is approximately 371.77% of Medicaid , or around 315.23 % of Medicare.

Historically, this payment arrangement has been based on actual utilization within the contract period and was structured such that the MCOs paid the customary Medicaid rate when adjudicating claims. Beginning the SFY25 contract period the Hospital ACR directed payment will be reimbursed outside of the Health Link capitation rates via a separate payment term structure. Effective March 2020, the MCOs began paying the enhanced ACR amount when adjudicating claims. Consistent with prior cycles, the basis for the supplemental payment is the difference between the customary Medicaid rate and the average commercial rate (minimum fee schedule) for specific physician service procedure codes. The MCOs are responsible for paying the calculated differential payments to qualifying practices based on actual utilization within the contract period.

H.2 UIHC Hospital ACR Payments - Description of Arrangement

The University of Iowa Hospital Average Commercial Rate (ACR) payments is a new state-directed alternative minimum fee schedule payment for inpatient and outpatient hospital services at qualifying Iowa State-Owned teaching hospitals with more than 500 beds and either or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education. The directed payment is effective July 1, 2021 and is structured in accordance with 42 CFR 438.6. . Currently, only the University of Iowa Hospitals and Clinics (UIHC) meets the eligibility criteria for this directed payment arrangement.

Beginning the SFY25 contract period the Hospital ACR directed payment will be reimbursed outside of the Health Link capitation rates via a separate payment term structure. The Actuarial contractor is required to develop estimates for the separate payment term and include a description of the arrangement when certifying the Health Link capitation rates. The methodology used to estimate the payments associated with the hospital directed payment is similar to the physician arrangement described previously. The basis for the supplemental payment is the difference between the provider's negotiated Medicaid managed care reimbursement and the average commercial rate (minimum alternative fee schedule) calculated using an ACR payment-to-charge ratio for inpatient and outpatient (both acute and behavioral health) hospital services. The MCOs are responsible for paying the calculated differential payments to qualifying providers based on actual utilization on a per claim basis within the contract period.

Once actual utilization for SFY25 is available, the Actuarial contractor and the Agency will calculate revised PMPMs using the actual claims incurred for each rate cell under the arrangement and actual membership for the contract period. Any differences between the original Hospital ACR estimate (calculated as the rate cell specific PMPMs x given SFY membership) and actual claims incurred under the arrangement will be paid out as a lump sum payment/recoupment from the Agency to the MCOs. After the rating period is complete and the State makes any necessary reconciliation payment/recoupment, the Actuarial vendor will submit a rate certification addendum outlining the distribution methodology and revised PMPMs that reflect the final payments made under this arrangement for SFY25.

The methodology used to calculate the initial estimate for this arrangement is described below and is consistent with the information submitted by the State in the 42 CFR 438.6 pre-print that was approved on August 12, 2021.

The additional payment made to these qualifying hospitals under the minimum fee schedule provide support for contracting and maintain/expand access to services essential for Medicaid beneficiaries. Under this arrangement, in accordance with 42 CFR 438.6, a supplemental payment for qualifying Inpatient and Outpatient hospital services will be made to reflect the reimbursement of the approved minimum fee schedule. Base reimbursement for these services is Iowa Medicaid reimbursement, which based on the historical mix of services for the applicable providers, is approximately 73.33 % of Medicare for Inpatient services and 82.94 % of Medicare for Outpatient services. The supplemental (directed) payment brings the final reimbursement to an Average Commercial Rate level, which is approximately 260.58 % of Medicare for Inpatient services and 277.31 % for Outpatient services.

H.3 Ground Emergency Transportation (GEMT) Payment Program - Description of Arrangement

Effective July 1, 2019, the State has implemented the Ground Emergency Medical Transportation (GEMT) Payment Program in accordance with 42 CFR 438.6(c). The GEMT Payment Program is made to qualifying Emergency Medical Service (EMS) providers within Iowa for Emergency Medical Transportation services. For purposes of this section, "qualifying EMS providers" means EMS providers that are enrolled in the Iowa State Directed Payment Program. The Agency provided the Actuarial contractor with the list of applicable providers and procedure codes that will be receiving the prospective provider-specific payment rates during the SFY25 contract period. The provider-specific rates reflect an approved minimum fee schedule and are based on CMS- approved GEMT cost reports submitted by the EMS providers. The EMS additional payments will provide support for contracting and maintain access for Medicaid beneficiaries to receive GEMT services. Under this arrangement, in accordance with 42 CFR 438.6, the supplemental payment for covered emergency transportation services will be billed under procedure code A0999 for the services provided by an approved EMS provider participating in the GEMT Payment Program. The A0999

procedure codes associated with the GEMT directed payment arrangement were excluded from the CY19 base data underlying rate development to avoid duplication with this supplemental payment calculation.

The payment arrangement for the SFY25 contract period will be based on actual emergency transportation service utilization within the contract period and is structured such that the MCOs pay both the customary Medicaid rate and the supplemental provider-specific prospective rate when adjudicating claims. The provider-specific prospective payment rate, billed under procedure code A0999, represents the additional uncompensated actual costs necessary to perform EMS transports based on submitted cost reports. Base reimbursement for the eligible emergency transportation services is Iowa Medicaid reimbursement. The supplemental (directed) payment brings the final reimbursement to approximately 10 times the standard Medicaid reimbursement.

H.4 Directed Payment Program for Hospital Inpatient and Hospital Outpatient Services

Effective July 1, 2023, the Agency implements a Medicaid state directed payment program for hospital inpatient and hospital outpatient services in accordance with 42 C.F.R. § 438 and guidance provided by the U.S. Centers for Medicare & Medicaid Services (“CMS”). The purpose of this directed payment is to increase Medicaid reimbursement for hospital inpatient and hospital outpatient services provided by qualifying Iowa hospitals to Medicaid recipients in such a manner that does not require a dedicated state appropriation and increases such reimbursement amounts to the maximum allowable under federal law.

The methodology used is consistent with 42 CFR §438.6(c)(2)(ii)(A). This proposal will direct Iowa Medicaid Managed Care Organizations to make directed payments to eligible Iowa hospitals for inpatient and outpatient hospital services provided to the Managed Care Organizations' enrollees. Each hospital will receive an interim quarterly payment based on inpatient and outpatient service utilization from a previous rating period. The Managed Care Organizations will be directed to pay uniform percentage add-on payments for every adjudicated claim for all eligible hospitals.

Due to the number of hospital stakeholders in Iowa, the Agency is entering into a Memorandum of Understanding (MOU) with the Iowa Hospital Association (IHA), as set forth in the Special Contract Exhibit I, to serve as a coordinating intermediary between the Agency and the qualifying hospitals participating in this program. The Managed Care Organizations are required to comply with all the requirements as set forth in the MOU – Exhibit I.

If an eligible Iowa hospital disagrees with the directed payment received from the Medicaid Managed Care Organization, the eligible Iowa hospital will resolve the difference with the Agency, and the Managed Care Organization will not be held responsible.

H.5. ARPA Section 9817 Home and Community Based Services (HCBS) - Description of Arrangement

The State Medicaid Agency directs the contracted MCOs to make payments to eligible HCB providers for targeted projects approved in Iowa’s Spending Plan for Implementation of the American Rescue Plan Act (ARPA) of 2021, Section 9817.

The Contractor shall make a one-time payment to eligible HCBS providers for the **Provider Capacity Building and Service Waitlist Reduction Grant**.

Eligible providers will receive a portion of the funds based on their total number of claims paid during State Fiscal Year 2024 (SFY 2024). Payments will be calculated on a per-claim basis for HCBS,

Applied Behavior Analysis (ABA), and Behavioral Health Intervention Services (BHIS) procedure codes. Iowa Medicaid will reconcile payments at both the MCO and HCBS provider levels to ensure the investment supports capacity expansion and reduced waitlists.

Payment information, including identifiable HCBS provider details and payment dates, will be reconciled with actual claims from the SFY 2025 rating period. Iowa Medicaid retains auditing rights to verify that payments are made to the correct providers.

Iowa Medicaid is distributing funds to MCOs for eligible providers under the ARPA Section 9817 Provider Capacity Building and Service Waitlist Reduction Grant. These funds are intended to help providers increase service capacity, reduce waitlists, expand service types, and increase the number of participants served. Eligible providers include:

- 1915(c) HCBS Waiver and 1915(i) State Plan HCBS Habilitation service providers with paid claims during SFY 2024 for specified procedure codes, and
- State Plan Applied Behavior Analysis (ABA) and Behavioral Health Intervention Services (BHIS)

Exhibit I: Memorandum of Understanding of State Directed Payments Between the Agency and the Iowa Hospital Association

Memorandum of Understanding

This Memorandum of Understanding ("MOU") is entered into by Iowa Medicaid, a division of the Iowa Department for Health and Human Services, an instrumentality of the State of Iowa ("Iowa Medicaid"), and the Iowa Hospital Association ("IHA"), (collectively, "Parties") on the effective date listed below.

Recitals

WHEREAS, Iowa Medicaid intends to implement a Medicaid state directed payment program ("Program") for hospital inpatient and hospital outpatient services in accordance with the 42 C.F.R. § 438 and guidance promulgated by the U.S. Centers for Medicare & Medicaid Services ("CMS");

WHEREAS, the purpose of Program is to increase Medicaid reimbursement for hospital inpatient and hospital outpatient services provided by qualifying Iowa hospitals to Medicaid recipients in such a manner that does not require a dedicated state appropriation and increases such reimbursement amounts to the maximum allowable under federal law;

WHEREAS, Iowa Medicaid seeks to implement the Program to progress toward a number of goals of the Medicaid program including, preserving and expanding access to health care, strengthening population health initiatives in rural communities, offsetting economic head-winds caused by workforce market changes and inflation because there is a direct correlation between increasing reimbursement rates and myriad economic and social benefits that derive from a healthy Iowa citizenry;

WHEREAS, due to the number of hospital stakeholders in Iowa, Iowa Medicaid recognizes the challenge of implementing the Program, and engages the assistance of IHA to serve as a coordinating intermediary between Iowa Medicaid and qualifying hospitals participating in Program to facilitate communications and operations for implementing Program in an efficient and compliant manner;

WHEREAS, IHA agrees to serve as intermediary between Iowa Medicaid and qualifying hospitals participating in Program in a manner consistent with this MOU and in full compliance with federal and state law;

THEREFORE, the Parties agree to the following terms and conditions:

Section 1. Definitions.

(A) "Inpatient Managed Care Gap" means an annual amount calculated as the maximum actuarially sound amount, determined at no less than ninety percent (90%) of average commercial rates, eligible for inclusion in managed care rates for hospital inpatient services provided by Qualifying Hospitals less the amount of total payments by all Managed Care Organizations to Qualifying Hospitals for hospital inpatient services.

(B) "Outpatient Managed Care Gap" means an annual amount calculated as the maximum actuarially sound amount, determined at no less than ninety percent

(90%) of average commercial rates, eligible for inclusion in managed care rates for hospital outpatient services provided by Qualifying Hospitals less the amount of total payments by all Managed Care Organizations to Qualifying Hospitals for hospital outpatient services.

(C) "Managed care organization" means an entity contracted with Iowa Medicaid to provide Medicaid benefits pursuant to 42 C.F.R. § 438.

(D) "Program Year" means the state fiscal year in which the Program is authorized by CMS.

(E) "Qualifying Hospital" means a Medicaid-participating, in-state hospital licensed by the State of Iowa, including acute care hospitals, long-term acute hospitals, and free-standing psychiatric hospitals, but excluding hospitals wholly owned by the state.

Section 2. Directed Payments

(A) To the extent allowable under federal law and in accordance with the implementation provisions outlined in this Section (2), Iowa Medicaid shall develop the following programs to increase Medicaid reimbursement for hospital services provided by Qualifying Hospitals to Medicaid recipients:

i. A program to increase hospital inpatient reimbursement to Qualifying Hospitals within the Medicaid managed care program in an aggregate amount equivalent to the Managed Care Gap for hospital inpatient services; and

ii. A program to increase hospital outpatient reimbursement to Qualifying Hospitals within the Medicaid managed care program in an aggregate amount equivalent to the Managed Care Gap for outpatient services

(B) Iowa Medicaid shall calculate the following values for the purpose of making the directed payments consistent with this MOU:

i. Inpatient Directed Payments

(1) With time frames subject to CMS approval of the Program, on an annual basis the following values shall be calculated sixty (60) days prior to the start of a Program Year:

(a) A maximum annual Inpatient Managed Care Gap.

(b) An "Inpatient Quarterly Gap Amount" calculated by dividing the annual Inpatient Managed Care Gap by four (4).

(c) At least ninety (90) days prior to the start of a Program Year, Iowa Medicaid shall provide IHA the base data utilized for the calculations in this subparagraph (1).

(d) Data shared with IHA shall not contain any personal health information or other patient identifying information.

(2) On a quarterly basis the following values shall be calculated on or around thirty (30) days prior to the start of a quarter:

(a) A uniform inpatient adjustment percentage for each Qualifying Hospital calculated as the Inpatient Quarterly Gap Amount divided by the total managed care inpatient paid claims for all Qualifying Hospitals.

(b) A directed payment to be made to each Qualifying Hospital by each Managed Care Organization calculated by multiplying the uniform inpatient adjustment percentage with the Qualifying Hospital's total managed care inpatient paid claims for the applicable quarter.

(c) The managed care inpatient paid claims data used in the calculations in this subparagraph shall be the data from two (2) quarters prior to the quarter for which the directed payment is made.

(d) At least thirty (30) days prior to the beginning of a quarter in which directed payments will be made, Iowa Medicaid shall provide IHA the base data utilized for all calculations that are made in this subparagraph.

(e) Data shared with IHA shall not contain any personal health information or other patient identifying information

ii. Outpatient Directed Payments

(1) With time frames subject to CMS approval of the Program, on an annual basis the following values shall be calculated sixty (60) days and prior to the start of a Program Year:

(a) A maximum annual Outpatient Managed Care Gap.

(b) An "Outpatient Quarterly Gap Amount" calculated by dividing the annual Outpatient Managed Care Gap by four (4).

(c) At least ninety (90) days prior to the start of a Program Year, Iowa Medicaid shall provide IHA the base data utilized for the calculations in this subparagraph.

(d) Data shared with IHA shall not contain any personal health information or other patient identifying information.

(2) On a quarterly basis the following values shall be calculated on or around thirty (30) days prior to the start of a quarter:

(a) A uniform outpatient adjustment percentage for each Qualifying Hospital calculated as the Outpatient Quarterly Gap Amount divided by the total managed care outpatient paid claims for all Qualifying Hospitals.

(b) A directed payment to be made to each Qualifying Hospital by each Managed Care Organization calculated by multiplying the uniform outpatient adjustment percentage with the Qualifying Hospital's total managed care outpatient paid claims for the applicable quarter.

(c) The managed care outpatient paid claims data used in the calculations in this subparagraph shall be the data from two (2) quarters prior to the quarter for which the directed payment is made.

(d) At least thirty (30) days prior to the beginning of a quarter in which directed payments will be made, Iowa Medicaid shall provider IHA the base data utilized for all calculations that are made in this subparagraph.

(e) Data shared with IHA shall not contain any personal health information or other patient identifying information.

iii. The Parties shall independently calculate the values expressed in this Section to validate the accuracy of the directed payments to be made to Qualifying Hospitals. Prior to the start of a Program Year or a quarter, as appropriate, the Parties shall communicate with each other promptly regarding the base data upon which values are calculated. The Parties agree to discuss promptly any discrepancies that may be discovered regarding base data or calculated values to assure that directed payments are accurate and made on a timely basis consistent with this MOU. Iowa Medicaid shall have the final determination of the amount of payments to be allocated to each Qualifying Hospital.

iv. At least ten (10) days prior to the start of the quarter, Iowa Medicaid shall provide each Managed Care Organization with a listing of the payments calculated under this subsection (B) that is to be transferred to each Managed Care Organization for payment to each Qualifying Hospital for both inpatient and outpatient services.

v. Iowa Medicaid shall have the flexibility and discretion to allocate the total directed payments to Qualifying Hospitals among the Managed Care Organizations so as to assure that each Qualifying Hospital receives the total amount of its directed payment as calculated in accordance with this subsection (B). In the event a new Managed Care Organization enters a contract with Iowa Medicaid, the Parties shall convene to determine the best manner for estimating paid claims data to be used in calculating the inpatient and outpatient directed payments to assure that Qualifying Hospitals receive to the total amount of funds eligible for directed payments.

(C) On the first day of the quarter, Iowa Medicaid shall provide each Managed Care Organization with a supplemental capitation payment to cover all quarterly directed payments to be made by the Managed Care Organizations to Qualifying Hospitals.

(D) Iowa Medicaid shall require each Managed Care Organization to pay the directed payments to each Qualifying Hospital within ten (10) business days of the Managed Care Organization receiving the supplemental capitation payment from Iowa Medicaid. Iowa Medicaid will amend its state contracts with Managed Care Organizations to provide that a Managed Care Organization that fails to make a directed payment in accordance with the terms of this MOU shall be subject to such remedies as exist within the Managed Care Organization's contract with the State. Consistent with the intent and purpose of this MOU Iowa Medicaid shall direct each Managed Care Organization to cooperate fully with IHA to fulfill the MOU in all material respects, including the timely execution of documents and the provision of reports intended to implement the Program.

(E) The process outlined in subsections (A) through (D) shall result in each Qualifying Hospital receiving four (4) quarterly directed payments within a Program Year in amounts determined by the calculations in subsection (B).

(F) *Reconciliation Adjustments*. Approximately nine (9) months after the conclusion of a Program Year Iowa Medicaid shall review and reconcile the directed payments made to each Qualifying Hospital in the Program Year. Because the directed payments are made based upon historical paid claims data, Iowa Medicaid will recalculate the values in subsection (B) using the actual paid claims data of the applicable quarter in which a directed payment was made. If the reconciliation re-calculations result in either a net overpayment or net underpayment in total for the Program Year, then Iowa Medicaid shall make any necessary adjustment to the Qualifying Hospital's next quarterly directed payment. In the event that the directed payment program is materially changed or terminated such that a payment adjustment cannot be made through directed payments, then an adjustment shall not be made.

(G) *Request for Department Reconsideration*. A Qualifying Hospital shall have the ability to request reconsideration of any material error alleged regarding a directed payment or reconciliation adjustment by notifying Iowa Medicaid of the allegation of material error and providing documentation supporting the allegation within thirty (30) days of the Qualifying Hospital receiving notice receipt of a quarterly supplemental payment from a Managed Care Organization. A "material error" is one in which the alleged error may affect at least five percent (5%) of the value of the Qualifying Hospital's quarterly directed payment attributable to either inpatient services or outpatient services. If Iowa Medicaid agrees that a material error occurred in a Qualifying Hospital's quarterly directed payment, Iowa Medicaid shall reconcile the payment error through an adjustment to the Qualifying Hospital's next quarterly directed payment. Iowa Medicaid's decision on the request for reconsideration shall be considered final agency action.

Section 3. Assessment

(A) Prior to the start of a Program Year, Iowa Medicaid shall estimate the total non-federal share funds necessary to obtain the federal matching funds to make both

the inpatient directed payments and outpatient directed payments calculated in Section 2.

(B) The non-federal share funds for inpatient directed payments ("Non- federal Share Inpatient Funds") and the non-federal share funds for outpatient directed payments ("Non-federal Share Outpatient Funds") shall be the target for calculating a quarterly inpatient assessment and a quarterly outpatient assessment that Qualifying Hospitals will pay consistent with the terms outlined in this Section 3. The total assessment collected shall not exceed the total non-federal share funds necessary to make the directed payments. In any given quarter, Iowa Medicaid shall collect assessments from a Qualifying Hospital only after the Qualifying Hospital has first received the inpatient directed payment and the outpatient directed payment for the quarter.

(C) On a quarterly basis Qualifying Hospitals will pay a hospital-specific quarterly inpatient assessment amount which, when paid by all Qualifying Hospitals in the aggregate, will equal the total quarterly inpatient assessment referenced in Subsection (B). Qualifying Hospitals licensed by Iowa as long-term acute care hospitals and free-standing psychiatric hospitals shall be excluded from the quarterly inpatient assessment and assessment calculations shall not include values from those excluded hospitals. The hospital-specific quarterly inpatient assessment amount shall be calculated consistent with the following terms.

i. Qualifying Hospitals shall be subject to a quarterly inpatient assessment percentage rate, ("Inpatient Rate"), except that Qualifying Hospitals that identify as rural either because it is designated by CMS as a critical access hospital or it is located outside a metropolitan statistical area as of January 1, 2023, shall be subject to a quarterly inpatient assessment percentage rate equal to eighty percent (80%) of the Inpatient Rate, ("Rural Inpatient Rate"). The Inpatient Rate and Rural Inpatient Rate shall be determined so that, in the aggregate, the total quarterly inpatient assessment collected equals the non-federal share funds necessary to make the inpatient directed payments.

ii. The Inpatient Rate and Rural Inpatient Rate shall be determined by calculating:

(1) The total net inpatient revenues less Medicare inpatient revenues of Qualifying Hospitals subject to the Inpatient Rate taken from Medicare cost reports for fiscal year 2021 on file by October 1, 2022 and as confirmed by IHA.

(2) The total net inpatient revenues less Medicare inpatient revenues of Qualifying Hospitals subject to the Rural Inpatient Rate, which shall be multiplied by eighty percent (80%) and taken from Medicare cost reports for fiscal year 2021 on file by October 1, 2022 and as confirmed by IHA.

(3) Adding the values in subparagraphs (1) and (2) of this subsection (C), into a sum ("Adjusted Inpatient Assessment Base").

(4) The Non-federal Share Inpatient Funds shall be divided by the Adjusted Inpatient Assessment Base to determine the Inpatient Rate.

(5) The Inpatient Rate shall be multiplied by eighty percent (80%) to determine the Rural Inpatient Rate.

(6) A Qualifying Hospital's hospital-specific net inpatient revenue less Medicare inpatient revenue, as taken from Medicare cost reports for fiscal year 2021 on file by October 1, 2022 and as confirmed by IHA, shall be multiplied by either the Inpatient Rate or Rural Inpatient Rate, as appropriate, to determine the Qualifying Hospital's hospital-specific quarterly inpatient assessment amount.

(D) On a quarterly basis Qualifying Hospitals will pay a hospital-specific quarterly outpatient assessment amount which, when paid by all Qualifying Hospitals in the aggregate, will equal the total quarterly outpatient assessment referenced in Subsection (B). Qualifying Hospitals licensed by Iowa as long-term acute care hospitals and free-standing psychiatric hospitals shall be excluded from the quarterly outpatient assessment and assessment calculations shall not include values from those excluded hospitals. The hospital-specific quarterly outpatient assessment amount shall be calculated consistent with the following terms.

i. Qualifying Hospitals shall be subject to a quarterly outpatient assessment percentage rate, ("Outpatient Rate"), except that Qualifying Hospitals that identify as rural either because it is designated by CMS as a critical access hospital or it is located outside a metropolitan statistical area as of January 1, 2023, shall be subject to a quarterly outpatient assessment percentage rate equal to eighty percent (80%) of the Outpatient Rate, ("Rural Outpatient Rate"). The Outpatient Rate and Rural Outpatient Rate shall be determined so that, in the aggregate, the total quarterly outpatient assessment collected equals the non-federal share funds necessary to make the outpatient directed payments.

ii. The Outpatient Rate and Rural Outpatient Rate shall be determined by calculating:

(1) The total net outpatient revenues less Medicare outpatient revenues of Qualifying Hospitals subject to the Outpatient Rate taken from Medicare cost reports for fiscal year 2021 on file by October 1, 2022 and as confirmed by IHA.

(2) The total net outpatient revenues less Medicare inpatient revenues of Qualifying Hospitals subject to the Rural Outpatient Rate, which shall be multiplied by eighty percent (80%) and taken from Medicare cost reports for fiscal year 2021 on file by October 1, 2022 and as confirmed by IHA.

(3) Adding the values in subparagraphs (1) and (2) of this subsection (D), into a sum ("Adjusted Outpatient Assessment Base").

(4) Dividing the Non-federal Share Outpatient Funds by the Adjusted Outpatient Assessment Base to determine the Outpatient Rate.

(5) The Rural Outpatient Rate shall be determined by multiplying the Outpatient Rate by eighty percent (80%).

(6) A Qualifying Hospital's hospital-specific net outpatient revenue less Medicare outpatient revenue, as taken from Medicare cost reports for fiscal year 2021 on file by October 1, 2022 and as confirmed by IHA, shall be multiplied by either the Outpatient Rate or Rural Outpatient Rate, as appropriate, to determine the Qualifying Hospital's hospital-specific quarterly outpatient assessment amount.

(E) Iowa Medicaid shall submit a Notice of Assessment to each Qualifying Hospital, with a copy to IHA, no earlier than ten (10) days after the start of the quarter. The Notice of Assessment shall provide a Qualifying Hospital's hospital-specific inpatient assessment and outpatient assessment for the quarter. The Notice shall contain all variables and values used in calculating the assessment so that each Qualifying Hospital is capable of validating the inpatient assessment and the outpatient assessment.

(F) The Notice of Assessment shall list a Qualifying Hospital's inpatient assessment separate from the outpatient assessment, and each shall be considered a distinct assessment. However, a Qualifying Hospital may submit one (1) payment in satisfaction of both the inpatient assessment and outpatient assessment listed in the Notice.

(G) Iowa Medicaid may charge an administrative fee to each Qualifying Hospital of no more than two percent (2%) of the Qualifying Hospital's total quarterly inpatient and outpatient assessments. An administrative fee shall be a line item on the Notice of Assessment.

(H) A Qualifying Hospital shall have no obligation to pay its quarterly assessment until the Qualifying Hospital has received its directed payments; however, once a Qualifying Hospital has received its directed payments, a Qualifying Hospital shall pay its quarterly assessment within thirty (30) days of receipt of its directed payments.

(I) Consistent with state law, a Qualifying Hospital shall not knowingly pass on the cost of any assessment to non-Medicaid payors, including as a fee or rate increase. A Qualifying Hospital that violates state law in this regard shall not receive directed payments for the remainder of the rate year as approved by CMS from the date the violation is discovered. Instead, the Qualifying Hospital shall be reimbursed only in accordance with its Medicaid managed care provider agreements for health care services as provided under the Iowa medical assistance program. IHA shall include such prohibition in any agreements it enters into with Qualifying Hospitals in its role as the intermediary for the Qualifying Hospitals in the Program.

(J) The assessments authorized under this MOU shall be used by Iowa Medicaid only for collecting the non-federal share of funds necessary for implementing the directed payments referenced in this MOU.

(K) A Qualifying Hospital shall have the right to request reconsideration regarding the calculation of any assessment by notifying Iowa Medicaid of the allegation of error and providing documentation supporting the allegation within thirty (30) days of the date of a Notice of Assessment. If the department agrees that an error occurred in a Qualifying Hospital's quarterly Notice of Assessment, Iowa Medicaid shall submit a corrected Notice of Assessment to the Qualifying Hospital for consideration of payment consistent with the terms of this MOU.

(L) The assessments authorized under this MOU shall not be implemented if federal financial participation is not available or, if required, a provider tax waiver is not approved by CMS. Conversely, a Qualifying Hospital shall have no obligation to pay an assessment to Iowa Medicaid if any federal agency determines that federal financial participation is not available for any assessment.

(M) Any assessments received by Iowa Medicaid that cannot be matched with federal funds shall be returned pro rata to each Qualified Hospital according to the assessment it paid.

(N) In the event that a Qualifying Hospital obtains approval from CMS to convert its provider designation to a rural emergency hospital (“REH”), Iowa Medicaid shall adjust that Qualifying Hospital’s assessment so that the Qualifying Hospital shall not be required to pay an assessment for inpatient services that the Qualifying Hospital will no longer be providing. Any adjustment shall be prospective only, not retrospective, and shall apply on the date CMS approved the Qualifying Hospital’s conversion to a REH.

Section 4. Quality Metrics

IHA will engage Qualifying Hospitals to aggregate and report data relative to the goals and objectives of the quality strategy (“Quality Strategy”) identified in the preprint approved by CMS. IHA and Iowa Medicaid shall establish a schedule to periodically report aggregated, statewide data relative to the Quality Strategy for the Program Year. The Parties may meet and confer regarding the method and content of the report submitted by IHA. Reports shall include only statewide, aggregate data, and shall not include data regarding any individual Qualifying Hospital. Consistent with the preprint approved by CMS, such data as IHA may report to Iowa Medicaid shall be for benchmark purposes only and shall not be a basis for withholding any directed payments in the event any quality and performance improvement targets are not achieved. Consistent with the Parties’ prior discussions, IHA and Iowa Medicaid will collaborate on the development of policy protocols for non- birthing Qualifying Hospitals to address precipitous deliveries and an attestation process for Qualifying Hospitals to attest that they are following the protocols that are developed.

Section 5. IHA as an Intermediary for Qualifying Hospitals

(A) The Parties recognize that the data collection and payment responsibilities, and associated communications, between Iowa Medicaid, Managed Care Organizations, and Qualifying Hospitals requires extensive coordination to ensure integrity in the Program. To promote integrity, consistency, efficiency and accountability in the Program, Iowa Medicaid invites IHA to facilitate data collection, payment and communication activities by and between Iowa Medicaid, Managed Care Organizations, and Qualifying Hospitals. Accordingly, Qualifying

Hospitals have engaged IHA to serve as a third-party administrator to perform various tasks to advance integrity, consistency, efficiency and accountability within the Program to ensure:

i. accurate and timely data collection of inpatient and outpatient paid claims data by Qualifying Hospitals to Iowa Medicaid for determining quarterly values and calculating the directed payments in accordance with the methodology within this MOU;

ii. accurate and timely data collection by Qualifying Hospitals to Iowa Medicaid to comply with quality metrics integrated with the Program;

iii. accurate and timely payments of assessments by Qualifying Hospitals to Iowa Medicaid; and

iv. accurate and timely processing of directed payments by Iowa Medicaid and Managed Care Organizations to Qualifying Hospitals.

(B) IHA's role and responsibilities shall be that of an intermediary by and for the benefit of Qualifying Hospitals participating in the Program. IHA agrees that its actions and responsibilities as an intermediary shall promote and facilitate compliance with federal and state laws governing federal financial participation in Medicaid, including 42 U.S.C. §1396b(w) and 42 C.F.R. § 438.6. IHA agrees to cooperate with requests by Iowa Medicaid to validate compliance with federal and state laws.

(C) In the event a Qualifying Hospital does not provide IHA authority to act as its intermediary in the implementation of the Program, IHA shall promptly identify the Qualifying Hospital and its designated representative to Iowa Medicaid and Managed Care Organizations so data collection, payments, and communications can be made directly with the Qualifying Hospital.

Section 6. Term of MOU

(A) The term of this MOU shall be for the time period in which CMS initially approves the Program ("Initial Term").

(B) The MOU shall automatically renew for any subsequent periods in which CMS may approve the Program ("Renewal Terms"), provided that the Parties shall revisit the terms and conditions of this MOU to consider whether amendment to the MOU is necessary as a result of any material change to the Program each time it is proposed to, or approved by, CMS.

Section 7. Miscellaneous

(A) No Cross-Subsidization. Iowa Medicaid shall prohibit Medicaid managed care organizations from setting, establishing or negotiating reimbursement rates with any Qualifying Hospital in any manner that takes into account, directly or indirectly, the directed payments that a Qualifying Hospital receives from the Program.

(B) Governing Law. This MOU shall be construed and enforced in accordance with, and governed by, the laws of the State of Iowa, without regard to its provisions concerning conflicts of laws.

(C) No Rights to Third-Parties. This MOU shall be enforceable only by the Parties. In all other respects this MOU is not intended and cannot be construed to create any rights to third-parties.

(D) Construction. Any ambiguities within this MOU shall be construed in a manner that achieves the objectives of the Program as approved by CMS and in accord with the If any language is stricken or deleted from this MOU, such language shall be deemed never to have appeared herein and no other connotation shall be drawn there from. The paragraph headings used herein are for convenience only and shall not be used in the construction or interpretation of this MOU.

(E) Notice. The Parties agree that timely and proactive communication is essential to the integrity and efficiency of the Program. Each Party shall provide prompt notice to the other Party regarding issues material to the Program. Notice shall be delivered through each Party's designated contact person(s) as set forth below.

To Iowa Medicaid	**To IHA**
Attn: Director	Attn: Legal Department
Hoover Building	100 East Grand Avenue
1305 E. Walnut St.	Des Moines, Iowa 50309
Des Moines, IA 50319	legal@ihaonline.org
ematney@dhs.state.ia.us or email of Iowa Medicaid Director at the time of notice.	

(F) Entire Agreement. This MOU, including any attachments, constitutes the sole and entire arrangement between Iowa Medicaid and IHA and may be modified only by a written amendment executed by both Parties. Any prior agreement, promises, negotiations or representations, either oral or written, relating to the subject matter of this MOU not expressly set forth in this MOU are of no force or effect.

(G) No Waiver. No waiver of any of the terms of this MOU shall be valid unless it is in writing and signed by all Parties to this MOU.

(H) Amendments. This MOU cannot be changed, modified or discharged orally, but only by the mutual written agreement of the Parties.

(I) Wind-down of the Program. In the event the Program is not renewed and this MOU expires or lapses, both Parties acknowledge that various performance obligations may exist following expiration or lapse of this MOU and the Parties agree to work in good faith to identify an orderly means of winding-down the Program in a manner that minimizes the burden and fiscal hardship on the Qualifying Hospitals.

(J) Severability. If a court of competent jurisdiction determines that any section or language within this MOU is invalid, illegal, or unenforceable for any reason, then

the offending section or language shall be severed from the MOU and the remainder of the MOU shall remain in full force and effect as if the offending section or phrase was never part of the MOU.

(K) Signing Authority. Each person signing this MOU hereby represents that he or she is authorized to enter into this MOU on behalf of the Party for which he or she is signing.

Effective Date. This MOU is effective as of 13th day of November 2023.

On behalf of Iowa Department of Health and Human Services	On behalf of IHA
DocuSigned by: Elizabeth Matney	DocuSigned by:
Signature	Signature
Elizabeth Matney	Chris Mitchell
Printed Name	Printed Name
Director of Medicaid	President and CEO
Title	Title
11/16/2023	11/14/2023
Date	Date

Exhibit J: Managed Care Premium Tax

The Premium Tax is applicable to, but not limited to:

1. Capitation Payments.
2. Maternity Case Rate Payments, which include but are not limited to: TANF Maternity Case Rate and Pregnant Women Case Rate.
3. Directed payments authorized under 42 CFR § 438.6(c), include but not limited to: GMET, GME, UIHC directed payments (physician and hospital) and all Hospital directed payments.
4. Payments for Medicaid Covered Services paid outside the capitation rates, which include but are not limited to specialty pharmaceuticals.
5. Pay for Performance withhold payments.