CONTRACT DECLARATIONS AND EXECUTION

RFP #	Contract #
RFP MED 18-029	MED-20-001
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 Human Services 1305 E. Walnut Des Moines, IA 50319-0114	**Agency Billing Contact Name / Address:** Elizabeth Matney 100 Army Post Rd. Des Moines, IA 50315 **Phone:** 515-974-3204
Agency Contract Manager (hereafter "Contract Manager") /Address ("Notice Address"): Elizabeth Matney 100 Army Post Rd. Des Moines, IA 50315	**Agency Contract Owner (hereafter "Contract Owner") / Address:** Michael Randol 100 Army Post Rd. Des Moines, IA 50315
E-Mail: ematney@dhs.state.ia.us	**E-Mail:** mrandol@dhs.state.ia.us
Phone: 515-974-3204	

Contractor: (hereafter "Contractor")	
Legal Name: **Iowa Total Care, Inc.**	**Contractor's Principal Address:** **7700 Forsyth Blvd** **Clayton, MO 63105**
Tax ID #: [redacted]	**Organized under the laws of:** State of Iowa
Contractor's Contract Manager Name/Address ("Notice Address"): Brent Layton Executive Vice President, Chief Business Development Officer 7700 Forsyth Blvd Clayton, MO 63105	**Contractor's Billing Contact Name/Address:** Brent Layton Executive Vice President, Chief Business Development Officer 7700 Forsyth Blvd Clayton, MO 63105
Phone: 770-241-9066	
E-Mail: BLAYTON@CENTENE.COM	

Contract Information	
Start Date: 7/1/2019	**End Date of Base Term of Contract:** 6/30/2023
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	
Security & Privacy Office Data Confirmation Number: 17-7	

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.

Iowa Total Care, Inc.
Signature of Authorized Representative:
Date: 10/15/18
Printed Name: Brent Layton
Title: EVP, Chief Business Development Officer

Iowa Department of Human Services
Signature of Authorized Representative:
Date: 10-17-18
Printed Name: Jerry Foxhoven
Title: Director

SECTION 1: SPECIAL TERMS

1.1 Special Terms Definitions.
Special Terms Definitions are stated in Exhibit A to Appendix 1, Scope of Work.

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 (hawk-i) programs. The Agency seeks to improve the quality of care and health outcomes for Medicaid and CHIP enrollees while leveraging the strength and success of current initiatives. The program has been designed to emphasize member choice, access, safety, independence, and responsibility. Contractors shall provide high quality healthcare services in the least restrictive manner appropriate to a member's health and functional status. Contractors shall be responsible for delivering covered benefits, including physical health, behavioral health and long-term services and supports (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.

1.3 Scope of Work.
1.3.1 Deliverables, Performance Measures, and Monitoring Activities.
The Contractor shall provide all of the requirements stated in the Scope of Work (the "SOW") attached as Appendix 1 and incorporated into this Contract. The SOW includes all of the Exhibits to the SOW and those Exhibits are incorporated into this Contract as part of the SOW.

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 SOW. If there is a conflict between the provisions of this Section and the SOW, the SOW supersede 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 Section 2.18 of Special Contract Appendix 1, Scope of Work.

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 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.

1.3.2.3 Reserved.

1.3.2.4 Reserved.

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 or upon occurrence of a qualifying maternity delivery. The capitation payments include both per member per month capitation rates and maternity case rate payments. The capitation payments and any Case rate shall be payment in full for goods and services provided pursuant to this Contract. Retroactive adjustments to reflect the actual cost of goods and services provided pursuant to the Contract are prohibited.

The parties anticipate Contractor to begin providing managed care services to its assigned Medicaid population on July 1, 2019. 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, the parties will agree on a matrix 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 and approved by CMS before the parties may contractually agree to the established rates.

Note, the capitation rates shown in the Attachment will be subject to risk adjustment as outlined in Appendix 1 Section 2.3.3 Risk Adjustment. In each subsequent rate period, 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 Attachments (i.e., Attachment 3.2-02, Attachment 3.2-03, 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 and only after the proposed rate changes have been approved by CMS.

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 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. 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 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 matrix applicable to the given Contract period. The Contractor shall supply documentation of the birth in a form and format determined by the Agency. 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 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 210 Days prior to Contractor's claim for a maternity case rate payment.

The capitation rates will be subject to a withhold amount as shown in the capitation rate matrix. 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 Appendix 1 Exhibit F, Pay-for-Performance requirements.

The actuarially sound capitation rates will include an amount for payment of the health insurer fee, as outlined in Section 9010 of the Affordable Care Act. The health insurer fee will be paid on a retrospective basis upon receipt of information regarding the amount of the fee due by the Contractor for the premium earned under the terms of this contract. The retrospective payment will include an adjustment for related income taxes and other adjustments, including tax credits. The Contractor will be responsible for submitting any requested documentation to the Agency regarding the amount of the fee. A corporate officer for the Contractor will also need to attest to the accuracy of the documentation.

For this Contract, the Agency will exclude from the capitation rates the select prescriptions drugs as set forth in Exhibit G from the pharmacy and/or the medical benefits included in the capitation rates. Contractor shall continue to provide coverage for these Exhibit G pharmaceuticals, and the Agency will reimburse the Contractor based on Contractor's invoice to the Agency for Exhibit G pharmaceuticals paid for. Contractor may only invoice for the actual pharmaceutical cost incurred by Contractor. 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 Exhibit G pharmaceuticals 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 the amount the Contractor actually paid for the pharmaceutical. Contractor must include with the invoice detailed as required by the Agency to document that the claim was appropriately paid, as well as an attestation from the Contractor that authorization criteria and medication adherence management were applied appropriately.

1.3.3.2 Payment Methodology.
The Agency will make capitated payments to the Plan as early in the month as possible, but no later than the 10th 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.

The Contractor shall comply with Agency policy and process regarding distribution of GME payments.

1.3.3.3.1 University of Iowa Health Care Physician Supplemental
To the extent that the Agency includes University of Iowa Health Care Physician Supplemental payments in capitated payments, the Plan shall pass through these payments to University of Iowa Health Care as early in the month as possible, but no later than the 15th Day of each month.

1.3.3.4 Reserved.

1.3.3.5 Reserved.

1.3.3.6 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.

1.3.3.7 Reserved.

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 Product/Completed Operations Aggregate Personal Injury Each Occurrence	$15 Million $15 Million $15 Million $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	$5 Million

	Aggregate	$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 Business Associate Agreement. The Contractor, acting as the Agency's Business Associate, performs certain services on behalf of or for the Agency pursuant to this Contract that require the exchange of information that is protected by the Health Insurance Portability and Accountability Act of 1996, as amended, and the federal regulations published at 45 CFR part 160 and 164. The Business Associate agrees to comply with the Business Associate Agreement Addendum (BAA), and any amendments thereof, as posted to the Agency's website: http://dhs.iowa.gov/HIPAA/baa. This BAA, and any amendments thereof, is incorporated into the Contract by reference.

By signing this Contract, the Business Associate consents to receive notice of future amendments to the BAA through electronic mail. The Business Associate shall file and maintain a current electronic mail address with the Agency for this purpose. The Agency may amend the BAA by posting an updated version of the BAA on the Agency's website at: http://dhs.iowa.gov/HIPAA/baa, and providing the Business Associate electronic notice of the amended BAA. The Business Associate shall be deemed to have accepted the amendment unless the Business Associate notifies the Agency of its non-acceptance in accordance with the Notice provisions of the Contract within 30 days of the Agency's notice referenced herein. Any agreed alteration of the then current Agency BAA shall have no force or effect until the agreed alteration is reduced to a Contract amendment that must be signed by the Business Associate, Agency Director, and the Agency Security and Privacy Officer.

1.6 Qualified Service Organization. The Contractor acknowledges that it will be receiving, storing, processing, or otherwise dealing with confidential patient records from programs covered by 42 CFR part 2, and the Contractor acknowledges that it is fully bound by those regulations. The Contractor will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by 42 CFR part 2. "Qualified Service Organization" as used in this Contract has the same meaning as the definition set forth in 42 CFR § 2.11.

SECTION 2. GENERAL TERMS FOR SERVICES CONTRACTS

2.1 Definitions. Definitions in this section correspond with capitalized terms in the Contract.

"Acceptance" means that the Agency has determined that one or more Deliverables satisfy the Agency's Acceptance Tests. Final Acceptance means that the Agency has determined that all Deliverables satisfy the Agency's Acceptance Tests. Non-acceptance means that the Agency has determined that one or more Deliverables have not satisfied the Agency's Acceptance Tests.
"Acceptance Criteria" means the Specifications, goals, performance measures, testing results and/or other criteria designated by the Agency and against which the Deliverables may be evaluated for purposes of Acceptance or Non-acceptance thereof.
"Acceptance Tests" or "Acceptance Testing" mean the tests, reviews, and other activities that are performed by or on behalf of the Agency to determine whether the Deliverables meet the Acceptance Criteria or otherwise satisfy the Agency, as determined by the Agency in its sole discretion.
"Bid Proposal" or "Proposal" means the Contractor's proposal submitted in response to the Solicitation, if this Contract arises out of a competitive process.
"Business Days" means any day other than a Saturday, Sunday, or State holiday as specified by Iowa Code §1C.2.
"Confidential Information" means, subject to any applicable State and federal laws and regulations, including but not limited to Iowa Code Chapter 22, any confidential or proprietary information or trade secrets disclosed by either party (a "Disclosing Party") to the other party (a "Receiving Party") that, at the time of disclosure, is designated as confidential (or like designation), is disclosed in circumstances of confidence, or would be understood by the parties, exercising reasonable business judgment, to be confidential. Regardless of whether or not the following information is designated as confidential, the term Confidential Information includes information that could be used to identify recipients or applicants of Agency services and recipients of Contract services including Protected Health Information (45 C.F.R. § 160.103) and Personal Information (Iowa Code § 715C.1(11)), Agency security protocols and procedures, Agency system architecture, information that could compromise the security of the Agency network or systems, and information about the Agency's current or future competitive procurements, including the evaluation process prior to the formal announcement of results.

Confidential Information does not include any information that: (1) was rightfully in the possession of the Receiving Party from a source other than the Disclosing Party prior to the time of disclosure of the information by the Disclosing Party to the Receiving Party; (2) was known to the Receiving Party prior to the disclosure of the information by the Disclosing Party; (3) was disclosed to the Receiving Party without restriction by an independent third party having a legal right to disclose the information; (4) is in the public domain or shall have become publicly available other than as a result of disclosure by the Receiving Party in violation of this Agreement or in breach of any other agreement with the Disclosing Party; (5) is independently developed by the Receiving Party without any reliance on Confidential Information disclosed by the Disclosing Party; (6) is disclosed or is required or authorized to be disclosed pursuant to law, rule, regulation, subpoena, summons, or the order of a court, lawful custodian, governmental agency or regulatory authority, or by applicable regulatory or professional standards; or (7) is disclosed by the Receiving Party with the written consent of the Disclosing Party.
"Contract" means the collective documentation memorializing the terms of the agreement between the Agency and the Contractor identified in the Contract Declarations and Execution Section and includes the signed Contract Declarations and Execution Section, the General Terms for Services Contracts, the Special Terms, and any Special Contract Attachments, as these documents may be amended from time to time.
"Deficiency" means a defect, flaw, anomaly, failure, omission, interruption of service, or other problem of any nature whatsoever with respect to a Deliverable,

including, without limitation, any failure of a Deliverable to conform to or meet an applicable specification. Deficiency also includes the lack of something essential or necessary for completeness or proper functioning of a Deliverable.

"Deliverables" means all of the services, goods, products, work, work product, data, items, materials and property to be created, developed, produced, delivered, performed, or provided by or on behalf of, or made available through, the Contractor (or any agent, contractor or subcontractor of the Contractor) in connection with this Contract. This includes data that is collected on behalf of the Agency.

"Documentation" means any and all technical information, commentary, explanations, design documents, system architecture documents, database layouts, test materials, training materials, guides, manuals, worksheets, notes, work papers, and all other information, documentation and materials related to or used in conjunction with the Deliverables, in any medium, including hard copy, electronic, digital, and magnetically or optically encoded media.

"Force Majeure" means an event that no human foresight could anticipate or which if anticipated, is incapable of being avoided. Circumstances must be abnormal and unforeseeable, so that the consequences could not have been avoided through the exercise of all due care. The delay or impossibility of performance must be beyond the control and without the fault or negligence of the parties. Force Majeure does not include: financial difficulties of the Contractor or any parent, subsidiary, affiliated or associated company of the Contractor; claims or court orders that restrict the Contractor's ability to deliver the Deliverables contemplated by this Contract; strikes; labor unrest; or supply chain disruptions.

"Solicitation" means the formal or informal procurement (and any Addenda thereto) identified in the Contracts Declarations and Execution Section that was issued to solicit the Bid Proposal leading to this Contract.

"Special Contract Attachments" means any attachment to this Contract.

"Special Terms" means the Section of the Contract entitled "Special Terms" that contains terms specific to this Contract, including but not limited to the Scope of Work and contract payment terms. If there is a conflict between the General Terms for Services Contracts and the Special Terms, the Special Terms shall prevail.

"Specifications" means all specifications, requirements, technical standards, performance standards, representations, and other criteria related to the Deliverables stated or expressed in this Contract, the Documentation, the Solicitation, and the Bid Proposal. Specifications shall include the Acceptance Criteria and any specifications, standards, or criteria stated or set forth in any applicable state, federal, foreign, and local laws, rules and regulations. The Specifications are incorporated into this Contract by reference as if fully set forth in this Contract.

"State" means the State of Iowa, the Agency, and all State of Iowa agencies, boards, and commissions, and when this Contract is available to political subdivisions, any political subdivisions of the State of Iowa.

*2.2 **Duration of Contract.*** The term of the Contract shall begin and end on the dates specified in the Contract Declarations and Execution Section, unless extended or terminated earlier in accordance with the termination provisions of this Contract. The Agency may, in its sole discretion, amend the end date of this Contract by exercising any applicable extension by giving the Contractor a written extension at least sixty (60) days prior to the expiration of the initial term or renewal term.

*2.3 **Scope of Work.*** As noted in Section I.3.1, The Contractor shall provide all of the requirements stated in the Scope of Work (the "SOW") attached as Appendix 1 and incorporated into this Contract. The SOW includes all of the Exhibits to the SOW and those Exhibits are incorporated into this Contract as part of the SOW. Deliverables shall be performed within the boundaries of the United States.

*2.4 **Compensation.***

2.4.1 Withholding Payments. In addition to pursuing any other remedy provided herein or by law, the Agency may withhold compensation or payments to the Contractor, in whole or in part, without penalty to the Agency or work stoppage by the Contractor, in the event the Agency determines that: (1) the Contractor has failed to perform any of its duties or obligations as set forth in this Contract; (2) any Deliverable has failed to meet or conform to any applicable Specifications or contains or is

experiencing a Deficiency; or (3) the Contractor has failed to perform Close-Out Event(s). No interest shall accrue or be paid to the Contractor on any compensation or other amounts withheld or retained by the Agency under this Contract.

2.4.2 Erroneous Payments and Credits. The Contractor shall promptly repay or refund the full amount of any overpayment or erroneous payment within thirty (30) Business Days after either discovery by the Contractor or notification by the Agency of the overpayment or erroneous payment.

2.4.3 Offset Against Sums Owed by the Contractor. In the event that the Contractor owes the State any sum under the terms of this Contract, any other contract or agreement, pursuant to a judgment, or pursuant to any law, the State may, in its sole discretion, offset any such sum against: (1) any sum Invoiced by, or owed to, the Contractor under this Contract, or (2) any sum or amount owed by the State to the Contractor, unless otherwise required by law. The Contractor agrees that this provision constitutes proper and timely notice under any applicable laws governing offset.

2.5 Termination.

The provisions for termination stated in this Section 2.5 are supplemented by the provisions stated in Section 15.1 of the SOW. If any of the provisions in this section conflict with the provisions in the SOW, the provisions in the SOW prevail over these provisions. In accordance with 42 C.F.R. § 438.710(b), before terminating this Contract under 42 C.F.R. § 438.708, the Agency shall provide the Contractor a pre-termination hearing. The Agency will give the Contractor written notice of its intent to terminate, the reason for termination, and the time and place of the hearing. After the hearing, the Agency will give the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of termination. For an affirming decision, the Agency will give enrollees of the Contractor notice of the termination and information, consistent with 42 C.F.R. § 438.10, on their options for receiving Medicaid services following the effective date of termination.

2.5.1 Termination for Cause by the Agency. The Agency may terminate this Contract upon written notice for the breach by the Contractor or any subcontractor of any material term, condition or provision of this Contract, if such breach is not cured within the time period specified in the Agency's notice of breach or any subsequent notice or correspondence delivered by the Agency to the Contractor, provided that cure is feasible. In addition, the Agency may terminate this Contract effective immediately without penalty and without advance notice or opportunity to cure for any of the following reasons:

2.5.1.1 The Contractor furnished any statement, representation, warranty, or certification in connection with this Contract, the Solicitation, or the Bid Proposal that is false, deceptive, or materially incorrect or incomplete;

2.5.1.2 The Contractor or any of the Contractor's officers, directors, employees, agents, subsidiaries, affiliates, contractors or subcontractors has committed or engaged in fraud, misappropriation, embezzlement, malfeasance, misfeasance, or bad faith;

2.5.1.3 The Contractor or any parent or affiliate of the Contractor owning a controlling interest in the Contractor dissolves;

2.5.1.4 The Contractor terminates or suspends its business;

2.5.1.5 The Contractor's corporate existence or good standing in Iowa is suspended, terminated, revoked or forfeited, or any license or certification held by the Contractor related to the Contractor's performance under this Contract is suspended, terminated, revoked, or forfeited;

2.5.1.6 The Contractor has failed to comply with any applicable international, federal, state (including, but not limited to Iowa Code Chapter 8F), or local laws, rules, ordinances, regulations, or orders when performing within the scope of this Contract;

2.5.1.7 The Agency determines or believes the Contractor has engaged in conduct that: (1) has or may expose the Agency or the State to material liability; or (2) has caused or may cause a person's life, health, or safety to be jeopardized;

2.5.1.8 The Contractor infringes or allegedly infringes or violates any patent, trademark, copyright, trade dress, or any other intellectual property right or proprietary right, or the Contractor misappropriates or allegedly misappropriates a trade secret;

2.5.1.9 The Contractor fails to comply with any applicable confidentiality laws, privacy laws, or any

provisions of this Contract pertaining to confidentiality or privacy; or

2.5.1.10 Any of the following has been engaged in by or occurred with respect to the Contractor or any corporation, shareholder or entity having or owning a controlling interest in the Contractor:

- Commencing or permitting a filing against it which is not discharged within ninety (90) days, of a case or other proceeding seeking liquidation, reorganization, or other relief with respect to itself or its debts under any bankruptcy, insolvency, or other similar law now or hereafter in effect; or filing an answer admitting the material allegations of a petition filed against it in any involuntary case or other proceeding commenced against it seeking liquidation, reorganization, or other relief under any bankruptcy, insolvency, or other similar law now or hereafter in effect with respect to it or its debts; or consenting to any such relief or to the appointment of or taking possession by any such official in any voluntary case or other proceeding commenced against it seeking liquidation, reorganization, or other relief under any bankruptcy, insolvency, or other similar law now or hereafter in effect with respect to it or its debts;
- Seeking or suffering the appointment of a trustee, receiver, liquidator, custodian or other similar official of it or any substantial part of its assets;
- Making an assignment for the benefit of creditors;
- Failing, being unable, or admitting in writing the inability generally to pay its debts or obligations as they become due or failing to maintain a positive net worth and such additional capital and liquidity as is reasonably adequate or necessary in connection with the Contractor's performance of its obligations under this Contract; or
- Taking any action to authorize any of the foregoing.

2.5.2 Termination Upon Notice. Following a thirty (30) day written notice, the Agency may terminate this Contract in whole or in part without penalty and without incurring any further obligation to the Contractor. Termination can be for any reason or no reason at all.

2.5.3 Termination Due to Lack of Funds or Change in Law. Notwithstanding anything in this Contract to the contrary, and subject to the limitations set forth below, the Agency shall have the right to terminate this Contract without penalty and without any advance notice as a result of any of the following:

2.5.3.1 The legislature or governor fail in the sole opinion of the Agency to appropriate funds sufficient to allow the Agency to either meet its obligations under this Contract or to operate as required and to fulfill its obligations under this Contract; or

2.5.3.2 If funds are de-appropriated, reduced, not allocated, or receipt of funds is delayed, or if any funds or revenues needed by the Agency to make any payment hereunder are insufficient or unavailable for any other reason as determined by the Agency in its sole discretion; or

2.5.3.3 If the Agency's authorization to conduct its business or engage in activities or operations related to the subject matter of this Contract is withdrawn or materially altered or modified; or

2.5.3.4 If the Agency's duties, programs or responsibilities are modified or materially altered; or

2.5.3.5 If there is a decision of any court, administrative law judge or an arbitration panel or any law, rule, regulation, or order is enacted, promulgated, or issued that materially or adversely affects the Agency's ability to fulfill any of its obligations under this Contract.

The Agency shall provide the Contractor with written notice of termination pursuant to this section.

2.5.4 Other remedies. The Agency's right to terminate this Contract shall be in addition to and not exclusive of other remedies available to the Agency, and the Agency shall be entitled to exercise any other rights and pursue any remedies, in law, at equity, or otherwise.

2.5.5 Limitation of the State's Payment Obligations. In the event of termination of this Contract for any reason by either party (except for termination by the Agency pursuant to Section 2.5.1, *Termination for Cause by the Agency*) the Agency shall pay only those amounts, if any, due and owing to the Contractor hereunder for Deliverables actually and satisfactorily provided in accordance with the provisions of this Contract up to and including the date of termination of this Contract and for which the Agency is obligated to pay pursuant to this Contract, except

- to the extent that the Agency is obligated to make additional payments under Section 15.1 of the SOW (Appendix 1); and
- in the event the Agency terminates this Contract pursuant to Section 2.5.3, Termination Due to Lack of Funds or Change in Law, the Agency's obligation to pay the Contractor such amounts

and other compensation shall be limited by, and subject to, legally available funds.

Payment will be made in accordance with the payment provisions under this Contract; notwithstanding, in the event the Agency terminates this Contract pursuant to Section 2.5.3, *Termination Due to Lack of Funds or Change in Law*, the Agency's obligation to pay the Contractor such amounts and other compensation shall be limited by, and subject to, legally available funds. Payment will be made only upon submission of Invoices and proper proof of the Contractor's claim.

Notwithstanding the foregoing, this section in no way limits the rights or remedies available to the Agency and shall not be construed to require the Agency to pay any compensation or other amounts hereunder in the event of the Contractor's breach of this Contract or any amounts withheld by the Agency in accordance with the terms of this Contract. The Agency shall not be liable, under any circumstances, for any of the following:

2.5.5.1 The payment of unemployment compensation to the Contractor's employees;

2.5.5.2 The payment of workers' compensation claims, which occur during the Contract or extend beyond the date on which the Contract terminates;

2.5.5.3 Any costs incurred by the Contractor in its performance of the Contract, including, but not limited to, startup costs, overhead, or other costs associated with the performance of the Contract;

2.5.5.4 Any damages or other amounts associated with the loss of prospective profits, anticipated sales, goodwill, or for expenditures, investments, or commitments made in connection with this Contract; or

2.5.5.5 Any taxes the Contractor may owe in connection with the performance of this Contract, including, but not limited to, sales taxes, excise taxes, use taxes, income taxes, or property taxes.

2.5.6 Contractor's Contract Close-Out Duties

Upon receipt of notice of termination, at expiration of the Contract, or upon the request of the agency ("Close-Out Event"), the Contractor shall carry out the Close-Out duties stated in Section I5.1.1 of the SOW (Appendix 1).

2.5.7 Termination for Cause by the Contractor.

The Contractor may only terminate this Contract for the breach by the Agency of any material term of this Contract, if such breach is not cured within sixty (60) days of the Agency's receipt of the Contractor's written notice of breach. In addition, in the event that Contractor decides not to proceed with implementation, Contractor may terminate the Contract by providing notice of termination issued no later than March 1, 2019.

2.6 Reserved.

2.7 Indemnification.

2.7.1 By the Contractor. The Contractor agrees to indemnify and hold harmless the State and its officers, appointed and elected officials, board and commission members, employees, volunteers, and agents (collectively the "Indemnified Parties"), from any and all costs, expenses, losses, claims, damages, liabilities, settlements, and judgments (including, without limitation, the reasonable value of the time spent by the Attorney General's Office,) and the costs, expenses, and attorneys' fees of other counsel retained by the Indemnified Parties directly or indirectly related to, resulting from, or arising out of this Contract, including but not limited to any claims related to, resulting from, or arising out of:

2.7.1.1 Any breach of this Contract;

2.7.1.2 Any negligent, intentional, or wrongful act or omission of the Contractor or any agent or subcontractor utilized or employed by the Contractor;

2.7.1.3 The Contractor's performance or attempted performance of this Contract, including any agent or subcontractor utilized or employed by the Contractor;

2.7.1.4 Any failure by the Contractor to make all reports, payments, and withholdings required by federal and state law with respect to social security, employee income and other taxes, fees, or costs required by the Contractor to conduct business in the State of Iowa;

2.7.1.5 Any claim of misappropriation of a trade secret or infringement or violation of any intellectual property rights, proprietary rights, or personal rights of any third party, including any claim that any Deliverable or any use thereof (or the exercise of any rights with respect thereto) infringes, violates, or misappropriates any patent, copyright, trade secret, trademark, trade dress, mask work, utility design, or other intellectual property right or proprietary right of any third party.

2.8 Insurance.

2.8.1 Insurance Requirements. The Contractor, and any subcontractor, shall maintain in full force and effect, with insurance companies licensed by the

State of Iowa, at the Contractor's expense, insurance covering its work during the entire term of this Contract, which includes any extensions or renewals thereof. The Contractor's insurance shall, among other things:

2.8.1.1 Be occurrence based and shall insure against any loss or damage resulting from or related to the Contractor's performance of this Contract regardless of the date the claim is filed or expiration of the policy. For all insurance that is not occurrence based, Contractor shall provide appropriate "tail" claim coverage to protect the State against late-filed claims.

2.8.1.2 Name the State of Iowa and the Agency as additional insureds or loss payees on the policies for all coverages required by this Contract, with the exception of Workers' Compensation, or the Contractor shall obtain an endorsement to the same effect; and

2.8.1.3 Provide a waiver of any subrogation rights that any of its insurance carriers might have against the State on the policies for all coverages required by this Contract, with the exception of Workers' Compensation.

The requirements set forth in this section shall be indicated on the certificates of insurance coverage supplied to the Agency.

2.8.2 Types and Amounts of Insurance Required. Unless otherwise requested by the Agency in writing, the Contractor shall cause to be issued insurance coverages insuring the Contractor and/or subcontractors against all general liabilities, product liability, personal injury, property damage, and (where applicable) professional liability in the amount specified in the Special Terms for each occurrence. In addition, the Contractor shall ensure it has any necessary workers' compensation and employer liability insurance as required by Iowa law.

2.8.3 Certificates of Coverage. The Contractor shall submit certificates of the insurance, which indicate coverage and notice provisions as required by this Contract, to the Agency upon execution of this Contract. The Contractor shall maintain all insurance policies required by this Contract in full force and effect during the entire term of this Contract, which includes any extensions or renewals thereof, and shall not permit such policies to be canceled or amended except with the advance written approval of the Agency. The insurer shall state in the certificate that no cancellation of the insurance will be made without at least a thirty (30) day prior written notice to the Agency. The certificates shall be subject to approval by the Agency. Approval of the insurance certificates by the Agency shall not relieve the Contractor of any obligation under this Contract.

2.8.4 Fidelity Bond. In accordance with Iowa Admin. Code 191 Chapter 40.13, the Contractor shall maintain in force a fidelity bond on employees and officers.

2.9 Ownership and Security of Agency Information.

2.9.1 Ownership and Disposition of Agency Information. Any information either supplied by the Agency to the Contractor, or collected by the Contractor on the Agency's behalf in the course of the performance of this Contract, shall be considered the property of the Agency ("Agency Information"). The Contractor will not use the Agency Information for any purpose other than providing services under the Contract, nor will any part of the information and records be disclosed, sold, assigned, leased, or otherwise provided to third parties or commercially exploited by or on behalf of the Contractor. The Agency shall own all Agency Information that may reside within the Contractor's hosting environment and/or equipment/media.

2.9.2 Foreign Hosting and Storage Prohibited. Agency Information shall be hosted and/or stored within the continental United States only.

2.9.3 Access to Agency Information that is Confidential Information. The Contractor's employees, agents, and subcontractors may have access to Agency Information that is Confidential Information to the extent necessary to carry out responsibilities under the Contract. Access to such Confidential Information shall comply with both the State's and the Agency's policies and procedures. In all instances, access to Agency Information from locations outside of those outlined in Section 2.3 Scope of Work, either by the Contractor, including a foreign office or division of the Contractor or its affiliates or associates, or any subcontractor, is prohibited.

2.9.4 No Use or Disclosure of Confidential Information. Confidential Information collected, maintained, or used in the course of performance of the Contract shall only be used or disclosed by the Contractor as expressly authorized by law and only with the prior written consent of the Agency, either during the period of the Contract or thereafter. The Contractor shall immediately report to the Agency any unauthorized use or disclosure of Confidential

Information. The Contractor may be held civilly or criminally liable for improper use or disclosure of Confidential Information.

2.9.5 Contractor Breach Notification Obligations. The Contractor agrees to comply with all applicable laws that require the notification of individuals in the event of unauthorized use or disclosure of Confidential Information or other event(s) requiring notification in accordance with applicable law. In the event of a breach of the Contractor's security obligations or other event requiring notification under applicable law, the Contractor agrees to follow Agency directives, which may include assuming responsibility for informing all such individuals in accordance with applicable laws, and to indemnify, hold harmless, and defend the State of Iowa against any claims, damages, or other harm related to such breach.

2.9.6 Compliance of Contractor Personnel. The Contractor and the Contractor's personnel shall comply with the Agency's and the State's security and personnel policies, procedures, and rules, including any procedure which the Agency's personnel, contractors, and consultants are normally asked to follow. The Contractor agrees to cooperate fully and to provide any assistance necessary to the Agency in the investigation of any security breaches that may involve the Contractor or the Contractor's personnel. All services shall be performed in accordance with State Information Technology security standards and policies as well as Agency security protocols and procedures. By way of example only, see Iowa Code 8A.206, http://secureonline.iowa.gov/links/index.html, and https://ocio.iowa.gov/home/standards.

2.9.7 Subpoena. In the event that a subpoena or other legal process is served upon the Contractor for records containing Confidential Information, the Contractor shall promptly notify the Agency and cooperate with the Agency in any lawful effort to protect the Confidential Information.

2.9.8 Return and/or Destruction of Information. Upon expiration or termination of the Contract for any reason, the Contractor agrees to comply with all Agency directives regarding the return or destruction of all Agency Information and any derivative work. Delivery of returned Agency Information must be through a secured electronic transmission or by parcel service that utilizes tracking numbers. Such information must be provided in a format useable by the Agency. Following the Agency's verified receipt of the Agency Information and any derivative work, the Contractor agrees to physically and/or electronically destroy or erase all residual Agency Information regardless of format from the entire Contractor's technology resources and any other storage media. This includes, but is not limited to, all production copies, test copies, backup copies and /or printed copies of information created on any other servers or media and at all other Contractor sites. Any permitted destruction of Agency Information must occur in such a manner as to render the information incapable of being reconstructed or recovered. The Contractor will provide a record of information destruction to the Agency for inspection and records retention no later than thirty (30) days after destruction.

2.9.9 Contractor's Inability to Return and/or Destroy Information. If for any reason the Agency Information cannot be returned and/or destroyed upon expiration or termination of the Contract, the Contractor agrees to notify the Agency with an explanation as to the conditions which make return and/or destruction not possible or feasible. Upon mutual agreement by both parties that the return and/or destruction of the information is not possible or feasible, the Contractor shall make the Agency Information inaccessible. The Contractor shall not use or disclose such retained Agency Information for any purposes other than those expressly permitted by the Agency. The Contractor shall provide to the Agency a detailed description as to the procedures and methods used to make the Agency Information inaccessible no later than thirty (30) days after making the information inaccessible. If the Agency provides written permission for the Contractor to retain the Agency Information in the Contractor's information systems, the Contractor will extend the protections of this Contract to such information and limit any further uses or disclosures of such information.

2.9.10 Contractors that are Business Associates. If the Contractor is the Agency's Business Associate, and there is a conflict between the Business Associate Agreement and this Section 2.9, the provisions in the Business Associate Agreement shall control.

2.10 Intellectual Property.

2.10.1 Ownership and Assignment of Other Deliverables. The Contractor agrees that the State and the Agency shall become the sole and exclusive

owners of all Deliverables. The Contractor hereby irrevocably assigns, transfers and conveys to the State and the Agency all right, title and interest in and to all Deliverables and all intellectual property rights and proprietary rights arising out of, embodied in, or related to such Deliverables, including copyrights, patents, trademarks, trade secrets, trade dress, mask work, utility design, derivative works, and all other rights and interests therein or related thereto. The Contractor represents and warrants that the State and the Agency shall acquire good and clear title to all Deliverables, free from any claims, liens, security interests, encumbrances, intellectual property rights, proprietary rights, or other rights or interests of the Contractor or of any third party, including any employee, agent, contractor, subcontractor, subsidiary, or affiliate of the Contractor. The Contractor (and Contractor's employees, agents, contractors, subcontractors, subsidiaries and affiliates) shall not retain any property interests or other rights in and to the Deliverables and shall not use any Deliverables, in whole or in part, for any purpose, without the prior written consent of the Agency and the payment of such royalties or other compensation as the Agency deems appropriate. Unless otherwise requested by the Agency, upon completion or termination of this Contract, the Contractor will immediately turn over to the Agency all Deliverables not previously delivered to the Agency, and no copies thereof shall be retained by the Contractor or its employees, agents, subcontractors, or affiliates, without the prior written consent of the Agency. Each party shall retain all of its respective rights in any intellectual property that pre-existed the execution of the contract or was independently developed outside of the scope of the contract. The contractors must independently assure that their agreements allow for the Agency to have access to the Agency property and data. The Contractor cannot in any way seek to claim some form of proprietary protection of information, data, and reports that are core Deliverables under the terms of the Contract. The Agency must be free to respond to legislative and public inquiries into the operations of the Agency and cannot be restricted in doing so by claims that such information is proprietary. The Agency will not agree to any form of confidentiality agreements from the Contractor or any subcontractor that would restrict the Agency's access or use of claim level detail regarding payments made through the MCO arrangement.

2.10.2 Waiver. To the extent any of the Contractor's rights in any Deliverables are not subject to assignment or transfer hereunder, including any moral rights and any rights of attribution and of integrity, the Contractor hereby irrevocably and unconditionally waives all such rights and enforcement thereof and agrees not to challenge the State's rights in and to the Deliverables.

2.10.3 Further Assurances. At the Agency's request, the Contractor will execute and deliver such instruments and take such other action as may be requested by the Agency to establish, perfect, or protect the State's rights in and to the Deliverables and to carry out the assignments, transfers and conveyances set forth in Section 2.10, *Intellectual Property*.

2.10.4 Publications. Prior to completion of all services required by this Contract, the Contractor shall not publish in any format any final or interim report, document, form, or other material developed as a result of this Contract without the express written consent of the Agency. Upon completion of all services required by this Contract, the Contractor may publish or use materials developed as a result of this Contract, subject to confidentiality restrictions, and only after the Agency has had an opportunity to review and comment upon the publication. Any such publication shall contain a statement that the work was done pursuant to a contract with the Agency and that it does not necessarily reflect the opinions, findings, and conclusions of the Agency.

2.10.5 Federal License. As this Contract is at least partially federally funded, the federal government reserves a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, or otherwise use and to authorize others to use for federal government purposes, software and associated documentation designed, developed or installed in whole or in part with federal funds pursuant to this Contract.

2.11 Warranties.

2.11.1 Construction of Warranties Expressed in this Contract with Warranties Implied by Law. Warranties made by the Contractor in this Contract, whether: (1) this Contract specifically denominates the Contractor's promise as a warranty; or (2) the warranty is created by the Contractor's affirmation or promise, by a description of the Deliverables to be provided, or by provision of samples to the Agency, shall not be construed as limiting or negating any warranty provided by law, including without

limitation, warranties that arise through the course of dealing or usage of trade. The warranties expressed in this Contract are intended to modify the warranties implied by law only to the extent that they expand the warranties applicable to the Deliverables provided by the Contractor. With the exception of Subsection 2.11.3, the provisions of this section apply during the Warranty Period as defined in the Contract Declarations and Execution Section.

2.11.2 Contractor represents and warrants that:

2.11.2.1 All Deliverables shall be wholly original with and prepared solely by the Contractor; or it owns, possesses, holds, and has received or secured all rights, permits, permissions, licenses, and authority necessary to provide the Deliverables to the Agency hereunder and to assign, grant and convey the rights, benefits, licenses, and other rights assigned, granted, or conveyed to the Agency hereunder or under any license agreement related hereto without violating any rights of any third party;

2.11.2.2 The Contractor has not previously and will not grant any rights in any Deliverables to any third party that are inconsistent with the rights granted to the Agency herein; and

2.11.2.3 The Agency shall peacefully and quietly have, hold, possess, use, and enjoy the Deliverables without suit, disruption, or interruption.

2.11.3 The Contractor represents and warrants that:

2.11.3.1 The Deliverables (and all intellectual property rights and proprietary rights arising out of, embodied in, or related to such Deliverables); and

2.11.3.2 The Agency's use of, and exercise of any rights with respect to, the Deliverables (and all intellectual property rights and proprietary rights arising out of, embodied in, or related to such Deliverables), do not and will not, under any circumstances, misappropriate a trade secret or infringe upon or violate any copyright, patent, trademark, trade dress or other intellectual property right, proprietary right or personal right of any third party. The Contractor further represents and warrants there is no pending or threatened claim, litigation, or action that is based on a claim of infringement or violation of an intellectual property right, proprietary right or personal right or misappropriation of a trade secret related to the Deliverables. The Contractor shall inform the Agency in writing immediately upon becoming aware of any actual, potential, or threatened claim of or cause of action for infringement or violation or an intellectual property right, proprietary right or personal right or misappropriation of a trade secret. If such a claim or cause of action arises or is likely to arise, then the Contractor shall, at the Agency's request and at the Contractor's sole expense:

- Procure for the Agency the right or license to continue to use the Deliverable at issue;
- Replace such Deliverable with a functionally equivalent or superior Deliverable free of any such infringement, violation, or misappropriation;
- Modify or replace the affected portion of the Deliverable with a functionally equivalent or superior Deliverable free of any such infringement, violation, or misappropriation; or
- Accept the return of the Deliverable at issue and refund to the Agency all fees, charges, and any other amounts paid by the Agency with respect to such Deliverable. In addition, the Contractor agrees to indemnify, defend, protect, and hold harmless the State and its officers, directors, employees, officials, and agents as provided in the Indemnification Section of this Contract, including for any breach of the representations and warranties made by the Contractor in this section.

The warranty provided in this Section 2.11.3 shall be perpetual, shall not be subject to the contractual Warranty Period, and shall survive termination of this Contract. The foregoing remedies provided in this subsection shall be in addition to and not exclusive of other remedies available to the Agency and shall survive termination of this Contract.

2.11.4 The Contractor represents and warrants that the Deliverables shall:

2.11.4.1 Be free from material Deficiencies; and

2.11.4.2 Meet, conform to, and operate in accordance with all Specifications and in accordance with this Contract during the Warranty Period, as defined in the Contract Declarations and Execution Section. During the Warranty Period the Contractor shall, at its expense, repair, correct or replace any Deliverable that contains or experiences material Deficiencies or fails to meet, conform to or operate in accordance with Specifications within five (5) Business Days of receiving notice of such Deficiencies or failures from the Agency or within such other period as the Agency specifies in the notice. In the event the Contractor is unable to repair, correct, or replace such Deliverable to the Agency's satisfaction, the Contractor shall refund the fees or other amounts paid for the Deliverables and for any services related thereto.

The foregoing shall not constitute an exclusive remedy under this Contract, and the Agency shall be entitled to pursue any other available contractual, legal, or equitable remedies. The Contractor shall be available at all reasonable times to assist the Agency with questions, problems, and concerns about the Deliverables, to inform the Agency promptly of any known Deficiencies in any Deliverables, repair and correct any Deliverables not performing in accordance with the warranties contained in this Contract, notwithstanding that such Deliverables may have been accepted by the Agency, and provide the Agency with all necessary materials with respect to such repaired or corrected Deliverable.

2.11.5 The Contractor represents, warrants and covenants that all services to be performed under this Contract shall be performed in a professional, competent, diligent, and workmanlike manner by knowledgeable, trained, and qualified personnel, all in accordance with the terms and Specifications of this Contract and the standards of performance considered generally acceptable in the industry for similar tasks and projects. In the absence of a Specification for the performance of any portion of this Contract, the parties agree that the applicable Specification shall be the generally accepted industry standard. So long as the Agency notifies the Contractor of any services performed in violation of this standard, the Contractor shall re-perform the services at no cost to the Agency, such that the services are rendered in the above-specified manner, or if the Contractor is unable to perform the services as warranted, the Contractor shall reimburse the Agency any fees or compensation paid to the Contractor for the unsatisfactory services.

2.11.6 The Contractor represents and warrants that the Deliverables will comply with any applicable federal, state, foreign and local laws, rules, regulations, codes, and ordinances in effect during the entire term of this Contract, which includes any extensions or renewals thereof, including applicable provisions of Section 508 of the Rehabilitation Act of 1973, as amended, and all standards and requirements established by the Architectural and Transportation Barriers Access Board and the Iowa Office of the Chief Information Officer.

2.11.7 Obligations Owed to Third Parties. The Contractor represents and warrants that all obligations owed to third parties with respect to the activities contemplated to be undertaken by the Contractor pursuant to this Contract are or will be fully satisfied by the Contractor so that the Agency will not have any obligations with respect thereto.

2.12 Acceptance of Deliverables.

2.12.1 Acceptance of Written Deliverables. For the purposes of this section, written Deliverables means documents including, but not limited to project plans, planning documents, reports, or instructional materials ("Written Deliverables"). Although the Agency determines what Written Deliverables are subject to formal Acceptance, this section generally does not apply to routine progress or financial reports. Absent more specific Acceptance Criteria in the Special Terms, following delivery of any Written Deliverable pursuant to the Contract, the Agency will notify the Contractor whether or not the Deliverable meets contractual specifications and requirements. Written Deliverables shall not be considered accepted by the Agency, nor does the Agency have an obligation to pay for such Deliverables, unless and until the Agency has notified the Contractor of the Agency's Final Acceptance of the Written Deliverables. In all cases, any statements included in such Written Deliverables that alter or conflict with any contractual requirements shall in no way be considered as changing the contractual requirements unless and until the parties formally amend the Contract.

2.12.2. Acceptance of Software Deliverables. Except as otherwise specified in the Scope of Work, all Deliverables pertaining to software and related hardware components ("Software Deliverables") shall be subject to the Agency's Acceptance Testing and Acceptance, unless otherwise specified in the Scope of Work. Upon completion of all work to be performed by the Contractor with respect to any Software Deliverable, the Contractor shall deliver a written notice to the Agency certifying that the Software Deliverable meets and conforms to applicable Specifications and is ready for the Agency to conduct Acceptance Testing; provided, however, that the Contractor shall pretest the Software Deliverable to determine that it meets and operates in accordance with applicable Specifications prior to delivering such notice to the Agency. At the Agency's request, the Contractor shall assist the Agency in performing Acceptance Tests at no additional cost to the Agency. Within a reasonable period of time after the Agency has completed its Acceptance Testing, the Agency shall provide the Contractor with written notice of Acceptance or Non-

acceptance with respect to each Software Deliverable that was evaluated during such Acceptance Testing. In the event the Agency provides notice of Non-acceptance to the Contractor with respect to any Software Deliverable, the Contractor shall correct and repair such Software Deliverable and submit it to the Agency within ten (10) days of the Contractor's receipt of notice of Non-acceptance so that the Agency may re-conduct its Acceptance Tests. In the event the Agency determines, after re-conducting its Acceptance Tests with respect to any Software Deliverable that the Contractor has attempted to correct or repair pursuant to this section, that such Software Deliverable fails to satisfy its Acceptance Tests, then the Agency shall have the continuing right, at its sole option, to: (1) require the Contractor to correct and repair such Software Deliverable within such period of time as the Agency may specify in a written notice to the Contractor; (2) refuse to accept such Software Deliverable without penalty and without any obligation to pay any fees or other amounts associated with such Software Deliverable (or receive a refund of any fees or amounts already paid with respect to such Software Deliverable); (3) accept such Software Deliverable on the condition that any fees or other amounts payable with respect thereto shall be reduced or discounted to reflect, to the Agency's satisfaction, the Deficiencies present therein and any reduced value or functionality of such Software Deliverable or the costs likely to be incurred by the Agency to correct such Deficiencies; or (4) terminate this Contract and/or seek any and all available remedies, including damages. Notwithstanding the provisions of Section 2.5.1, *Termination for Cause by the Agency*, of this Contract, the Agency may terminate this Contract pursuant to this section without providing the Contractor with any notice or opportunity to cure provided for in the termination provisions of this Contract. The Agency's right to exercise the foregoing rights and remedies, including termination of this Contract, shall remain in effect until Acceptance Tests are successfully completed to the Agency's satisfaction and the Agency has provided the Contractor with written notice of Final Acceptance.

2.12.3 Notice of Acceptance and Future Deficiencies. The Contractor's receipt of any notice of Acceptance, including Final Acceptance, with respect to any Deliverable shall not be construed as a waiver of any of the Agency's rights to enforce the terms of this Contract or require performance in the event the Contractor breaches this Contract or any Deficiency is later discovered with respect to such Deliverable.

2.13 Contract Administration.

2.13.1 Independent Contractor. The status of the Contractor shall be that of an independent contractor. The Contractor, its employees, agents, and any subcontractors performing under this Contract are not employees or agents of the State or any agency, division, or department of the State simply by virtue of work performed pursuant to this Contract. Neither the Contractor nor its employees shall be considered employees of the Agency or the State for federal or state tax purposes simply by virtue of work performed pursuant to this Contract. The Agency will not withhold taxes on behalf of the Contractor (unless required by law).

2.13.2 Reserved.

2.13.3 Intent of References to Bid Documents. To the extent this Contract arises out of a Solicitation, the references to the parties' obligations, which are contained in this Contract, are intended to supplement or clarify the obligations as stated in the Solicitation and the Bid Proposal. The failure of the parties to make reference to the terms of the Solicitation or the Bid Proposal in this Contract shall not be construed as creating a conflict and will not relieve the Contractor of the contractual obligations imposed by the terms of the Solicitation and the Contractor's Bid Proposal. Terms offered in the Bid Proposal, which exceed the requirements of the Solicitation, shall not be construed as creating an inconsistency or conflict with the Solicitation or the Contract. The contractual obligations of the Agency are expressly stated in this document. The Bid Proposal does not create any express or implied obligations of the Agency.

2.13.4 Compliance with the Law. The Contractor, its employees, agents, and subcontractors shall comply at all times with all applicable federal, state, and local laws, rules, ordinances, regulations, orders, guidance, and policies in place at Contract execution as well as any and all future amendments, changes, and additions to such laws (the "Applicable Law") as of the effective date of such change. All such Applicable Law is incorporated into this Contract as of the effective date of the Applicable Law. The Contractor and Agency expressly reject any proposition that future changes to Applicable Law are

inapplicable to this Contract and the Contractor's provision of Deliverables and/or performance in accordance with this Contract. When providing Deliverables pursuant to this Contract the Contractor, its employees, agents, and subcontractors shall comply with all Applicable Law.

Applicable Law includes, without limitation, all laws that pertain to the prevention of discrimination in employment and in the provision of services. For employment, this would include equal employment opportunity and affirmative action, and the use of targeted small businesses as subcontractors or suppliers. The Contractor may be required to provide a copy of its affirmative action plan, containing goals and time specifications, and non-discrimination and accessibility plans and policies regarding services to clients. Failure to comply with this provision may cause this Contract to be cancelled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for future state contracts or be subject to other sanctions as provided by law or rule. The Contractor, its employees, agents, and subcontractors shall also comply with all federal, state, and local laws regarding business permits and licenses that may be required to carry out the work performed under this Contract. The Contractor may be required to submit its affirmative action plan to the Iowa Department of Management to comply with the requirements of 541 Iowa Administrative Code chapter 4. If all or a portion of the funding used to pay for the Deliverables is being provided through a grant from the Federal Government, the Contractor acknowledges and agrees that pursuant to applicable federal laws, regulations, circulars, and bulletins, the awarding agency of the Federal Government reserves certain rights including, without limitation, a royalty-free, non-exclusive and irrevocable license to reproduce, publish or otherwise use, and to authorize others to use, for Federal Government purposes, the Deliverables developed under this Contract and the copyright in and to such Deliverables.

2.13.5 Procurement. The Contractor shall use procurement procedures that comply with all applicable federal, state, and local laws and regulations.

2.13.6 Non-Exclusive Rights. This Contract is not exclusive. The Agency reserves the right to select other contractors to provide Deliverables similar or identical to those described in the Scope of Work during the entire term of this Contract, which includes any extensions or renewals thereof.

2.13.7 Amendments. This Contract may only be amended by mutual written consent of the parties, with the exception of (1) the Contract end date, which may be extended under the Agency's sole discretion, and (2) the Business Associate Agreement, which may be modified or replaced on notice pursuant to Section 1.5, *Business Associate Agreement.* Amendments shall be executed on a form approved by the Agency that expressly states the intent of the parties to amend this Contract. This Contract shall not be amended in any way by use of terms and conditions in an Invoice or other ancillary transactional document. To the extent that language in a transactional document conflicts with the terms of this Contract, the terms of this Contract shall control. Notwithstanding any language to the contrary contained in the Contract, an expansion of benefits or additions of new services which result in an increased medical or administrative cost to the Contractor, and not known at the time of capitation rate development, shall only take effect through the Contract amendment process.

2.13.8 No Third Party Beneficiaries. There are no third party beneficiaries to this Contract. This Contract is intended only to benefit the State and the Contractor.

2.13.9 Use of Third Parties. The Agency acknowledges that the Contractor may contract with third parties for the performance of any of the Contractor's obligations under this Contract. 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 Agency reserves the right to review and approve all subcontracts. The Contractor may enter into these contracts to complete the project provided that the Contractor remains responsible for all Deliverables provided under this Contract. All restrictions, obligations, and responsibilities of the Contractor under this Contract shall also apply to the subcontractors and the Contractor shall include in all of its subcontracts a clause that so states. The Agency shall have the right to request the removal of a subcontractor from the Contract for good cause. The provisions of this Section 2.13.9 are in addition to any provisions stated in the SOW. If there is a conflict between the provisions of this Section and

the SOW, the SOW supersedes the provisions of this Section.

2.13.10 Choice of Law and Forum. The laws of the State of Iowa shall govern and determine all matters arising out of or in connection with this Contract without regard to the conflict of law provisions of Iowa law. Any and all litigation commenced in connection with this Contract shall be brought and maintained solely in Polk County District Court for the State of Iowa, Des Moines, Iowa, or in the United States District Court for the Southern District of Iowa, Central Division, Des Moines, Iowa, wherever jurisdiction is appropriate. This provision shall not be construed as waiving any immunity to suit or liability including without limitation sovereign immunity in State or Federal court, which may be available to the Agency or the State of Iowa.

2.13.11 Assignment and Delegation. The Contractor may not assign, transfer, or convey in whole or in part this Contract without the prior written consent of the Agency. For the purpose of construing this clause, a transfer of a controlling interest in the Contractor shall be considered an assignment. The Contractor may not delegate any of its obligations or duties under this Contract without the prior written consent of the Agency. The Contractor may not assign, pledge as collateral, grant a security interest in, create a lien against, or otherwise encumber any payments that may or will be made to the Contractor under this Contract.

2.13.12 Integration. This Contract represents the entire Contract between the parties. The parties shall not rely on any representation that may have been made which is not included in this Contract.

2.13.13 No Drafter. No party to this Contract shall be considered the drafter of this Contract for the purpose of any statute, case law, or rule of construction that would or might cause any provision to be construed against the drafter.

2.13.14 Headings or Captions. The paragraph headings or captions used in this Contract are for identification purposes only and do not limit or construe the contents of the paragraphs.

2.13.15 Not a Joint Venture. Nothing in this Contract shall be construed as creating or constituting the relationship of a partnership, joint venture, (or other association of any kind or agent and principal relationship) between the parties hereto. No party, unless otherwise specifically provided for herein, has the authority to enter into any contract or create an obligation or liability on behalf of, in the name of, or binding upon another party to this Contract.

2.13.16 Joint and Several Liability. If the Contractor is a joint entity, consisting of more than one individual, partnership, corporation, or other business organization, all such entities shall be jointly and severally liable for carrying out the activities and obligations of this Contract, for any default of activities and obligations, and for any fiscal liabilities.

2.13.17 Supersedes Former Contracts or Agreements. This Contract supersedes all prior contracts or agreements between the Agency and the Contractor for the Deliverables to be provided in connection with this Contract.

2.13.18 Waiver. Except as specifically provided for in a waiver signed by duly authorized representatives of the Agency and the Contractor, failure by either party at any time to require performance by the other party or to claim a breach of any provision of the Contract shall not be construed as affecting any subsequent right to require performance or to claim a breach.

2.13.19 Notice. With the exception of the Business Associate Agreement, as set forth in Section 1.5, *Business Associate Agreement*, any notices required by the Contract shall be given in writing by registered or certified mail, return receipt requested, by receipted hand delivery, by Federal Express, courier or other similar and reliable carrier which shall be addressed to each party's Contract Manager as set forth in the Contract Declarations and Execution Section. From time to time, the parties may change the name and address of a party designated to receive notice. Such change of the designated person shall be in writing to the other party.

Each such notice shall be deemed to have been provided:

- At the time it is actually received in the case of hand delivery;
- Within one (1) day in the case of overnight delivery, courier or services such as Federal Express with guaranteed next-day delivery; or
- Within five (5) days after it is deposited in the U.S. Mail.

2.13.20 Cumulative Rights. The various rights, powers, options, elections, and remedies of any party provided in this Contract, shall be construed as cumulative and not one of them is exclusive of the others or exclusive of any rights, remedies or priorities allowed either party by law, and shall in no

way affect or impair the right of any party to pursue any other equitable or legal remedy to which any party may be entitled.

2.13.21 Severability. If any provision of this Contract is determined by a court of competent jurisdiction to be invalid or unenforceable, such determination shall not affect the validity or enforceability of any other part or provision of this Contract.

2.13.22 Time is of the Essence. Time is of the essence with respect to the Contractor's performance of the terms of this Contract. The Contractor shall ensure that all personnel providing Deliverables to the Agency are responsive to the Agency's requirements and requests in all respects.

2.13.23 Authorization. The Contractor represents and warrants that:

2.13.23.1 It has the right, power, and authority to enter into and perform its obligations under this Contract.

2.13.23.2 It has taken all requisite action (corporate, statutory, or otherwise) to approve execution, delivery, and performance of this Contract, and this Contract constitutes a legal, valid, and binding obligation upon itself in accordance with its terms.

2.13.24 Successors in Interest. All the terms, provisions, and conditions of the Contract shall be binding upon and inure to the benefit of the parties hereto and their respective successors, assigns, and legal representatives.

2.13.25 Records Retention and Access.

2.13.25.1 Financial Records. The Contractor shall maintain accurate, current, and complete records of the financial activity of this Contract which sufficiently and properly document and calculate all charges billed to the Agency during the entire term of this Contract, which includes any extensions or renewals thereof, and for a period of at least ten (10) years following the date of final payment or completion of any required audit (whichever is later). If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the ten (10) year period, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular ten (10) year period, whichever is later. The Contractor shall permit the Agency, the Auditor of the State of Iowa or any other authorized representative of the State and where federal funds are involved, the Comptroller General of the United States or any other authorized representative of the United States government, to access and examine, audit, excerpt and transcribe any directly pertinent books, documents, papers, electronic or optically stored and created records, or other records of the Contractor relating to orders, Invoices or payments, or any other Documentation or materials pertaining to this Contract, wherever such records may be located. The Contractor shall not impose a charge for audit or examination of the Contractor's books and records. Based on the audit findings, the Agency reserves the right to address the Contractor's board or other managing entity regarding performance and expenditures. When state or federal law or the terms of this Contract require compliance with OMB Circular A-87, A-110, or other similar provision addressing proper use of government funds, the Contractor shall comply with these additional records retention and access requirements:

2.13.25.1.1 Records of financial activity shall include records that adequately identify the source and application of funds. The Contractor shall maintain all financial accounting records in accordance with National Association of Insurance Commissioner (NAIC) guidelines. Accounting records shall be maintained separately for the Contractor's line of business arising out of this Contract and provided to the Agency as requested. As applicable, the Contractor shall incorporate the performance and financial data of all risk-bearing subcontractors. When the terms of this Contract require matching funds, cash contributions made by the Contractor and third-party in-kind (property or service) contributions, these funds must be verifiable from the Contractor's records. These records must contain information pertaining to contract amount, obligations, unobligated balances, assets, liabilities, expenditures, income, and third-party reimbursements. The Contractor must timely provide copies of the requested records to the Agency, DHHS, OIG or MFCU within ten (10) business days from the date of the request. 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. 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 CFR Sections 160 through 164.

2.13.25.1.2 The Contractor shall maintain accounting records supported by source documentation that may include but are not limited to cancelled checks, paid bills, payroll, time and attendance records, and contract award documents.

2.13.25.1.3 The Contractor, in maintaining project expenditure accounts, records and reports, shall make any necessary adjustments to reflect refunds, credits, underpayments or overpayments, as well as any adjustments resulting from administrative or compliance reviews and audits. Such adjustments shall be set forth in the financial reports filed with the Agency.

2.13.25.1.4 The Contractor shall maintain a sufficient record keeping system to provide the necessary data for the purposes of planning, monitoring, and evaluating its program.

2.13.25.2 The Contractor shall retain all non-medical and medical client records for a period of ten (10) years from the last date of service for each patient; or in the case of a minor patient or client, for a period consistent with that established by Iowa Code § 614.1(9), whichever is greater.

2.13.26 Audits. Local governments and non-profit subrecipient entities that expend $500,000 or more in a year in federal awards (from all sources) shall have a single audit conducted for that year in accordance with the provisions of OMB Circular A-133 "Audit of States, Local Governments, and Non-Profit Organizations." A copy of the final audit report shall be submitted to the Agency if either the schedule of findings and questioned costs or the summary schedule of prior audit findings includes any audit findings related to federal awards provided by the Agency. If an audit report is not required to be submitted per the criteria above, the subrecipient must provide written notification to the Agency that the audit was conducted in accordance with Government Auditing Standards and that neither the schedule of findings and questioned costs nor the summary schedule of prior audit findings includes any audit findings related to federal awards provided by the Agency. See A-133 Section 21 for a discussion of subrecipient versus vendor relationships. The Contractor shall provide the Agency with a copy of any written audit findings or reports, whether in draft or final form, within two (2) Business Days following receipt by the Contractor. The requirements of this paragraph shall apply to the Contractor as well as any subcontractors.

2.13.27 Reimbursement of Audit Costs. If the Auditor of the State of Iowa notifies the Agency of an issue or finding involving the Contractor's noncompliance with laws, rules, regulations, and/or contractual agreements governing the funds distributed under this Contract, the Contractor shall bear the cost of the Auditor's review and any subsequent assistance provided by the Auditor to determine compliance. The Contractor shall reimburse the Agency for any costs the Agency pays to the Auditor for such review or audit.

2.13.28 Staff Qualifications and Background Checks. The Contractor shall be responsible for assuring that all persons, whether they are employees, agents, subcontractors, or anyone acting for or on behalf of the Contractor, are properly licensed, certified, or accredited as required under applicable state law and the Iowa Administrative Code. The Contractor shall provide standards for service providers who are not otherwise licensed, certified, or accredited under state law or the Iowa Administrative Code.

The Agency reserves the right to conduct and/or request the disclosure of criminal history and other background investigation of the Contractor, its officers, directors, shareholders, and the Contractor's staff, agents, or subcontractors retained by the Contractor for the performance of Contract services.

2.13.29 Solicitation. The Contractor represents and warrants that no person or selling agency has been employed or retained to solicit and secure this Contract upon an agreement or understanding for commission, percentage, brokerage, or contingency excepting bona fide employees or selling agents maintained for the purpose of securing business.

2.13.30 Obligations Beyond Contract Term. All obligations of the Agency and the Contractor incurred or existing under this Contract as of the date of expiration or termination will survive the expiration or termination of this Contract. Contract sections that survive include, but are not necessarily limited to, the following: (1) Section 2.4.2, *Erroneous Payments and Credits*; (2) Section 2.5.5, *Limitation of the State's Payment Obligations*; (3) Section 2.5.6, *Contractor's Contract Close-Out Duties*; (4) Section 2.7, *Indemnification*, and all subparts thereof; (5) Section 2.9, *Ownership and Security of Agency Information*, and all subparts thereof; (6) Section 2.10, *Intellectual Property*, and

all subparts thereof; (7) Section 2.13.10, *Choice of Law and Forum*; (8) Section 2.13.16, *Joint and Several Liability*; (9) Section 2.13.20, *Cumulative Rights*; (10) Section 2.13.24 *Successors In Interest*; (11) Section 2.13.25, *Records Retention and Access*, and all subparts thereof; (12) Section 2.13.26, *Audits*; (13) Section 2.13.27, *Reimbursement of Audit Costs*; (14) Section 2.13.35, *Repayment Obligation*; and (15) Section 2.13.39, *Use of Name or Intellectual Property.*

2.13.31 Counterparts. The parties agree that this Contract has been or may be executed in several counterparts, each of which shall be deemed an original and all such counterparts shall together constitute one and the same instrument.

2.13.32 Delays or Potential Delays of Performance. Whenever the Contractor encounters any difficulty which is delaying or threatens to delay the timely performance of this Contract, including but not limited to potential labor disputes, the Contractor shall immediately give notice thereof in writing to the Agency with all relevant information with respect thereto. Such notice shall not in any way constitute a basis for an extension of the delivery schedule or be construed as a waiver by the Agency or the State of any rights or remedies to which either is entitled by law or pursuant to provisions of this Contract. Failure to give such notice, however, may be grounds for denial of any request for an extension of the delivery schedule because of such delay. Furthermore, the Contractor will not be excused from failure to perform that is due to a Force Majeure unless and until the Contractor provides notice pursuant to this provision.

2.13.33 Delays or Impossibility of Performance Based on a Force Majeure. Neither party shall be in default under the Contract if performance is prevented, delayed, or made impossible to the extent that such prevention, delay, or impossibility is caused by a Force Majeure. If a delay results from a subcontractor's conduct, negligence or failure to perform, the Contractor shall not be excused from compliance with the terms and obligations of the Contract unless the subcontractor or supplier is prevented from timely performance by a Force Majeure as defined in this Contract.

If a Force Majeure delays or prevents the Contractor's performance, the Contractor shall immediately use its best efforts to directly provide alternate, and to the extent possible, comparable performance. Comparability of performance and the possibility of comparable performance shall be determined solely by the Agency.

The party seeking to exercise this provision and not perform or delay performance pursuant to a Force Majeure shall immediately notify the other party of the occurrence and reason for the delay. The parties shall make every effort to minimize the time of nonperformance and the scope of work not being performed due to the unforeseen events. Dates by which performance obligations are scheduled to be met will be extended only for a period of time equal to the time lost due to any delay so caused.

2.13.34 Right to Address the Board of Directors or Other Managing Entity. The Agency reserves the right to address the Contractor's board of directors or other managing entity of the Contractor regarding performance, expenditures, and any other issue the Agency deems appropriate.

2.13.35 Repayment Obligation. In the event that any State and/or federal funds are deferred and/or disallowed as a result of any audits or expended in violation of the laws applicable to the expenditure of such funds, the Contractor shall be liable to the Agency for the full amount of any claim disallowed and for all related penalties incurred. The requirements of this paragraph shall apply to the Contractor as well as any subcontractors.

2.13.36 Reporting Requirements. If this Contract permits other State agencies and political subdivisions to make purchases off of the Contract, the Contractor shall keep a record of the purchases made pursuant to the Contract and shall submit a report to the Agency on a quarterly basis. The report shall identify all of the State agencies and political subdivisions making purchases off of this Contract and the quantities purchased pursuant to the Contract during the reporting period.

2.13.37 Immunity from Liability. Every person who is a party to the Contract is hereby notified and agrees that the State, the Agency, and all of their employees, agents, successors, and assigns are immune from liability and suit for or from the Contractor's and/or subcontractors' activities involving third parties and arising from the Contract.

2.13.38 Public Records. The laws of the State require procurement and contract records to be made public unless otherwise provided by law.

2.13.39 Use of Name or Intellectual Property. The Contractor agrees it will not use the Agency and/or State's name or any of their intellectual property, including but not limited to, any State, state agency,

board or commission trademarks or logos in any manner, including commercial advertising or as a business reference, without the expressed prior written consent of the Agency and/or the State.

2.13.40 Taxes. The State is exempt from Federal excise taxes, and no payment will be made for any taxes levied on the Contractor's employees' wages. The State is exempt from State and local sales and use taxes on the Deliverables.

2.13.41 No Minimums Guaranteed. The Contract does not guarantee any minimum level of purchases or any minimum amount of compensation.

2.14 Contract Certifications. The Contractor will fully comply with obligations herein. If any conditions within these certifications change, the Contractor will provide written notice to the Agency within twenty-four (24) hours from the date of discovery.

2.14.1 Certification of Compliance with Pro-Children Act of 1994. The Contractor must comply with Public Law 103-227, Part C Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act). This Act requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the Deliverables are funded by federal programs either directly or through State or local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees, and contracts. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities (other than clinics) where Women, Infants, and Children (WIC) coupons are redeemed.

The Contractor further agrees that the above language will be included in any subawards that contain provisions for children's services and that all subgrantees shall certify compliance accordingly. Failure to comply with the provisions of this law may result in the imposition of a civil monetary penalty of up to $1,000.00 per day.

2.14.2 Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion—Lower Tier Covered Transactions

By signing this Contract, the Contractor is providing the certification set out below:

2.14.2.1 The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the Contractor knowingly rendered an erroneous certification, in addition to other remedies available to the federal government, the Agency or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

2.14.2.2 The Contractor shall provide immediate written notice to the Agency if at any time the Contractor learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.

2.14.2.3 The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principle, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. Contact the Agency for assistance in obtaining a copy of those regulations.

2.14.2.4 The Contractor agrees by signing this Contract that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the Agency or agency with which this transaction originated.

2.14.2.5 The Contractor further agrees by signing this Contract that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion—Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

2.14.2.6 A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows

that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. A participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Nonprocurement Programs.

2.14.2.7 Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

2.14.2.8 Except for transactions authorized under Section 2.14.2.4 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the federal government, the Agency or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

2.14.2.9 The Contractor certifies, by signing this Contract, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.

Where the Contractor is unable to certify to any of the statements in this certification, such Contractor shall attach an explanation to this Contract.

2.14.3 Certification Regarding Lobbying. The Contractor certifies, to the best of his or her knowledge and belief, that:

2.14.3.1 No federal appropriated funds have been paid or will be paid on behalf of the sub-grantee to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of the Congress, an officer or employee of the Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan, or cooperative agreement.

2.14.3.2 If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of the Congress, or an employee of a Member of Congress in connection with this Contract, grant, loan, or cooperative agreement, the applicant shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

2.14.3.3 The Contractor shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C.A. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000.00 and not more than $100,000.00 for each such failure.

2.14.4 Certification Regarding Drug Free Workplace

2.14.4.1 Requirements for Contractors. Who are Not Individuals. If the Contractor is not an individual, the Contractor agrees to provide a drug-free workplace by:

2.14.4.1.1 Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition;

2.14.4.1.2 Establishing a drug-free awareness program to inform employees about:

- The dangers of drug abuse in the workplace;
- The Contractor's policy of maintaining a drug- free workplace;
- Any available drug counseling, rehabilitation, and employee assistance programs; and
- The penalties that may be imposed upon employees for drug abuse violations;

2.14.4.1.3 Making it a requirement that each employee to be engaged in the performance of such

contract be given a copy of the statement required by Subsection 2.14.4.1.1;

2.14.4.1.4 Notifying the employee in the statement required by Subsection 2.14.4.1.1 that as a condition of employment on such contract, the employee will:

- Abide by the terms of the statement; and
- Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction;

2.14.4.1.5 Notifying the contracting agency within ten (10) days after receiving notice under the second unnumbered bullet of Subsection 2.14.4.1.4 from an employee or otherwise receiving actual notice of such conviction;

2.14.4.1.6 Imposing a sanction on, or requiring the satisfactory participation in a drug abuse assistance or rehabilitation program by, any employee who is so convicted, as required by 41 U.S.C. § 703; and

2.14.4.1.7 Making a good faith effort to continue to maintain a drug-free workplace through implementation of this section.

2.14.4.2 Requirement for Individuals. If the Contractor is an individual, by signing the Contract, the Contractor agrees not to engage in the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance in the performance of the Contract.

2.14.4.3 Notification Requirement. The Contractor shall, within thirty (30) days after receiving notice from an employee of a conviction pursuant to 41 U.S.C. § 701(a)(1)(D)(ii) or 41 U.S.C. § 702(a)(1)(D)(ii):

2.14.4.3.1 Take appropriate personnel action against such employee up to and including termination; or

2.14.4.3.2 Require such employee to satisfactorily participate in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency.

2.14.5 Conflict of Interest. The Contractor represents, warrants, and covenants that no relationship exists or will exist during the Contract period between the Contractor and the Agency that is a conflict of interest. No employee, officer, or agent of the Contractor or subcontractor shall participate in the selection or in the award or administration of a subcontract if a conflict of interest, real or apparent, exists. The provisions of Iowa Code chapter 68B shall apply to this Contract. If a conflict of interest is proven to the Agency, the Agency may terminate this Contract, and the Contractor shall be liable for any excess costs to the Agency as a result of the conflict of interest. The Contractor shall establish safeguards to prevent employees, consultants, or members of governing bodies from using their positions for purposes that are, or give the appearance of being, motivated by the desire for private gain for themselves or others with whom they have family, business, or other ties. The Contractor shall report any potential, real, or apparent conflict of interest to the Agency.

2.14.6 Certification Regarding Sales and Use Tax. By executing this Contract, the Contractor certifies it is either (1) registered with the Iowa Department of Revenue, collects, and remits Iowa sales and use taxes as required by Iowa Code chapter 423; or (2) not a "retailer" or a "retailer maintaining a place of business in this state" as those terms are defined in Iowa Code § 423.1(42) and (43). The Contractor also acknowledges that the Agency may declare the Contract void if the above certification is false. The Contractor also understands that fraudulent certification may result in the Agency or its representative filing for damages for breach of contract.

2.14.7 Certification Regarding Iowa Code Chapter 8F. If the Contractor is or becomes subject to Iowa Code chapter 8F during the entire term of this Contract, which includes any extensions or renewals thereof, the Contractor shall comply with the following:

2.14.7.1 As a condition of entering into this Contract, the Contractor shall certify that it has the information required by Iowa Code § 8F.3 available for inspection by the Agency and the Legislative Services Agency.

2.14.7.2 The Contractor agrees that it will provide the information described in this section to the Agency or the Legislative Services Agency upon request. The Contractor shall not impose a charge for making information available for inspection or providing information to the Agency or the Legislative Services Agency.

2.14.7.3 Pursuant to Iowa Code § 8F.4, the Contractor shall file an annual report with the Agency and the Legislative Services Agency within ten (10) months following the end of the Contractor's fiscal year (unless the exceptions provided in Iowa Code § 8F.4(1)(b) apply). The annual report shall contain:

2.14.7.3.1 Financial information relative to the expenditure of state and federal moneys for the prior

year pursuant to this Contract. The financial information shall include but is not limited to budget and actual revenue and expenditure information for the year covered.

2.14.7.3.2 Financial information relating to all service contracts with the Agency during the preceding year, including the costs by category to provide the contracted services.

2.14.7.3.3 Reportable conditions in internal control or material noncompliance with provisions of laws, rules, regulations, or contractual agreements included in external audit reports of the Contractor covering the preceding year.

2.14.7.3.4 Corrective action taken or planned by the Contractor in response to reportable conditions in internal control or material noncompliance with laws, rules, regulations, or contractual agreements included in external audit reports covering the preceding year.

2.14.7.3.5 Any changes in the information submitted in accordance with Iowa Code §8F.3

2.14.7.3.6 A certification signed by an officer and director, two directors, or the sole proprietor of the Contractor, whichever is applicable, stating the annual report is accurate and the recipient entity is in full compliance with all laws, rules, regulations, and contractual agreements applicable to the recipient entity and the requirements of Iowa Code chapter 8F.

2.14.7.3.7 In addition, the Contractor shall comply with Iowa Code chapter 8F with respect to any subcontracts it enters into pursuant to this Contract. Any compliance documentation, including but not limited to certifications, received from subcontractors by the Contractor shall be forwarded to the Agency.

Special Terms Appendix 1 – Scope of Work

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1.5 General Contractor Responsibilities

1.5.1 *Federal and State Laws and Regulations*

Contractor shall:

(1) Comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; and section 1557 of the Patient Protection and Affordable Care Act.

(2) Comply with the conflict of interest safeguards described in 42 C.F.R. § 438.58 and with the prohibitions described in section 1902(a)(4)(C) of the Social Security Act applicable to contracting officers, employees, or independent contractors.

1.5.2 *Qualifications*

The Contractor represents and warrants that it is experienced in the business of furnishing Medicaid and CHIP capitated services comparable in size and complexity to the requirements of this Contract.

1.6 Effects of the Federal Waiver

The State shall seek waiver authority(s) from the Centers for Medicare and Medicaid Services (CMS) to operate this program. The Contractor shall comply with any modifications to this Contract resulting from the waiver approval process. If CMS denies the waiver request(s) after the Contract is awarded and signed, the Agency may terminate the Contract immediately in writing to the Contractor without penalty. If the Contract is terminated under this section, the Agency shall not be liable or required to compensate the Contractor for any work performed or expenses incurred prior to termination.

2 General and Administrative Requirements

2.1 Licensure/Accreditation

2.1.1 *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 191 Iowa Administrative Code Chapter 40. As a strategy to facilitate continuity of care for 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.

2.1.2 *Accreditation*

The Contractor shall attain and maintain accreditation from the National Committee for Quality Assurance (NCQA). If not already accredited, the Contractor shall demonstrate it has initiated the accreditation process as of the Contract effective date. The Contractor shall achieve accreditation at the earliest date allowed by NCQA. Accreditation shall be maintained throughout the life of the Contract at no additional cost to the Agency. When accreditation standards conflict with the standards set forth in the Contract, the Contract prevails unless the accreditation standard is more stringent. The Contractor shall comply with the following requirements in accordance with 42 C.F.R. § 438.332:

(a) Contractor shall inform the Agency whether it has been accredited by a private independent accrediting entity.

(b) If Contractor has received accreditation by a private independent accrediting entity, Contractor hereby authorizes the private independent accrediting entity to provide the Agency a copy of its most recent accreditation review, including:

(1) Accreditation status, survey type, and level (as applicable);

(2) Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and

(3) Expiration date of the accreditation.

(c) Reserved.(1) Reserved.

(2) Reserved.

2.2 Subcontracts

The Contractor shall comply with the terms of this section, pursuant to 42 C.F.R. § 438.230.

(a) *Applicability.* The requirements of this section, and those below, apply to any contract or written arrangement that Contractor has with any subcontractor.

(b) *General rule.*

(1) Notwithstanding any relationship(s) that Contractor may have with any subcontractor, Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract with the Agency; and

(2) All contracts or written arrangements between the Contractor and any subcontractor must meet the requirements of paragraph (c) of this section.

(c) Each contract or written arrangement described in paragraph (b)(2) of this section must specify that:

(1) If any of Contractor's activities or obligations under its Contract with the Agency are delegated to a subcontractor—

(i) The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.

(ii) The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the Contractor's contract obligations.

(iii) The contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the Agency or the Contractor determine that the subcontractor has not performed satisfactorily.

(2) The subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions;

(3) The subcontractor agrees that—

(i) The Agency, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's Contract with the Agency.

(ii) The subcontractor will make available, for purposes of an audit, evaluation, or inspection under paragraph (c)(3)(i) of this section, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members.

(iii) The right to audit under paragraph (c)(3)(i) of this section will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

(iv) If the Agency, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the Agency, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

In addition, pursuant to 42 C.F.R. 438.3(k), all of Contractor's subcontracts must fulfill the requirements of 42 C.F.R. part 438 for the service or activity delegated under the subcontract in accordance with 42 C.F.R. § 438.230.

2.2.1 *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.

2.2.2 *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.

2.2.3 *Subcontractor Financial Stability*

If the Contractor subcontracts with prepaid health plans, physician-hospital organizations or another entity that accepts financial risk for services the Contractor does not directly provide, the Contractor shall monitor the financial stability of subcontractor(s) whose payments are equal to or greater than five percent (5%) of premium/revenue. The Contractor shall obtain the following information from the subcontractor at least quarterly and use it to monitor the subcontractor's performance: (i) a statement of revenues and expenses; (ii) a balance sheet; (iii) cash flows and changes in equity/fund balance; and (iv) incurred but not received (IBNR) estimates. The Agency reserves the right to require additional financial reporting on subcontractors. The Contractor shall make these documents available to the Agency upon request.

2.2.4 *Excluded Subcontractors*

The Contractor is prohibited from subcontracting with providers who have been excluded from participation by the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) under section 1128 of the Social Security Act, or 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 thirty (30) calendar days. The Contractor shall check the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the System for Award Management (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.

2.2.5 *Integrated Subcontracting*

Any subcontracting relationship shall provide for a seamless experience for 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 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.

2.2.6 *Protecting Member Against Liability for Payment*

In compliance with 42 C.F.R. § 438.106, Contractor's Medicaid Members shall not be held liable for any of the following:

(a) The Contractor's debts, in the event of Contractor's insolvency.

(b) Covered services provided to the Member, for which—

(1) The Agency does not pay the Contractor; or

(2) The Agency, or the Contractor does not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement.

(c) Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Member would owe if the Contractor covered the services directly.

2.3 Financial Stability

As set forth in Section 2.1.1, the 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 191 Iowa Administrative Code Chapter 40.12 and reporting requirements at 191 Iowa Administrative Code §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.

2.3.1 *Solvency*

The Contractor shall maintain a fiscally solvent operation in accordance with federal requirements and Iowa Insurance Division requirements for minimum net worth. The ultimate controlling parent of the Contractor, if any, shall guarantee it will provide financial resources to the Contractor sufficient to maintain a 200% or higher RBC ratio as defined by the NAIC. This guarantee shall be for the term of the Contract and shall be submitted in writing to the Agency prior to Contract signature.

(a) *Assurances.*

(1) Contractor shall provide assurances satisfactory to the Agency showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid Members will not be liable for the Contractor's debts if the Contractor becomes insolvent.

(2) Federally qualified HMOs, as defined in section 1310 of the Public Health Service Act, are exempt from this requirement.

(b) *Other requirements—*

(1) *General rule.* Except as provided in paragraph (b)(2) of this section, if Contractor is an MCO or PIHP, Contractor must meet the solvency standards established by the State for private health maintenance organizations, or be licensed or certified by the State as a risk-bearing entity.

(2) *Exception.* Paragraph (b)(1) of this section does not apply to an MCO or PIHP that meets any of the following conditions:

(i) Does not provide both inpatient hospital services and physician services.

(ii) Is a public entity.

(iii) Is (or is controlled by) one or more Federally qualified health centers and meets the solvency standards established by the State for those centers.

(iv) Has its solvency guaranteed by the State.

2.3.2 *Reinsurance*

The Contractor shall comply with reinsurance requirements at 191 Iowa Administrative Code § 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.

2.3.3 *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 Contractors' rates will 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.

2.3.3.1 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. Nursing Facility) and Home and Community-Based Services (HCBS) populations into one 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.

2.3.3.2 Non-LTSS Benefit

The Agency or their consultants will apply a system of assigning severity (risk) to the individuals enrolled using claims data which may include diagnosis codes, services provided, or pharmacy data. Once all of the individual risks have been assigned, a total average risk score will be developed for each program Contractor. The risk score for all program Contractors and any fee-for-service (FFS) population will be adjusted (normalized) to 1.0. This normalization will result in an adjustment factor which is applied to the total risk score of each program Contractor producing their risks relative to the total risks of the entire population. In the case of a prospective risk adjustment once sufficient enrollment information is available the program Contractor relative risk score will be used to adjust the capitation payments to the program Contractors either upward or downward. However, the total capitation payments will remain unchanged to all program Contractors. In the case of a retrospective risk adjustment process, the risk scores will be used to move amounts paid to participating program Contractors to adjust for the higher/lower risks covered during the prior period by each program Contractor but with the total payments made by the Agency remaining unchanged.

After the first six months, rates will be adjusted every twelve (12) months, based on 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 year of

age.

2.3.4 *Patient Protection and Affordable Care Act Health Insurer Fee*

Under the Patient Protection and Affordable Care Act Section 9010, non-excluded covered entities providing health insurance in the United States of American are subject to a fee as determined by the Internal Revenue Service (IRS). For the purpose of this Contract, the fee known as the Health Insurer Fee (HIF) will not be included prospectively in capitation rates to set aside for later HIF payment. The Contractor shall exclude LTSS costs from the accounting provided to the IRS as these costs are not applied a HIF. The Contractor shall submit accounting to the Agency for review, approval, and reimbursement for the period in which the HIF is applied to this Contract's costs. Once the HIF accounting has been reviewed and approved by the Agency, the Agency will adjust the taxed period's capitation rates to include the distributed HIF amount.

2.3.5 *Annual Independent Audit*

In accordance with 42 C.F.R. § 438.3(m) the 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. 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) third party liability 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.

2.3.6 *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.

2.3.7 *Insurance Requirements*

See the Contract's General Terms for Service Contracts, Section 2.8 for amounts of insurance and insurance requirements.

2.4 Maintenance of Records

In accordance with 42 C.F.R. §438.3(u), Contractor shall retain, and require subcontractors to retain, as applicable, the following information: 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, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

2.4.1 *Financial Records*

See General Terms for Service Contracts, Section 2.13.25 Records Retention and Access.

2.4.2 *Medical Records*

The Contractor shall maintain records that fully disclose the extent of services provided to individuals under the Contract for a period of ten (10) years, or for the duration of contested case proceedings, whichever is longer.

2.4.3 *Response to Record Requests*

In accordance with 42 C.F.R. 438.3(h), the Agency, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the Contractor, or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 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 Medicaid Fraud Control Unit (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 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.

2.5 Disclosures

2.5.1 *Reserved.*

2.5.2

(a) *The Contractor shall not contract with any of the following entities.*

(1) An entity that could be excluded under section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual.

(2) An entity that has a substantial contractual relationship as defined in 42 C.F.R. § 431.55(h)(3) of this chapter, either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Social Security Act or an individual described in 42 C.F.R. § 438.610(a) and (b).

(3) An entity that employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:

(i) Any individual or entity described in 42 C.F.R. § 438.610(a) and (b).

(ii) Any individual or entity that would provide those services through an individual or entity described in 42 C.F.R. § 438.610(a) and (b).

2.5.3 *Reserved.*

2.5.4 *Reserved.*

2.5.5 *Reserved.*

2.5.6 *Reporting of Business Transactions of the Contractor.*

2.5.6.1 The Contractor shall furnish to the Agency and/or the Secretary on request, information related to business transactions in accordance with the subsection below.

2.5.6.2 The Contractor must submit, within 35 Days of the date on a request by the Secretary or the Agency full and complete information about –

2.5.6.2.1 The ownership of any Subcontractor with whom the Contractor has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

2.5.6.2.2 Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any Subcontractor, during the 5-year period ending on the date of the request.

2.5.6.3 FFP is not available in expenditures for services furnished by the Contractor if the Contractor fails to comply with a request made by the Secretary or the Medicaid agency under this section or under 42 C.F.R. § 420.205. The Contractor shall not be entitled to payment under the Contract (i.e., no Capitation Payment will be paid) for services provided during the period beginning on the day following the date the information was due to the Secretary or the Agency.

2.5.7 *Contractor Disclosure of Information on Persons Convicted of Crimes.*

2.5.7.1 Information that must be disclosed. Upon signing this Contract, or at any time upon written request by the Agency, the Contractor must disclose to the Agency the identity of any person who:

2.5.7.1.1 Has ownership or control interest in the Contractor, or is an agent or managing employee of the Contractor; and

2.5.7.1.2 Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX program since the inception of those programs.

2.5.7.1.3 Has been convicted of a criminal offense not otherwise described since the inception of those programs.

2.5.7.2 Notification to Inspector General.

2.5.7.2.1 The Agency must notify the Inspector General of the HHS of any disclosures made under this subsection within 20 working Days from the date it receives the information.

2.5.7.2.2 The Agency will also promptly notify the Inspector General of HHS of any action it takes in respect to the Contract.

2.5.7.3 Denial or Termination of Contract.

2.5.7.3.1 The Agency may refuse to enter into or renew a Contract with the Contractor if any person who has an ownership or control interest in the Contractor, or who is an agent or managing employee of the Contractor, 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.

2.5.7.3.2 The Agency may refuse to enter into or may terminate the Contract if it determines that the Contractor did not fully and accurately make any disclosure required under this section.

2.5.8 *Reserved.*

2.5.9 *Disclosure by the Contractor's Providers and Fiscal Agents: Information on Ownership and Control.*

2.5.9.1 Who must provide disclosures. The Contractor must obtain disclosures from disclosing entities, fiscal agents, and network Providers.

2.5.9.2 What disclosures must be provided. The Contractor must require that disclosing entities, fiscal agents, and network Providers provide the following disclosures:

2.5.9.2.1

2.5.9.2.1.1 Name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or network Provider. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

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

2.5.9.2.1.3 Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or network Provider) or in any Subcontractor in which the disclosing entity (or fiscal agent or network Provider) has a 5 percent or more interest.

2.5.9.2.2 Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or network Provider) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any Subcontractor in which the disclosing entity (or fiscal agent or network Provider) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

2.5.9.2.3 The name of any other disclosing entity (or fiscal agent or network Provider) in which an owner of the disclosing entity (or fiscal agent or network Provider) has an ownership or control interest.

2.5.9.2.4 The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or network Provider).

2.5.9.3 When the disclosures must be provided.

2.5.9.3.1 Disclosures from network Providers or disclosing entities. Disclosure from any network Provider or disclosing entity is due at any of the following times:

2.5.9.3.1.1 Upon the network Provider or disclosing entity submitting the Provider application.

2.5.9.3.1.2 Upon the network Provider or disclosing entity executing the Provider agreement.

2.5.9.3.1.3 Upon request of the Agency during the re-validation of enrollment process.

2.5.9.3.1.4 Within 35 Days after any change in ownership of the disclosing entity or network Provider.

2.5.9.3.2 Disclosures from fiscal agents. Disclosures from fiscal agents are due at any of the following times:

2.5.9.3.2.1 Upon the fiscal agent submitting the proposal in accordance with the procurement process.

2.5.9.3.2.2 Upon the fiscal agent executing the contract with the Contractor.

2.5.9.3.2.3 Upon renewal or extension of the contract with a fiscal agent.

2.5.9.3.2.4 Within 35 Days after any change in ownership of the fiscal agent.

2.5.9.3.3 Disclosures from managed care entities. Disclosures from managed care entities (MCOs, PIHPs, PAHPs, and HIOs), except PCCMs are due at any of the following times:

2.5.9.3.3.1 Upon the Managed Care Entity submitting the proposal in accordance with the procurement process.

2.5.9.3.3.2 Upon the Managed Care Entity executing the contract with the Contractor.

2.5.9.3.3.3 Upon renewal or extension of the contract.

2.5.9.3.3.4 Within 35 Days after any change in ownership of the Managed Care Entity.

2.5.9.3.4 Disclosures from PCCMs. PCCMs will comply with disclosure requirements under this section.

2.5.9.4 To whom must the disclosures be provided. All disclosures must be provided to the Contractor, who will make them available to the Agency.

2.5.9.5 Consequences for failure to provide required disclosures. Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.

2.5.10 *Disclosure by Providers: Information Related to Business Transactions.*

2.5.10.1 Provider agreements. The Contractor must enter into an agreement with each Provider under which the Provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with this section.

2.5.10.2 Information that must be submitted. A Provider must submit, within 35 Days of the date on a request by the Secretary, the Agency or the Contractor, full and complete information about:

2.5.10.2.1 The ownership of any Subcontractor with whom the Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

2.5.10.2.2 Any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any Subcontractor, during the 5-year period ending on the date of the request.

2.5.10.3 Denial of Federal financial participation (FFP).

2.5.10.3.1 FFP is not available in expenditures for services furnished by Providers who fail to comply with a request made by the Secretary, the Agency, or the Contractor under this section or under 42 C.F.R. § 420.205.

2.5.10.3.2 FFP will be denied in expenditures for services furnished during the period beginning on the Day following the date the information was due to the Secretary, the Agency, or the Contractor and ending on the Day before the date on which the information was supplied.

2.5.11 *Disclosure by Providers: Information on Persons Convicted of Crimes.*

2.5.11.1 Information that must be disclosed. Before the Contractor enters into or renews a Provider agreement, or at any time upon written request by the Agency, or the Contractor, the Provider must disclose to the Contractor and the Agency the identity of any person who:

2.5.11.1.1 Has ownership or control interest in the Provider, or is an agent or managing employee of the Provider; and

2.5.11.1.2 Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

2.5.11.2 Notification to Inspector General.

2.5.11.2.1 The Contractor shall notify the Agency of any disclosures made under this section within 10 working Days from the date it receives the information. The Agency will forward the information to the Office of Inspector General of HHS.

2.5.11.2.2 The Contractor must also promptly notify the Agency of any action it takes on the Provider's application for participation in the program.

2.5.11.3 Denial or termination of Provider participation.

2.5.11.3.1 The Contractor may refuse to enter into or renew an agreement with a Provider and Agency may refuse to allow the Contractor to renew or enter into such an agreement if any person who has an ownership or control interest in the Provider, or who is an agent or managing employee of the Provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XXI Services Program.

2.5.11.3.2 The Contractor may refuse to enter into or may terminate a Provider agreement and the Agency may refuse to allow the Contractor to renew or enter into such an agreement if any of the three entities determines that the Provider did not fully and accurately make any disclosure required under this section.

2.5.12 *Federal Database Checks. The Contractor must do all of the following:*

2.5.12.1 Confirm the identity and determine the exclusion status of Providers and any person with an ownership or control interest or who is an agent or managing employee of the Provider through routine checks of Federal databases.

2.5.12.2 Check the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the General Services Administration's Excluded Parties List System (EPLS), the Medicare

Exclusion Database (the MED) and any such other databases as the Secretary of HHS may prescribe.

2.5.12.3 Other

2.5.12.3.1 Consult appropriate databases to confirm identity upon enrollment and reenrollment; and

2.5.12.3.2 Check the LEIE, EPLS, the MED and any such other databases as the Secretary of HHS may prescribe, no less frequently than monthly.

2.5.13 *Affiliations Prohibited.*

(a) In compliance with 42 C.F.R. § 438.610, Contractor may not knowingly have a relationship of the type described in paragraph (c) of this section with the following:

(1) An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

(2) An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 C.F.R. § 2.101, of a person described in paragraph (a)(1) of this section.

(b) Contractor may not have a 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.

(c) The relationships described in paragraph (a) of this section, are as follows:

(1) A director, officer, or partner of the Contractor.

(2) A subcontractor of the Contractor, as governed by 42 C.F.R. § 438.230.

(3) A person with beneficial ownership of 5 percent or more of the Contractor's equity.

(4) A network provider or person with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under the Contract.

(d) If the Agency finds that Contractor is not in compliance with paragraphs (a) and (b) of this section, the Agency:

(1) Will notify the Secretary of the noncompliance.

(2) May continue an existing agreement with the Contractor unless the Secretary directs otherwise.

(3) May not renew or otherwise extend the duration of an existing agreement with the Contractor unless the Secretary provides to the Agency and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.

(4) Nothing in this section must be construed to limit or otherwise affect any remedies available to the U.S. under sections 1128, 1128A or 1128B of the Social Security Act.

(e) *Consultation with the Inspector General.* Any action by the Secretary of HHS described in paragraphs (d)(2) or (3) of this section is taken in consultation with the Inspector General.

2.5.14 The Contractor shall not expend Medicaid funds for Providers excluded by Medicare, Medicaid, or CHIP, as notified by the Agency, except for Emergency Services.

2.5.15 The Contractor must require each individually contracted physician to have a unique identifier.

2.5.16 *Reserved.*

2.5.17 *Reserved*

2.5.18 *Financial Disclosures for Pharmacy Services*

The Contractor must disclose all financial terms and arrangements for remuneration of any kind that apply between the Contractor or the Contractor's PBM subcontractor and any prescription drug wholesaler, manufacturer or labeler, including, without limitation, formulary management, education support, claims processing, pharmacy network fees, drug product sales or pricing agreements, data sales fees, and any other fees. The Agency or State auditors may audit such information at any time. The Agency agrees to maintain the confidentiality of information, disclosed by the Contractor pursuant to the Contract, to the extent that such information is confidential under Iowa or federal law.

2.5.19 *Reserved.*

2.6 Reserved.

2.7 Medical Loss Ratio

The Contractor shall maintain, at minimum, an annual Medical Loss Ratio (MLR) as set forth in Attachment 2.7 – Medical Loss Ratio. In the event the MLR falls below the established target, the Agency shall recoup excess capitation paid to the Contractor.

2.8 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.

2.9 Staffing

2.9.1 *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.

2.9.2 *Staffing Plan*

2.9.2.1 Initial and Subsequent Staffing Plans.

The Contractor shall provide an initial final staffing plan to the Agency following the parameters and time periods outlined under 2.9.3. In addition, the Contractor shall include a staffing plan in any Work Plan required under Section 2.13, except that the Contractor and Agency shall follow the time requirements for the initial staffing plan set forth in Section 2.9.3, rather than the time requirements set forth in Section 2.13 for the initial Work Plan.

2.9.2.2 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 2.9.2. In its staffing model, including Key Personnel identified in Section 2.9.3, the Contractor shall encourage a local presence in Iowa, particularly in relation to the delivery of member and provider services.

2.9.2.3 Inclusion in Staffing Plan

In its staffing plan, the Contractor shall) 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 2.9.2;

(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:

(i) the process for replacement of personnel in the event of a loss of Key Personnel or others before or after signing the Contract;

(ii) allocation of additional resources to the Contract in the event of an inability to meet a performance standard;

(iii) replacement of staff with key qualifications and experience and new staff with similar qualifications and experience;

(iv) the time frame necessary for obtaining replacements; and

(v) the method of bringing replacement or additions up to date regarding the Contract;

(e) include Key Personnel positions including the following:

(i) *Contract Administrator/CEO/COO*: Responsible for overseeing the entire operations of the Contractor. Has full and final responsibility for contract compliance.

(ii) *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 utilization management. 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 utilization management committee.

(iii) Chief Financial Officer: Shall oversee the Contractor's budget, accounting systems and financial reporting for the program.

(iv) 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. 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.

(v) 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 Pharmacy Benefit Manager (PBM) pharmacy requirements including drug rebate. Shall attend the Agency Pharmaceutical & Therapeutics (P&T) Committee and Drug Utilization Review (DUR) Commission meetings.

(vi) Grievance & Appeals Manager: Manages the Contractor's grievance and appeals process, ensuring compliance with processing timelines and policy and procedure adherence.

(vii) 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 is shall oversee the Contractor's Quality Management and Improvement program and ensure compliance with quality management requirements and quality improvement initiatives.

(viii) 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 utilization management 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 Section 11.

(ix) 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, utilization management, 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.
(x) 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.

(xi) Provider Services Manager: The Provider Services Manager is 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.

(xii) Information Systems Manager: Serves as a liaison between the Contractor and the Agency, or its designee, regarding encounter claims 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.

(xiii) Claims Administrator: Shall ensure prompt and accurate provider claims processing in accordance with the terms of the Contract.

(xiv) 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.

(xv) Program Integrity Manager: Shall ensure oversight of the Contractor's special investigations unit (SIU) activity. 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 in the Iowa offices. The position shall be dedicated at least ninety percent (90%) 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.

(xvi) Long Term Care Manager: Shall ensure oversight of the Contractor's implantation of the state's community based and facility programs. The Long Term Care Manager shall, at minimum, have at least five years of experience in long term care policy and have a comprehensive understanding of CMS rules and regulations. The Long Term Care Manager shall oversee long-term care provider reviews, utilization reviews, member satisfaction surveys, and member health and welfare;

(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 2.9.2: 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 member needs are met, manages resources effectively, and ensure member's health, safety, and welfare are met. Assist the members in gaining access to appropriate resources. Recommend staff have bachelor's degree in social work or related field or commensurate experience.

2.9.3 *Submission of Staffing Plan; Agency Review*

2.9.3.1 Initial Final Staffing Plan

On or before the tenth day following execution of the Contract, the Contractor shall provide to the Agency a final initial staffing plan. On or before the fifteenth day after receiving the final initial staffing plan, the Agency will review and approve or disapprove the final initial staffing plan.

2.9.3.2 Subsequent Staffing Plans

The Contractor shall provide the Agency with subsequent staffing plans after the initial final staffing plan as a part of the Work Plans required by Section 2.13.

2.9.3.2 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.

2.9.3.3 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. In matters related to healthcare delivery system transformation 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.

2.9.4 *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) calendar 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) business days after a candidate's acceptance to fill a Key Personnel position or ten (10) business 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) calendar days of departure, unless a different time frame is approved by the Agency.

2.9.5 *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.

2.9.6 *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 enrollees 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), Contractor shall not be located outside of the United States, and 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.

2.9.7 *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 is 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 is 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 12.2.3; (vi) HIPAA training; (vii) clinical protocol training for all clinical staff; (viii) training regarding interpretation and application of utilization management guidelines for all utilization management staff; (ix) assessment processes, person-centered planning and population specific training relevant to the enrolled populations for all care managers; and (x) training and education to understand abuse, neglect, exploitation and prevention including the detection, mandatory reporting, investigation and remediation procedures and requirements. 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.

2.10 The 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. 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.

2.11 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:

2.11.1 *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 member processes. The Agency reserves the right to mandate cross-contractor requirements to facilitate the development of streamlined provider and member processes.

2.11.2 *Iowa Department of Public Health*

The Iowa Department of Public Health (IDPH) is a critical partner of DHS. IDPH is the designated substance abuse authority for the State of Iowa and is responsible for setting substance abuse policy for the State. Other programs referenced in the Contract for which IDPH holds authority include: local

public health services, family planning services, the Iowa Health Information Network (IHIN), Maternal and Child Health services, and tobacco cessation services. Information about IDPH services can be found at http://www.idph.state.ia.us/bh/medicaid_managed_care.asp.

2.11.3 *Iowa Department of Education*

The Contractor shall work closely with the Iowa Department of Education.

2.11.4 *Iowa Division of Mental Health and Disability Services*

The Agency's Division of Mental Health and Disability Services (MHDS) is the designated Mental Health Authority for the State of Iowa. MHDS is responsible for planning, coordinating, monitoring, improving and partially funding mental health and disability services for the State of Iowa. The Contractor shall work closely with MHDS throughout the term of the Contract.

2.11.5 *The Agency Child Welfare and Juvenile Justice Services*

The Agency's Division of Adult, Family, and Children Services has responsibility for program standards and the budget for most child welfare and juvenile justice services. The Contractor's membership shall include individuals receiving child welfare/juvenile justice (CW/JJ) services and individuals within the state's foster care or subsidized adoption program. The Contractor shall coordinate with ACFS to meet goals for safety, permanency and well-being of the child and shall authorize appropriate healthcare services to complement CW/JJ services upon request from the Agency field workers or juvenile court officers. As an integral part of the system which provides services and supports to adopted children and their families, the Contractor shall be required to collaborate with the Agency and the Iowa Foster and Adoptive Parents Association to develop services and supports to meet the specialized health needs of children who have been adopted from Iowa's foster care system.

2.11.6 *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.

2.11.7 *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.

2.11.8 *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.

2.11.9 *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.

2.11.10 *Iowa Insurance Division*

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 with the Agency.

2.12 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.

2.13 Written Policies and Procedures; Work Plan

The Contractor shall develop and maintain written policies and procedures for each functional area in a global work plan (the "Work Plan"), including, but not limited to the strategies, policies, procedures, descriptions, mechanisms, and the like identified in the Contract to be included in the Work Plan. In drafting any Work Plan, the Contractor shall be guided by the Clarifications of this Special Terms Appendix 1 – Scope of Work. Unless otherwise indicated, the Contractor shall submit a draft Work Plan to the Agency on or before the fifteenth day following execution of the Contract.

2.14 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 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.

2.15 Confidentiality of Member Medical Records and Other Information

The Contractor shall develop, implement, and adhere to written policies and procedures, subject to Agency review and approval, pertaining to maintaining the confidentiality of all medical records and other pertinent information, including, but not limited to, health and enrollment information.

In compliance with 42 C.F.R. § 438.224, for medical records and any other health and enrollment information that identifies a particular Member, Contractor shall only use and disclose such individually identifiable health information in accordance with the privacy requirements in 45 C.F.R. parts 160 and 164, subparts A and E), to the extent that these requirements are applicable.

The Contractor shall also comply with all other applicable State and Federal privacy and confidentiality requirements. The Contractor shall protect and maintain the confidentiality of mental health information by implementing policies for staff and through contract terms with network providers which allow release of mental health information only as allowed by Iowa Code §228. Further, the Contractor shall protect and maintain the confidentiality of substance use disorder information, allowing the release of substance use disorder information only in compliance with policies set forth in 42 C.F.R. Part 2 and other applicable State and Federal law and regulations. The Contractor shall notify the Agency of a HIPAA-related breach in accordance with the terms of Section 1.5 of the Contract's Special Terms. The Contractor shall notify the Agency within one (1) Business Day upon discovery of a non-HIPAA-related breach.

Breach Reporting: The Contractor shall have a mechanism in place to immediately report to the Agency any actual or suspected unauthorized access to, use of or disclosure of Agency data or information of which the Contractor becomes aware.

Breach Notification Obligations: The Contractor must have a mechanism in place to comply with all applicable laws that require the notification of individuals in the event of unauthorized access to, use of or disclosure of confidential information or other event(s) requiring notification in accordance with applicable law. In the event of a breach of Agency data or information, the Contractor must follow the Agency's directives which may include assuming responsibility for informing all individuals with accordance with applicable laws, and to indemnity and hold harmless the Agency against any claims, damages or other harm related to such breach.

2.16 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, enrollees, 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.

2.17 Dissemination of Information

Upon request of the Agency, the Contractor shall distribute information prepared by the Agency or the federal government to its members and provider network as appropriate.

2.18 Agency Ongoing Monitoring

The Agency will conduct ongoing monitoring of the Contractor, in accordance with 42 C.F.R. § 438.66, to ensure compliance with Contract requirements and performance standards. The method and frequency of monitoring is at the discretion of the Agency and may include, but is not limited to, both scheduled and unannounced onsite visits, review of policies and procedures and performance reporting. Reporting requirements are detailed further in Section 14. The reviews will identify and make recommendations for areas of improvement, monitor the Contractor's progress towards implementing mandated programs or operational enhancements, and provide the Contractor with technical assistance when necessary. In preparation for planned onsite reviews, the Contractor shall cooperate with the Agency by forwarding in advance policies, procedures, job descriptions, contracts, records, logs and other material upon request. Documents not requested in advance shall be made available during the course of the review. Contractor personnel shall be available at all times during review activities. The Contractor shall have available work space and access to staff and systems for the Agency staff while onsite.

2.19 Future Program Guidance

The Agency will make its best efforts to publish a Policies and Procedures Manual before the Contract start date. In addition to complying with the Policies and Procedures Manual, the Contractor shall operate in compliance with future program manuals, guidance and policies and procedures, as well as any amendments thereto, 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.

2.20 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 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.

3 Scope and Covered Benefits

3.1 Scope

3.1.1 *Eligible Members*

The majority of Medicaid and CHIP members will be enrolled in the program unless specifically excluded as described in Section 3.1.1.2. Refer to Exhibit C for a detailed description of the eligibility categories enrolled in the Contract.

3.1.1.1 Reserved

3.1.1.2 Excluded Populations

The Contract will not include (i) undocumented immigrants receiving time-limited coverage of certain emergency medical conditions; (ii) beneficiaries that have a Medicaid eligibility period that is retroactive; (iii) persons eligible for the Program of All-Inclusive Care for the Elderly (PACE) who voluntarily elect PACE coverage; (iv) persons enrolled in the Health Insurance Premium Payment program (HIPP); (v) persons deemed Medically Needy; (vi) persons incarcerated and ineligible for full Medicaid benefits; (vii) persons presumed eligible for services (i.e. Presumptive Eligibility); (viii) persons residing in the Iowa Veteran's Home; (ix) effective July 1, 2017, beneficiaries who are eligible only for the Family Planning Waiver; and (x) persons eligible only for the Medicare Savings Program. Alaskan Native and American Indian populations shall be enrolled voluntarily.

3.1.1.3 Excluded Services

The Contract will not include: (i) services included in the PACE program; (ii) dental services provided outside of a hospital setting; (iii) MFP grant services; and (iv) school-based services provided by the Areas Education Agencies or Local Education Agencies.

3.1.2 *Effective Date of Contractor Enrollment*

Assignments to the Contractor and changes to the enrollees' aid type shall be made on a retroactive basis for HIPP, 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) hawk-i members back to 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.

3.1.3 *Geographic Service Area*

The Contractor shall provide statewide coverage. There will be no regional coverage.

3.2 Covered Benefits

3.2.1 *General*

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. In accordance with 42 C.F.R. § 438.210(a)(3), the Contractor shall furnish covered services in an amount, duration and scope reasonably expected to achieve the purpose for which the services are furnished. The Contractor may not arbitrarily deny or reduce the amount, duration and scope of a required service solely because of diagnosis, type of illness, or condition of the Member. The Contractor may place appropriate limits on a service on the basis of medical necessity criteria for the purpose of utilization control, provided the services can reasonably be expected to achieve their purpose. Further information on allowable and required utilization control measures is outlined in Section 11. The Contractor shall not avoid costs for services covered in the Contract by referring 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 mental health and disability services regions in supporting intensive residential service homes and Access Centers.

3.2.2 *Benefit Packages*

The Contractor shall ensure the provision of covered benefits in accordance with the member's eligibility group as described below and in Exhibit D.

3.2.2.1 Iowa Health and Wellness Plan

Members enrolled in the Iowa Health and Wellness Plan, who have not been identified as Medically Exempt, as described in Table 3.2.13.1, 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 Section 3.2.13.1, 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.

The Contractor shall provide the outlined Iowa Health and Wellness Plan services to members as described.

3.2.2.2 Reserved.

3.2.2.3 Reserved

3.2.2.4 Children's' Health Insurance Plan (CHIP) and hawk-i

The Contractor shall provide benefits to members of the CHIP program and hawk-i are described in Exhibit D.

3.2.2.5 Other

Members not specified in Section 3.2.2.1 through Section 3.2.2.4 who are enrolled with the Contractor are eligible for all medically necessary covered benefits in Iowa's State Plan Amendment and all waivers approved by CMS, including medically necessary dental procedures provided in a hospital setting as outlined in Informational Letter 1090 and any subsequent Informational Letters that clarify this policy. The Contractor shall provide services to members for which they are eligible as described in this Contract.

3.2.3 *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) calendar days from the date the notice is given.

3.2.4 *Integrated Care*

In delivering services under the Contract, the Contractor shall develop and implement 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.

3.2.5 *Emergency Services*

(a) *Definitions.* As used in this section—

Emergency medical condition means 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:

(i) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

(ii) Serious impairment to bodily functions.

(iii) Serious dysfunction of any bodily organ or part.

Emergency services means covered inpatient and outpatient services that are as follows:

(i) Furnished by a provider that is qualified to furnish these services under Title XIX of the Social Security Act.

(ii) Needed to evaluate or stabilize an emergency medical condition.

Poststabilization care services means covered services, related to an emergency medical condition that are provided after a Member is stabilized to maintain the stabilized condition, or, under the circumstances described in paragraph (e) of this section, to improve or resolve the Member's condition.

(b) *Coverage and payment: General rule.* The Contractor is responsible for coverage and payment of emergency services and poststabilization care services.

(c) *Coverage and payment: Emergency services.* (1) Contractor

(i) shall cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor; and

(ii) shall not deny payment for treatment obtained under either of the following circumstances:

(A) A Member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (1), (2), and (3) of the definition of emergency medical condition in paragraph (a) of this section.

(B) A representative of the Contractor instructs the Member to seek emergency services.

(2) Reserved.

(d) *Additional rules for emergency services.* (1) Contractor shall not --

(i) Limit what constitutes an emergency medical condition with reference to paragraph (a) of this section, on the basis of lists of diagnoses or symptoms; and

(ii) Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Member's primary care provider, MCO, PIHP, PAHP or applicable State entity of the Member's screening and treatment within 10 calendar days of presentation for emergency services.

(2) A Member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

(3) The attending emergency physician, or the provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in paragraph (b) of this section as responsible for coverage and payment.

(e) *Coverage and payment: Poststabilization care services.* Poststabilization care services are covered and paid for in accordance with provisions set forth at 42 C.F.R. § 422.113(c). In

applying those provisions, reference to "MA organization" and "financially responsible" must be read as reference to the entities responsible for Medicaid payment, as specified in paragraph (b) of this section, and payment rules governed by Title XIX of the Social Security Act and the States.

(f) *Applicability to PIHPs and PAHPs.*

Emergency services shall be available twenty-four (24) hours a day, seven (7) days a week. Contractor shall pay non-contracted 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.

3.2.5.1 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 limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms and may not deny or pay less than the allowed amount for the Current Procedural Terminology (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. Additionally, the Contractor may not refuse to cover emergency services based on the emergency room provider or hospital failing to notify the Contractor or primary care provider within ten (10) calendar days of presentation for emergency services.

3.2.5.2 Claim Coverage

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 member. The Contractor shall be required to pay for all emergency services which are medically necessary until the clinical emergency is stabilized.

3.2.5.3 Reserved.

3.2.5.4 Post-Stabilization Services

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

3.2.5.5 Emergency Room Utilization Management

The Contractor shall demonstrate the following mechanisms are in place to manage emergency room utilization and to facilitate appropriate reimbursement of emergency room services: (i) methods for plan providers or Contractor representatives to respond to all emergency room providers twenty-four (24) hours a day, seven (7) days a week within one (1) hour; (ii) methods to track emergency services notification to the Contractor of a member's presentation for emergency services; and (iii) methods to document a member's primary care provider (PCP) referral to the emergency room and pay claims accordingly.

3.2.6 *Pharmacy Services*

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:

(1) Contractor shall provide coverage of covered outpatient drugs as defined in section 1927(k)(2) of the Social Security Act, in a manner that meets the standards for such coverage imposed by section 1927 of the Social Security Act as if such standards applied directly to Contractor.

(2) Contractor shall report drug utilization data that is necessary for States to bill manufacturers for rebates in accordance with section 1927(b)(1)(A) of the Social Security Act in accordance with subsection 3.2.6.11.1 below. Such utilization information must include, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code of each covered outpatient drug dispensed or covered by the Contractor.

(3) 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 as set forth in subsections 3.2.6.11.2 through 3.2.6.11.4 below.

(4) Contractor shall operate a drug utilization review program that complies with the requirements described in section 1927(g) of the Social Security Act and 42 C.F.R. part 456, subpart K, as if such requirement applied to the Contractor instead of the Agency. Contribution to and participation in the Agency's DUR Board (Commission) meetings and activities, as well as adherence to DUR oversight conducted on the fee-for-service population, as described in these authorities will satisfy those specific drug utilization review program requirements. No DUR initiatives can be implemented without review and recommendation from the FFS DUR Board.

(5) Contractor shall provide a detailed description of its drug utilization review program activities to the Agency on an annual basis in a format, content, and timeline as required by CMS.

(6) 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.

3.2.6.1 Covered Services

3.2.6.1.1 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 FFS pharmacy benefit. Additional over-the-counter products may be covered at the discretion of the Contractor. The Medicaid FSS pharmacy benefit includes outpatient drugs self-administered by the member or in the home.

3.2.6.1.2 Medicaid is required to cover all medications which 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 Sect. 1927 (d)(2) of the Act. The Medicaid FFS excludes or restricts coverage consistent with Sect. 1927 (d)(2) of the Act, as indicated in 441 Iowa Administrative Code § 78.2(4)b. The Contractor is required to enforce the rebate requirement, including physician administered drugs and diabetic supplies, and to provide coverage, at a minimum, for the same categories in the excluded/restricted classes, to the same extent they are covered by the Medicaid FFS pharmacy benefit.

3.2.6.1.3 Over-the-Counter drugs for members in a nursing facility, PMIC, or ICF/ID shall be included in the per diem rate.

3.2.6.2 Pharmacy Preferred Drug List (PDL) and Recommended Drug List (RDL)

3.2.6.2.1 Preferred Drug List (PDL)

3.2.6.2.1.1 Iowa law permits the Agency to restrict access to prescription drugs through the use of a Preferred Drug List with PA 441 Iowa Administrative Code § 78.2(4)a.

3.2.6.2.1.2 The Contractor will follow and enforce the PDL under the Medicaid FFS Pharmacy benefit with PA criteria, including quantity limits and days' supply limitations.

3.2.6.2.1.3 The Contractor shall provide a minimum of thirty days' notice to providers prior to implementation of PDL and PA changes.

3.2.6.2.2 Recommended Drug List (RDL)

3.2.6.2.2.1 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 preferred drug list. The Agency developed a RDL for these drug categories and included Antihemophilic Agents. The Contractor will 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.

3.2.6.2.2.2 The Contractor will enforce any Medicaid FFS PA criteria, including quantity limits and days' supply limitations on the RDL drugs or categories.

3.2.6.3 Pharmacy Prior Authorization (PA): Consistent with all applicable laws, the Contractor is required to use a PA program to ensure the appropriate use of medications. For any drugs that require prior authorization:

3.2.6.3.1 Reserved.

3.2.6.3.2 Reserved.

3.2.6.3.3 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:

3.2.6.3.3.1 Examining up to 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.).

3.2.6.3.3.2 Gathering and applying appropriate decision criteria needed to make an automated authorization or precertification decision.

3.2.6.3.3.3 Integrating with the Point of Service (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 second.

3.2.6.3.3.4 Reserved

3.2.6.3.3.5 Submitting PA requests electronically in HIPAA compliant transaction formats using the most current standard.

3.2.6.3.3.6 Providing a detailed reporting package.

3.2.6.3.3.7 Generating and distributing PA Denial letters to members and applicable healthcare providers; and PA Approval letters to applicable healthcare providers.

3.2.6.3.3.8 Communicating the decision clearly and quickly to the healthcare provider.

3.2.6.3.3.9 Updating internal records in adjudication/claims systems and call tracking systems in conjunction with claims adjudication.

3.2.6.3.3.10 Providing continuity care contingencies upon the implementation of revisions to the Prescription Drug List (PDL) and PA programs.

3.2.6.3.3.11 Providing capability to utilize a prescriber's specialty code in rendering an automated prior authorization determination.

3.2.6.3.4 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:

3.2.6.3.4.1 Minimizing the burden on the provider community while driving appropriate utilization;

3.2.6.3.4.2 Supplying access to electronic health records to healthcare providers via a secure login process;

3.2.6.3.4.3 Electronically and securely submit pharmacy PA requests for automated and manual review by examining up to 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.);

3.2.6.3.4.4 Providing authorized users with access to a member's:

3.2.6.3.4.4.1 Patient profile information; Prescriber information;

3.2.6.3.4.4.2 PA history;

3.2.6.3.4.4.3 PA questions;

3.2.6.3.4.4.4 Reserved.

3.2.6.3.4.4.5 Approval and Denial outcomes; and

3.2.6.3.4.4.6 Ability to attach applicable medical record data to PA submissions;

3.2.6.3.4.4.7 Reserved.

3.2.6.3.5 Prospective DUR (proDUR): The Contractor is responsible for ensuring the implementation of the Medicaid FFS proDUR edits through its point-of-sale pharmacy claims processing system and/or vendor.

3.2.6.3.5.1 The Contractor shall implement all Medicaid FFS Prospective DUR edits.

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

3.2.6.3.7 Educational Component: The Contractor shall participate and collaborate with the Agency's DUR Board (Commission) activities related to the educational program/interventions for physicians 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.

3.2.6.3.8 Reporting: The Contractor shall report prospective and retrospective DUR activities and educational initiatives to the Department or its designee, quarterly, and assist in data collection and reporting to the Department of data necessary to complete the CMS DUR annual report.

3.2.6.3.9 DUR Commission: Contractor shall collaborate with the Department on all federally required activities as well as development and review of prior authorization criteria and prospective drug utilization review edits, which will be forwarded for review and approval by the DUR Board (Commission) and Agency staff.

3.2.6.4 Utilization Management

3.2.6.4.1 Contractor may determine its own utilization controls, unless otherwise required or prohibited under this Contract, to ensure appropriate utilization. These controls shall be reviewed and approved by the Agency in advance of implementation.

3.2.6.4.2 Programs: Any program mentioned below or recommended by the Contractor shall be reviewed and approved by the Agency:

3.2.6.4.2.1 Member Education: The Contractor shall provide Member education to ensure appropriate utilization (correcting overutilization and underutilization), at a minimum, and to improve adherence;

3.2.6.4.2.2 Lock In: The Contractor may implement a restriction program including policies, procedures and criteria for establishing the need for the lock-in, which shall be approved by the Agency in advance of implementation;

3.2.6.4.2.3 Medication Therapy Management (MTM): The Contractor may implement a MTM program. These programs shall be developed to identify and target members who would most benefit from these interactions. They shall include coordination between the Contractor, the member, the pharmacist and the prescriber using various means of communication and education;

3.2.6.4.2.4 Reporting: The Contractor shall provide reports on Utilization Management in a format and on a timeline as directed by the Agency.

3.2.6.5 Pharmacy Network, Access Standards and Reimbursement

3.2.6.5.1 Pharmacy Benefit Manager (PBM)

3.2.6.5.1.1 The Contractor shall use a PBM to process prescription claims online through a real-time, rules-based point-of-sale (POS) claims processing.

3.2.6.5.1.2 The Contractor shall ensure that the PBM be directly available to the Agency staff.

3.2.6.5.1.3 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 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 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 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.

3.2.6.5.1.4 The Contractor shall develop a plan for oversight of the PBM's performance, including provider issues at a minimum, and submit it to the Agency for review within 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 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.

3.2.6.5.1.5 System Requirements

3.2.6.5.1.5.1 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.

3.2.6.5.1.5.2 Transaction standards: The Contractor shall support electronic submission of claims using most current HIPAA compliant transaction standard (currently NCPDP D.0).

3.2.6.5.1.5.3 Pharmacy claim edits shall include eligibility, drug coverage, benefit limitations, prescriber and prospective/concurrent drug utilization review edits.

3.2.6.5.1.5.4 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 for both retail and specialty drugs, including price, shall be updated at a minimum every seven (7) calendar days, at the Contractor's discretion they may update the file more frequently.

3.2.6.5.1.5.5 The historical encounter data submission shall be retained for a period not less than six (6) years, following generally accepted retention guidelines.

3.2.6.5.1.5.6 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 and shall be 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.

3.2.6.5.1.5.7 The Contractor shall ensure that the manufacturer number, product number, and package number for the drug dispensed shall be listed on all claims. This information shall be taken from the actual package from which the drug is usually purchased by a provider, from a supplier whose products are generally available to all pharmacies and reported in one or more national compendia.

3.2.6.5.1.5.8 Provisions shall be made to maintain permanent history by service date for those services identified as "once-in-a-lifetime."

3.2.6.6 Pharmacy Network

3.2.6.6.1 The Contractor shall provide a pharmacy network that complies with Exhibit B requirements but at a minimum includes only licensed and registered pharmacies that conform to the Iowa Board of Pharmacy rules concerning the records to be maintained by a pharmacy.

3.2.6.6.2 Reserved.

3.2.6.7 Pharmacy Access

3.2.6.7.1 Pharmacy Mail Order: Contractor agrees that although they may offer mail order pharmacy as an option to beneficiaries, they or their Pharmacy Benefits Manager (PBM) are not allowed to require or incentivize the use of Mail Order Pharmacy.

3.2.6.7.2 Specialty Pharmacy: Contractor may require members to receive medications from a specialty pharmacy program following specialty pharmacy program approval by the Agency. This may include limited distribution of specialty drugs from a network of specialty pharmacies that meet reasonable requirements to distribute specialty drugs and is willing to accept the terms of the Contractor's agreement. The Contractor may define a specialty pharmacy product, but proposed specialty designations on medications shall be approved by the Agency.

3.2.6.8 Reimbursement: Contractor shall reimburse pharmacy providers according to a reimbursement methodology proposed by the Contractor and approved by the Agency.

3.2.6.8.1 Drug Ingredient Reimbursement:

3.2.6.8.1.1 Contractor shall reimburse pharmacy providers at a rate comparable to the current Medicaid FFS reimbursement. Reimbursement shall be the lower of Iowa Average Actual Acquisition Cost (AAC) or Wholesale Acquisition Cost (WAC) if no AAC, Federal Upper Limit (FUL), including FUL overrides until April 30, 2016 or Usual and Customary (U&C). Contractor shall reimburse at National Average Drug Acquisition Cost (NADAC) if the Agency discontinues the Iowa AAC.

3.2.6.8.1.2 Reserved

3.2.6.8.2 Dispensing Fee:

3.2.6.8.2.1 Contractor shall reimburse pharmacy providers at a dispensing fee as determined and approved by the Medicaid FFS cost of dispensing study performed every two years.

3.2.6.8.3 340B Drug Pricing Program:

3.2.6.8.3.1 340 B Covered Entities: The Contractor shall ensure that all 340B Covered Entities that use 340B drugs and serve Iowa Medicaid managed care enrollees adhere to one of the following methodologies:

3.2.6.8.3.1.1 Carve out Iowa Medicaid managed care prescriptions and other products from the 340B program. If this methodology is chosen, the Contractor shall ensure that the entity: (i) uses only non-340B are used drugs, vaccines, and diabetic supplies for all Iowa Medicaid managed care enrollees served; (ii) only bills the Contractor for drugs, vaccines, and diabetic supplies purchased outside the 340B program; (iii) does not bill the Contractor for drugs, vaccines, or diabetic supplies purchased through the 340B program; and (iv) consults the Iowa Medicaid Managed Care Pharmacy Identification for assistance in identifying Medicaid managed care enrollees.

3.2.6.8.3.1.2 Carve in Iowa Medicaid managed care prescriptions and other products into the 340B program. If this methodology is chosen, the Contractor shall ensure that the entity: (i) uses 340B drugs, vaccines, and diabetic supplies for all Iowa Medicaid managed care enrollees served; (ii) informs HRSA at the time of 340B enrollment that the entity intends to purchase and dispense 340B drugs for Medicaid managed care enrollees; (iii) does not bill the Contractor for 340B acquired drugs and products if the entities NPI is not on the HRSA Medicaid Exclusion File; (iv) purchases all drugs and other products billed to the Contractor under 340B unless the product is not eligible for 340B pricing; (v) submits pharmacy claims for 340B acquired drugs to the Contractor at the entities AAC with values of "08" in Basis of Cost Determination field 423-DN OR in Compound Ingredient Basis of Cost Determination field 490-UE AND insert "20" in the Submission Clarification Code field 420-DK; and (vi) submits vaccines and diabetic supply claims for 340B acquired products to the Contractor at the entities 340B AAC on the UB04 or CMS1500 claim forms.

3.2.6.8.4 340B Contract Pharmacies: The Contractor shall ensure that all contract pharmacies using 340B drugs, vaccines, and diabetic supplies carve out Iowa Medicaid managed care prescriptions from the 340B program. The Contractor shall ensure that the entity: (i) purchases all drugs and products outside the 340B program if billed to the Contractor, and (ii) consults the Iowa Medicaid Managed Care Pharmacy Identification for assistance in identifying managed care enrollees.

3.2.6.9 Drug Rebates

3.2.6.9.1 The Contractor shall ensure compliance with the requirements under Section 1927 of the Social Security Act pursuant to rebates.

3.2.6.9.2 Pursuant to requirements of the federal Patient Protection and Affordable Care Act (PPACA), P.L. 111-148 and Health Care and Education Reconciliation Act of 2010 (HCERA), P.L. 111-152, together called the Affordable Care Act, the Contractor shall provide information on drugs administered/dispensed to individuals enrolled in the MCO if

the Contractor is responsible for coverage of such drugs. 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 Centers for Medicare and Medicaid Services. The Contractor shall submit all drug encounters including physician administered drugs, with the exception of inpatient hospital drug encounters and any select prescription drugs reimbursed by the Contractor and invoiced separately to the Agency, 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.

3.2.6.9.3 The Agency participates in the federal supplemental drug rebate program, as such the Contractor and its subcontractors including their PBM are prohibited from obtaining manufacturer drug rebates or other form of reimbursement on the Medicaid enrollees. This provision excludes the hawk-i program.

3.2.6.10 Drug Encounter Claims Submission

3.2.6.10.1 The Contractor shall submit a claim-level detail file once every two weeks of drug encounters to the Agency or its designee.

3.2.6.10.2 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 and a rebate file to the Agency or its designee. The Contractor shall comply with all file layout requirements including, but not limited to, format and naming conventions and submission of paid amounts. A complete listing of claim fields required will be determined by the Agency.

3.2.6.10.3 The Contractor shall ensure that its pharmacy claims process recognizes claims from 340B pharmacies for products purchased through the 340B discount drug program at the claim level utilizing the NCPDP field designed for this purpose.

3.2.6.10.4 The Contractor shall ensure that the physician administered drug claims process recognizes claims from 340B providers at the claim level.

3.2.6.11 Disputed Drug Encounter Submissions

3.2.6.11.1 The Contractor shall assist the Agency or the Agency's designee in resolving drug rebate disputes with a manufacturer, at the Contractor's expense.

3.2.6.11.2 On a weekly basis, the Agency will review the Contractor's drug encounter claims and send a file back to the Contractor of disputed encounters that were identified through the drug rebate invoicing process.

3.2.6.11.3 Within 60 calendar days of receipt of the disputed encounter file from the Agency, the Contractor shall, if needed, correct and resubmit any disputed encounters and send a response file that includes 1) corrected and resubmitted encounters as described in the

Rebate Section of the Contractor Systems Companion Guide (to be developed and approved by the Agency in coordination with its rebate vendor and the Contractor's), and/or 2) a detailed explanation of why the disputed encounters could not be corrected including Documentation of all attempts to correct the disputed encounters at an encounter claim level detail, as described in the Rebate Section of the Contractor Systems Companion Guide.

3.2.6.11.4 In addition to the administrative sanctions of this Contract, failure of the Contractor to submit weekly drug encounter claims files and/or a response file to the disputed encounters file within sixty (60) calendar days as detailed above for each disputed encounter shall result in a quarterly offset to the capitation payment equal to the value of the rebate assessed on the disputed encounters being deducted from the Contractor's capitation payment.

3.2.7 *EPSDT Services*

The Contractor shall provide early and periodic screening, diagnosis and treatment (EPSDT) services to all members under twenty-one (21) years of age in accordance with law. Iowa's EPSDT program is referred to as "Care for Kids."

3.2.7.1 Screening, Diagnosis and Treatment

The Contractor shall implement strategies to ensure the completion of health screens and preventive visits in accordance with the Care for Kids 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.

3.2.7.2 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.

3.2.7.3 Outreach

The Contractor shall implement outreach, monitoring, and evaluation strategies for EPSDT. The Contractor shall develop provider and member education activities that increase beneficiary awareness of and access to EPSDT services.

3.2.8 *Behavioral Health Services*

The Contractor shall deliver behavioral health services, which includes mental health and substance use disorder treatment and support services, as part of a recovery-oriented care system that welcomes and engages members in their personal recovery efforts. The Contractor shall develop and implement strategies approved by the Agency to build community capacity for behavioral health and LTSS. Contractor delivery and reimbursement of behavioral health services shall be aligned with the philosophy outlined in 3.2.8.1.

3.2.8.1 Philosophy in the Design & Delivery of Behavioral Health Services and Supports

The Contractor shall incorporate into its behavioral health policies and practices the following values: (i) hope based in the knowledge that personally-valued recovery is possible; (ii) member self-determination; (iii) empowering relationships; (iv) members having a meaningful, productive role in society; and (v) eliminating stigma and discrimination.

The Contractor shall adhere to the following principles related to the delivery of behavioral health services: (i) the Contractor shall allow each member to choose his or her behavioral health professional(s) to the fullest extent possible and appropriate; (ii) the Contractor shall establish policies that support the involvement of the member, and those significant in the member's life as appropriate, in decisions about services provided to meet the member's behavioral health needs; (iii) the Contractor shall establish and promote strategies to engage members who may have histories of inconsistent involvement in treatment; (iv) services for adult members who have a serious mental illness and members that are children with a serious emotional disturbance (SED) shall focus on helping the 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 areas of the state; (vii) to the extent possible, the Contractor shall work with all providers and other entities serving a member to coordinate services for the purpose of eliminating both gaps in service and duplication of services.

The Agency is dedicated to serving individuals in the communities of their choice within the resources available and to implementing the United States Supreme Court's mandate in Olmstead v. L.C. Funding decisions by the Contractor shall consider individual member choice and community-based alternatives within available resources to promote the State's goal of maximum community integration.

For members who require individualized, enhanced staffing patterns to support them in a less-restrictive setting, the Contractor shall not reduce the enhanced staffing arbitrarily or without a supporting reduction in clinical need as documented by provider records.

3.2.8.2 Rehabilitation, Recovery and Strengths-Based Approach to Services

The Contractor shall provide tbe following core activities as part of its effort to provide recovery-based services to members: (i) identification and implementation of the preferences of individuals and families in the design of services and supports; (ii) 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; (iii) facilitation of the utilization of natural supports; (iv) facilitation of the development of resources to support self-management and relapse prevention skills; and (v) activities to support the development and maintenance of healthy social networks and skills, employment, school performance or retirement activities.

3.2.8.3 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.

3.2.8.4 Individual Service Coordination and Treatment Planning Requirements

The Contractor shall work with providers to emphasize the importance of exploring member strengths in the process of service planning and including the member in the design of the member's person-centered, wellness oriented treatment plan that meet all applicable Iowa Administrative Codes including a crisis plan or relapse management plan that addresses the member's self-identified triggers.

3.2.8.5 Scope of Covered Mental Health Services

The Contractor shall deliver behavioral health services in accordance with the scope of covered services outlined in 441 Iowa Administrative Code Chapter 78, the Iowa Medicaid State Plan, and all CMS approved waivers. Please see limitations that apply to Iowa Health and Wellness Plan members. Additionally, the Contractor shall make the following services available to members:

(i) Outpatient therapy provided by a licensed qualified provider including family therapy and in-home family therapy as medically necessary to address the needs of the child or other members in the family;
(ii) Medication management provided by a professional licensed to prescribe medication;
(iii) In-patient hospital psychiatric services including, except as limited, services in the state mental health institutes;
(iv) Services that meet the concurrent substance use disorder and mental health needs of individuals with co-occurring condition;
(v) Community-based and facility based sub-acute services;
(vi) Crisis Services including, but not limited to:
    a. 24 hour crisis response;
    b. Mobile crisis services;
    c. Crisis assessment and evaluation;
    d. Non-hospital facility based crisis services;
    e. Twenty-three (23) hour observation in a twenty-four (24) hour treatment facility;
(vii) Care consultation by a psychiatric physician to a non-psychiatric physician;

(viii) Integrated health home mental health services and supports;
(ix) Intensive psychiatric rehabilitation services;
(x) Peer support services for persons with serious mental illness;
(xi) Community support services including, but not limited to:
a. Monitoring of mental health symptoms and functioning/reality orientation,
b. Transporting to and from behavioral health services and placements,
c. Establishing and building supportive relationship,
d. Communicating with other providers,
e. Ensuring member attends appointments and obtains medications, crisis intervention and developing a crisis plan, and
f. Developing and coordinating natural support systems for mental health support;
(xii) Habilitation program services;
(xiii) Children's mental health waiver services;
(xiv) Stabilization services;
(xv) In-home behavioral management services;
(xvi) Behavioral interventions with child and with family including behavioral health intervention services (BHIS) and both Medicaid and non-Medicaid funded applied behavior analysis (ABA) services for children with autism; and
(xvii) Psychiatric Medical Institutions for Children (PMIC).

Mental health services shall be provided to meet the individual's medical necessity unless as dictated in Section 3.2.8.11.

3.2.8.6 Scope of Covered Substance Use Disorder Services

The Contractor shall ensure, arrange, monitor and reimburse the following substance use disorder treatment services in accordance with Iowa Code chapter 125, 641 Iowa Administrative Code Chapter 155, and the most current version of the ASAM Criteria as published by the American Society of Addiction Medicine. All services shall be appropriately provided as part of substance use disorder treatment, which vary according to the level of care. Please see limitations that apply to Iowa Health and Wellness Plan members.

i. Outpatient treatment;
ii. Ambulatory detoxification;
iii. Intensive outpatient;
iv. Partial hospitalization (day treatment);
v. Clinically managed low intensity residential treatment;
vi. Clinically managed residential detoxification;
vii. Clinically managed medium intensity residential treatment;
viii. Clinically managed high intensity residential treatment;
ix. Medically monitored intensive inpatient treatment;
x. Medically monitored inpatient detoxification;
xi. Medically managed intensive inpatient services;
xii. Detoxification services including such services by a provider licensed under Iowa Code chapter 135B;

xiii. Peer support and peer counseling;
xiv. PMIC substance use disorder services consisting of treatment provided by a substance use disorder licensed PMIC and consistent with the nature of care provided by a PMIC as described in Iowa Code chapter 135H;
xv. Emergency services for substance use disorder conditions;
xvi. Ambulance services for substance use disorder conditions;
xvii. Intake, assessment and diagnosis services, including appropriate physical examinations, urine screening and all necessary medical testing to determine a substance use disorder diagnosis, identification of medical or health problems, and screening for contagious diseases;
xviii. Evaluation, treatment planning and service coordination;
xix. Substance use disorder counseling services when provided by approved opioid treatment programs that are licensed under Iowa Code chapter 125;
xx. Substance use disorder treatment services determined necessary subsequent to an EPSDT screening;
xxi. Substance use disorder screening, evaluation and treatment for members convicted of Operating a Motor Vehicle While Intoxicated (OWI), Iowa Code §321J.2 and members whose driving licenses or non-resident operating privileges are revoked under Iowa Code chapter 321J, provided that such treatment service meets the criteria for service necessity;
xxii. Court-ordered evaluation for substance use disorder;
xxiii. Court-ordered testing for alcohol and drugs;
xxiv. Court-ordered treatment which meets criteria for treatment services; and
xxv. Second opinion as medically necessary and appropriate for the member's condition and identified needs from a qualified health care professional within the network or arranged for outside the network at no cost to the member.

3.2.8.7 Iowa Health and Wellness Plan

Members who are enrolled in the Iowa Health and Wellness Plan, with the exception of Medically Exempt members, are eligible for the services under the Iowa Wellness Plan Alternative Benefit Plan State Plan Amendment.

3.2.8.8 Peer Support/Counseling

The Contractor shall implement a certified peer support/counselling program to empower members to take an active role in their recovery from mental illness and return to active roles in their community, where possible. Certified peer specialists shall work to establish recovery self-help groups, peer support/counseling, Recovery/Wellness Centers where members can learn coping skills for all aspects of life, including employment skills, and warm line counseling to assist members in distress. The Contractor shall develop substance use disorder peer support or peer counseling services. Such services may give recovering persons volunteer or employment opportunities through which they support their own recovery by supporting others in their recovery efforts. The Contractor shall develop a service description for substance use disorder peer support/counseling coaching that includes practitioner qualifications.

3.2.8.9 Integrated Mental Health Services and Supports

The Contractor shall integrate informal support services provided by family members, friends and community-based support services into member's behavioral health treatment plans, especially for those who can benefit from services and supports designed to assist member remain in or return to their home. Integrated services and supports are specifically tailored to an individual 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 member's treatment plan and may provide compensation 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 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 members unique services to address the 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 based on documented success in other states. The Contractor shall implement and adhere to the Agency approved strategy.

3.2.8.10 Prevention and Early Intervention

The Contractor shall have a network of service providers that screen members for risk factors and early signs of mental health or substance use disorder symptoms and implement evidenced based early intervention strategies and 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.

3.2.8.11 Court-Ordered Mental Health Services

The Contractor shall provide all covered and required mental health services ordered for members through a court action pursuant to chapter 125 or chapter 229 for a period of at least three days, regardless of medical necessity. Notwithstanding this provision, the Contractor may only end funding of court ordered services under chapter 125 or chapter 229 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 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 Medicaid enrollee except as limited by 3.2.8.13.2.

3.2.8.12 Court-Ordered Substance Use Disorder Services

The Contractor shall provide all substance use disorder services ordered for members through a court action, for a period of three days regardless of medical necessity, when: (i) except for evaluations, the services ordered by the court meet the ASAM Criteria after the initial three days (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.

3.2.8.13 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 member's age in accordance with the following:

3.2.8.13.1 For Members Age 21 and Under or 65 and Older

The Contractor shall authorize and pay for all inpatient treatment for 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 Utilization Management Guidelines. If the member is a resident of inpatient treatment on their 21st birthday, the Contractor shall authorize and pay for treatment until their 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 Utilization Management Guidelines are met, when a 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 a member's clinical condition falls within the Contractor's Utilization Management 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.

3.2.8.13.2 For Members Over Age 21 and Under Age 65

Notwithstanding provisions of 3.2.8.13.1, the Contractor may pay for inpatient psychiatric treatment in an inpatient psychiatric hospital that is an institution for mental disease (IMD) for stays that are 15 days or less in a calendar month in lieu of similar services covered by the state plan for individuals between 22 and 65 years of age consistent with the provisions of 42 C.F.R. § 438.6(e). During the first 15 IMD member days, the member will remain enrolled in the Plan, and the Plan will continue to provide care coordination services and reimburse all covered services for the member. Contractor may utilize other services to assist the member and is not required to utilize the IMD psychiatric hospital except when constrained by court order. The member must be given the option to utilize other Medicaid services as opposed to the IMD psychiatric hospital except when constrained by court order.

3.2.8.13.3

For stays exceeding the 15 days in a calendar month as allowed under Section 3.2.8.13.2, the 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.

3.2.8.13.4

When the member is served in an IMD for 15 days or less in a calendar month pursuant to Section 3.2.8.13.2, the Contractor shall reimburse the IMD for the IMD member days using the current weighted average inpatient hospitalization rate, and the Contractor shall be entitled to the full capitation payment attributable to the member for that month.

For IMD stays that exceed the 15 member days permitted under Section 3.2.8.13.2, the Contractor will not reimburse the IMD for any of the IMD member days in that month, and Contractor shall be entitled to retain only the capitation payment associated with days the member did not spend in the IMD using an average daily value of monthly capitation paid for the member month.

3.2.8.14 Reserved

3.2.8.15 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 identify EBPs used, measurement to fidelity where available and assurances submitted to department; alignment with MHDS regions.

3.2.8.16 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 community mental health agencies.

3.2.8.17 Reserved

3.2.8.18 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 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 member, 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 members; and (v) providing out-of-network coverage for mental health or substance use disorder benefits when made available for medical and surgical benefits.

3.2.8.19 Mental Health, Substance Use Disorder, and Physical Health Integration

If an individual is not enrolled in an Integrated Health Home, the Contractor shall ensure the coordination of physical health, substance use disorder, and mental health care among all providers treating the member. The Contractor shall coordinate 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 member approved health information between physical health, substance use disorder, and mental health providers to ensure the provision of integrated 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 and implement mechanisms to improve coordination and continuity of care based on monitoring outcomes. Additionally, integration shall occur when members are also receiving LTSS.

3.2.9 *Health Homes*

The Contractor shall administer and fund the State's Health Home services, or like functions, within the approved State Plan Amendment. If the Contractor chooses to meet the State Plan Amendment criteria related to the functions that provide comprehensive care coordination in a manner other than use of Health Home provider types, this shall be communicated to the Agency and shall be subject to periodic monitoring to ensure all functions are met. 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. If supplemental services are required to ensure quality of Health Home services to

members, the cost of such supplemental services provided to ensure quality may be deducted from Health Home payments.

3.2.10 *Reserved*

3.2.11 *1915(i) Habilitation Program Services and 1915(c) Children's Mental Health (CMH) Services*

The Contractor shall deliver the State's 1915(i) State Plan HCBS Habilitation Program services and 1915(c) CMH Waiver services to all enrolled members meeting the eligibility criteria and authorized to be served by these programs. The Contractor shall provide: (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.

3.2.11.1 Initial Determination for Non-Members

The Agency has designated the tools that will be used to determine the level of care, functional assessments, and assessed supports needed for individual wishing to access either community supports or facility care, as described. The intention of the multi-purpose evaluation is to provide uniformity and streamline the documents completed to determine the appropriate level of care or functional eligibility and outline the assessed needs of the individual. The tool is also used to evaluate whether or not the needs are being met and the provider's ability to perform the tasks as assigned. The tools currently designated by the department, notwithstanding future decisions or input from stakeholders, are as follows:

Program	Children's Mental Health	Habilitation
Assessment	InterRAI-HC	InterRAI-HC

The Contractor shall not revise or add to the tools without express approval from the Agency and may require consensus among all Contractors and stakeholder engagement.

The Contractor shall not be responsible for determining the initial level of care assessments, functional assessments, and needs-based assessments for 1915(i) Habilitation Program and 1915(c) Children's Mental Health Waiver enrollment for individuals who are not enrolled with the Contractor and are applying for initial Medicaid eligibility. This responsibility is maintained by the Agency or its designee. The Contractor shall refer all inquiries regarding Medicaid enrollment and initial level of care or functional eligibility determinations to the Agency or its designee in the form and format developed by the Agency.

3.2.11.2 Level of Care and Needs Based Eligibility Assessments and Annual Support Assessments

3.2.11.2.1 Identification

In any Work Plan required by Section 2.13, the Contractor shall develop policies and procedures for ongoing identification of members who may be eligible for 1915(i) Habilitation Program and 1915(c) Children's Mental Health Waiver, which will include, at minimum the following processes: (i) processing referrals from a member's provider(s); (ii) processing member self-referrals; (iii) incorporation of hospital admission notifications; and (iv) ongoing review of claims data. The Contractor shall conduct an assessment, as described using a tool and process prior approved by the Agency, for members who have been identified through any of these processes as potentially meeting an institutional level of care and in need of institutional placement or CMH waiver or Habilitation enrollment. 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.

3.2.11.2.2 Initial Assessment and Annual Support Assessment

The Contractor shall ensure that level of care and needs-based assessments for members potentially eligible for 1915(i) Habilitation Program and 1915(c) Children's Mental Health Waiver enrollment include an assessment of the individual's ability to have his or her needs met safely and effectively in the community and at a cost that does not exceed the limits established in each 1915(i) Habilitation Program and 1915(c) Children's Mental Health Waiver. If the Contractor determines a member's needs cannot be safely met in the community and within the monthly costs and service limits defined in the 1915 (i) Habilitation Program or 1915(c) HCBS Children's Mental Health Waiver in which the member is enrolled, the Contractor shall determine if additional services may be otherwise available through the Contractor's own Exception to Policy process as described in Section 8.15.10, to allow the member to continue to reside safely in the community. If the Contractor determines that it is not reasonable or appropriate to provide an exception to cost or service limits, the Contractor shall provide seamless transition to another setting. A Contractor denial of an exception to cost or service limits is not appealable.

If a member does not appear to meet enrollment criteria such as meeting the target population group, the Contractor shall comply with the requirements. The Contractor shall obtain Agency approval of timeframes in which the level of care or functional eligibility assessment shall occur. The Agency will establish timelines which will promptly assess the member's needs and ensure member safety.

The Contractor shall conduct level of care and needs-based eligibility reassessments, using the Agency designated tools by population annually and when the Contractor becomes aware that the member's functional or medical status has changed in a way that may affect the member's level of care eligibility. The Contractor may perform needs-based eligibility reassessments annually and when the member's function or medical status has changed. The Contractor shall track level of care and needs-based eligibility expiration dates to ensure this requirement is met. This requirement applies to all members on a 1915(i) Habilitation Program and 1915(c) Children's Mental Health Waiver. The Contractor shall obtain Agency approval of timeframes

in which reassessments shall occur for individuals identified as having a medical or functional status change. The Agency will establish timelines, which the Contractor shall adhere to, for the Contractor to promptly assess the member's needs and ensure member safety.

Once the assessment is completed, the Contractor shall submit the level of care or functional eligibility assessment to the Agency in the manner prescribed by the Agency. The Agency will retain all authority for determining Medicaid categorical, financial, level of care or needs-based eligibility and enrolling members into a Medicaid eligibility category. The Agency will notify the Contractor when a member has been enrolled in a 1915(i) Habilitation Program and 1915(c) Children's Mental Health Waiver eligibility category and any applicable patient liability amounts.

The Contractor shall administer all needs assessments in a conflict free manner consistent with Balancing Incentive Program (BIP) requirements.

In any Work Plan required by Section 2.13, the 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 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.

3.2.11.2.3 Documentation Requirements

The Contractor shall submit Documentation to the Agency, in the timeframes described in 3.2.11.2.2 and 4.2.2.2 and in the format determined by the Agency, for all reassessments that indicate change in the member's level of care or needs-based eligibility. The Agency or its designee shall have final review and approval authority for any reassessments that indicate a change in the level of care. The Contractor shall comply with the findings of the Agency or its designee in these cases. If the level of care or needs-based eligibility reassessment indicates no change in level of care, the member is approved to continue at the already established level of care and the Contractor shall maintain all Documentation of the assessment and make it available to the Agency upon request. 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.

3.2.11.2.4 Appearance of Ineligibility

As described, if the member does not appear to meet criteria for 1915(i) Habilitation Program and 1915(c) Children's Mental Health Waiver, the Contractor may advise the member verbally that he or she does not appear to meet the criteria for enrollment but shall also advise that he or she has the right to continue the process. A decision to discontinue the assessment process must be made by the member or the member's representative. The Contractor shall not encourage the member or the member's representative to discontinue the process. If the member decides to continue the assessment process, the Contractor shall complete the assessment process,

including submission of the level of care or functional eligibility assessment to the Agency. If the member decides to discontinue the assessment process, the Contractor shall document the member's decision to terminate the assessment process, including the member or the member's representative's signature and date. Within a timeframe designated by the department, the Contractor shall provide the Documentation of members who decide to terminate the assessment process.

3.2.11.2.5 Waiting List

In the event there is a waiting list for the 1915(c) CMH Waiver, at the time of initial assessment, the Contractor shall advise the member there is a waiting list and that they may choose to receive other support services if 1915(c) CMH Waiver enrollment is not immediately available. The Contractor shall ensure that members are receiving additional non-waiver supports and services while on the waiting list. The Agency will work with the Contractor to ensure members are provided slots, when available, based on date of application. When a member is in a facility and qualifies for a reserved capacity slot, the Agency will work with the Contractor for slot release. Additional information about LTSS coordination and HCBS Waiver slot management is found at 4.2.3.1.

3.2.11.2.6 Service Plan Development

The Contractor shall ensure service plan development for each 1915(i) Habilitation Program and 1915(c) Children's Mental Health Waiver enrollee. The Contractor shall ensure that all components of the service plan process shall meet contractual requirements as well as State and Federal regulations and policies, including 42 C.F.R. § 438.208(c)(3)(i)-(v).

3.2.11.2.7 Frequency

The Contractor shall ensure that the service plan is completed and approved prior to the provision of 1915(i) Habilitation Program and 1915(c) Children's Mental Health Waiver services. The Contractor shall ensure that the service plan is reviewed and revised: (i) at least every twelve (12) months; or (ii) when there is significant change in the member's circumstance or needs; or (iii) at the request of the member.

3.2.11.2.8 Person-Centered Planning Process

The Contractor shall ensure that the service plan is established through a person-centered service planning process that is led by the member where possible. The member's representative shall have a participatory role, as needed and as defined by the member. The Contractor shall establish a team for the member that shall include the Integrated Health Home care coordination staff and others as appropriate and desired by the member. The team shall work to assess the member's need for services based on member's needs and desires as well as the availability and appropriateness of services. The Contractor shall work with the team to identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or when the member's needs change. The Contractor shall ensure the person-centered planning process:

3.2.11.2.8.1 Includes people chosen by the individual;

3.2.11.2.8.2 Includes the use of an team of professionals and non-professionals with adequate knowledge, training and expertise surrounding community living and person-centered service delivery and includes, at minimum, the member and if appropriate the member's legal representative, family, service providers and others directly involved in the member's care including input from the member's PCP (if applicable), specialists and behavioral health providers;

3.2.11.2.8.3 Allows the member to choose which team member shall serve as the lead and the member's main point of contact. If the member elects not to exercise this choice, the team will make the decision who will serve as the lead;

3.2.11.2.8.4 Promotes self-determination principles and actively engages the member;

3.2.11.2.8.5 Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;

3.2.11.2.8.6 Is timely and occurs at times and locations of convenience to the member;

3.2.11.2.8.7 Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 C.F.R. § 435.905(b);

3.2.11.2.8.8 Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;

3.2.11.2.8.9 Offers informed choices to the member regarding the services and supports they receive and from whom. The Contractor shall provide members with information about potential providers of waiver services and assist members in selecting or changing providers, as requested by the member;

3.2.11.2.8.10 Includes a method for the member to request updates to the plan as needed;

3.2.11.2.8.11 Records the alternative home and community-based settings that were considered by the member; and

3.2.11.2.8.12 Records discussion and options provided for meaningful day activities, employment, and education opportunities. Members shall be offered choices that improve quality of life and integration into the community.

3.2.11.2.9 Emergency Plan Requirements

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

3.2.11.2.10 Home Based Habilitation

In addition to the service plan content requirements outlined in Section 3.2.11.2, the service plan for members in a home based habilitation service setting shall include: (i) the member's living environment at the time of 1915(i) enrollment; (ii) the number of hours per day of on-site staff supervision needed by the member; (iii) the number of other waiver consumers who will live with the member in the living unit; and (iv) an identification and justification of any restriction of the member's rights, including but not limited to maintenance of personal funds or self-administration of medications.

3.2.11.2.11 Refusal to Sign

In any Work Plan required by Section 2.13, the Contractor shall develop and implement policies and procedures describing measure to be taken by the Contractor to address instances when a member refuses to sign a service plan, including an escalation process that includes a review of the reasons for the member's refusal as well as actions take to resolve any disagreements with the service plan.

3.2.11.2.12 Compliance with Home and Community-Based Setting

In accordance with 42 C.F.R. § 441.301(b)(1), the Contractor shall ensure waiver services are not furnished to individuals who are inpatient in a hospital, nursing facility, institution for mental diseases, or ICF/ID. Further, in accordance with 42 C.F.R. § 438.3(o), Contractor shall deliver any services covered under the Contract that could be authorized through a waiver under section 1915(c) of the Social Security Act or a State plan amendment authorized through sections 1915(i) or of the Social Security Act in settings consistent with 42 C.F.R. § 441.301(c)(4) and 42 C.F.R. § 441.710(a).

3.2.11.2.13 Disenrollment

There are certain conditions that shall be met for an individual to be eligible for a 1915(i) Habilitation Program and 1915(c) Children's Mental Health Waiver. The Contractor shall track the information described in this section and notify the Agency, in the manner prescribed by the Agency, when any of these scenarios occur. The Agency will have sole authority for determining if the member will continue to be eligible under the 1915(i) Habilitation Program and 1915(c) Children's Mental Health Waiver, and the Contractor shall comply with the Agency's determination.

3.2.11.2.14 Minimum Service Requirements

To be eligible under the 1915(c) Children's Mental Health Waiver, a member must receive, at a minimum, one (1) billable unit of service under the waiver per calendar quarter. Members shall need waiver services on a regular basis to be eligible. The Contractor shall monitor receipt and utilization of the 1915(c) Children's Mental Health Waiver services and notify the Agency, in the manner prescribed by the Agency, if a member has not received at least one (1) billable unit of service under the waiver in a calendar quarter.

3.2.11.2.15 Frequency of Care Coordination Contact

At a minimum, the care coordinator shall contact 1915(i) Habilitation Program and 1915(c) Children's Mental Health Waiver members either in person or by telephone at least monthly. Members shall be visited in their residence or location of service face-to-face by their care coordinator as frequently as necessary but at least every three months.

3.2.11.2.16 Monitoring Receipt of Services

In any Work Plan required by Section 2.13, the Contractor shall develop and implement policies and procedures for identifying, responding to, and resolving service gaps. In any Work Plan required by Section 2.13, the Contractor shall develop policies and processes for identifying changes to a member's risk and for addressing any changes, including, but not limited to an update to the member's risk agreement.

After the initiation of services identified in the member's service plan, the Contractor shall implement strategies to monitor the provision of services, to confirm services have been initiated and are being provided on an ongoing basis as authorized in the service plan. At minimum, the care coordinator shall contact 1915(i) Habilitation Program and 1915(c) Children's Mental Health Waiver members within five (5) Business Days of scheduled initiation of services to confirm that services are being provided and that member's needs are being met. This initial contact may be conducted via phone. The Contractor shall obtain Agency approval of monitoring strategies to meet this requirement. The Contractor shall implement and adhere to the Agency approved plan. Any changes made to the plan shall require the Agency's approval. The Contractor shall identify and address service gaps and ensure that back-up plans are being implemented and are functioning effectively.

3.2.12 *Family Planning Services*

In accordance with 42 C.F.R. § 431.51(b)(2), members shall not be restricted in freedom of choice of Agency providers of family planning services. Therefore, 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.

3.2.13 *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 Exhibit D. This includes members in the categories of Wellness Plan and Marketplace Choice under the Iowa Health and Wellness Plan. The Contractor shall ensure the delivery of services to Iowa Health and Wellness Plan enrollees in accordance with the ABP, with the exception of Medically Exempt enrollees.

3.2.13.1 Medically Exempt

Individuals who are identified as Medically Exempt shall have a choice between the Iowa Wellness Plan and regular Medicaid State Plan benefits, as described in 441 Iowa Administrative Code Chapter 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 he or she has one 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 Social Security Administration criteria. Table 3.2.13.1 provides more detailed definitions of the categories of exempt individuals. "Activities of daily living" as used in Table 3.2.13.1 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 3.2.13.1: Medically Exempt Definition

Category	Definition
Individuals with Disabling Mental Disorder	The member has a diagnosis of at least one of the following: • Psychotic disorder • Schizophrenia • Schizoaffective disorder • Major depression • Bipolar disorder • Delusional disorder • Obsessive-compulsive disorder • Or member is identified to have a chronic behavioral health condition and the Global Assessment Functioning (GAF) score is 50 or less
Individuals with Chronic Substance Use Disorders	• The member has a diagnosis of substance use disorder, AND • The member meets the Severe Substance Use Disorder level on the DSM-V Severity Scale by meeting six or more diagnostic criteria, OR • The 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.)

Category	Definition
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 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 • The condition significantly impairs the ability to perform one 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 441 Iowa Administrative Code § 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 22; • Is likely to continue indefinitely; • Results in substantial functional limitations in three 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 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 Social Security Administration

3.2.13.1.1 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 member survey and determining if, based on the survey, the 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 a member is Medically Exempt. The Agency will communicate the

findings from the member survey and attestation and referral form to the Contractor. The Contractor may assist in identifying members that fit the medically exempt criteria but determinations shall be subject to the Agency approval.

3.2.13.1.2 Benefits for Medically Exempt Members

The Agency will communicate the findings from the member survey and attestation and referral form described in Section 3.2.13.1.1 to the Contractor and the Contractor shall provide State Plan versus Alternative Benefit Plan benefits to Medically Exempt 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 member in the Iowa Wellness Plan benefits in the event he or she opts-out of State Plan coverage.

3.2.14 *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 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.

3.2.14.1 Applicability

If Value Added Services were approved by the Agency during the contracting process, the Contractor shall include those Value Added Services in any Work Plan required by Section 2.13.

3.2.14.2 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.

3.2.14.3 Program Description

In any Work Plan required by Section 2.13, the Contractor shall clearly describe: (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 members about the availability of such Value-Added Services while still meeting the federal marketing requirements; and (v) how a member may obtain or access the Value-Added Services.

3.2.14.4 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.

3.2.15 *Administration of Covered Benefits*

3.2.15.1 Medical Necessity Determinations

In accordance with Section 11 requirements relating to utilization management 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 member and his/her medical history.

3.2.15.2 Second Opinions

The Contractor shall provide for a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health conditions when requested by a member, parent and/or legally appointed representative. The second opinion shall be provided by a contracted qualified health care professional or the Contractor shall arrange for a member to obtain one from a non-contract provider. The second opinion shall be provided at no cost to the member.

3.2.15.3 Cost Sharing and Patient Liability

The Contractor and all providers and subcontractors shall not require any cost sharing or patient liability responsibilities for covered services except to the extent that cost sharing or patient liability responsibilities are required for those services in accordance with law and as described in Section 5. Further, the Contractor and all providers and subcontractors charge members for missed appointments.

3.2.16 *Physician Administered Drugs*

The Contractor shall provide coverage and reimbursement for physician 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. Such drugs would typically be injected or infused. The billing information shall

comply with Medicaid FFS billing requirements including, but not limited to, inclusion of the NDC for rebate and 340B purposes. The 340B billing guidelines and other guidelines can be found in Informational Letters posted on the Agency's website.

3.3 Continuity of Care

The Contractor shall implement mechanisms to ensure the continuity of care of 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:

(i) The member has access to services consistent with the access they previously had, and is permitted to retain their current provider for a period of time if that provider is not in the Contractor's network.

(ii) The member is referred to appropriate providers of services that are in the network.

(iii) The entity (Contractor or Agency) previously serving the member, fully and timely complies with requests for historical utilization data from the new entity in compliance with Federal and State law.

(iv) Consistent with Federal and State law, the member's new provider(s) are able to obtain copies of the member's medical records, as appropriate.

(v) Any other necessary procedures as specified by the Centers for Medicare and Medicaid Services to ensure continued access to services to prevent serious detriment to the 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 7.4.

3.3.1 *Prior Authorizations*

During year one (1) of the Contract, with the exception of LTSS, residential services and certain services rendered to dual diagnosis populations, which are addressed in Sections 3.3.4 – 3.3.5 and Section 3.3.7, the Contractor shall honor existing authorizations for covered benefits for a minimum of ninety (90) calendar days, without regard to whether such services are being provided by contract or non-contract providers, when a 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. Beginning one (1) year from the Contract effective date, the Contractor shall honor existing authorizations for a minimum of thirty (30) calendar days when a 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 a 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.

3.3.2 *Transition Period-Out of Network Care*

During the first ninety (90) days of the Contract, with the exception of LTSS, residential services and certain services rendered to dual diagnosis populations, which are addressed in Sections 3.3.4 – 3.3.5 and Section 3.3.7, the Contractor shall allow a 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 or otherwise authorize non-network care past the initial ninety (90) days of the Contract to provide continuity of care for 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.

3.3.3 *Transitions during Inpatient Stays*

The Contractor shall provide care coordination after the member has disenrolled from the Contractor whenever the member disenrollment occurs during an inpatient stay. Acute inpatient hospital services for members who are hospitalized at the time of disenrollment from the Contractor shall be paid by the Contractor until the member is discharged from acute care or for sixty (60) days after disenrollment, whichever is less, unless the 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 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 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.

3.3.4 *Long Term Services and Supports (LTSS)*

The Contractor shall not reduce, modify or terminate LTSS services in the absence of an up-to-date assessment of needs 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 shall be documented by the Contractor as part of the service planning process. The Contractor shall ensure 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 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 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.

3.3.5 *Residential Services*

3.3.5.1 Year One Operations

During the first year of the Contract, the Contractor shall permit members using a residential provider at the time of enrollment with the Contractor to access the residential provider being utilized at the time of enrollment for up to one (1) year, even on a non-network basis. For purposes of this requirement a residential provider is defined as a: (i) nursing facility; (ii) ICF/ID; and (iii) support for the member to live in a residential setting either controlled by the member or the provider funded through 1915(i) Habilitation waiver provider or a 1915(c) HCBS waiver.

3.3.5.2 Ongoing Operations

Effective one (1) year after the Contract effective date, the Contractor shall not transition members using residential providers, as defined in Section 3.3.5.1, to another residential provider unless the following conditions are met: (i) the member or his/her representative specifically requests to transition; (ii) the member or his/her 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 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 member's transition to a contracted provider, subject to the member's agreement with such transition; or (iii) continue to reimburse services from the non-contract provider. If a 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 member's seamless transition to a new provider. The Contractor shall permit a member with a dual diagnosis of a behavioral health condition and developmental disorder to remain with their residential provider for at least one 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, a member can no longer be served by his/her residential provider the Contractor shall find and make available to the member an alternative residential provider that can meet the member's needs so there is no break in services.

3.3.6 *Pregnancy Continuity of Care*

In any Work Plan required by Section 2.13, the Contractor shall develop and implement, a continuity of care policy to address members who are pregnant at the time of enrollment with the Contractor and are receiving services from an out-of-network provider.

3.3.7 *Dual Diagnosis Continuity of Care*

Even if the provider is not in-network with the Contractor, the Contractor shall permit 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 member or when a change in providers is requested in writing by the member or the member's representative.

3.4 Coordination with Medicare

The Contractor shall provide medically necessary covered services to 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 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 members who are also eligible for Medicare. In compliance with 42 C.F.R. § 438.3(t), the Contractor shall enter into a Coordination of Benefits Agreement with Medicare and participate in the automated claims crossover process. In any Work Plan required by Section 2.13, the Contractor shall develop a plan to coordinate care for duals.

4 Long Term Services and Support

4.1 General

The Contractor shall ensure that services are provided in a manner that facilitates maximum community placement and participation for members that require LTSS. 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. Funding decisions by the Contractor shall consider individual member choice and community-based alternatives within available resources to promote the Agency's goal of maximum community integration. The Contractor shall support and enhance person-centered care. When 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. Members residing in these facilities receive additional care coordination and quality oversight from the Contractor. When 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 member's participation and in consultation with the member's provider(s) develop a person-centered care plan to address the member's care and treatment needs, providing assurances for health and safety, and proactively address potential risks related to members' desire to live as independently as possible. For members who require individualized, enhanced staffing patterns to support them in a less-restrictive setting, the Contractor shall not reduce the enhanced staffing arbitrarily or without supporting documentation.

4.2 Level of Care and Support Assessments

4.2.1 *Initial Determination for Non-Members*

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 either community supports or facility care, as described. The intention of the multi-purpose evaluation is to provide uniformity and streamline the documents completed to determine the appropriate level of care and outline the assessed needs of the individual. The tool is also used to evaluate whether or not the needs are being met and the provider's ability to perform the tasks as assigned. The tools currently designated by the department, notwithstanding future decisions or input from stakeholders, are as follows:

AIDS/HIV	0 - 3	Case Management (CM) Comprehensive Assessment
	4 - 20	interRAI - Pediatric Home Care (PEDS-HC)
	21 +	interRAI - Home Care (HC)
AIDS/HIV with Habilitation	16 - 18	inter-RAI Child and Youth Mental Health (ChYMH)
AIDS/HIV with Habilitation	19 +	interRAI - Community Mental Health (CMH)
Brain Injury (BI)	0 - 3	CM Comprehensive Assessment
	4 - 20	interRAI - Pediatric Home Care (PEDS-HC)
	21 +	interRAI - Home Care (HC)
BI with Habilitation	16 - 18	inter-RAI Child and Youth Mental Health (ChYMH)
BI with Habilitation	19 +	interRAI - Community Mental Health (CMH)
Children's Mental Health	0 - 3	CM Comprehensive Assessment (or modified PIHH)
	4 - 20	interRAI - Child and Youth Mental Health (ChYMH)
	12 - 18	interRAI - Adolescent Supplement (in addition to ChYMH)
Elderly	65 +	interRAI - Home Care (HC)
Elderly with Habilitation	65 +	interRAI - Community Mental Health (CMH)
Health and Disability (HD)	0 - 3	CM Comprehensive Assessment
	4 - 20	interRAI - Pediatric Home Care (PEDS-HC)
	21 - 64	interRAI - Home Care (HC)
HD with Habilitation	16 - 18	inter-RAI Child and Youth Mental Health (ChYMH)
HD with Habilitation	19 +	interRAI - Community Mental Health (CMH)
Intellectual Disability (ID)	0 - 4	CM Comprehensive Assessment
	5 - 15	Supports Intensity Scale - Child (SIS-C)
	16+	Supports Intensity Scale - Adult (SIS-A)

ID with Habilitation	16 +	Supports Intensity Scale - Adult (SIS-A)
Physical Disability (PD)	18 - 20	interRAI - Pediatric Home Care (PEDS-HC)
	21 +	interRAI - Home Care (HC)
PD with Habilitation	16 - 18	inter-RAI Child and Youth Mental Health (ChYMH)
PD with Habilitation	19 +	interRAI - Community Mental Health (CMH)
Habilitation Services	16 - 18	interRAI - Child and Youth Mental Health (ChYMH)
	19 +	interRAI - Community Mental Health (CMH)

The Contractor shall not revise or add to the tools without express approval from the Agency and may require consensus among all Contractors and stakeholder engagement.

The Contractor shall not be responsible for determining the initial level of care assessments for nursing facility or ICF/ID or 1915(c) HCBS waiver enrollment for individuals who are not enrolled with the Contractor and are applying for initial Medicaid LTSS eligibility. This responsibility is maintained by the Agency or its designee. The Contractor shall refer all inquiries regarding Medicaid enrollment and initial level of care determinations to the Agency or its designee in the form and format developed by the Agency.

4.2.2 *Level of Care Assessments and Annual Support Assessments*

4.2.2.1 Identification

In any Work Plan required by Section 2.13, the Contractor shall develop and implement policies and procedures for ongoing identification of members who may be eligible for LTSS, which includes, at minimum the following processes: (i) processing referrals from a member's provider(s); (ii) processing member self-referrals; (iii) incorporation of hospital admission notifications; and (iv) ongoing review of claims data. 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 members who have been identified through any of these processes as potentially meeting an institutional level of care and in need of institutional placement or 1915(c) HCBS waiver enrollment. 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.

4.2.2.2 Initial Assessment and Annual Support Assessment

The Contractor shall ensure that level of care and assessment for members potentially eligible for 1915(c) HCBS waiver enrollment includes an assessment of the individual's ability to have his or her needs met safely and effectively in the community and at a reasonable cost to the Agency. If a member's needs exceed limits established in Iowa Administrative Code or the approved 1915(c) waivers, the Contractor has discretion but is not required to authorize services that exceed those limits. If a member does not appear to meet enrollment criteria such as meeting the target

population group, the Contractor shall comply with the requirements related to the appearance of ineligibility. The Contractor shall obtain Agency approval for timeframes in which the level of care assessment shall occur. The Agency will establish timelines which will promptly assess the member's needs and ensure member safety.

The Contractor shall conduct level of care reassessments, using the Agency designated tools by population annually and when the Contractor becomes aware that the member's functional or medical status has changed in a way that may affect level of care eligibility. The Contractor may perform needs-based eligibility reassessments annually and when the member's function or medical status has changed. The Contractor shall track level of care expiration dates to ensure this requirement is met. This requirement applies to all members eligible under a 1915(c) HCBS waiver. The Contractor shall obtain Agency approval for timeframes in which reassessments shall occur for individuals identified as having a change in medical or functional status. The Agency will establish timelines, which the Contractor shall adhere to, for the Contractor to promptly assess the member's needs and ensure member safety.

Once the assessment is completed, the Contractor shall submit the level of care/support needs assessment to the Agency in the manner prescribed by the Agency. 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 a member has been enrolled in nursing facility or ICF/ID or 1915(c) HCBS waiver eligibility category and any applicable patient liability amounts.

In any Work Plan required by Section 2.13, the Contractor shall develop and implement the mechanism in which the needs assessments shall be administered in a conflict free manner consistent with BIP requirements. The Contractor shall include in that mechanism 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 member's circumstances which necessitates a new assessment. The Contractor shall conduct reassessments at least every twelve (12) months.

4.2.2.3 Documentation Requirements

The Contractor shall submit Documentation to the Agency, in the timeframes described in 3.2.11.2.2 and 4.2.2.2 and in the format determined by the Agency, for all reassessments that indicate change in the member's level of care. The Agency or its designee shall have final review and approval authority for any reassessments that indicate a change in the level of care. The Contractor shall comply with the findings of the Agency or its designee in these cases. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care, and the Contractor shall maintain all Documentation of the assessment and make it available to the Agency upon request. The Contractor shall maintain the ability to track and report on level of care reassessment data, including but not limited to, the date the reassessment was completed.

4.2.2.4 Preadmission Screening and Resident Review

Prior to admission to a nursing facility and any time there is a significant change in status, members shall receive a pre-admission screening and resident review (PASRR) by the State or its designee. 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 member's status In any Work Plan required by Section 2.13, the Contractor shall describe how it intends to work with Agency or its designee responsible for implementing the PASRR process and for oversight that PASRR screenings are conducted prior to admission or when there is a significant change in the member's status. The Contractor shall be responsible for ensuring that members receive specialized services identified by the process. The Agency remains responsible for specialized services identified through PASRR for non-members. The Contractor shall pull all members identified as requiring specialized services into their utilization review sample and report the results to the Agency.

4.2.3 *Appearance of Ineligibility*

As described in Section 4.2.2, if the member does not appear to meet criteria for LTSS, the Contractor may advise the member verbally that he or she does not appear to meet the criteria for enrollment but shall also advise that he or she has the right to continue the process. A decision to discontinue the assessment process must be made by the member or the member's representative. The Contractor shall not encourage the member or the member's representative to discontinue the process. If the member decides to continue the assessment process, the Contractor shall complete the assessment process, including submission of the level of care assessment to the Agency. If the member decides to discontinue the assessment process, the Contractor shall document the member's decision to terminate the assessment process, including the member or the member's representative's signature and date. Within a timeframe designated by the department, the Contractor shall provide the Documentation of members who decide to terminate the assessment process.

4.2.3.1 Waiting List

In the event there is a waiting list for a 1915(c) HCBS waiver, at the time of initial assessment, the Contractor shall advise the member there is a waiting list and that they may choose to receive facility-based services if 1915(c) HCBS waiver enrollment is not immediately available. The Contractor shall ensure that members are receiving additional non-waiver supports and services while on the waiting list. The Agency will work with the Contractor to ensure members are provided slots, when available, based on date of application. When a member is in a facility and qualifies for a reserved capacity slot, the Agency will work with the Contractor for slot release.

4.2.3.1.1 The Contractor shall work with the Agency to ensure that the number of 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 Contraetor shall not add members to LTSS without the Agency authorization resulting from joint LTSS access meetings.

4.2.3.1.2 The above expectations notwithstanding, the Contractor shall authorize all admissions of members that meet level of care requirements to nursing facilities and ICFs/ID that have a contract in good standing with the Contractor. The Contractor may also authorize on its own, without authority from the Agency, access to the elderly HCBS waiver for any member that requests such services and meets the level of care requirements. The Contractor is also authorized on its own, without authority from the Agency, access to any HCBS waiver to serve an additional individual that requests such services and meets the level of care requirements when the Contractor adequately demonstrates to the Agency that it has reduced the corresponding number of nursing facility, ICF/ID, or PMIC beds.

4.3 Community-Based Case Management Requirements

The Contractor shall provide for the delivery of community-based case management. Community-based case management is all of the activities described in this section and the equivalent of: (i) targeted case management to members who are eighteen (18) years of age or over and have a primary diagnosis of mental retardation or who have a developmental disability as defined in 441 Iowa Administrative Code Chapter 90 whether or not the member is receiving LTSS; and (ii) case management to members who are receiving services under the 1915(c) HCBS waivers and any amendments thereto as a result of this Contract except the 1915(c) HCBS waiver for children with a serious emotional disturbance who may be receiving case management services through an IHH. Adult members with a severe mental illness or members that are children with a serious emotional disturbance, as described in Section 3.2.8, shall receive care coordination via the Integrated Health Home in lieu of community-based case management described in this section.

The Contractor shall assign to each member receiving home and community-based LTSS a community-based case manager who is the member's main point of contact with the Contractor and their service delivery system. The Contractor shall establish mechanisms to ensure ease of access and a reasonable level of responsiveness for each member to their community-based case manager during regular business hours. Community-based case manager staff shall have knowledge of community alternatives for the target populations and the full range of long-term care resources as well as specialized knowledge of the conditions and functional limitations of the target populations served by the Contractor, and of the individual members to whom they are assigned. The Contractor shall provide community-based case management services to all members receiving community-based LTSS in accordance with this section. The Contractor shall also ensure that additional requirements are met including Section 4.4 applicable to members receiving 1915(c) HCBS waivers.

The Contractor shall ensure community-based case management shall be provided in a conflict free manner that administratively separates the final approval of 1915(c) HCBS waiver plans of care and approval of funding amount done by the Contractor. Community-based case management efforts made by the Contractor or its designee shall avoid duplication of other coordination efforts provided within the members' system of care.

4.3.1 *Community-Based Case Manager Qualifications*

In any Work Plan required by 2.13, the Contractor shall submit the required qualifications, experience and training of community-based case managers. The assigned community-based case manager for

members who choose to self-direct services, as described in Section 4.4.8, shall have specific experience with self-direction and additional training regarding self-direction. The Agency will not prescribe specific community-based case manager to member ratios that shall be maintained. However, 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 community-based case management staff to properly and timely perform its obligations under the Contract. Community-based case management shall meet all of the applicable qualifications and requirements as specified in 441 Iowa Administrative Chapter 90.

4.3.2 *External Communication and Coordination*

The Contractor shall facilitate access to covered benefits and monitor the receipt of services to ensure member's needs are being adequately met. The Contractor shall maintain ongoing communications with a member's community and natural supports to monitor and support their ongoing participation in the member's care. The Contractor shall also coordinate with stakeholders, such as community organizations, rendering non-Contractor covered services to the member that are important to the member's health, safety and well-being and/or impact a member's ability to reside in the community. The Contractor shall implement strategies to coordinate and share information with a member's service providers across the healthcare delivery system, to facilitate a comprehensive, holistic and person-centered approach to care and address issues and concerns as they arise. The Contractor shall ensure that there is no duplication of community-based case management for each member. The Contractor shall also provide assistance to members in resolving concerns about service delivery or providers. The Contractor shall provide to contract 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 member's circumstances, of any significant changes in the member's condition or care, hospitalizations, or recommendations for additional services. The Contractor shall ensure adequate and timely communication with other managed care contractors in the event that a member transitions from one Contractor to another such that there is no interruption or delay in the member's service delivery.

4.3.3 *Internal Contractor Communications*

The Contractor shall implement strategies to ensure there is internal communication among departments to ensure community-based case managers are made aware of issues relevant to the members on their assigned caseload.

4.3.4 *Changes in Community-Based Case Managers*

The Contractor shall permit members to change to a different community-based case manager if the 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 community-based case management 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 a 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 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.

In any Work Plan required by Section 2.13, the Contractor shall develop and implement policies and procedures regarding notice to members of community-based case manager changes initiated by either the Contractor or the 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 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 member and the out-going community-based case when possible.

In the initial Work Plan required by Section 2.13, the Contractor shall develop and implement policies and procedures to provide seamless, effective transition from the member's targeted case manager or case manager assigned prior to implementation of the managed care contract and any change in community-based case management that the Contractor shall pursue after implementation of the contract. In any subsequent Work Plans required by Section 2.13, the Contractor shall update its policies and procedures as needed and required.

4.3.5 *Discharge Planning*

In any Work Plan required by Section 2.13, the Contractor shall develop and implement policies and procedures to ensure that community-based case managers are actively involved in discharge planning when an LTSS recipient is hospitalized or served in any other higher level of care for less than 60 days. The Contractor shall define circumstances which require that hospitalized members receive an in-person visit to complete a needs reassessment and an update to the member's plan of care.

4.3.6 *In-Person Requirements*

The Contractor shall ensure that each in-person visit by a community-based case manager to a member includes observations and Documentation of the following: (i) member's physical condition including observations of the member's skin, weight changes and any visible injuries; (ii) member's physical environment; (iii) member's satisfaction with services and care; (iv) member's upcoming appointments; (v) member's mood and emotional well-being; (vi) member's falls and any resulting injuries; (vii) statement by the member regarding any concerns or questions; and (viii) statement from the member's representative or caregiver regarding any concerns or questions (when the representative/caregiver is available).

4.3.7 *Response to Problems and Issues*

The Contractor shall identify, document, and immediately respond to problems and issues including but not limited to: (i) service gaps; and (ii) complaints or concerns regarding the quality of care rendered by providers, workers, or community-based case management staff.

4.3.8 *Community-Based Case Management Monitoring*

The Contractor shall develop a comprehensive program for monitoring, on an ongoing basis, the effectiveness of its community-based case management processes. The Contractor shall include a description of that program, along with its policies and procedures, in any Work Plan required by Section 2.13. 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 community-based case management processes and resolve areas of non-compliance or member dissatisfaction; and (iv) measure the success of such strategies in addressing identified issues. At a minimum, the Contractor shall monitor the following:

4.3.8.1 Community-based case management tools and protocols are consistently and objectively applied and outcomes are continuously measured to determine effectiveness and appropriateness of processes;

4.3.8.2 Level of care assessments and reassessments occur on schedule;

4.3.8.3 Comprehensive needs assessments and reassessment, as applicable, occur on schedule and in compliance with the Contract;

4.3.8.4 Care plans are developed in accordance with 42 C.F.R. § 438.208(c)(3)(i)-(v), by a person trained in person-centered planning using a person-centered process and plan, with enrollee participation and provider consultation; and updated on schedule and in compliance with the Contract;

4.3.8.5 Care plans reflect needs identified in the comprehensive needs assessment and reassessment process;

4.3.8.6 Care plans are appropriate and adequate to address the member's needs;

4.3.8.7 Services are delivered as described in the care plan and authorized by the Contractor;

4.3.8.8 Services are appropriate to address the member's needs, and in accordance with 42 C.F.R. § 438.208(c)(4), Contractor allows 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;

4.3.8.9 Services are delivered in a timely manner;

4.3.8.10 Service utilization is appropriate;

4.3.8.11 Service gaps are identified and addressed in a timely manner;

4.3.8.12 Minimum community-based case manager contacts are conducted;

4.3.8.13 Community-based case manager-to-member ratios are appropriate; and

4.3.8.14 Service limits are monitored and appropriate action is taken if a member is nearing or exceeds needs-based 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 member's needs in the community.

4.3.9 *Admissions*

If a member is unable to be placed in the nursing facility, ICF/ID or community-based residential alternative setting requested by the member, the Contractor shall meet with the member and/or his or her designated/legal representative, as applicable, 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 a member's admission to a nursing facility, the Contractor shall ensure that all PASRR requirements have been met prior to the member's admission to a nursing facility, including a PASRR level I screening and as applicable, a level II PASRR evaluation. The Contractor shall ensure that members have the option to receive HCBS in more than one (1) residential setting appropriate to their needs and shall educate members on the available settings.

4.3.10 *Transitions between Facilities*

The Contractor shall not transition nursing facility, ICF/ID, 1915(i) Habilitation or 1915(c) community-based residential alternative residents to another facility or residence unless: (i) the member or his/her representative specifically requests to transition; (ii) the member or his/her 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.

The Contractor shall establish contractual terms with its providers, subject to approval by the Agency, that protect an individual from involuntary discharge that may lead to a placement in an inappropriate or more restrictive setting. The Contractor shall facilitate a seamless transition whenever a member transitions between facilities or residences.

4.3.11 *Implementation*

In addition to the continuity of care requirements described in Section 3.3, the Contractor shall implement a comprehensive strategy to ensure a seamless transition of services during program implementation. In any Work Plan required by 2.13, the Contractor shall develop and implement a strategy and timeline within which all members receiving LTSS will receive an in-person visit from appropriate Contractor

staff and an updated needs assessment and service plan. 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.

4.3.12 *Nursing Facilities and ICF/IDs*

4.3.12.1 Case Management Requirements
In any Work Plan required under Section 2.13, the Contractor shall obtain Agency approval of strategies for monitoring services for members in nursing facilities and ICF/IDs that meet the requirements of this section.

The Contractor shall work with nursing facilities and ICF/IDs to coordinate the provision of care for members. The Contractor shall participate, as appropriate, and allowed by the member, in the nursing facility and ICF/ID care planning process and advocate for the member. The Contractor shall evaluate the nursing facility and ICF/ID care plans to determine adequacy and ensure timely discharge planning is addressed and implemented. The Contractor shall develop a care plan for members in a nursing facility or ICF/ID but may use the care plan developed by the facility to supplement the care plan. The Contractor shall develop and implement targeted strategies to improve the health, functional and quality of life outcomes of members residing in a nursing facility or ICF/ID. The Contractor shall develop and implement policies and procedures, subject to Agency review and approval, to escalate and report concerns regarding nursing facility and ICF/ID quality. The Contractor shall provide nursing facility members' options counseling and transition activities when a member has been identified through the quarterly screening of MDS Section Q, Participation in Assessment and Goal Setting, to return to their home and/or community of their choice.

4.3.12.2 Client Participation Assistance

As described in Section 5.4, some members residing in a nursing facility or ICF/ID have a patient liability that must be met prior to Medicaid reimbursing for services. The Contractor shall ensure that patient liability is met prior to reimbursing providers for nursing facility or ICF/ID services. If a nursing facility or ICF/ID is considering discharging a member due to non-payment of the patient liability, the Contractor shall work to find an alternate nursing facility or ICF/ID willing to serve the member. The Contractor shall document these efforts.

4.3.12.3 State Resource Centers

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:

4.3.12.3.1 All admissions to SRCs shall be consistent with the requirements of the Conner Consent Decree and Iowa Code § 222.13.

4.3.12.3.2 The SRC superintendent has the final determination regarding whether or not to admit an individual to the SRC.

4.3.12.3.3 Each SRC's bed capacity shall be reduced by no less than 12 beds each State fiscal year as specified by the Agency.

4.3.12.3.4 The Contractor shall fund outplacement and transition activities, including training staff at the new placement, staff visits, and staffing for overnight visits during the transition period.

4.3.12.3.5 The Contractor shall fund diversion referral activities to appropriately divert referrals from SRC placement to available services in the community.

4.3.12.3.6 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) which fall within the Contractor's Utilization Management Guidelines.

4.3.12.4 Diversion Strategies

In any Work Plan required by Section 2.13, the Contractor shall develop a comprehensive institutional diversion program. The Contractor's program shall target and address the needs of the following: (i) members waiting placement in a nursing home, ICF/ID or other institutional setting, including members who may be on an HCBS waiver waitlist; (ii) members who have a change in circumstance or deterioration in health or functioning and request nursing facility or ICF/ID services; (iii) waiver enrollees admitted to a hospital or inpatient rehabilitation program; and (iv) individuals in a nursing facility for a short-term stay.

4.3.12.5 Community Transition Activities

In any Work Plan required by Section 2.13, the Contractor shall develop strategies to identify members who desire to transition from a nursing facility or ICF/ID setting to community integrated settings. In addition to the Money Follows the Person (MFP) Grant activities, the Contractor shall include strategies to identify members who have the ability or desire to transition from a nursing facility or ICF/ID setting to the community.

The Contractor shall conduct a transition assessment, using tools pre-approved by the Agency, on members who have been identified by the Contractor. The transition assessment shall include, at minimum, an assessment of the member's desire and ability to transition to the community as well as an identification of risks. For those identified through the assessment process as candidates for transition to the community, the Contractor shall facilitate development of a transition plan and engage the member and representative of his or her choosing in the transition plan development process. The transition plan shall address all transition needs and services necessary to safely transition the 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 member enrolls in a 1915(c) HCBS waiver, the needs assessment and service plan requirements described in Section 4.4.2 shall apply.

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. Grant funds provide funding for the transition services and enhanced supports needed for the first year after an individual transition into the community. MFP assistance is available to individuals with a diagnosis of an intellectual disability or brain injury who have lived in an ICF/ID or nursing facility for at least three (3) months. The Contractor shall work in collaboration with the State's MFP designee in implementing the MFP program. The Contractor shall identify current members who may be eligible for MFP participation and referring those members to the State's MFP designee. The State retains authority for determining MFP eligibility and MFP enrollment. Once an individual is enrolled in the MFP program, the Contractor shall work in collaboration with the State's MFP designee in developing the transition plan. The Contractor's care coordinator shall serve as a member of the MFP planning team convened by the State's MFP designee. The State's MFP designee shall be responsible for the authorization and delivery of services which are non-Medicaid covered services. The Contractor shall ensure authorization and delivery of Medicaid covered services. The Agency MFP designed shall be responsible for the authorization and delivery of all of the MFP grant services and those which are non-Medicaid covered services. The Contractor shall implement Agency approved strategies to prevent duplication and fragmentation of care. When the Money Follows the Person grant is no longer authorized by CMS, the Contractor shall assist with the development and implementation of the sustainability plan, subject to the approval of the Agency.

4.3.12.6 Post Transition Monitoring

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 nursing facility and ICF/ID readmissions for 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 member, at minimum: within two (2) days of the transition to the community; every two (2) weeks for the first two (2) months from discharge; and once per month for the first year after transition. More frequent contact shall occur based on an individualized assessment of the member's needs and risk factors.

4.3.12.7 Reserved.

4.4 1915(c) HCBS Waivers

4.4.1 *Overview*

The State currently operates seven (7) 1915(c) HCBS waivers including: (i) Health and Disability Waiver; (ii) AIDS/HIV Waiver; (iii) Elderly Waiver; (iv) Intellectual Disability Waiver; (v) Brain Injury Waiver; (vi) Physical Disability Waiver; and (vii) Children's Mental Health Waiver. The Contractor shall deliver the State's 1915(c) services to all members meeting the eligibility criteria and authorized to be served by these programs. The Contractor shall be responsible 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. More information on the Children's Mental Health Waiver requirements can be found in the section of the scope related to behavioral health.

4.4.2 *Service Plan Development*

The Contractor shall provide service plan development for each 1915(c) HCBS waiver enrollee. In any Work Plan required by Section 2.13, the Contractor shall include how they 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).

4.4.2.1 Frequency

The Contractor shall ensure service plans are completed and approved prior to the provision of waiver services. The Contractor shall ensure service plans are reviewed and revised: (i) at least every twelve (12) months; or (ii) when there is significant change in the member's circumstance or needs; or (iii) at the request of the member.

4.4.2.2 Person-Centered Planning Process

The Contractor shall ensure service plans are established through a person-centered service planning process which is led by the member whenever possible as dictated by CMS standards for the person-centered planning process. The member's representative shall have a participatory role, as needed and as defined by the member. The Contractor shall establish a team for the member, and with the team, identify the member's need for services based on member's needs and desires as well as the availability and appropriateness of services. The Contractor shall work with the team to identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or when the member's needs change. The Contractor shall ensure the person-centered planning process:

4.4.2.2.1 Includes people chosen by the individual;

4.4.2.2.2 Includes the use of team of professionals and non-professionals with adequate knowledge, training and expertise surrounding community living and person-centered service delivery and includes, at minimum, the member and if appropriate the member's legal representative, family, service providers and others directly involved in the member's care including input from the member's PCP (if applicable), specialists and behavioral health providers;

4.4.2.2.3 Allows the member to choose which team member shall serve as the lead and the member's main point of contact. If the member elects not to exercise this choice, the team will make the decision who will serve as the lead;

4.4.2.2.4 Promotes self-determination principles and actively engages the member;

4.4.2.2.5 Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;

4.4.2.2.6 Is timely and occurs at times and locations of convenience to the member;

4.4.2.2.7 Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 C.F.R. § 435.905(b);

4.4.2.2.8 Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;

4.4.2.2.9 Offers informed choices to the member regarding the services and supports they receive and from whom. The Contractor shall provide members with information about potential providers of waiver services and assist members in selecting or changing providers, as requested by the member;

4.4.2.2.10 Includes a method for the member to request updates to the plan as needed;

4.4.2.2.11 Records the alternative home and community-based settings that were considered by the member; and

4.4.2.2.12 Records discussion and options provided for meaningful day activities, employment, and education opportunities. Members shall be offered choices that improve quality of life and integration into the community.

4.4.3 *Service Plan Content*

In accordance with 42 C.F.R. 441.301 and the 441 Iowa Administrative § 90.5(1)b and 441 Iowa Administrative Chapter 83 the Contractor shall ensure the service plan reflects the services and supports that are important for the member to meet the needs identified through the needs assessment, as well as what is important to the member with regard to preferences for the delivery of such services and supports. The service plan shall reflect the 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 provided by both the Contractor or available in the community to ensure the maximum degree of integration and the best possible health outcomes and participant satisfaction. The Contractor shall ensure the service plan:

4.4.3.1.1 Reflects that the setting in which the individual resides is chosen by the member. The Contractor shall ensure that the setting chosen by the member is integrated in, and supports full access of individuals 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;

4.4.3.1.2 Reflects the member's strengths and preferences;

4.4.3.1.3 Reflects the clinical and support needs as identified through the needs assessment;

4.4.3.1.4 Includes individually identified goals and desired outcomes that are observable and measurable;

4.4.3.1.5 Includes the interventions and supports needed to meet members' goals and incremental action steps as appropriate;

4.4.3.1.6 Reflects the services and supports, both paid and unpaid, that will assist the individual to achieve identified goals, the frequency of services and the providers of those services and supports, including natural supports;

4.4.3.1.7 Includes the names of providers responsible for carrying out the interventions or supports including who is responsible for implementing each goal on the plan and the timeframes for each service;

4.4.3.1.8 Includes the identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan;

4.4.3.1.9 Includes a description of any restrictions on the member's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications;

4.4.3.1.10 Reflects risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;

4.4.3.1.11 Includes a plan for emergencies as further described in Section 4.4.3.2;

4.4.3.1.12 Is understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it shall be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 C.F.R. § 435.905(b);

4.4.3.1.13 Identifies the individual and/or entity responsible for monitoring the plan;

4.4.3.1.14 Is finalized and agreed to, with the informed consent of the member in writing, and signed by all individuals and providers responsible for its implementation;

4.4.3.1.15 Is distributed to the member and other people involved in the plan;

4.4.3.1.16 Indicates if the member has elected to self-direct services and, as applicable, which services the individual elects to self-direct as described further in Section 4.4.8; and

4.4.3.1.17 Prevents the provision of unnecessary or inappropriate services and supports.

4.4.3.2 Emergency Plan Requirements

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

4.4.3.3 Supported Community Living

In addition to the service plan content requirements outlined in Section 4.4.3, the service plan for members in supported community living shall include: (i) the member's living environment at the time of 1915(c) HCBS waiver enrollment; (ii) the number of hours per day of on-site staff supervision needed by the member; (iii) the number of other waiver consumers who will live with the member in the living unit; and (iv) an identification and justification of any restriction of the member's rights, including but not limited to maintenance of personal funds or self-administration of medications.

4.4.3.4 Refusal to Sign

In any Work Plan required by Section 2.13, the Contractor shall develop and implement policies and procedures describing measure to be taken by the Contractor to address instances when a member refuses to sign a service plan, including an escalation process that includes a review of the reasons for the member's refusal as well as actions take to resolve any disagreements with the service plan.

4.4.4 *Compliance with Home and Community-Based Setting*

In accordance with 42 C.F.R. § 441.301 (b)(1) the Contractor shall ensure waiver services are not furnished to individuals who are inpatient in a hospital, nursing facility, institution for mental diseases, or ICF/ID. Further, the Contractor shall ensure non-institutional LTSS are provided in settings which

comport with the CMS home and community-based setting requirements as defined in regulations at 42 C.F.R. § 441.301(c)(4) and 42 C.F.R. § 441.710(a).

4.4.5 *Disenrollment*

There are certain conditions that must be met for an individual to be eligible for a 1915(c) HCBS waiver. The Contractor shall track the information described in this section and notify the Agency, in the manner prescribed by the Agency, when any of these scenarios occur. The Agency shall have sole authority for determining if the member will continue to be eligible under the 1915(c) HCBS waiver and the Contractor shall comply with the Agency's determination.

4.4.5.1 Minimum Service Requirements

To be eligible under a 1915(c) HCBS waiver, a member must receive, at a minimum, one (1) billable unit of service under the waiver per calendar quarter. Members shall need waiver services on a regular basis to be eligible. The Contractor shall monitor receipt and utilization of LTSS and notify the Agency, in the manner prescribed by the Agency, if a member has not received at least one (1) billable unit of service under the waiver in a calendar quarter.

4.4.5.2 Service Needs

The Contractor shall continually monitor 1915(c) HCBS waiver member's service needs are met to assist the member in remaining in the least restrictive setting of the member's choice. If the Contractor determines a member's needs cannot be safely met in the community and within the monthly costs and service limits defined in the 1915(c) HCBS waiver in which the member is enrolled, the Contractor shall determine if additional services may be otherwise available through the Contractor's own Exception to Policy process as described in Section 8.15.10, to allow the member to continue to reside safely in the community. If the Contractor determines that it is not reasonable or appropriate to provide an exception to cost or service limits, the Contractor shall provide seamless transition to another setting. A Contractor denial of an exception to cost or service limits is not appealable.

4.4.5.3 Receipt of Long Term Care

The Contractor shall notify the Agency if a 1915(c) HCBS waiver member receives care in a hospital, nursing facility, or ICF/ID for thirty (30) days in one stay for purposes other than respite care.

4.4.6 *Frequency of Community-Based Case Manager Contact*

At a minimum, the community-based case manager shall contact 1915(c) HCBS waiver members either in person or by telephone at least monthly. Members shall be visited in their residence face-to-face by their care coordinator as frequently as necessary but at least every three months.

4.4.7 *Monitoring Receipt of Services*

After the initiation of services identified in the member's service plan, the Contractor shall implement strategies to monitor the provision of services, to confirm services have been initiated and are being provided on an ongoing basis as authorized in the service plan. At minimum, the care coordinator shall contact 1915(c) HCBS waiver members within five (5) business days of scheduled initiation of services to confirm that services are being provided and that member's needs are being met. This initial contact may be conducted via phone.

In any Work Plan required by Section 2.13, the Contractor shall: (1)develop monitoring strategies to meet this requirement; (2) develop and implement policies and procedures for identifying, responding to, and resolving service gaps; and (3)develop and implement policies and procedures for ensuring that back-up plans are implemented and functioning effectively.

In any Work Plan required by Section 2.13, the Contractor shall develop policies and processes for identifying changes to a member's risk and for addressing any changes, including, but not limited to an update to the member's risk agreement.

4.4.8 *Self-Direction*

The Contractor shall offer 1915(c) HCBS waiver enrollees the option to self-direct waiver services. In Iowa Medicaid, the self-direction option is referred to as the Consumer Choices Option (CCO) consistent with all applicable rules and regulations.

4.4.8.1 General Responsibilities

The Contractor shall ensure that the member and/or the member's representative fully participate in developing and administering the CCO and that sufficient supports are made available to assist members who require assistance. The Contractor shall work with a member to determine the appropriate level of assistance necessary to recruit, interview and hire providers. 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 member's needs; (ii) developing a budget to address the needs of the member; (iii) conducting employer-related activities such as assisting a member in identifying a designated representative if needed, finding and hiring employees and providers, and completing all Documentation required to pay self-directed providers; (iv) identifying and resolving issues related to the implementation of the budget; (v) assisting the member with quality assurance activities to ensure implementation of the 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 10.4; (vii) facilitating resolution of any disputes regarding payment to 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.

4.4.8.2 Self-Assessment

During the service planning process, the Contractor shall advise 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 a member's ability to make decisions regarding his or her health services and knowledge of available resources to access for assistance. If the self-assessment results reveal that the member is unable to self-direct services, but he or she is still interested in electing the option, the member will be required to appoint a representative to assume the self-direction responsibilities on his or her behalf.

4.4.8.3 Documentation

The Contractor shall ensure all members who elect to self-direct sign an informed consent contract. The boilerplate language for informed consent contracts is subject to the Agency review and approval in accordance with Section 8.2.4. All 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.

4.4.8.4 Use of Representatives

Services may be self-directed by a member, or a representative selected by the member. The representative may be either a legal representative or non-legal representative freely chosen by an adult member. If the member selects a non-legal representative, the non-legal representative cannot be a paid provider of services and must be eighteen (18) years or age or older. The member and the non-legal representative must sign a consent form designating who they have chosen as their non-legal representative and what responsibilities the representative will have. The choice of representative shall be documented in the member's file and provided to the member and the member's representative. At a minimum, the non-legal representative's responsibilities include ensuring decisions made do not jeopardize the health and welfare of the member and ensuring decisions made do not financially exploit the member. The Contractor shall implement quality assurance processes, including but not limited to, member interviews, to determine if a non-legal representative is working in the best interest of the member.

4.4.8.5 Support Brokers

In any Work Plan required by Section 2.13, the Contractor shall develop a strategy, policies and procedures to implement Support Broker functions. Support Broker functions shall include: (i) educating members on how to use self-directed supports and services; (ii) reviewing, monitoring and documenting progress of the member's self-directed budget; (iii) assisting in managing budget expenditures and budget revisions; (iv) assisting with employer functions such as recruiting, hiring and supervising providers; (v) assisting with approving and processing job descriptions for direct supports; (vi) assisting with completing forms related to employees; (vii) assisting with approving timesheets and purchase orders or invoices for goods; (viii) obtaining quotes for services and goods as well as identifying and negotiating with vendors; and (ix) assisting with problem solving employee and vendor payment issues. In developing its strategy, policies, and procedures, the Contractor 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.

4.4.8.6 Financial Management Services

The Contractor shall contract with an entity or entities for financial management services (FMS) to assist members who elect the Community Choices Option. The FMS approach shall help individuals understand billing and Documentation responsibilities, perform payroll and employer-related duties, purchase approved goods and services, track and monitor individual budget expenditures and identify expenditures that are over or under the budget.

4.4.8.7 Back-Up Plan

The Support Broker shall assist the member or representative in developing a back-up plan for self-directed benefits that adequately identifies how the member or representative will address situations when a scheduled provider is not available or fails to show up as scheduled. The Contractor shall maintain a copy of the back-up plan in the 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 providers.

4.4.8.8 Budget

The Support Broker and member shall work collaboratively to develop a budget for the self-directed services the member is identified to need. The budget shall be based on the member's assessed needs and the member shall have the flexibility to negotiate provider rates. The Support Broker shall closely monitor the adequacy and appropriateness of the services and rates to determine the extent to which adjustments to the care plan will necessitate adjustments to the budget and that the member does not exceed his or her budget.

4.4.8.9 Payment

The member or his or her representative shall review and approve timesheets of their providers to determine accuracy and appropriateness. Self-directed services may not exceed forty (40) hours per week per individual provider. The Contractor shall recoup any unspent funds monthly for service accounts and annually for savings accounts.

4.4.8.10 Services Pending Implementation of Self-Directed Services

The Contractor shall provide all 1915(c) HCBS waiver services to members who elect the Community Choices Option with Contractor network providers until all necessary requirements have been fulfilled in order to implement the self-direction of services. This includes, but is not limited to verification of the provider's qualifications and completion and signature on all service agreements. If the 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 care coordinator at the frequency determined necessary to ensure the member's needs are met.

4.4.8.11 Provider Qualifications and Employment Agreement

The Contractor's FMS solution, as described in Section 4.4.8.6, shall verify that potential 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. Members shall have an employment agreement or vendor agreement, as appropriate, with each of their providers. The template for this agreement shall be reviewed and approved by the Agency. Prior to a payment being made to a provider under the Community Choices Option, the Contractor shall ensure through its FMS that: (i) the provider meets all qualifications; and (ii) an employment/vendor agreement is signed. 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 member and/or representative and also maintained in the member file. Providers under the Community Choices Option are not required to be network providers with the Contractor. The Contractor shall not require Community Choices Option providers to sign a provider agreement with the Contractor.

4.4.8.12 Training

The Contractor shall require that all members or representatives participate in a training program prior to assuming self-direction. The Contractor shall also provide ongoing member or representative training upon request and/or if it is determined a member needs additional training. At minimum, the self-direction training programs shall address the following: (i) understanding the role of members and/or representatives in self-direction; (ii) selecting and terminating providers; (iii) being an employer and managing employees; (iv) conducting administrative tasks such as staff evaluations and approval of time sheets; (v) scheduling providers; and (vi) back-up planning.

4.4.8.13 Monitoring

The Contractor shall monitor the quality of service delivery and the health, safety and welfare of members participating in the Consumer Choices Option. The Contractor shall also monitor implementation of the back-up plan as described in Section 4.4.8.7. The Contractor shall monitor the member's participation in Consumer Choices Option to determine the success and viability of the 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 member.

4.4.8.14 Disenrollment from Self-Direction

The Contractor shall ensure members have the option to voluntarily discontinue the self-direction option at any time. The Contractor shall develop a new service plan with the member if he or she voluntarily discontinues the self-direction option. The Contractor may only initiate involuntarily termination of a 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 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 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 member regarding the termination in accordance with the Agency policy and procedures. The Contractor shall facilitate a seamless transition from the Community Choices Option to ensure there are no interruptions or gaps in service delivery.

5 Billing and Collections

5.1 General Provisions

In accordance with 42 C.F.R. § 438.108, Contractor shall not impose any cost sharing on Medicaid Members that is not in accordance with 42 C.F.R. §§ 447.50 through 447.82, all applicable State Plan obligations, and any approved waivers of that State Plan.

5.1.1 *Aggregate Cost Sharing Limit*

Member's total cost sharing shall not exceed five percent (5%) of their quarterly household income. The Contractor shall track members' cost sharing to ensure that if the five percent (5%) quarterly limit is reached, cost sharing is no longer collected until the beginning of a new quarter and the provider's reimbursement is adjusted accordingly; that is, any co-payment amounts are no longer deducted from claims reimbursement. The Contactor shall ensure that when tracking if the five percent (5%) limit is reached, all cost sharing incurred by all members of the household is included in the calculation.

5.1.2 *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.

5.2 Healthy Behaviors Program

In accordance with the terms of the State's 1115 waiver, by August 1st of each year, the State will submit a protocol for CMS review and approval for the Healthy Behaviors Program standards for the subsequent year. 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 implement policies and procedures to ensure compliance.

Once an Iowa Health and Wellness Plan member is enrolled with the Contractor, the Contractor shall establish mechanisms to: (i) track member completion of the healthy behaviors and (ii) educate members on the importance and benefits of healthy behavior completion.

5.3 Copayments

The Contactor shall impose copayments for Iowa Health and Wellness Plan participants in accordance with the State's 1115 waiver and hawk-i 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.

5.3.1 *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:

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

5.3.1.2 Individuals under age one (1), eligible under 42 C.F.R. § 435.118;

5.3.1.3 Disabled or blind individuals under age eighteen (18) eligible under 42 C.F.R. § 435.120 or 42 C.F.R. § 435.130;

5.3.1.4 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;

5.3.1.5 Disabled children eligible for Medicaid under the Family Opportunity Act;

5.3.1.6 Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the sixty (60) day period following termination of pregnancy ends;

5.3.1.7 Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs;

5.3.1.8 An individual receiving hospice care, as defined in Section 1905(o) of the Social Security Act;

5.3.1.9 An Indian (as defined at Section 7.5) who is currently receiving or has ever received an item or service furnished by an Indian health care provider or through referral under contract health services; and

5.3.1.10 Individuals who are receiving Medicaid by virtue of their breast or cervical cancer diagnosis under 42 C.F.R. § 435.213.

5.3.2 *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); and (iv) family planning services and supplies described in section 1905(a)(4)(C) of the Social Security Act.

5.3.3 *Reserved*

5.3.4 *Nonemergency Use of Emergency Room (ER)*

The Contractor shall impose an eight dollar ($8) copayment for Iowa Health and Wellness Plan member's nonemergency use of an ER and a twenty-five dollar ($25) copayment for hawk-i member's non-emergency use of an ER. A copayment shall not be imposed on hawk-i members whose family income is less than one-hundred and fifty percent (150%) 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:

5.3.4.1 Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;

5.3.4.2 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;

5.3.4.3 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 enrollee; and

5.3.4.4 Provide a referral to coordinate scheduling for treatment by the alternative provider.

5.3.5 *Inability to Pay*

Members can assert to providers that they are unable to pay the copayment. Providers may not deny care or services to any member because of his or her 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 members who report they have been denied services for inability to pay.

5.3.6 *Claims Payment*

As described in Section 13.4.8, the Contractor shall reduce the payment it makes to a provider, by the amount of the 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).

5.4 Patient Liability

Some members have a patient liability, also referred to as client participation, which must be met before Medicaid reimbursement for services is available. The Agency has sole responsibility for determining the patient liability amount. This includes a portion of members eligible for Medicaid on the following bases: (i) members in an institutional setting; and (ii) 1915(c) HCBS waiver enrollees. The Contractor shall develop and implement policies and procedures, subject to Agency review and approval, to ensure that, where applicable, members pay their patient liability. The Agency will notify the Contractor of any applicable patient liability amounts for members. The Contractor shall implement mechanisms to communicate the liability amount to providers and shall delegate the collection of patient liability to the network providers. The Contractor shall pay providers net of the applicable patient liability amount.

5.5 Reserved

6 Provider Network Requirements

6.1 General Provisions

6.1.1 *Provider Network*

The Contractor shall provide all covered services specified in the Contract and as required by 42 C.F.R. § 438.206. In addition, per 42 C.F.R. § 438.207, the Contractor shall submit an electronic file of provider information to the Agency, in a format specified by the Agency, to demonstrate to the State that it, and that it offers an appropriate range of preventive, primary care, specialty services, and long term care services that is adequate for the anticipated number of enrollees for the service area (1) at the time it enters into the Contract with the Agency, and (2) 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 Exhibit B. 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 members, whether specified above or not.

6.1.2 *Provider Agreements*

In accordance with 42 C.F.R. § 438.206, the Contractor shall establish written agreements with all network providers. Contractors shall obtain Agency approval of all template provider agreements. 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 members.

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 third party liability, including the provider's obligations to identify third party liability 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 180 days of the date of service.

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 State Fiscal Year 2020. The VBP arrangement shall recognize population health outcome improvement as measured through the VIS 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 members that are part of a VBP must be assigned by the Contractor to a designated primary care provider (PCP). This PCP information shall be immediately reported by the Contractor for use in system wide coordination enhancements as specified by the Agency, such as provider alerts through the Iowa Health Information Network (IHIN); the Contractor shall also require that all contracted hospitals report admission and discharge information to support this exchange and coordination. Contractors shall use the State-wide Alert Notification (SWAN) system, or other processes as approved by the Agency, to satisfy hospital inpatient reporting requirements for Medicaid members. The Contractor shall use the SWAN system, or other Agency approved tool, to provide a consistent, real-time notification platform for hospitals to uniformly report inpatient and ED events for Medicaid members to the Contractor and care teams participating in VBP agreement. 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 for subcontracts as outlined in Section 2.2 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.

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 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 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.

If the Contract directs Contractor's expenditures under 42 C.F.R. §438.6(c)(1)(i) or (c)(1)(ii), the arrangement:

(a) Will make participation in the value-based purchasing initiative, delivery system reform or performance improvement initiative available, using the same terms or performance, to a class of providers providing services under the contract related to the reform or improvement initiative;

(b) Will use a common set of performance measures across all of the payers and providers;

(c) Will not set the amount or frequency of the expenditures; and

(d) Will not allow the State to recoup any unspent funds allocated for these arrangements from Contractor.

6.1.2.1 Nursing Facility Provider Agreements

In addition to the general provider agreement requirements listed in Section 6.1.2, the Contractor shall also include, at minimum, the following requirements in all provider agreements with nursing facilities:

6.1.2.1.1 Require the nursing facility to promptly notify the Contractor of a member's admission or request for admission to the nursing facility as soon as the facility has knowledge of such admission or request for admission;

6.1.2.1.2 Require the nursing facility to notify the Contractor immediately if the nursing facility is considering discharging a member and to consult with the member's care coordinator;

6.1.2.1.3 Require the nursing facility to notify the member and/or the member's representative (if applicable) in writing prior to discharge in accordance with State and Federal requirements;

6.1.2.1.4 Specify the nursing facility's responsibilities regarding patient liability as described in Section 5.4;

6.1.2.1.5 Require the nursing facility to notify the Contractor of any change in a member's medical or functional condition that could impact the member's level of care eligibility for the currently authorized level of nursing facility services;

6.1.2.1.6 Require the nursing facility to comply with federal Preadmission Screening and Resident Review (PASRR) requirements to provide or arrange to provide specialized services and all applicable Iowa law governing admission, transfer and discharge policies; and

6.1.2.1.7 Provide that if the nursing facility is involuntarily decertified by the State or CMS, the provider agreement shall automatically be terminated in accordance with federal requirements.

6.1.2.2 HCBS Providers

In addition to the general provider agreement requirements listed in Section 6.1.2, the Contractor shall also include, at minimum, the following requirements in all provider agreements with HCBS providers:

6.1.2.2.1 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 a member and to cooperate with the member's care coordinator to facilitate a seamless transition to alternate providers;

6.1.2.2.2 Require that in the event that a HCBS provider change is initiated for a member, regardless of any other provision in the provider agreement, the transferring HCBS provider continue to provide services to the member in accordance with the member's plan of care until the 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;

6.1.2.2.3 Require the HCBS provider to immediately report any deviations from a member's service schedule to the member's care coordinator;

6.1.2.2.4 Require the HCBS provider to comply with the critical incident reporting requirements as described in Section 10.4.2; and

6.1.2.2.5 Require the HCBS provider to comply with all child and dependent adult abuse reporting requirements.

6.1.3 *Provider Credentialing*

In accordance with 42 C.F.R. §438.214, the Contractor shall comply with the following requirements:

(a) *General rules.* Contractor shall implement written policies and procedures for selection and retention of network providers and ensure that those policies and procedures, at a minimum, meet the requirements of this section.

(b) *Credentialing and recredentialing requirements.* (1) 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 441 Iowa Administrative Code Chapter 88 as well as all State and Federal rules and regulations.

(2) Contractor shall follow a documented process for credentialing and recredentialing of network providers.

(c) *Nondiscrimination.* Contractor network provider selection policies and procedures, consistent with 42 C.F.R. § 438.12, must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

(d) *Excluded providers.* (1) Contractor may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.

(c) Reserved

6.1.3.1 Credentialing Policies and Procedures

In any Work Plan required by Section 2.13, the Contractor shall develop and implement 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 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.

6.1.3.2 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).

6.1.3.3 Timeliness

The Contractor shall ensure that credentialing of all providers applying for network provider status shall be completed as follows: (i) eighty-five percent (85%) within thirty (30) calendar days; and (ii) ninety-eight (98%) within forty-five (45) calendar days. The start time begins when the Contractor has received all necessary credentialing materials from the provider. Credentialing timeliness is measured to include any and all necessary functions performed after complete credentialing packet materials are submitted by the provider, including but not limited to credentialing committee and onsite provider reviews. If the Contractor requests additional materials, not already submitted by the provider, as a result of committee review the time shall not be measured while the Contractor is waiting for the requested materials. Completion time ends when written communication is mailed or faxed to the provider notifying them of the Contractor's decision. See Exhibit F for more details.

6.1.3.4 LTSS Providers

The Contractor shall ensure each LTSS 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 LTSS 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. Specifically, the Contractor shall ensure criminal history checks and child and dependent adult background checks are conducted for non-agency affiliated self-direction service providers such as Consumer Directed Attendant Care (CDAC) and Consumer Choices Options (CCO) employees. Each of the State's 1915(c) and 1915(i) HCBS waivers, delineate the minimum provider qualifications for each covered service. The Contractor shall ensure all HCBS waiver providers meet these qualification requirements.

6.1.3.5 Facility Requirements

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

6.1.3.6 Substance Use Disorder Providers

The Contractor shall ensure that substance use disorder treatment services provided to 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 441 Iowa Administrative § 155.21(8) as an acceptable credential for practitioners employed by a licensed substance use disorder treatment program.

6.1.3.7 Non-Licensed Providers

When individuals providing covered services under the Contract are not required to be licensed 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.

6.1.4 *Cultural Competence*

In accordance with 42 C.F.R. § 438.206, the Contractor shall participate in the Agency's efforts to promote the delivery of services in a culturally competent manner. The Contractor shall promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The Contractor shall address the special health needs of members who are poor, homeless and/or members of a minority population group. The Contractor shall incorporate in its polices, administration and service practice the value of: (i) honoring members' beliefs; (ii) sensitivity to cultural diversity; and (iii) fostering in staff and providers attitudes and interpersonal communication styles which respect members' cultural backgrounds. The Contractor shall have specific policy statements on these topics and communicate them to network providers and subcontractors.

6.1.4.1 Culturally Appropriate Care.

The Contractor shall permit members to choose providers from among the Contractor's network based on cultural preference. The Contractor shall permit members to change providers, within the Contractor's network, based on cultural preference. 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 member and provide care with sensitivity, understanding, and respect for the member's culture.

6.1.5 *Provider-Patient Communications.*

(a) *General rules.*

(1) Pursuant to 42 C.F.R. § 438.102, Contractor shall not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient, for the following:

(i) The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

(ii) Any information the Member needs to decide among all relevant treatment options.

(iii) The risks, benefits, and consequences of treatment or non-treatment.

(iv) The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

(2) Subject to the information requirements of paragraph (b) of this section, if Contractor would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service because of the requirement in paragraph (a)(1) of this section, Contractor is not required to do so if the Contractor objects to the service on moral or religious grounds.

(b) *Information requirements: Contractor responsibility.*

(1)(i) If Contractor elects the option provided in paragraph (a)(2) of this section, Contractor must furnish information about the services it does not cover as follows:

(A) To the Agency—

(1) With its application for a Medicaid contract.

(2) Whenever it adopts the policy during the term of the contract.

(B) Consistent with the provisions of 42 C.F.R. § 438.10, to Members, within 90 days after adopting the policy for any particular service.

(ii) In addition to the provisions and timeframe provided in (b)(1)(i) above, and consistent with the requirements of 42 C.F.R. § 438.10(g)(4), the Contractor shall furnish to the Agency the information as required in section (b)(1) at least 30 days before the effective date of the policy.

(2) As specified in 42 C.F.R. § 438.10(g)(2)(ii)(A) and (B), the Contractor must inform Members how they can obtain information from the Agency about how to access the service excluded under paragraph (a)(2) of this section.

(c) *Information requirements: Agency responsibility.* For each service excluded by an Contractor under paragraph (a)(2) of this section, the Agency will provide information to Members on how and where to obtain the service, as specified in 42 C.F.R. § 438.10.

(d) *Sanction.* If Contractor violates the prohibition of paragraph (a)(1) of this section, it is subject to intermediate sanctions as set forth in 42 C.F.R. part 438, subpart I and this Contract.

6.1.6 *Provider Relations and Communications*

In any Work Plan required by Section 2.13, the Contractor shall develop and implement a comprehensive provider relations and communications strategy. This strategy shall include, at minimum, the following requirements:

6.1.6.1 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:

6.1.6.1.1 Program benefits and limitations;

6.1.6.1.2 Claims filing instructions;

6.1.6.1.3 Criteria and process to use when requesting prior authorizations;

6.1.6.1.4 Cost sharing requirements;

6.1.6.1.5 Definition and requirements pertaining to urgent and emergent care;

6.1.6.1.6 Participants' rights;

6.1.6.1.7 Providers' rights for advising or advocating on behalf of his or her patient;

6.1.6.1.8 Provider non-discrimination information;

6.1.6.1.9 Policies and procedures for grievances and appeals in accordance with 42 C.F.R. § 438.414 and consistent with Section 8.2.1 and 8.15.

6.1.6.1.10 Contractor and the Agency contact information such as addresses and phone numbers; and

6.1.6.1.11 Policies and procedures for third party liability and other collections.

6.1.6.2 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 6.1.6.1 and provider training as described in Section 6.1.6.4. This website shall be accessible and functional via cell phone.

6.1.6.3 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 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 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.

6.1.6.4 Provider Training.

The Contractor shall provide ongoing and at a minimum annual, education and training to the provider network. All training materials may be reviewed and are subject to approval by the Agency. The Contractor shall develop training plans to support traditional LTSS providers in transitioning to rendering services under this program through assistance with features such as information technology, billing and systems operations. All provider training shall address, at minimum, the following topics:

6.1.6.4.1 The role of the care coordinator and the importance of notifying a member's care coordinator, as expeditiously as warranted by the member's circumstances, of any significant changes in the member's condition or care, hospitalizations, or recommendations for additional services;

6.1.6.4.2 Critical incident training as described in Section 10.4.3;

6.1.6.4.3 Abuse and neglect training including procedures and requirements for: (i) preventing; (ii) identifying; (iii) reporting; (iv) investigating; and (v) remediating suspected abuse, neglect and exploitation of members;

6.1.6.4.4 Provider requirements and responsibilities;

6.1.6.4.5 Prior authorization policies and procedures;

6.1.6.4.6 Claims resubmission processes;

6.1.6.4.7 Claims dispute resolution processes;

6.1.6.4.8 Any applicable Medicaid policies including updates and changes;

6.1.6.4.9 Person Centered Planning Process; and

6.1.6.4.10 HCBS settings per CMS regulations.

6.1.6.5 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) calendar 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)

calendar days prior to use. 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.

6.1.7 *Contractor Developed Materials*

All materials developed by the Contractor shall be made available to the Department and archived in an electronic library. The materials shall be available to the Department throughout the Contract term and transitioned to the Department after the Contract term.

6.1.8 *Notification of Provider Disenrollment*

In addition to the requirement to comply with Section 8.2.1 obligations regarding member notification of provider disenrollment, Contractor shall notify the Department and the Office of the Inspector General of provider disenrollments for program integrity reasons and in compliance with 42 C.F.R. Part 1001.

6.1.9 *Medical Records*

In any Work Plan required by Section 2.13, the Contractor shall develop and implement policies, procedures and contractual requirements for participating provider medical records content and documentation in compliance with the provisions of Iowa Admin. Code 441 Chapter 79.3. 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 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 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.

6.1.9.1 Maintenance and Retention

The Contractor shall maintain a medical records system which: (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.

6.1.9.2 Member Rights

In accordance with 42 C.F.R. § 438.100(b)(2)(vi), the Contractor shall maintain methods and procedures that guarantee each participant the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected. The Contractor's providers shall provide a copy of a member's medical record upon reasonable request by the member at no charge, and the provider shall facilitate the transfer of the member's medical record to another provider at the member's request. Confidentiality of, and access to, medical records shall be provided in accordance with the standards mandated in the Health Insurance Portability and Accountability Act (HIPAA) and all other State and Federal requirements.

6.1.9.3 Access to Medical and Financial Records

Within the timeframe designated by the Department or other authorized entity, the Contractor's providers shall permit the Contractor, representatives of the Agency, and other authorized entities to review 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.

6.1.10 *Reserved.*

6.1.11 *Provider Compliance*

In any Work Plan required by Section 2.13, 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 Exhibit B, 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 Exhibit B for more details.

6.2 Network Development and Adequacy

6.2.1 *Member Choice*

Consistent with the requirements in Exhibit F, the Contractor shall maintain a network sufficient to offer members a choice of providers to the extent possible and appropriate. The Contractor shall ensure 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 member to continue with the

same provider if the member so desires. In this case, the provider would be requested to meet the same qualifications as other providers in the network. Please see Section 3.3 on specific requirements related to continuity of care.

6.2.2 *Network Development and Maintenance*

The Contractor shall maintain and monitor the provider network in accordance with all Federal and State of Iowa laws and regulations. The Contractor shall demonstrate to the Agency that all providers are credentialed. In establishing and maintaining the network, the Contractor shall:

6.2.2.1 Not execute provider agreements with providers who have been excluded from participation in the Medicare, Medicaid, and/or CHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with a State's Medicaid program or the Medicare program;

6.2.2.2 Consider (i) the anticipated Medicaid enrollment; (ii) the expected utilization of services, taking into consideration the characteristics and health care needs of the specific populations included in the Contract; (iii) the number and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services; (iv) the number of network providers who are not accepting new Medicaid patients; and (v) the geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for members with disabilities;

6.2.2.3 In any Work Plan required by Section 2.13 develop and implement written policies and procedures, subject to Agency review and approval, for the selection, credentialing, recredentialing, and retention of providers, which, in accordance with 42 C.F.R. § 438.214(c), shall not discriminate against particular providers that serve high-risk population or specialize in conditions that require high cost treatment;

6.2.2.4 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;

6.2.2.5 (a) *General rules.*

(1) In accordance with 42 C.F.R. § 438.12, Contractor shall not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If Contractor declines to include individual or groups of providers in its provider network, it must give the affected providers written notice of the reason for its decision.
(2) In all contracts with network providers, Contractor shall comply with the requirements specified in 42 C.F.R. § 438.214.

(b) *Construction.* Paragraph (a) of this section may not be construed to—

(1) Require the Contractor to contract with providers beyond the number necessary to meet the needs of its Members;

(2) Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

(3) Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Members.

(c) The Contractor shall not limit any providers from providing services to any other IA Health Link MCO.

6.2.2.6 As permitted by law, for the first (2) years of the Contract, 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) community mental health centers (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 attempts to offer a reasonable rate as part of the contracting process 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;

6.2.2.7 For the first six (6) months and for all provider types not described in Section 6.2.2.6, the Contractor shall give providers, who are currently enrolled as Agency providers, the opportunity to be part of its network. . The Contractor shall reimburse these provider types at a rate that is equal to or exceeds the current Agency defined Iowa Medicaid rate, or as otherwise mutually agreed upon by the Contractor and the provider. The Contractor may use national or multi-state contracts for Durable Medical Equipment or Medical Supplies. Pharmacy providers shall be reimbursed in accordance with Section 3.2.6.9.1.1;

6.2.2.8 Notwithstanding the requirements set forth in 6.2.2.6 and 6.2.2.7, 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;

6.2.2.9 Reserved

6.2.2.10 Develop, implement, and at all times comply with provider selection policies and procedures including a uniform documented process for credentialing and re-credentialing providers who have signed contracts with the Contractor.

6.2.3 *Network Adequacy*

The Contractor shall document adequate network capacity at the time it enters into the Contract with the Agency, during the Agency's readiness review, at any time there is a significant 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. The Documentation of network adequacy shall be signed by the Contractor's Chief Executive Officer (CEO) and submitted at the required frequency and in the required format as determined by the Agency. Network adequacy is addressed through different performance indicators specified in the Contract that focus on specific time and distance measures and the provider number, mix and geographic distribution, including the general access standards set forth in Exhibit B and as designated in 42 CFR § 438.206. The Contractor shall provide the Agency written notice at least ninety (90) calendar days in advance of the Contractor's inability to maintain a sufficient network in any county.

(a)Delivery network. The Contractor shall meet the following requirements:

(1) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities.

(2) Provides female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.

(3) Provides for a second opinion from a network provider, or arranges for the member to obtain one outside the network, at no cost to the member.

(4) If the provider network is unable to provide necessary services, covered under the contract, to a particular member, the Contractor must adequately and timely cover these services out of network for the member, for as long as the Contractor's provider network is unable to provide them.

(5) The Contractor shall coordinate with out-of-network providers for payment and ensure the cost to the member is no greater than it would be if the services were furnished within the network.

(6) Demonstrate that its network providers are credentialed as required by 42 C.F.R. § 438.214.

(7) Demonstrate that its network includes sufficient family planning providers to ensure timely access to covered services.

(b)Furnishing of services. The Contractor shall comply with the following requirements.

(1)Timely access. The Contractor must do the following:

(i) Meet and require its network providers to meet Agency standards for timely access to care and services, taking into account the urgency of the need for services.

(ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid FFS, if the provider serves only Medicaid members.

(iii) Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.

(iv) Establish mechanisms to ensure compliance by network providers.

(v) Monitor network providers regularly to determine compliance.

(vi) Take corrective action if there is a failure to comply by a network provider.

(2)Access and cultural considerations. The Contractor shall participate in the Agency's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

(3)Accessibility considerations. The Contractor shall ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

(c)Nature of supporting documentation. The Contractor shall submit documentation to the State, in a format specified by the Agency, to demonstrate that it complies with the following requirements:

(1) Offers an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of enrollees for the service area.

(2) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

(d)Timing of documentation. The Contractor shall submit the documentation described in paragraph (c) of this section as specified by the Agency, but no less frequently than the following:

(1) At the time it enters into a contract with the Agency.

(2) On an annual basis.

(3) At any time there has been a significant change (as defined by the Agency) in the Contractor's operations that would affect the adequacy of capacity and services, including -

(i) Changes in the Contractor's services, benefits, geographic service area, composition of or payments to its provider network; or

(ii) Enrollment of a new population.

6.2.3.1 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.

6.2.4 *Out of Network Providers*

With the exception of family planning, emergency services and continuity of care requirements described in Section 3.3, once the Contractor has met the network adequacy standards set forth in Exhibit B, the Contractor may require all of its 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 member using contract providers, the Contractor shall adequately and timely cover these services for that member using non-contract providers for as long as the Contractor's provider network is unable to provide them.

The Contractor shall negotiate and execute written single-case agreements or arrangements with non-network providers, when necessary, to ensure access to covered services. With the exception of single case agreements and other arrangements established with non-network providers, out-of-network providers shall coordinate with the Contractor with respect to payment at 80% of the rate of reimbursement to in-network providers.

The Contractor shall ensure that no provider bills a member for all or any part of the cost of a treatment service, except as allowed for Title XIX cost sharing and patient liability as further described in Section 5. The Contractor shall coordinate payment with out-of-network providers and ensure that the cost to the enrollee is no greater than it would be if services were provided within the network.

6.2.4.1 Out of Network Care for Duals

Generally, when a 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:

6.2.4.1.1 The ordered service requires prior authorization the contract start date;

6.2.4.1.2 Dually eligible 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

6.2.4.1.3 The Contractor assists the member in obtaining a timely appointment with a contract provider upon request of the member or upon receipt of an order from a non-contract provider.

6.3 Requirements by Provider Type

6.3.1 *Primary Care Providers*

The specific primary care provider (PCP) designation is required for those members under a value based purchasing arrangement described in section 6.1.2. If using a PCP model, in any Work Plan required by Section 2.13, the 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 members to PCPs.

Contractor shall demonstrate compliance with 42 C.F.R. § 438.208.

6.3.2 *Physician Extenders*

In accordance with 42 C.F.R. § 441.22, State Medicaid programs are required to make nurse practitioner services available to Medicaid enrollees. The Contractor shall ensure this requirement is met for enrollees through the provider network.

6.3.3 *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 Exhibit B.

6.3.4 *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 Exhibit B.

6.3.5 *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 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 Exhibit B who accept new Medicaid enrollees 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 Exhibit B.

6.3.6 *Health Homes*

The Contractor shall develop a network of Integrated Health Homes and Health Homes. The Contractor shall develop strategies to encourage additional participation, particularly in areas of the State where participation has been low. In developing the Integrated Health Homes and Health Homes networks, the Contractor shall ensure all providers meet the minimum requirements for participation as

defined in the State Plan and the Agency policy. Refer to Section 3.2.9 for additional detail on all health home requirements.

6.3.7 *Federally Qualified Health Centers and Rural Health Clinics*

The Contractor shall offer to contract with all federally qualified health centers (FQHCs) and rural health clinics (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 Prospective Payment System (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.

6.3.8 *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.

6.3.9 *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.

6.3.10 *Urgent Care Clinics*

In any Work Plan required by Section 2.13, the Contractor shall develop strategies, policies, and procedures describing how it intends to utilize urgent care clinics in the delivery of care to members.

6.3.11 *Other Safety Net Providers and Community Partners*

In any Work plan required by Section 2.13, the Contractor shall develop strategies, policies, and procedures describing how it intends to utilize and partner with community entities and advocates.

6.3.12 *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 sixty (60) miles between a member's community-based residential alternative placement and the member's residence before entering the facility.

6.3.13 *Reserved.*

7 Enrollment

7.1 Eligibility

Persons eligible for enrollment with the Contractor are those encompassed by the categories listed in Exhibit C. The State shall have the exclusive right to determine an individual's eligibility for Medicaid 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 member's eligibility has changed.

7.2 MCO Selection and Assignment

Enrollment with a Contractor may be the result of an enrollee's selection of a particular Contractor or assignment by the Agency.

7.2.1 *Current Enrollees*

Except as provided in Section 7.2.1.1, enrollees who are known to be eligible for enrollment with the Contractor as of the start date of operations ("Current Enrollees") shall be assigned by the Agency to a program Contractor in accordance with the auto-assignment process set forth in Section 7.2.3. Following auto-assignment of Current Enrollees, the Agency will notify the member that they have ninety (90) days to choose another Contractor if they wish. The Enrollment Broker will accept requests for a change in Contractor.

7.2.1.1 1915(c) HCBS Waiver Enrollees and Institutional Populations

Individuals residing in an institution, nursing facility or ICF/ID, and individuals enrolled in a 1915(c) HCBS waiver will have the opportunity to select a program Contractor in advance of the start date of operations. If no selection is made in the required timeline, these individuals shall be assigned by the Agency to a program Contractor in accordance with the auto-assignment process set forth in Section 7.2.3, with the opportunity to change Contractors in the first ninety (90) days of enrollment.

7.2.2 *New Enrollees*

Applicants shall have the opportunity to select a Contractor at the time of application, based on the plan information provided to them at the time of application. New enrollees who do not select a Contractor at the time of application shall be auto-assigned to one in accordance with the auto-assignment process set forth in Section 7.2.3. Information shall be provided to new enrollees in accordance with Section 8.2.1.

7.2.2.1 Reserved.

7.2.3 *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 long-term services and supports (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. Per 42 C.F.R. § 438.56(c), the Agency will automatically reenroll with the Contractor beneficiaries who are disenrolled solely because of loss of eligibility for a time period of two (2) months or less. 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.

Due to planning for staffing and operations for Iowa Total Care implementation, the Agency will provide the Contractor a projected July 2019 minimum enrollment no later than November 1, 2018.

7.3 Enrollment Discrimination

In compliance with 42 C.F.R § 438.3(d), the Contractor:

(1) shall accept individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the Contract.

(2) Reserved.

(3) shall not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll.

(4) shall not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability.[1]

7.4 Member Disenrollment

(a) *Applicability.* The provisions of this section apply to all managed care programs and applies specifically to Contractor.

(b) *Disenrollment requested by the Contractor.*

(1) Reserved.

(2) Contractor shall not request disenrollment because of an adverse change in the Member's health status, or because of the Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the Contractor seriously impairs the entity's ability to furnish services to either this particular Member or other Members).

(3) Contractor shall assure the Agency that it does not request disenrollment for reasons other than those permitted under the Contract. All requests by the Contractor for the Agency to disenroll a Member shall be in writing and shall specify the basis for the request. The Contractor shall provide evidence to the Agency that continued enrollment of a Member seriously impairs the Contractor's ability to furnish services to either this particular Member or other Members. If applicable, the Contractor's request must document that reasonable steps were taken to educate the Member regarding proper behavior, and that the Member refused to comply. The Agency retains sole authority for determining if conditions for disenrollment have been met and disenrollment will be approved. The Agency will review and approve all MCO initiated requests for disenrollment. The Agency retains sole authority for determining if this condition has been met and disenrollment will be approved.

(c) *Disenrollment requested by the Member.* A Member may request disenrollment as follows:

(1) For cause, at any time.

(2) Without cause, at the following times:

(i) During the 90 days following the date of the Member's initial enrollment into the Contractor, or during the 90 days following the date the Agency sends the Member notice of that enrollment, whichever is later.

(ii) At least once every 12 months thereafter.

(iii) Upon automatic reenrollment under paragraph (g) of this section, if the temporary loss of Medicaid eligibility has caused the Member to miss the annual disenrollment opportunity.

(iv) When the Agency imposes the intermediate sanction specified in 42 C.F.R. § 438.702(a)(4) and this Contract.

(d) *Procedures for disenrollment—*

(1) *Request for disenrollment.* The Member (or his or her representative) must submit an oral or written request, as required by the Agency—

(i) Reserved.

(ii) To the Contractor.

(2) *Cause for disenrollment.* The following are cause for disenrollment:

(i) The Member moves out of the Contractor's service area.

(ii) The Contractor does not, because of moral or religious objections, cover the service the Member seeks.

(iii) The Member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the Member's primary care provider or another provider determines that receiving the services separately would subject the Member to unnecessary risk.

(iv) For Members that use MLTSS, the Member would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the Contractor and, as a result, would experience a disruption in their residence or employment.

(v) Other reasons, including but not limited to poor quality of care, lack of access to services covered under the Contract, or lack of access to providers experienced in dealing with the Member's care needs.

(3) *Contractor action on request.*

(i) If the Contractor receives a Member's request for disenrollment, the Contractor shall address the request through the Contractor's grievance process and, if the Member remains dissatisfied with the result of the grievance process, the Contractor shall thereafter refer the request to the Agency.

(ii) If the Agency fails to make a disenrollment determination so that the Member can be disenrolled within the timeframes specified in paragraph (e)(1) of this section, the disenrollment is considered approved.

(4) *Agency action on request.* For a request received directly from the Member, the Agency will refer the request to the Contractor to be addressed through the Contractor's grievance process. For a request referred by the Contractor following the Contractor's grievance process, the Agency must take action to approve or disapprove the request based on the following:

(i) Reasons cited in the request.

(ii) Information provided by the Contractor at the Agency's request.

(iii) Any of the reasons specified in paragraph (d)(2) of this section.

(5) *Use of the Contractor's grievance procedures.*

(i) The Agency requires that the Member seek redress through the Contractor's grievance system before making a determination on the Member's request.

(ii) The grievance process must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the timeframe specified in paragraph (e)(1) of this section. Contractor shall follow the timelines of an expedited grievance.

(iii) Reserved.

(e) *Timeframe for disenrollment determinations.*

(1) The effective date of an approved disenrollment made by the Agency must be no later than the first day of the second month following the month in which the Member requests disenrollment or Contractor refers the request to the Agency.

(2) If the Agency fails to make the determination within the timeframes specified in paragraph (e)(1) of this section, the disenrollment is considered approved for the effective date that would have been established had the Agency complied with paragraph (e)(1) of this section.

(f) *Notice and appeals.* The Agency will:

(1) Provide that Members and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period. The notice must include an explanation of all of the Member's disenrollment rights as specified in this section.

(2) Ensure timely access to State fair hearing for any Member dissatisfied with an Agency determination that there is not good cause for disenrollment.

(g) *Automatic reenrollment*: Any Member who is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less will be reenrolled with the Contractor.[2]

7.4.1 *Reserved.*

7.4.2 *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 the Health Insurance Premium Payment Program (HIPP) is more cost-effective than enrollment in the Contract; and (v) death.[3]

7.4.3 *Notification of Member Death or Incarceration*

The Contractor shall notify the Agency, in the manner prescribed by the State, within thirty (30) calendar days of the date it becomes aware of the death or incarceration of one of its members, giving the member's full name, address, Social Security Number, member identification number and date of death. Recoupment of capitation payments made to the Contractor will occur where the member is not eligible for Medicaid services. The Contractor shall have no authority to pursue recovery against the estate of a deceased Medicaid member.

7.5 Indian Medicaid Managed Care

[4](a) *Definitions.* As used in this section, the following terms have the indicated meanings:

Indian means 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:

(i) Is a member of a Federally recognized Indian tribe;

(ii) Resides in an urban center and meets one or more of the four criteria:

(A) 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;

(B) Is an Eskimo or Aleut or other Alaska Native;

(C) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(D) Is determined to be an Indian under regulations issued by the Secretary of Health and Human Services;

(iii) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(iv) 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.

Indian health care provider (IHCP) means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

(b) *Network and coverage requirements.* In accordance with 42 C.F.R. § 438.I4(b) Contractor shall:

(1) Demonstrate that there are sufficient IHCPs participating in the provider network of the Contractor to ensure timely access to services available under the Contract from such providers for Indian members who are eligible to receive services.

(2) Pay IHCPs, whether participating or not, for covered services provided to Indian members who are eligible to receive services from such providers as follows:

(i) At a rate negotiated between the Contractor, and the IHCP, or

(ii) In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the Contractor would make for the services to a participating provider which is not an IHCP; and

(iii) Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 C.F.R. §§ 447.45 and 447.46.

(3) Permit any Indian member to receive services from a IHCP primary care provider participating as a network provider, to choose that IHCP as his or her primary care provider, as long as that provider has capacity to provide the services.

(4) Permit Indian members to obtain services covered under the Contract from out-of-network IHCPs from whom the member is otherwise eligible to receive such services.

(5) If at any point in time access to covered services cannot be ensured in the Agency due to few or no IHCPs, Contractor will be considered to have met the requirement in paragraph (b)(1) of this section if—

(i) Indian members are permitted by the Contractor to access out-of-State IHCPs; or

(ii) If this circumstance is deemed to be good cause for disenrollment from both Contractor and the State's managed care program in accordance with 42 C.F.R. § 438.56(c).

(6) Contractor must permit an out-of-network IHCP to refer an Indian member to a network provider.

(c) *Payment requirements.* (1) When an IHCP is enrolled in Medicaid as a FQHC but not a participating provider of Contractor, it must be paid an amount equal to the amount the Contractor would pay a FQHC that is a network provider but is not an IHCP, pursuant to Special Terms Appendix 1 – Scope of Work, Section 6.3.7.

(2) When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of Contractor or not, the Contractor shall reimburse the IHCP at its applicable encounter rate published annually in the Federal Register by the Indian Health Service, 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.

(3) Reserved.

(d) Reserved.

8 Member Services

8.1 Marketing

8.1.1 *Marketing Activities*

(a) *Definitions.* As used in this section, the following terms have the indicated meanings:

Contractor includes any of the entity's employees, network providers, agents, or contractors.

Cold-call marketing means any unsolicited personal contact by the Contractor with a potential Member for the purpose of marketing as defined in this paragraph (a).

Marketing means any communication, from Contractor to a Medicaid Member who is not enrolled in Contractor, that can reasonably be interpreted as intended to influence the Member to enroll in Contractor's Medicaid product, or either to not enroll in or to disenroll from another

MCO's, PIHP's, PAHP's, PCCM's or PCCM entity's Medicaid product. Marketing does not include communication to a Medicaid Member from the issuer of a qualified health plan, as defined in 45 CFR § 155.20, about the qualified health plan.

Marketing materials means materials that—

(i) Are produced in any medium, by or on behalf of Contractor; and

(ii) Can reasonably be interpreted as intended to market the Contractor to potential Members.

MCO, PIHP, PAHP, PCCM or PCCM entity include any of the entity's employees, network providers, agents, or contractors.

Private insurance does not include a qualified health plan, as defined in 45 CFR § 155.20.

(b) *Requirements.*

(1) Contractor—

(i) shall not distribute any marketing materials without first obtaining Agency approval.

(ii) shall distribute the materials statewide.

(iii) Reserved.

(iv) shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

(v) shall not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities.

(2) The Contractor shall ensure that a potential member can make his or her own decision as to whether or not to enroll. Contractor's marketing materials shall be accurate and not mislead, confuse, or defraud the beneficiaries or the Agency. Statements that will be considered inaccurate, false, or misleading include, but are not limited to, any assertion or statement (whether written or oral) that—

(i) The Member must enroll with Contractor to obtain benefits or to not lose benefits; or

(ii) The Contractor is endorsed by CMS, the Federal or State government, or similar entity; or

(iii) The Contractor's health plan is the only opportunity to obtain benefits under the program; or

(iv) The Contractor's marketing materials mislead or falsely describe covered or available services, membership or availability of network providers, and qualifications and skills of network providers.

(c) *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. In reviewing the marketing materials submitted by the entity, the Agency will consult with the Medical Care Advisory Committee established under 42 C.F.R. § 431.12 or an advisory committee with similar membership, for all materials intended for distribution to the Medicaid population.[5]

8.1.1.1 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.

8.2 Member Communications

8.2.1 *General*

The Contractor shall comply with the information requirements at 42 C.F.R. § 438.10 as set forth below.

[6](a) *Definitions.* As used in this section, the following terms have the indicated meanings:

Limited English proficient (LEP) means potential members and 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.

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

Readily accessible means electronic information and services which 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.

(b) *Applicability.* The provisions of this section apply to Contractor.

(c) *Basic rules.* (1) Contractor must provide all required information in this section to members and potential members in a manner and format that may be easily understood and is readily accessible by such members and potential members.

(2) Reserved.

(3) Reserved.

(4) For consistency in the information provided to members, the Agency will develop and require Contractor to use:

(i) Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care; and

(ii) Model member handbooks and member notices.

(5) Contractor shall provide the required information in this section to each member.

(6) Member information required in this section may not be provided electronically by the Agency, or Contractor unless all of the following are met:

(i) The format is readily accessible;

(ii) The information is placed in a location on the Agency or Contractor's Web site that is prominent and readily accessible;

(iii) The information is provided in an electronic form which can be electronically retained and printed;

(iv) The information is consistent with the content and language requirements of this section; and

(v) The member is informed that the information is available in paper form without charge upon request and provides it upon request within 5 business days.

(7) Contractor must have in place mechanisms to help members and potential members understand the requirements and benefits of the plan.

(d) *Language and format.* The Agency will:

(1) Reserved.

(2) Make oral interpretation available in all languages and written translation available in each prevalent non-English language. All written materials for potential members must include

taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free telephone number of the entity providing choice counseling services as required by 42 C.F.R. § 438.71(a). Large print means printed in a font size no smaller than 18 point.

(3) Require Contractor to make its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its particular service area. Written materials must also be made available in alternative formats upon request of the potential member or member at no cost. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost. Written materials must 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 and the toll-free and TTY/TDY telephone number of Contractor's member/customer service unit. Large print means printed in a font size no smaller than 18 point.

(4) Make interpretation services available to each potential member and require Contractor to make those services available free of charge to each member. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language. Oral interpretation requirements apply to all non-English languages, not just those that the Agency identifies as prevalent.

(5) Notify potential members, and require Contractor to notify its members—

(i) That oral interpretation is available for any language and written translation is available in prevalent languages;

(ii) That auxiliary aids and services are available upon request and at no cost for members with disabilities; and

(iii) How to access the services in paragraphs (d)(5)(i) and (ii) of this section.

(6) Provide, and require Contractor to provide, all written materials for potential members and members consistent with the following:

(i) Use easily understood language and format.

(ii) Use a font size no smaller than 12 point.

(iii) Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency.

(iv) Include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. Large print means printed in a font size no smaller than 18 point.

(e) *Information for potential members.* (1) The Agency must provide the information specific in paragraph (e)(2) of this section not each potential member, either in paper or electronic form as follows:

(i) At the time the potential member first becomes eligible to enroll in a voluntary managed care program, or is first required to enroll in a mandatory managed care program; and

(ii) Within a timeframe that enables the potential member to use the information in choosing among available Contractors.

(2) The information for potential members must include, at a minimum, all of the following:

(i) Information about the potential member's right to disenroll consistent with the requirements of 42 C.F.R. § 438.56 and which explains clearly the process for exercising this disenrollment right, as well as the alternatives available to the potential member based on their specific circumstance;

(ii) The basic features of managed care;

(iii) Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program. For mandatory and voluntary populations, the length of the enrollment period and all disenrollment opportunities available to the member must also be specified;

(iv) The service area covered by each Contractor;

(v) Covered benefits including:

(A) Which benefits are provided by the Contractor; and

(B) Which, if any, benefits are provided directly by the Agency.

(C) For a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Agency must provide information about where and how to obtain the service;

(vi) The provider directory and Preferred Drug List (PDL) information required in paragraphs (h) and (i) of this section;

(vii) Any cost-sharing that will be imposed by the Contractor consistent with those set forth in the State plan;

(viii) The requirements for each Contractor to provide adequate access to covered services, including the network adequacy standards established in 42 C.F.R. § 438.68;

(ix) The Contractor's responsibilities for coordination of member care; and

(x) To the extent available, quality and performance indicators for each Contractor, including member satisfaction.

(3) The Contractor will comply with requests for information submitted by the Agency or its contracted representative and required for the development of information specified in paragraph (e)(2) of this section.

(f) *Information for all members with Contractor: General requirements.* (1) Contractor must make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

(2) The Agency will notify all members of their right to disenroll consistent with the requirements of 42 C.F.R. § 438.56 at least annually. Such notification will clearly explain the process for exercising this disenrollment right, as well as the alternatives available to the member based on their specific circumstance.

(3) Contractor must make available, upon request, any physician incentive plans in place as set forth in 42 C.F.R. § 438.3(i).

(g) *Information for members with Contractor—Member handbook.* (1) Contractor must provide each member a member handbook, within seven days after receiving notice of the beneficiary's enrollment, which serves a similar function as the summary of benefits and coverage described in 45 C.F.R. § 147.200(a).

(2) The content of the member handbook must include information that enables the member to understand how to effectively use the managed care program. This information must include at a minimum:

(i) Benefits provided by Contractor.

(ii) How and where to access any benefits provided by the Agency, including any cost sharing, and how transportation is provided.

(A) In the case of a counseling or referral service that Contractor does not cover because of moral or religious objections, Contractor must inform members that the service is not covered by Contractor.

(B) Contractor must inform members how they can obtain information from the Agency about how to access the services described in paragraph (g)(2)(i)(A) of this section.

(iii) The amount, duration, and scope of benefits available under the Contract in sufficient detail to ensure that members understand the benefits to which they are entitled.

(iv) Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider.

(v) The extent to which, and how, after-hours and emergency coverage are provided, including:

(A) What constitutes an emergency medical condition and emergency services.

(B) The fact that prior authorization is not required for emergency services.

(C) The fact that, subject to the provisions of this section, the member has a right to use any hospital or other setting for emergency care.

(vi) Any restrictions on the member's freedom of choice among network providers.

(vii) The extent to which, and how, members may obtain benefits, including family planning services and supplies from out-of-network providers. This includes an explanation that Contractor cannot require a member to obtain a referral before choosing a family planning provider.

(viii) Cost sharing.

(ix) Member rights and responsibilities, including the elements specified in 42 C.F.R. § 438.100.

(x) The process of selecting and changing the member's primary care provider.

(xi) Grievance, appeal, and fair hearing procedures and timeframes, consistent with Special Terms Appendix 1 – Scope of Work, Section 8.15, in an Agency-developed or Agency-approved description. Such information must include:

(A) The right to file grievances and appeals.

(B) The requirements and timeframes for filing a grievance or appeal.

(C) The availability of assistance in the filing process.

(D) The right to request a State fair hearing after Contractor has made a determination on a member's appeal which is adverse to the member.

(E) The fact that, when requested by the member, benefits that Contractor seeks to reduce or terminate will continue if the member files an appeal or a request for Agency fair hearing within the timeframes specified for filing, and that the member may, consistent with Agency policy, be required to pay the cost of services furnished while the appeal or State fair hearing is pending if the final decision is adverse to the member.

(xii) How to exercise an advance directive, as set forth in 42 C.F.R. § 438.3(j).

(xiii) How to access auxiliary aids and services, including additional information in alternative formats or languages.

(xiv) The toll-free telephone number for member services, medical management, and any other unit providing services directly to members.

(xv) Information on how to report suspected fraud or abuse;

(xvi) Any other content required by the Agency including, but not limited to information listed in Special Terms Appendix 1 – Scope of Work, Section 8.2.6.

(3) Information required by this paragraph to be provided by Contractor will be considered to be provided if the Contractor:

(i) Mails a printed copy of the information to the member's mailing address;

(ii) Provides the information by email after obtaining the member's agreement to receive the information by email;

(iii) Posts the information on the Web site of Contractor and advises the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or

(iv) Provides the information by any other method that can reasonably be expected to result in the member receiving that information.

(4) The Contractor must give each member notice of any change that the Agency defines as significant including, but not limited to, those changes set forth at Special Terms Appendix 1 – Scope of Work, Section 8.2.8, in the information specified in this paragraph (g), at least 30 days before the intended effective date of the change.

(h) *Information for all members of Contractor—Provider Directory.* (1) Contractor must make available in paper form upon request and electronic form, the following information about its network providers:

(i) The provider's name as well as any group affiliation.

(ii) Street address(es).

(iii) Telephone number(s).

(iv) Web site URL, as appropriate.

(v) Specialty, as appropriate.

(vi) Whether the provider will accept new members.

(vii) The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.

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

(2) The provider directory must include the information in paragraph (h)(1) of this section for each of the following provider types covered under the Contract:

(i) Physicians, including specialists;

(ii) Hospitals;

(iii) Pharmacies;

(iv) Behavioral health providers; and

(v) LTSS providers, as appropriate.

(3) Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.

(4) Provider directories must be made available on Contractor's Web site in a machine readable file and format as specified by the Secretary.

(i) *Information for all members of Contractor: Preferred Drug List.* Contractor must make available in electronic or paper form, the following information about its Preferred Drug List (PDL) as described at Special Terms Appendix 1 – Scope of Work, Section 3.2.6.2.1:

(1) Which medications are covered (both generic and name brand).

(2) What tier each medication is on.

(3) PDLs must be made available on Contractor's Web site in a machine readable file and format as specified by the Secretary, or through a link to the PDL on the Agency's Web site.

(j) Reserved.

8.2.2 *Language Requirements*

The Contractor shall provide information to members who are limited English proficient through the provision of language services at no cost to the individual. 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. 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 enrollee. The Contractor shall utilize this information to ensure communication materials are distributed in the appropriate language. The Contractor shall also identify additional languages that are prevalent among the Contractor's membership. For purposes of this requirement, prevalent language is defined as any language spoken by at least five percent (5%) of the general population in the Contractor's service area. Written information shall be provided in any such prevalent languages identified by the Contractor.

8.2.3 *Alternative Formats*

The Contractor shall make written materials available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. This includes 508 compliance, Braille, large font, audiotape and verbal explanations of written materials.

8.2.4 *State Review and Approval of Member Communications*

The Contractor shall obtain Agency prior approval of all Contractor developed member communications. All materials shall be submitted at least thirty (30) calendar days or within the timeframe requested by the Department, 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) calendar days or within the timeframe requested by the Department, prior to use. 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 member communication materials upon the Agency request. The Agency reserves the right to mandate that specific language be included in member communication materials.

MCO must provide/produce the number of brochures determined by the department to be placed in the enrollment packets Brochures must be full color, tri-fold, 8.5x11, front-back.

8.2.5 *Policies and Procedures*

The Contractor shall develop and implement policies and procedures, subject to Agency review and approval, to ensure that materials are accurate in content, accurate in translation relevant to language or alternate formats and do not defraud, mislead or confuse the member. The Contractor shall provide the Department with copies of such policies and procedures upon request from the Department.

8.2.6 *New Member Communications*

The Contractor shall distribute enrollment materials to each member. All information in the enrollment materials shall meet the requirements set forth in Section 8.2 and shall be submitted for the Agency review and approval prior to distribution in accordance with the process established in Section 8.2.4. In addition to information set forth in Section 8.2.1, the enrollment materials shall include the following information:

8.2.6.1 Reserved;

8.2.6.2 Contractor's contact information, including address, telephone number, web site;

8.2.6.3 Reserved;

8.2.6.4 Contractor's office hours/days, including the availability of the Member Helpline and the 24-hour Nurse Call Line;

8.2.6.5 Reserved;

8.2.6.6 Reserved;

8.2.6.7 Description of how to complete a health risk screening, a process described in Section 9.1.1;

8.2.6.8 Reserved;

8.2.6.9 Reserved;

8.2.6.10 Reserved;

8.2.6.11 If applicable, any cost-sharing information, including patient liability responsibilities for 1915(c) HCBS waiver enrollees, 1915(i) program enrollees, ICF/ID, and nursing facility residents, and contact information where the member can ask questions regarding their cost-sharing obligations and consequences for failure to comply with cost sharing and patient liability requirements;

8.2.6.12 Reserved;

8.2.6.13 Reserved;

8.2.6.14 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;

8.2.6.15 Standards and expectations for receiving preventive health services;

8.2.6.16 Procedures for changing Contractors and circumstances under which this is possible, as described in Section 7.4;

8.2.6.17 Procedures for making complaints and recommending changes in policies and services;

8.2.6.18 Reserved;

8.2.6.19 Information on how to contact the Iowa Medicaid Enrollment Broker;

8.2.6.20 Information on alternative methods or formats of communication for visually and hearing-impaired and non-English speaking enrollees and how members can access those methods or formats at no expense;

8.2.6.21 Information and procedures on how to report suspected abuse and neglect, including the phone numbers to call to report suspected abuse and neglect;

8.2.6.22 Contact information and description of the role of the Ombudsman; and

8.2.6.23 For members enrolled in a 1915(c) HCBS Waiver or 1915(i) State Plan, the Contractor shall also provide the following information:

8.2.6.23.1 A description of the community-based case management's or integrated health home care coordinator's roles and responsibilities;

8.2.6.23.2 Information on how to change community based case management or integrated health homes care coordination; and

8.2.6.23.3 When applicable, information on the option to self-direct, a process described in Section 4.4.8, including but not limited to: (i) the roles and responsibilities of the member; (ii) the ability of the member to select a representative; (iii) the services that can and cannot be self-directed; (iv) the 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 member to perform the services; and information on estate recovery.

8.2.7 *Reserved.*

8.2.8 *Notification of Significant Change*

In addition to notification of a material change in operation as described in Section 2.20, the Contractor shall provide written member notice when there is a significant change, defined as any change that may impact member accessibility to services and benefits, in:

8.2.8.1 Restrictions on the member's freedom of choice among network providers;

8.2.8.2 Member rights and protections;

8.2.8.3 Grievance and fair hearing procedures;

8.2.8.4 Amount, duration and scope of benefits available;

8.2.8.5 Procedures for obtaining benefits, including authorization requirements;

8.2.8.6 The extent to which, and how, enrollees may obtain benefits from out-of-network providers;

8.2.8.7 The extent to which and how after-hours and emergency coverage are provided;

8.2.8.8 Policy on referrals for specialty care and for other benefits not furnished by the member's primary care provider; or

8.2.8.9 Cost sharing.

8.2.9 *Notice of Action*

The Contractor shall give members written notice of any action, not just service authorization actions, within the timeframes for each type of action as described in State and Federal rules, regulations, and policies. Information specific to authorization actions is found in 11.2.7.

8.3 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 member inquiries. The telephone line shall be staffed with live-voice coverage during normal working days (Monday through Friday), excluding State holidays, and shall be accessible, at minimum, during working hours of 7:30 a.m. - 6:00 p.m. Central Time. The State holidays are: (i) New Years Day; (ii) Martin Luther King, Jr.'s Birthday; (iii) Memorial Day; (iv) July 4th; (v) Labor Day; (vi) Veterans Day; (vii) Thanksgiving; (viii) Day after Thanksgiving; and (ix) Christmas Day. The Contractor shall provide a voice message system that informs callers of the Contractor's business hours and offers an opportunity to leave a message after business hours. Calls received in the voice message system shall be returned within one (1) business day. The Contractor shall have the ability to warm transfer enrollees 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 Interactive Voice Response (IVR) system, but shall ensure a caller is

connected to a live person within one (1) minute if the caller chooses that option.

8.3.1 *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 members. Additionally, the Contractor shall ensure communication between the Contractor and 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.

8.3.2 *Helpline Staff and Knowledge*

The Contractor's member services helpline staff shall be prepared to efficiently respond to 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 patient liability inquiries; and (ix) incentive programs.

8.3.3 *Helpline Performance Metrics*

99% of calls will be answered by an individual or an electronic device without receiving a busy signal. 80% of all calls will be answered in 30 seconds or less. The average speed for answering calls will be 30 seconds or less.[7]

8.3.4 *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.

8.3.5 *Integration of Service Lines*

To facilitate the delivery of integrated healthcare services, the member services helpline shall be used by all members, regardless of whether the member is calling about physical health, behavioral health and/or long-term care services. The Contractor shall not have separate numbers for 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 enrollee to call a separate number regarding behavioral healtb and/or long-term care services.

8.3.6 *Tracking and Reporting*

The Contractor shall maintain a system for tracking and reporting the number and type of 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.

8.4 Nurse Call Line

The Contractor shall operate a toll-free Nurse Call Line which provides nurse triage telephone services for 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 members to help discourage inappropriate emergency room use. The Nurse Call Line shall have a system in place to communicate all issues with the 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.

8.5 Electronic Communications

The Contractor shall leverage technology to promote timely and effective communications with members. All electronic communications shall be in compliance with 42 C.F.R. § 438.10, as further described in Section 8.2.1.[8] The Contractor shall collect information on member's preferred mode of receipt of Contractor-generated communications and send materials in the selected format. Options shall include, but are not limited to, the ability to receive paper communications via mail or electronic communications through a secure web portal. When a member notifies the Contractor of selection to receive communications electronically, that choice shall be confirmed through regular mail with instructions on how to change the selection if desired. Additionally, emails shall be sent to members alerting them anytime an electronic notice is posted to the portal; no confidential information shall be included in emails. In the event such a notification email is returned as undeliverable, the Contractor shall send the notice by regular mail within three (3) business days of the failed email. When applicable, the Contractor shall comply with a member's election to change the preferred mode of communication. The Contractor shall receive electronic communications from members via email and the member website. The Contractor shall respond to electronic inquiries within one (1) business day. The Contractor is also encouraged to utilize mobile technology, such as delivering medication and appointment reminders through personalized voice or text messaging.

8.6 Member Website

The Contractor shall develop a member website and mobile applications available in English and Spanish that is accessible and functional via cell phone. The member website shall include, at minimum, the information required in the enrollment materials as described in Section 8.2.6. 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, prior to posting, for the Agency review and approval in accordance with Section 8.2.4.

8.7 Health Education and Initiatives

The Contractor shall develop programs and participate in activities to enhance the general health and well-being of members. The Contractor shall develop a strategy to participate in and interface with the Healthiest State Initiative. Examples of health education, disease prevention and outreach programs and activities include, but not limited to, the following:

8.7.1 *Example Programs*

8.7.1.1 General physical, behavioral/mental health and long-term care education;

8.7.1.2 Education regarding the importance of preventive care, including flu shots and age appropriate recommended screenings;

8.7.1.3 Education to prepare members for participation in and reaction to specific medical procedures and to instruct patients in self-management of medical problems and disease prevention;

8.7.1.4 Smoking cessation programs with targeted outreach for adolescents and pregnant women;

8.7.1.5 Nutrition counseling;

8.7.1.6 Early intervention and risk reduction strategies to avoid complications of disability and chronic illness;

8.7.1.7 Prevention and treatment of substance use disorder;

8.7.1.8 Self-care training, including self-examination;

8.7.1.9 Education to assist members with a clear understanding of how to take medications and the importance of coordinating all medications;

8.7.1.10 Understanding the difference between emergent, urgent and routine health conditions;

8.7.1.11 Education for members on the significance of their role in their overall health and welfare and available resources; and

8.7.1.12 Education for members and caregivers about identification and reporting of suspected abuse and neglect.

8.8 Cost and Quality Information

Subject to the Agency approval and with the timeframes specified, the Contractor shall implement innovative strategies to provide price and quality transparency to members. Making cost and quality information available to members increases transparency and has the potential to reduce costs and improve quality. The Contractor shall make cost and quality information available to 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.

8.8.1 *Explanation of Benefits*

The Contractor shall provide explanation of benefits (EOBs) to all members or a statistically valid sample of all members. This includes members in the Iowa Health and Wellness Plan as well as hawk-i. EOBs shall be available via paper and secure web based portal. EOBs shall be delivered to members based on their preferred mode of receipt of Contractor communications as described in Section 8.5. At a minimum, EOBs shall be designed to address requirements in 42 C.F.R. § 433.116(e) and (f). To maintain member confidentiality, EOBs shall not be sent on family planning services.

8.8.2 *Quality Information*

The Contractor shall make provider quality information available to members. The Contractor shall capture quality information about its network providers and shall make this information available to members based on their preferred mode of receipt of Contractor communications as described in Section 8.5. The Contractor may choose to quantitatively and qualitatively rate providers. In making the information available to members, the Contractor shall identify any limitations of the data.

8.9 Advance Directive Information

The Contractor shall comply with the advance directive requirements outlined in Section 8.9.1 and Section 8.9.2 below.

8.9.1 *Advance Directives.*

(1) If Contractor is an MCO or PIHP as defined in 42 C.F.R. part 438, the Contractor shall comply with the requirements of 42 C.F.R. § 422.128 for maintaining written policies and procedures for advance directives, as if such regulation applied directly to the Contractor.

(2) If Contractor is a PAHP as defined in 42 C.F.R. part 438, the Contractor shall comply with the requirements of 42 C.F.R. § 422.128 for maintaining written policies and procedures for advance directives as if such regulation applied directly to Contractor if the Contractor includes, in its network, any of those providers listed in 42 C.F.R. § 489.102(a).

(3) Contractor shall provide adult Members with written information on advance directives policies, and include a description of applicable State law.

(4) The information provided adult Members must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.[9]

8.9.2 *No Discrimination*

Contractor shall not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive.

8.10 Member Rights

(a) *General rule.* In compliance with 42 C.F.R. §438.100 or 42 C.F.R. § 457.1220, as applicable:

(1) Contractor shall have written policies regarding the Member rights specified herein; and

(2) Contractor shall comply with any applicable Federal and State laws that pertain to Member rights, and ensure that its employees and contracted providers observe and protect those rights.

(b) *Specific rights*—

(1) *Basic requirement.* Contractor shall ensure that each Member is guaranteed the rights as specified in paragraphs (b)(2) and (3) below.

(2) An Member with the Contractor has the following rights: The right to—

(i) Receive information in accordance with 42 C.F.R. § 438.10.

(ii) Be treated with respect and with due consideration for his or her dignity and privacy, including but not limited to the right to fully participate in the community and to work, live and learn to the fullest extent possible; and

(iii) Receive information on available treatment options and alternatives, including treatment in the least restrictive setting, presented in a manner appropriate to the Member's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in 42 C.F.R. § 438.10(g)(2)(ii)(A) and (B).)

(iv) Participate in decisions regarding his or her health care, including the right to refuse treatment.

(v) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

(vi) Request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526.

(3) An Member with the Contractor (consistent with the scope of the contracted services if the Contractor is a PAHP) has the right to be furnished health care services in accordance with 42 C.F.R. §§ 438.206 through 438.210.

(c) *Free exercise of rights.* The Agency must ensure that each Member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Contractor and its network providers or the Agency treat the Member.

(d) *Compliance with other Federal and State laws.* Contractor shall comply with any other applicable Federal and State laws (including: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 C.F.R. part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 C.F.R. part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.[10]

8.11 Redetermination Assistance

The Contractor may assist its members in the eligibility redetermination process.

8.11.1 *Permissible Activities*

The Contractor may conduct the following redetermination assistance activities: (i) conduct outreach calls or send letters to members reminding them to renew their eligibility; (ii) assist the member in understanding the redetermination process; and (iii) help the member obtain required documentation and collateral verification needed to process the application.

8.11.2 *Prohibited Activities*

In providing redetermination assistance, the Contractor shall not engage in any of the following activities: (i) discriminate against members, including particularly high-cost members or members that have indicated a desire to change Contractors; (ii) talk to members about changing Contractors, these calls shall be referred to the Enrollment Broker; (iii) provide any indication as to whether the 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 member complete the redetermination process; (v) sign the member's redetermination form; or (vi) complete or send redetermination materials to the Agency on behalf of the member.

8.12 Member Stakeholder Engagement

In any Work Plan required by Section 2.13, the Contractor shall develop a comprehensive 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 members. Representatives from the MCO will participate in DHS sponsored outreach and education activities as requested by the Department.

8.12.1 *Stakeholder Advisory Board*

The Contractor shall convene a Stakeholder Advisory Board in accordance with the following requirements of 42 C.F.R. § 438.110:

(a) *General rule.* Contractor shall establish and maintain a stakeholder advisory board within 90 days of the effective date of the Contract.

(b) *Committee composition.* The committee required in paragraph (a) of this section must include at least a reasonably representative sample of the LTSS populations, or other individuals representing those members, covered under the Contract with the Contractor as further described at Section 8.12.1.2.

The purpose of the Stakeholder Advisory Board is to serve as a forum for 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) member rights and responsibilities; (iv) resolution of grievances and appeals; (v) operational issues; (vi) program monitoring and evaluation; (vii) member and provider education; and (viii) priority issues identified by members.

8.12.1.1 Advisory Board Plan

In any Work Plan required by Section 2.13, the Contractor shall develop a plan for the Stakeholder Advisory Board. In the plan, the Contractor shall identify the steps to be taken and include a timeline with target dates. In the plan, the Contractor shall include, but is not limited to including, procedures for implementing the Stakeholder Advisory Board and details discussing how the Contractor will ensure meaningful representation from member stakeholder groups.

8.12.1.2 Stakeholder Advisory Board Composition

The Stakeholder Advisory Board shall be comprised of 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 members in terms of race, gender, special populations and Iowa geographic areas. At least fifty-one percent (51%) of the Stakeholder Advisory Board shall be comprised of members and/or their representatives (e.g., family members or caregivers). Provider membership shall be representative of the different services covered under the Contract, including, but not limited to: (i) nursing facility providers; (ii) behavioral health providers; (iii) primary care; (iv) hospitals; (v) 1915(c) HCBS waiver providers; and (vi) 1915(i) habilitation providers.

8.12.1.3 Documentation

The Contractor shall maintain written Documentation of all attempts to invite and include 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.

8.12.1.4 Facilitating Member Participation

The Contractor shall implement strategies to facilitate member participation in the Stakeholder Advisory Board meetings, including through the provision of transportation, interpretation services, and personal care assistance.

8.12.1.5 Meeting Frequency

The Contractor shall convene the Stakeholder Advisory Board, at minimum, on a quarterly basis at a central location. The Contractor shall advise the Agency of all meetings at least fifteen (15) calendar days in advance of the meeting.

8.12.1.6 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.

8.13 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, members and their families or caregivers. This includes publicizing methods by which 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.

8.14 Implementation Support

The Contractor shall publicize methods for members to obtain support and ask questions during program implementation, including information on how to contact the Ombudsman and Contractor via the member services hotline.

8.15 Grievance Appeals and State Fair Hearings

8.15.1 *General*

[11]Pursuant to 42 C.F.R. § 438.402, the following requirements shall apply:

(a) *The grievance and appeal system.* Contractor must have a grievance and appeal system in place for members.

(b) *Level of appeals.* Contractor may have only one level of appeal for members.

(c) *Filing requirements*—(1) *Authority to file.* (i) A member may file a grievance and request an appeal with the Contractor. A member may request a State fair hearing after receiving notice under 42 C.F.R. § 438.408, as described at Section 8.15.4, that the adverse benefit determination is upheld.

(A) *Deemed exhaustion of appeals processes.* In the case of Contractor failing to adhere to the notice and timing requirements in 42 C.F.R. § 438.408, as described at Section 8.15.4, the member is deemed to have exhausted the Contractor's appeals process. The member may initiate a State fair hearing.

(B) Reserved.

(ii) State law permits a provider or an authorized representative, with the written consent of the member, to request an appeal or file a grievance, or request a State fair hearing, on behalf of a member. When the term "member" is used throughout this section 8.15 and all its subsections, it includes providers and authorized representatives consistent with this paragraph, with the exception that providers cannot request continuation of benefits as specified in 42 C.F.R. § 438.420(b)(5).

(2) *Timing*—(i) *Grievance.* A member may file a grievance with Contractor at any time.

(ii) *Appeal.* Following receipt of a notification of an adverse benefit determination by Contractor, a member has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the managed care plan.

(3) *Procedures*—(i) *Grievance.* The member may file a grievance either orally or in writing with the Contractor.

(ii) *Appeal.* The member may request an appeal either orally or in writing. Further, unless the member requests an expedited resolution, an oral appeal must be followed by a written, signed appeal. The Contractor shall direct the member to the Agency Appeal and Request for Hearing form as an option for submitting a request for an appeal.

Member eligibility and eligibility related grievances and appeals (including but not limited to long-term care eligibility and enrollment), including termination of eligibility, effective dates of coverage, and the determination of premium, copayment, and patient liability responsibilities shall be directed to the Agency.

8.15.2 *Notice of Adverse Benefit Determination*

In accordance with 42 C.F.R. §438.404, the following requirements shall apply:

(a) *Notice.* The Contractor must give members timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below and in 42 C.F.R. § 438.10.

(b) *Content of notice.* Pursuant to 42 C.F.R. § 438.10, the Contractor must use language developed by the Agency for the notice, with the only non-Agency developed language being permissible for content described at (1) - (2). The notice must explain the following:

(1) The adverse benefit determination the Contractor has made or intends to make.

(2) The reasons for the adverse benefit determination, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. Citation of the Iowa Code and/or Iowa Administrative Code sections supporting the adverse benefit determination shall also be provided.

(3) The member's right to request an appeal of the Contractor's adverse benefit determination, including information on exhausting the Contractor's one level of appeal described at 42 C.F.R. § 438.402(b) and the right to request a State fair hearing consistent with 42 C.F.R. § 438.402(c).

(4) The procedures for exercising the rights specified in this paragraph (b) of this subsection.

(5) The circumstances under which an appeal process can be expedited and how to request it.

(6) The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with Agency policy, under which the member may be required to pay the costs of these services.

(c) *Timing of notice.* The Contractor must mail the notice within the following timeframes:

(1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in 42 C.F.R. §§ 431.211, 431.213, and 431.214.

(2) For denial of payment, at the time of any action affecting the claim.

(3) For standard service authorization decisions that deny or limit services, within the timeframe specified in 42 C.F.R. § 438.210(d)(1).

(4) If Contractor meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with 42 C.F.R. § 438.210(d)(1)(ii), it must—

(i) Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and

(ii) Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

(5) For service authorization decisions not reached within the timeframes specified in 42 C.F.R. § 438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.

(6) For expedited service authorization decisions, within the timeframes specified in 42 C.F.R. § 438.210(d)(2).

8.15.3 *Handling of Grievances and Appeals*

In accordance with 42 C.F.R. §438.406, the following requirements shall apply:

(a) *General requirements.* In handling grievances and appeals, the Contractor must give members any reasonable assistance in completing forms and taking 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 that have adequate TTY/TTD and interpreter capability.

(b) *Special requirements.* Contractor's process for handling member grievances and appeals of adverse benefit determinations must:

(1) Acknowledge receipt of each grievance and appeal within 3 business days.

(2) Ensure that the individuals who make decisions on grievances and appeals are individuals—

(i) Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

(ii) Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the Agency, in treating the member's condition or disease.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

(iii) Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

(3) Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the member or the provider requests expedited resolution.

(4) Provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 42 C.F.R. § 438.408(b) and (c) in the case of expedited resolution.

(5) Provide the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by Contractor (or at the direction of the Contractor) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 C.F.R. § 438.408(b) and (c).

(6) Include, as parties to the appeal—

(i) The member and his or her representative; or

(ii) The legal representative of a deceased member's estate.

8.15.4 *Grievance and Appeals Resolution and Notification*

In accordance with 42 C.F.R. § 438.408, the following requirements shall apply:(a) *Basic rule.* Contractor must resolve each grievance and appeal, and provide notice, as expeditiously as the member's health condition requires, within Agency-established timeframes that may not exceed the timeframes specified in this section.

(b) *Specific timeframes*—(1) *Standard resolution of grievances.* For standard resolution of a grievance, the Contractor shall resolve and provide notice to the affected parties within 30 calendar days from the day Contractor receives the grievance.

(2) *Standard resolution of appeals.* For standard resolution of an appeal, the Contractor shall resolve and provide notice to the affected parties within 30 calendar days from the day the Contractor receives the appeal. This timeframe may be extended under paragraph (c) of this subsection.

(3) *Expedited resolution of appeals.* For expedited resolution of an appeal, the Contractor shall resolve and provide notice to affected parties within 72 hours after the Contractor receives the appeal. This timeframe may be extended under paragraph (c) of this section.

(c) *Extension of timeframes.* (1) The Contractor may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if—

(i) The member requests the extension; or

(ii) The Contractor shows (to the satisfaction of the Agency, upon its request) that there is need for additional information and how the delay is in the member's interest.

(2) *Requirements following extension.* If Contractor extends the timeframes not at the request of the member, it must complete all of the following:

(i) Make reasonable efforts to give the member prompt oral notice of the delay.

(ii) Within 2 calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.

(iii) Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

(3) *Deemed exhaustion of appeals processes.* If Contractor fails to adhere to the notice and timing requirements in this section, the member is deemed to have exhausted the Contractor's appeals process. The member may initiate a State fair hearing.

(d) *Format of notice*—(1) *Grievances.* The Contractor must provide a member with written notice of the resolution of a grievance consistent with, at a minimum, the standards described at 42 C.F.R. § 438.10.

(2) *Appeals.* (i) For all appeals, the Contractor must provide written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 C.F.R. § 438.10.

(ii) For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice.

(e) *Content of notice of appeal resolution.* Pursuant to 42 C.F.R. §438.10, the Contractor must use language developed by the Agency for the notice, with the only non-Agency developed language being permissible for content described at (1). The written notice of the resolution must include the following:

(1) The results of the resolution process and the date it was completed.

(2) For appeals not resolved wholly in favor of the members—

(i) The right to request a State fair hearing, and how to do so.

(ii) The right to request and receive benefits while the hearing is pending, and how to make the request.

(iii) That the member may, consistent with Agency policy, be held liable for the cost of those benefits if the hearing decision upholds the Contractor's adverse benefit determination.

(f) *Requirements for State fair hearings*—(1) *Availability.* A member may request a State fair hearing only after receiving notice that the Contractor is upholding the adverse benefit determination.

(i) *Deemed exhaustion of appeals processes.* If Contractor fails to adhere to the notice and timing requirements in 42 C.F.R. § 438.408, the member is deemed to have exhausted the Contractor's appeals process. The member may initiate a State fair hearing.

(ii) Reserved.

(2) *State fair hearing.* The member must request a State fair hearing no later than 120 calendar days from the date of the Contractor's notice of resolution.

(3) *Parties.* The parties to the State fair hearing include the Contractor, as well as the member and his or her representative or the representative of a deceased member's estate.

8.15.5 *Expedited Resolution of Appeals*

In accordance with 42 C.F.R. § 438.410, the following requirements shall apply:

(a) *General rule.* Contractor must establish and maintain an expedited review process for appeals, when the Contractor determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

(b) *Punitive action.* Contractor must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.

(c) *Action following denial of a request for expedited resolution.* If Contractor denies a request for expedited resolution of an appeal, it must—

(1) Transfer the appeal to the timeframe for standard resolution in accordance with 42 C.F.R. § 438.408(b)(2).

(2) Follow the requirements in 42 C.F.R. § 438.408(c)(2).

8.15.6 *Information About the Grievance and Appeal Process*

In accordance with 42 C.F.R. § 438.414, the Contractor must provide information specified in 42 C.F.R. § 438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.

8.15.7 *Recordkeeping Requirements*

In accordance with 42 C.F.R. § 438.416, the following requirements shall apply:

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

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

(1) A general description of the reason for the appeal or grievance.

(2) The date received.

(3) The date of each review or, if applicable, review meeting.

(4) Resolution at each level of the appeal or grievance, if applicable.

(5) Date of resolution at each level, if applicable.

(6) Name of the covered person for whom the appeal or grievance was filed.

(c) The record must be accurately maintained in a manner accessible to the Agency and available upon request to CMS.

8.15.8 *Continuation of Benefits*

In accordance with 42 C.F.R. §438.420, the following requirements shall apply to all members other than those members receiving coverage pursuant to Iowa Code ch. 514I:

(a) *Definition.* As used in this section—

Timely files means files for continuation of benefits on or before the later of the following:

(i) Within 10 calendar days of the Contractor sending the notice of adverse benefit determination.

(ii) The intended effective date of the Contractor's proposed adverse benefit determination.

(b) *Continuation of benefits.* The Contractor must continue the member's benefits if all of the following occur:

(1) The member files the request for an appeal timely in accordance with 42 C.F.R. § 438.402(c)(1)(ii) and (c)(2)(ii);

(2) The appeal involves the termination, suspension, or reduction of previously authorized services;

(3) The services were ordered by an authorized provider;

(4) The period covered by the original authorization has not expired; and

(5) The member timely files for continuation of benefits.

(c) *Duration of continued or reinstated benefits.* If, at the member's request, the Contractor continues or reinstates the member's benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of following occurs:

(1) The member withdraws the appeal or request for State fair hearing.

(2) The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal under 42 C.F.R. § 438.408(d)(2).

(3) A State fair hearing office issues a hearing decision adverse to the member.

(d) *Member responsibility for services furnished while the appeal or State fair hearing is pending.* If the final resolution of the appeal or State fair hearing is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of services furnished to the member while the appeal and State fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section. The Contractor shall not be required to continue benefits beyond any Agency defined benefit limits as outlined in Exhibit D.

8.15.9 *Effectuation of Reversed Appeal Resolutions*

In accordance with 42 C.F.R. § 438.424, the following requirements shall apply:

(a) *Services not furnished while the appeal is pending.* If the Contractor, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

(b) *Services furnished while the appeal is pending.* If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Contractor must pay for those services, in accordance with Agency policy and regulations.

8.15.10 *Exception to Contractor Policy Process*

The Contractor may operate an exception to policy process. Under the exception to policy process, a member can request an item or service not otherwise covered by the Agency or the Contractor. Exceptions to policy may be granted to Contractor policies, but they cannot be granted to federal or State law and regulations. An exception to policy is a last resort request and is not appealable as the request is for services outside of state plan or waiver benefits.

9 Care Coordination

9.1 General Obligations Applicable to Care Coordination.[12]

[13](a) *Basic requirement*—(1) *General rule.* The Contractor shall comply with the requirements of this section in accordance with 42 C.F.R. § 438.208.

(2) Reserved.

(3) Reserved.

(b) *Care and coordination of services for all members.* Contractor shall implement procedures to deliver care to and coordinate services for all Contractor members pursuant to Special Terms Appendix 1 – Scope of Work, Sections 4 and 9. These procedures must meet Agency requirements and must do the following:

(1) Ensure that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. The member must be provided information on how to contact their designated person or entity;

(2) Coordinate the services the Contractor furnishes to the member:

(i) Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays;

(ii) With the services the member receives from any other MCO, PIHP, or PAHP;

(iii) With the services the member receives in FFS Medicaid; and

(iv) With the services the member receives from community and social support providers.

(3) Provide that Contractor makes a best effort to conduct an initial screening of each member's needs, within 90 days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful;

(4) Share with the Agency or other MCOs, PIHPs, and PAHPs serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities;

(5) Ensure that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards; and

(6) Ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 C.F.R. parts 160 and 164 subparts A and E, to the extent that they are applicable.

(c) *Additional services for members with special health care needs or who need LTSS*—(1) Persons who need LTSS or persons with special health care needs will be identified by the Contractor through the initial screening described in paragraph (b)(3), through identification processes pursuant to Special Terms Appendix 1 – Scope of Work, Section 4.2.2 or by the Agency.

(i) Reserved.

(ii) Reserved.

(2) *Assessment.* Contractor shall implement mechanisms to comprehensively assess each member identified as needing LTSS or having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring pursuant to Special Terms Appendix 1 – Scope of Work, Section 4.2.2. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of the Agency or the Contractor as appropriate.

(3) *Treatment/service plans.* Contractor shall produce a treatment or service plan meeting the criteria in paragraphs (c)(3)(i) through (v) of this section and pursuant to Special Terms Appendix 1 – Scope of Work, Section 4.4.2 and 4.4.3 for members who require LTSS and, if the Agency requires, must produce a treatment or service plan meeting the criteria in paragraphs (c)(3)(iii) through (v) of this section for members with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan must be:

(i) Developed by an individual meeting LTSS service coordination requirements with member participation, and in consultation with any providers caring for the member;

(ii) 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) for LTSS treatment or service plans;

(iii) Approved by the Contractor in a timely manner, if this approval is required by the Contractor;

(iv) In accordance with any applicable Agency quality assurance and utilization review standards; and

(v) Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the member's circumstances or needs change significantly, or at the request of the member per 42 C.F.R. § 441.301(c)(3).

(4) *Direct access to specialists.* For members with special health care needs determined through an assessment (consistent with paragraph (c)(2) of this section) to need a course of treatment or regular care monitoring, Contractor must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.

(d) Reserved.

9.1.1 *Initial Screening*

The Contractor shall obtain Agency approval for a plan to conduct initial health risk screenings for: (i) new members, within ninety (90) days of enrollment for the purpose of assessing need for any special health care or care coordination services; (ii) members who have not been enrolled in the prior twelve (12) months; and (iii) members for whom there is a reasonable belief they are pregnant. During the initial health risk screening process, 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 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.

9.1.1.1 Tool

The Contractor shall obtain Agency approval of an initial health risk screening tool. At minimum, information collected shall assess the 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 questions that can tie to social determinants of health. The actual tool used will be designated by the Agency shortly after execution of the Contract. Contractor tools will be compared against the current approach by the Agency and a uniform tool is preferred across Contractors.

9.1.1.2 Subsequent Screenings

The Contractor shall also be required to conduct a subsequent health screening, using the tool reviewed and approved by the Agency, if a member's health care status is determined to have changed since the original screening. Such evidence may be available through methods such as claims review or provider notification.

9.1.1.3 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 members in order to complete the initial health screening.

9.1.2 *Comprehensive Health Risk Assessment*

The initial health screening described in Section 9.1.1 shall be followed by a comprehensive health risk assessment by a health care professional when a 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. The comprehensive health risk assessment shall include an assessment of a member's need for assignment to a health home, as described in Section 3.2.10.

9.1.2.1 Tool

The Contractor shall obtain Agency approval for use of an initial health risk assessment tool. At minimum, information collected shall assess the 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 must also comply with NCQA standard for health risk screenings and contain questions that can tie to social determinants of health.

9.1.2.2 Timeline for Completion

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

9.1.3 *Care Coordination*

9.1.4 The Contractor shall design and operate a care coordination program, subject to the Agency review and approval, to monitor and coordinate the care for members identified as having a special health care need. *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 member participating in the care coordination program.

9.1.5 *Member Identification*

In addition to identifying 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) member and caregiver requests; and (iv) physician referrals.

9.1.6 *Care Plan Development*

The Contractor shall develop a care plan for all members eligible for the care coordination program. The care plan shall be individualized and person-centered based on the findings of the initial health risk screening, comprehensive health risk assessment, available medical records, and other sources needed to ensure that care for members is adequately coordinated and appropriately managed. The care plan shall: (i) establish prioritized goals and actions; (ii) facilitate seamless transitions between care settings; (iii) create a communication plan with providers and members; and (iv) monitor whether the member is receiving the recommended care.

9.1.6.1 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 enrollee, the Contractor shall ensure that there is a mechanism for members, their families and/or advocates and caregivers, or others chosen by the member, to be actively involved in the care plan development. Care plans shall be conducted jointly with other caseworkers for 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.

9.1.6.2 Care Plan Requirements

9.1.6.3 The care plan shall reflect cultural considerations of the member. In addition, the care plan development process shall be conducted in plain language, and be accessible to members who have disabilities and/or have limited English proficiency. The care plan shall be approved by the Contractor in a timely manner and in accordance with applicable quality measures and utilization review standards. For enrollees determined to meet a course of treatment or regular monitoring, the Contractor shall have direct access to a specialist as appropriate for the enrollee's condition and identified needs. The Contractor shall ensure that the care plan is provided to the member's PCP (if applicable) or other significant providers. The Contractor shall also provide the member the opportunity to review the care plan as requested.

In accordance with 42 C.F.R. § 438.208(c)(3), the care plan shall be (i) Developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee; (ii) Approved by the Contractor in a timely manner; and (iii) In accord with any applicable State quality assurance and utilization review standards.

9.1.7 *Tracking and Reporting*

The Contractor shall integrate information about members in order to facilitate positive member outcomes through care coordination. The system shall have the ability to track the results of the initial health risk screening, comprehensive health risk assessment, the care plan, and member outcomes and have the ability to share care coordination information with the member, his or her authorized representatives, and all relevant treatment providers, including, but not limited to: (i) behavioral health providers; (ii) primary

care providers; 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.

9.1.8 *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.

9.1.9 *Reassessments*

The Contractor shall develop a process for reviewing and updating the care plans with members on an as-needed basis, but no less often than annually. In addition, 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 members periodically to determine if their present care levels are adequate. The Contractor shall also identify triggers which would immediately move the member to a more assistive level of service. Additionally, any member or provider can request a reassessment at any time.

9.2 LTSS Care Coordination[14]

The Contractor shall comply with Section 9.1 and Section 4 when providing LTSS care coordination services.

9.3 Non-LTSS Care Coordination[15]

The care coordination requirements in this section apply to non-LTSS services; see Section 4 for LTSS assessment, care plan and community-based case management requirements. For members receiving LTSS who are identified as eligible for services under the Contractor's care coordination program, as described in this section, the Contractor shall implement strategies to ensure the integration of LTSS case management and Contractor care coordination program services.

The Contractor shall implement a care coordination program in compliance with the requirements of this section. Care coordination programs shall also have a demonstrated record of: (i) improving quality outcomes; (ii) coordinating care across the healthcare delivery system; (iii) increasing member compliance with recommended treatment protocols; (iv) increasing member understanding of their healthcare conditions and prescribed treatment; (v) empowering members; (vi) coordinating care with other Contractors and/or Agencies; and (vii) providing flexible person-centered care.

9.3.1 Initial Screening

The Contractor shall conduct initial health risk screenings for: (i) new members, within ninety (90) days of enrollment for the purpose of assessing need for any special health care or care coordination services; (ii) members who have not been enrolled in the prior twelve (12) months; and (iii) members for whom there is a reasonable belief they are pregnant. During the initial health risk screening process, 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 member's potential risk, if any, for specific diseases or conditions.

9.3.1.1 Tool

The Contractor shall obtain Agency approval of an initial health risk screening tool. At minimum, information collected shall assess the 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 questions that can tie to social determinants of health.

9.3.1.2 Subsequent Screenings

The Contractor shall also be required to conduct a subsequent health screening if a member's health care status is determined to have changed since the original screening. Such evidence may be available through methods such as claims review or provider notification.

9.3.1.3 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 members in order to complete the initial health screening.

9.3.2 Comprehensive Health Risk Assessment

The initial health screening described in Section 9.1.1 shall be followed by a comprehensive health risk assessment when a 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.

9.3.2.1 Tool

The Contractor shall obtain Agency approval for use of an initial health risk assessment tool. At minimum, information collected shall assess the 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 must also comply with NCQA standard for health risk screenings and contain questions that can tie to social determinants of health.

9.3.2.2 Timeline for Completion

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

9.3.3 Care Coordination

The Contractor shall design and operate a care coordination program [16] to monitor and coordinate the care for 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 members overusing and/or abusing services; (iv) discharge planning; and (v) transition planning.

9.3.4 Risk Stratification

The Contractor shall utilize risk stratification levels [17] to determine the intensity and frequency of follow-up care that is required for each member participating in the care coordination program.

9.3.5 Member Identification

In addition to identifying 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) member and caregiver requests; and (iv) physician referrals.

9.3.6 Care Plan Development

The Contractor shall develop a care plan for all members eligible for the care coordination program. The care plan shall be individualized and person-centered based on the findings of the initial health risk screening, comprehensive health risk assessment, available medical

records, and other sources needed to ensure that care for members is adequately coordinated and appropriately managed. The care plan shall: (i) establish prioritized goals and actions; (ii) facilitate seamless transitions between care settings; (iii) create a communication plan with providers and members; and (iv) monitor whether the member is receiving the recommended care.

9.3.6.1 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 enrollee, the Contractor shall ensure that there is a mechanism for members, their families and/or advocates and caregivers, or others chosen by the member, to be actively involved in the care plan development. Care plans shall be conducted jointly with other caseworkers for 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.

9.3.6.2 Care Plan Requirements

The care plan shall reflect cultural considerations of the member. In addition, the care plan development process shall be conducted in plain language, and be accessible to members who have disabilities and/or have limited English proficiency. The care plan shall be approved by the Contractor in a timely manner and in accordance with applicable quality measures and utilization review standards. For enrollees determined to meet a course of treatment or regular monitoring, the Contractor shall have direct access to a specialist as appropriate for the enrollee's condition and identified needs. The Contractor shall ensure that the care plan is provided to the member's PCP (if applicable) or other significant providers. The Contractor shall also provide the member the opportunity to review the care plan as requested.

9.3.7 Tracking and Reporting

The Contractor shall integrate information about members in order to facilitate positive member outcomes through care coordination. The system shall have the ability to track the results of the initial health risk screening, comprehensive health risk assessment, the care plan, and member outcomes and have the ability to share care coordination information with the member, his or her authorized representatives, and all relevant treatment providers, including, but not limited to: (i) behavioral health providers; (ii) primary care providers; 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.

9.3.8 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.

9.3.9 Reassessments

The Contractor shall develop a process for reviewing and updating the care plans with members on an as-needed basis, but no less often than annually. In addition, 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 members periodically to determine if their present care levels are adequate. The Contractor shall also identify triggers which would immediately move the member to a more assistive level of service. Additionally, any member or provider can request a reassessment at any time.

10 Quality Management and Improvement Strategies

10.1 Contractor Quality Management/Qnality Improvement (QM/QI) Program

10.1.1 *Program Objectives*

The Agency seeks to improve the quality of care and outcomes for Medicaid and CHIP enrollees 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. Through the QM/QI program, the Contractor shall have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to members consistent with 42 C.F.R. § 438.330, as described below.[18] The Contractor shall use the result of its QM/QI activities to improve the quality of physical health, behavioral health, and long-term care service delivery with appropriate input from provider and members.[19]

[20](a) *General rules.* (1) Contractor shall establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its members that includes the elements identified in paragraph (b) of this section.

(2) Reserved.

(3) Reserved.

(b) *Basic elements of quality assessment and performance improvement programs.* The comprehensive quality assessment and performance improvement program described in paragraph (a) of this section must include at least the following elements:

(1) Performance improvement projects in accordance with paragraph (d) of this section.

(2) Collection and submission of performance measurement data in accordance with paragraph (c) of this section.

(3) Mechanisms to detect both underutilization and overutilization of services.

(4) Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs, as defined by the Agency in the quality strategy under 42 C.F.R. § 438.340.

(5) For Contractors providing long-term services and supports:

(i) Mechanisms to assess the quality and appropriateness of care furnished to members using long-term services and supports, including assessment of care between care settings and a comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable; and

(ii) Participate in efforts by the Agency to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per 42 C.F.R. §§ 441.302 and 441.730(a)) that are based, at a minimum, on the requirements on the Agency for home and community-based waiver programs per 42 C.F.R. § 441.302(h).

(c) *Performance measurement.*

(1) Standard performance measures will include those performance measures that may be specified by CMS under 42 C.F.R. § 438.330(a)(2), relating to the performance of Contractor.

(2) Contractor shall, on an annual basis either:

(i) Measure and report to the Agency on its performance, using the standard measures required by the Agency;

(ii) Submit to the Agency data, specified by the Agency, which enables the Agency to calculate the Contractor's performance using the standard measures identified by the Agency; or

(iii) Perform a combination of the activities described in paragraphs (c)(2)(i) and (ii) of this section.

(d) *Performance improvement projects.* (1) Contractor shall conduct performance improvement projects, including any performance improvement projects required by CMS in accordance with 42 C.F.R. § 438.330(a)(2), that focus on both clinical and nonclinical areas.

(2) Each performance improvement project must be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and must include the following elements:

(i) Measurement of performance using objective quality indicators.

(ii) Implementation of interventions to achieve improvement in the access to and quality of care.

(iii) Evaluation of the effectiveness of the interventions based on the performance measures in paragraph (d)(2)(i) of this section.

(iv) Planning and initiation of activities for increasing or sustaining improvement.

(3) Contractor shall report the status and results of each project conducted per paragraph (d)(1) of this section to the Agency as requested, but not less than once per year.

(4) Reserved.

(e) *Program review by the Agency.* (1) The Agency will arrange for an annual, external independent review of the Contractor's quality of, timeliness of, and access to health care services covered under the Contract, pursuant to Special Terms Appendix 1 – Scope of Work, Section 10.2.2.

(2) Reserved.

10.1.2 *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.[21] 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 members. The QM/QI program shall be submitted to the Agency for approval within 60 days after Contract initiation and include, at minimum, all of the following elements:

10.1.2.1 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;

10.1.2.2 Dedicated resources (staffing, data sources and analytical resources), including a QM/QI committee that oversees the QM/QI functions;

10.1.2.3 Address physical health, behavioral health and long-term care services;

10.1.2.4 Reserved;

10.1.2.5 A process to monitor variation in practice patterns and identify outliers;

10.1.2.6 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;

10.1.2.7 Analysis of the effectiveness of treatment services, employing both standard measures of symptom reduction/management, and measures of functional status;

10.1.2.8 Monitor the prescribing patterns of network prescribers to improve the quality of care coordination services provided to members through strategies such as: (i) identifying medication utilization that deviates from current clinical practice guidelines; (ii) identifying 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;

10.1.2.9 Written policies and procedures for quality improvement including methods, timelines and individuals responsible for completing each task;

10.1.2.10 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;

10.1.2.11 Incorporation of clinical studies and use of Healthcare Effectiveness Data and Information Set® (HEDIS®) rate data, health care quality measures for Medicaid-eligible adults described in Section 1139B of the Social Security Act, Consumer Assessment of Health Plans (CAHPS) survey results and data from other similar sources to periodically and regularly assess the quality and appropriateness of care provided to members;

10.1.2.12 Implement utilization of and report on the Iowa Participant Experience Survey tool for members receiving HCBS services;

10.1.2.13 Submit a report on any performance measures required by CMS;

10.1.2.14 Implement utilization of and report on all quality measures required by the Agency, as described in Section 14, including, but not limited to quarterly health outcomes and clinical reports, and the 3M Treo Solutions Value Index Score (VIS) measures;

10.1.2.15 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;

10.1.2.16 Procedures for a provider pay-for-performance program;

10.1.2.17 Member incentive programs aligned with the Healthiest State Initiative and other quality outcomes; and

10.1.2.18 Procedures to assess member satisfaction not already defined.

10.1.3 *QM/QI Committee*

The Contractor shall have a QM/QI committee, which shall include medical, behavioral health, and long-term care 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.

10.1.3.1 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.

10.1.3.2 Notice of Meetings

The Contractor shall provide the Agency with (10) calendar 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.

10.1.3.3 Reserved.

10.2 State Quality Initiatives

10.2.1 *State Quality Review*

In accordance with 42 C.F.R. § 438.340, the Agency will establish a written strategy for assessing and improving the quality of services offered by program Contractors. The Agency will regularly monitor and evaluate the Contractor's compliance with Contractor's QM/QI program.

10.2.2 *External Independent Review*

10.2.2.1 External Review Goals

Pursuant to federal regulations at 42 C.F.R. § 438.350 through 438.370, the Agency will arrange for an annual, external independent review of the Contractor's quality of, timeliness of and access to health care services covered under the Contract.

10.2.2.2 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 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 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.

10.2.2.3 Availability of Results

The results of each external independent review shall be posted on the Agency's website required under 42 C.F.R. § 438.10(c)(3) and made available, upon request, to interested parties such as participating health care providers, members, and potential members of the Contractor, member advocacy groups, and members of the general public,[22] except that the results may not be made available in a manner that discloses the identity of any individual patient.

10.2.3 *Healthiest State Initiative*

The Contractor shall obtain Agency approval of an approach to support the Healthiest State Initiative. The Contractor shall implement and adhere to the Agency-approved approach. Changes to this approach shall receive the Agency's prior approval.

10.2.4 *Mental Health and Disability Services Redesign*

The Contractor shall obtain Agency approval of an approach to support the Mental Health and Disability Services Redesign. The Contractor shall implement and adhere to the Agency-approved approach. Changes to this approach shall receive the Agency's prior approval.

10.2.5 *State Innovation Model (SIM)*

The Contractor shall obtain Agency approval of an approach to support Iowa's State Innovation Model (SIM) project. This includes, but is not limited to, the use of the Value Index Score (VIS) as a tool to drive multi-payer aligned delivery system transformation consistent with Centers for Medicare & Medicaid Services' (CMS) Triple Aim. The Triple Aim consists of three 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. The Contractor shall implement and adhere to the Agency-approved strategies. Changes to these strategies shall receive the Agency's prior approval.

10.2.6 *Reserved*

10.3 Incentive Programs

10.3.1 *General*

The Agency will implement a pay for performance program to reward the Contractor's efforts to improve quality and outcomes as described in Exhibit F. In the first year of the Contract, pending the availability of sufficient clinical baseline data, the performance measures selected are operational in nature and shall measure the Contractor's performance during implementation and initial member enrollment. Beginning in year two (2) of the Contract, eligibility for payment under the pay for performance program will be based primarily on Contractor performance on clinical outcomes.

10.3.2 *Provider Incentive Program*

10.3.2.1 General

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 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 members and in any marketing materials in accordance with the disclosure requirements stipulated in federal regulations.

10.3.2.2 Incentive Payment Restrictions

(1) In compliance with 42 C.F.R. § 438.3(i), Contractor shall comply with the requirements set forth in 42 C.F.R. §§ 422.208 and 422.210 related to physician incentive plans.

(2) In applying the provisions of 42 C.F.R. §§ 422.208 and 422.210, references to "MA organization," "CMS," and "Medicare beneficiaries" must be read as references to "Contractor," "State," and "Medicaid beneficiaries," respectively.[23]

10.3.3 *Member Incentive Program*

10.3.3.1 General

The Contractor shall establish member incentive programs to increase quality outcomes, encourage appropriate utilization of health services and healthy behaviors. The Contractor shall obtain the Agency approval prior to implementing any member incentives and before making any changes to an approved incentive. Member incentives may be financial or non- financial. The Contractor shall determine its own methodology for incenting 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.

10.3.3.2 Incentive Payment Restrictions

If implementing the member incentive programs, the Contractor shall comply with all marketing provisions in 42 C.F.R. § 438.104 as delineated in Section 8.1[24], as well as federal and State regulations regarding inducements.

10.4 Critical Incidents

10.4.1 *General*

The Contractor shall develop and implement 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 and implement 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 and implement appropriate strategies to reduce the occurrence of incidents and improve the quality of care.

10.4.2 *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.

10.4.3 *Training*

The Contractor shall provide staff and provider training on critical incident policies and procedures.

10.4.4 *Corrective Action*

The Contactor shall take corrective action as needed to ensure provider compliance with critical incident requirements.

10.4.5 *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 and implement strategies to reduce the occurrence of critical incidents and improve the quality of care delivered to members.

10.5 Provider Preventable Conditions

In accordance with 42 C.F.R. § 438.3(g), Contractor shall comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 C.F.R. § 434.6(a)(12) and 42 C.F.R. § 447.26. Contractor shall report all identified provider-preventable conditions in a form and frequency as specified by the Agency. The Contractor shall comply with any future additions to the list of non-reimbursable provider-preventable conditions.[25]

11 Utilization Management

11.1 Utilization Management Program

The Contractor shall develop, operate and maintain a Utilization Management (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. UM of substance use disorder services shall use the most current version of The ASAM Criteria as published by the American Society of Addiction Medicine. All UM strategies shall be approved by the Agency and noticed to the community thirty (30) days prior to implementation.

11.1.1 *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, to the extent possible; (ii) are applied based on individual needs; (iii) are applied based on 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.

11.1.2 *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 norms. Upon request by the Agency, 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 long-term care services.

11.1.3 *Work Plan*

The UM program shall be supported by an associated work plan and shall be evaluated annually and updated as necessary. The UM Program description, 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 UM program descriptions, associated work plan, and annual evaluation of the UM program shall be annually submitted to the Agency for review and approval prior to implementation. The initial draft of these materials is due within 15 days of Contract execution. The work plan shall identify the steps to be taken and include a timeline with target dates. A final work plan, incorporating any changes requested by the Agency, shall be submitted to the Agency within 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.

11.1.4 *UM Subcontractors and Staff*

In accordance with 42 C.F.R. § 438.210(e) the Contractor shall assure that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member. If the Contractor

delegates some or all of its UM activities, including prior authorization functions, to subcontractors, the Contractor shall conduct annual audits and ongoing monitoring to ensure the subcontractor's performance complies with the Contract, the Contractor's policies and procedures and State and Federal law.

11.1.5 *Practice Guidelines*

(a) *Basic rule.* Contractor shall meet the requirements of this section in accordance with 42 C.F.R. § 438.236.

(b) *Adoption of practice guidelines.* Contractor shall adopt practice guidelines that meet the following requirements:

(1) Are based on valid and reliable clinical evidence or a consensus of providers in the particular field.

(2) Consider the needs of the Contractor's members.

(3) Are adopted in consultation with contracting health care professionals.

(4) Are reviewed and updated periodically as appropriate.

(c) *Dissemination of guidelines.* Contractor shall disseminate the guidelines to all affected providers and, upon request, to members and potential members.

(d) *Application of guidelines.* Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

11.1.6 *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 supports the Quality Management and Improvement Program. The UM program shall have policies and procedures and systems in place to assist UM staff 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 members to the Contractor's care coordination program as described in Section 9. The Contractor's UM program shall also encourage health literacy and informed healthcare decisions. The Contractor shall also identify and address barriers that may inhibit a member's ability to maintain a healthy lifestyle such as obtaining preventive care and successful participation in drug maintenance programs. As part of its utilization review, the Contractor shall monitor access to preventive care, specifically to identify members who are not accessing preventive care services in accordance with accepted preventive care standards. The Contractor shall develop education, incentives and outreach plans tailored to its member population to increase member compliance with preventive care standards. The Contractor shall particularly monitor

use of services for its members with special needs and members with diagnoses of severe mental illness or substance use disorder.

11.1.7 *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 members; (ii) monitoring the medical appropriateness and necessity of health care services provided to its 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.

11.2 Coverage and Authorization of Services

11.2.1 *General*

(a) *Coverage.* In accordance with 42 C.F.R. §438.210, the Contractor shall provide covered services as outlined in Special Terms Appendix 1 – Scope of Work, Section 3.2, and no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid, as set forth in 42 C.F.R. § 440.230, and for members under the age of 21, as set forth in 42 C.F.R. subpart B of part 441.

(1) Reserved.

(2) Reserved.

(3) The Contractor—

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.

(4) The Contractor is permitted to place appropriate limits on a service—

(i) On the basis of criteria applied under the State plan, such as medical necessity; or

(ii) For the purpose of utilization control, provided that—

(A) The services furnished can reasonably achieve their purpose, as required in paragraph (a)(3)(i) of this section;

(B) The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member's ongoing need for such services and supports; and

(C) Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 C.F.R. § 441.20.

(5) The Contractor must furnish Medically Necessary Services as defined in Exhibit A and in a manner that—

(i) Is no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

(ii) Addresses:

(A) The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability.

(B) The ability for a member to achieve age-appropriate growth and development.

(C) The ability for a member to attain, maintain, or regain functional capacity.

(D) The opportunity for a member receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

(b) *Authorization of services.* For the processing of requests for initial and continuing authorizations of services, Contractor shall —

(1) Have in place, and follow, written policies and procedures.

(2)(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

(ii) Consult with the requesting provider for medical services when appropriate.

(iii) Authorize LTSS based on a member's current needs assessment and consistent with the person-centered service plan.

(3) Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's medical, behavioral health, or long-term services and supports needs.

(c) *Notice of adverse benefit determination.* Contractor shall notify the requesting provider, and give the member written notice of any decision by Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The member's notice must meet the requirements of 42 C.F.R. § 438.404.

(d) *Timeframe for decisions.*

(1) *Standard authorization decisions.* For standard authorization decisions, Contractor shall provide notice as expeditiously as the member's condition requires and within 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if—

(i) The member, or the provider, requests extension; or

(ii) The Contractor justifies (to the Agency upon request) a need for additional information and how the extension is in the member's interest.

(2) *Expedited authorization decisions.* (i) For cases in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service.

(ii) The Contractor may extend the 72 hour time period by up to 14 calendar days if the 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 member's interest.

(3) *Covered outpatient drug decisions.* For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Social Security Act.

(4) *Failure to respond.* If the Contractor fails to respond to a member's prior authorization request as outlined in paragraph (d)(1), the authorization is deemed granted unless otherwise prohibited by law.

(e) *Compensation for utilization management activities.* Consistent with 42 C.F.R. § 438.3(i), and 42 C.F.R. § 422.208, Contractor shall not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

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 members. Consultation with the requesting provider shall be ensured when appropriate.

11.2.1.1 *Reserved.*

11.2.2 *Reserved.*

11.2.3 *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 and implement 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 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.

11.2.4 *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 which 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 member and not primarily for the convenience of the member, the provider, or the Contractor; and (v) are the most appropriate type of service which would reasonably meet the need of the member in the least costly manner.

The determination of psychosocial necessity shall be made after consideration of: (i) the 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 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 member (e.g., availability of transportation, lack of natural supports including a place to live); and (vi) the 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 Section 11.1.5.

11.2.5 *Prior Authorization Requests*

11.2.5.1 *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 Section 11.2.1) 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 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 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 a member's health condition shall be deemed to require an expedited authorization decision by the Contractor shall include requests for home health services for members being discharged from a hospital or other inpatient setting when such home health services are needed to begin upon discharge.

11.2.5.2*Exceptions to Prior Authorization and/or Referrals*

As part of the UM function, the Contractor shall facilitate provider requests for authorization for primary and preventive care services and shall assist the provider in providing appropriate referrals for specialty services by locating resources for appropriate referral.

11.2.5.2.1.1 *Pharmacy Prior Authorization*

Pharmacy prior authorization requests shall be processed in accordance with 42 U.S.C. § 1396r-8(d)(5).

11.2.5.2.1.2 Reserved

11.2.5.2.1.3 Reserved

11.2.5.2.1.4 Reserved

11.2.5.2.1.5 *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.

11.2.5.2.1.6 *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.

11.2.5.2.1.7 *EPSDT*

The Contractor shall not require prior authorization or PCP (if applicable) referral for the provision of EPSDT screening services.

11.2.5.2.1.8 *Behavioral Health Services*

The Contractor shall not require a PCP referral (if applicable) for members to access a behavioral health provider.

11.2.5.2.1.9 *Transition of New Members*

Pursuant to the requirements in Section 3.3 regarding transition of new members, the Contractor shall provide for the continuation of medically necessary covered services regardless of prior authorization or referral requirements.

11.2.6 *Tracking and Reporting*

11.2.6.1 *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.

11.2.6.2 *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).

12 Program Integrity

12.1 General Expectations and Regulatory Compliance.

12.1.1 *General Expectations*

The Contractor shall:

(a) diligently safeguard against fraud and abuse in the implementation of the Contractor's Contract with the Agency;

(b) create and implement policies and procedures to diligently safeguard against fraud and abuse, as required by the provisions of this Article of the Contract; and

(c) cooperate and collaborate with the Agency and its representatives on program integrity issues, including, but not limited to cooperation with the program integrity contractor.

12.1.2 *Regulatory Compliance*

In accordance with 42 C.F.R. § 438.608, the following requirements shall apply:

(a) *Administrative and management arrangements or procedures to detect and prevent fraud, waste and abuse.* The Contractor, or subcontractor to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under the contract between the Agency and the Contractor, shall implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following:

(1) A compliance program that includes, at a minimum, all of the following elements:

(i) Written policies, procedures, and standards of conduct that articulate the Contractor or subcontractor's commitment to comply with all applicable requirements and standards under the Contract, and all applicable Federal and State requirements.

(ii) The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the board of directors.

(iii) The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the Contractor or subcontractor's compliance program and its compliance with the requirements under the Contract.

(iv) A system for training and education for the Compliance Officer, the Contractor or subcontractor's senior management, and the Contractor or subcontractor's employees for the Federal and State standards and requirements under the Contract.

(v) Effective lines of communication between the compliance officer and the Contractor or subcontractor's employees.

(vi) Enforcement of standards through well-publicized disciplinary guidelines.

(vii) 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.

(2) Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the Agency.

(3) Provision for prompt notification to the Agency when it receives information about changes in a member's circumstances that may affect the member's eligibility including all of the following:

(i) Changes in the member's residence;

(ii) The death of a member.

(4) Provision for notification to the Agency when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor.

(5) Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members and the application of such verification processes on a regular basis.

(6) In the event that Contractor makes or receives annual payments under the Contract of at least $5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers.

(7) Provision 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 Medicaid Fraud Control Unit.

(8) Provision for the Contractor's suspension of payments to a network provider for which the Agency determines there is a credible allegation of fraud in accordance with 42 C.F.R. § 455.23.

(b) Reserved.

(c) *Disclosures.* Contractor and any subcontractors shall:

(1) Provide written disclosure of any prohibited affiliation under 42 C.F.R. § 438.610.

(2) Provide written disclosures of information on ownership and control required under 42 C.F.R. § 455.104.

(3) Report to the Agency within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the Contract.

(d) *Treatment of recoveries made by the Contractor of overpayments to providers.*

(1) Reporting and Retention of Overpayments:

(i) The Contractor will follow the retention policies (outlined in Section 12.8 of this Agreement) for the treatment of recoveries 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.

(ii) The Contractor will follow the process, timeframes, and documentation required (outlined in Section 12.3 of this Agreement) for reporting the recovery of all overpayments.

(iii) The Contractor will follow the process, timeframes, and documentation required for payment of recoveries of overpayments to the Agency (outlined in Section 12.3 of this Agreement) in situations where the Contractor is not permitted to retain some or all of the recoveries of overpayments.

(iv) This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

(2) Contractor shall require and have a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days after the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment.

(3) Contractor must report annually to the Agency on their recoveries of overpayments.

(4) The Agency will use the results of the information and documentation collected in paragraph (d)(1) of this section and the report in paragraph (d)(3) of this section for setting actuarially sound capitation rates for Contractor consistent with the requirements in 42 C.F.R. § 438.4.

12.2 Compliance Plan

The Contractor shall develop, implement, and adhere to a mandatory compliance plan (the "Compliance Plan") that describes in detail how it will comply with the compliance program required by 42 C.F.R. §438.608(a)(1) as well as any additional requirements of this Agreement. The Contractor shall include the Compliance Plan in any Work Plan required by Section 2.13 and follow the timelines set forth in Section 2.13.

The Compliance Plan shall include:

12.2.1 Identification of a data system, resources, and staff sufficient to perform compliance responsibilities, including, but not limited to, the ability of the system, resources and staff to adequately and sufficiently perform the following compliance responsibilities: run algorithms on claims, data analytics, predictive analytics, trending claims behavior, and provider and member profiling.

12.2.2 Designation of a Compliance Officer and a Compliance Committee who will be accountable to senior management. The Contractor shall require the Compliance Officer to meet with State audit and investigations representatives at the frequency required by the Agency.

12.2.3 Effective training and education for the Contractor's employees, including the Compliance Officer, that is adequate to train and educate the Contractor's employees in the detection of fraud, waste, and abuse. The Contractor shall identify the frequency of the training and shall ensure that Contractor's employees will be trained no less than annually. The Contractor shall identify the type of training that it will provide and the Contractor's training plan shall include training related to the False Claims Act, as directed by CMS and the Agency.

12.2.4 Identification of how information related to identifying and reporting fraud and abuse will be included in provider and member materials.

12.2.5 Program integrity related goals, objectives, and planned activities for the year following the establishment of the Compliance Plan or the year following the submission of an updated plan.

12.2.6 Reporting procedures in compliance with Section 12.3.

12.2.7 Designation of an SIU Manager. The Contractor shall employ an SIU Manager. The Contractor shall:

(a) ensure that the SIU Manager is dedicated full-time to the Contractor's Iowa Medicaid product lines;

(b) require the SIU Manager to be located in Iowa;

(c) require that the qualifications of the SIU Manager are equal to those of the Agency Program Integrity Director; and

(d) ensure that the SIU Manager responsibilities include:

(i) directing the activities of Special Investigation Unit staff;

(ii) attending meetings with the State, including meeting with the State as the State directs, but no less than meeting on a monthly basis;

(iii) acting as a subject matter expert for Medicaid program integrity; and

(iv) reducing or eliminating wasteful, fraudulent, or abusive healthcare billings and services.

12.2.8 *SIU Staff.*

(a) In addition to employing the SIU Manager, the Contractor shall employ one full-time dedicated SIU staff member for each 100,000 members assigned to Contractor under this Contract.

(b) The Contractor shall require the SIU staff to review and investigate Contractor's providers and members to identify fraud, waste, and abuse.

(c) The Contractor shall ensure that, including the SIU Manager, a majority of SIU staff work in Iowa.

12.3 Program Integrity Activity Reporting.

12.3.1 *Monthly Reporting*

In addition to any reporting required by the federal regulations, including 42 C.F.R. § 438.608(d)(3), the Contractor shall provide the Agency with a monthly Program Integrity Activity Report outlining the Contractor's program integrity activities for the previous calendar month. To the extent that the federal regulations require reporting less frequently than the

provisions of this Contract, these reporting requirements of this Contract are in addition to the less frequent reporting requirements under the federal regulations.

In the monthly Program Integrity Activity Report, the Contractor shall provide the information requested by the Agency, in the format requested by the Agency, including, but not limited to:

(a) A list of the Contractor's program integrity related activities for the month.

(b) Identification of the Contractor's progress in meeting the program integrity goals and objectives of the Contractor's Plan.

(c) Identification of the recoupment totals for the reporting period.

(d) A summary of state fiscal year to date information of the Contractor.

(e) With respect to each provider reviewed:

1) The name and NPI of the provider.
2) The data source, referral, or other reason for the review.
3) Identification of any action taken by the Contractor, including, but not limited to, suspension, termination, recoupment, payment reduction, denial of enrollment or reenrollment, identification as excluded pursuant to 42 C.F.R. § 455.
4) Identification of the reason for the action and, if a payment or recoupment is involved, all of the relevant financial information related to the action.

12.3.2 Quarterly Audit Report

In addition to any reporting required by the federal regulations, including 42 C.F.R. § 438.608(d)(3), the Contractor shall provide the Agency with a quarterly audit report. To the extent that the federal regulations require reporting less frequently than the provisions of this Contract, these reporting requirements of this Contract are in addition to the less frequent reporting requirements under the federal regulations.

On a quarterly basis the Contractor shall submit a detailed audit report to the Agency which outlines the Contractor's program integrity-related activities, as well as identifies the Contractor's progress in meeting program integrity-related goals and objectives. The audit report should also specify individual provider recoupment, repayment schedules, and actions taken for each audit or investigation. The Agency shall review and approve, approve with modifications, or reject the audit report and specify the grounds for rejection. Recoupment totals and summaries for each reporting period (quarterly unless otherwise specified by the Agency) must also be submitted in the audit report.

12.3.3 Reporting of Suspected Fraud, Waste or Abuse

The Contractor shall report possible fraud or abuse activity to the Agency. The Contractor shall initiate an immediate investigation to gather facts regarding the possible fraud or abuse. Documentation of the findings of the investigation shall be delivered to the Agency within two (2) days of the identification of suspected fraud or abuse activity. In addition, the Contractor shall provide reports of its investigative, corrective, and legal activities with respect to fraud and abuse to the Agency in accordance with contractual and regulatory requirements. The Contractor and its

subcontractors shall cooperate fully in any Agency reviews or investigations and in any subsequent legal action. The Contractor shall implement corrective actions in instances of fraud and abuse detected by the State agency, or other authorized agencies or entities. The Contractor shall report to the Agency the following information monthly and in the manner required by the Agency: (i) the number of complaints of fraud and abuse made to the Agency that warrant preliminary investigation; and (ii) for each complaint which warrants investigation: (a) the name and ID number; (b) source of complaint; (c) type of provider; (d) type of provider; (e) nature of complaint; (f) approximate dollars involved; (g) disposition of the case, (h) service type, and (i) any other relevant information requested by the Agency.

12.4 Required Fraud, Waste and Abuse Activities.

12.4.1 The Contractor shall conduct regular review and audits of operations, including incorporation of Correct Coding Initiative editing in the Contractor's claims adjudication process.

12.4.2 The Contractor shall assess and strengthen internal controls to ensure claims are submitted and paid properly.

12.4.3 The Contractor shall educate employees, providers, and members about fraud and abuse and how to report it.

12.4.4 The Contraetor shall ensure the accuracy, completeness, and truthfulness of claims and payment data as required by 42 C.F.R. Part 438 Subpart H and 42 C.F.R. § 457.950(a)(2).

12.4.5 The Contractor shall ensure sufficient organizational resources to effectively respond to complaints of fraud and abuse.

12.4.6 The Contractor shall effectively process fraud and abuse complaints.

12.4.7 The Contractor shall report information to the Agency in a format designated by the Agency. Information shall be reported to the Agency monthly.

12.4.8 The Contractor shall monitor data and shall collect information related to utilization and service patterns of and potential overpayments made to providers, subcontractors, and members and compile that information including, but not limited to, the following compilations:

(a) A list of automated pre-payment claims edits.
(b) A list of automated post-payment claims edits.
(c) A list of desk audits on post—processing review of claims.
(d) A list of reports of provider profiling and credentialing created in conducting program and payment integrity reviews.

12.4.9 The Contractor shall also collect and compile the following information:

(a) A list of surveillance and utilization management protocols used to safeguard unnecessary or inappropriate use of Medicaid systems.
(b) A list of provisions in the subcontractor and provider agreements that ensure the integrity of provider credentials.

(c) A list of references in provider and member material regarding fraud and abuse referrals.
(d) Any claims algorithms, use of predictive modeling, or editing required by the Agency.

12.4.10 The Contractor shall develop data mining techniques and conduct on-site audits.

12.5 Coordination of Program Integrity Efforts

[26]The Contractor shall coordinate any and all program integrity efforts with IME personnel, IDPH personnel, and Iowa's Medicaid Fraud Control Unit (MFCU), located within the Iowa Department of Inspections and Appeals. At minimum, the Contractor shall:

12.5.1 Meet no less than two times each month and as otherwise required with the Agency Program Integrity Unit, IDPH staff, and MFCU staff.

12.5.2 Provide any and all Documentation or information upon request to the Agency, the MFCU, HHS-OIG or the US Department of Justice related to any aspect of the Contract, including but not limited to policies, procedures, subcontracts, provider agreements, claims data, encounter data, provider records and report on recoupment actions and receivables.

12.5.3 Coordinate PI activities with other contractors as directed by the Agency

12.6 Verification of Services Provided

The Contractor shall have in place a method and procedures to verify whether services reimbursed by the Contractor were actually furnished to members as billed by providers.

12.7 Program Integrity Payment Related Issues

12.7.1 *Credible Allegation of Fraud Temporary Suspensions*

The Contractor 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 the MFCU) has identified in writing good cause for not suspending payments or to suspend payments only in part. The Contactor shall issue a notice of payment suspension that comports in all respects with the obligations set forth in 42 C.F.R. § 455.23(b) and maintain the suspension for the durational period set forth in 42 C.F.R. § 455.23(c). In addition, the notice of payment suspension shall

state that payments are being withheld in accordance with 42 C.F.R. § 455.23. The Contractor shall not suspend payments until consulting first with the MFCU and second with the Agency. The Contractor shall maintain all materials related to payment suspensions for a minimum of five (5) years in compliance with the obligations set forth in 42 C.F.R. § 455.23(g). The Contractor shall afford a grievance process to providers for whom payments have been suspended by the Contractor under this section.

12.7.2 *Overpayments*

The Contractor shall maintain policies and procedures to ensure that providers comply with Iowa Code Chapter 249A Subchapter II – Program Integrity including but not limited to application of interest related to provider overpayments.

12.7.3 Circumstances Whereby the Contractor May Not Recoup or Withhold Improperly Paid Funds

The Contractor is prohibited from taking any actions 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 or more of the following criteria:

12.7.3.1 The improperly paid funds have already been recovered by the State of Iowa directly or through resolution of a State or federal investigation, and/or lawsuit, including but not limited to false claims act cases; or

12.7.3.2 The funds have already been recovered by the Recovery Audit Contractor (RAC); or

12.7.3.3 When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Iowa, are the subject of pending federal or State litigation or investigation, or are being audited by the Iowa RAC.

This prohibition described above shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. The Contractor shall check with the IME Program Integrity Unit before initiating any recoupment or withhold of any program integrity related funds to ensure that the recoupment or withhold is permissible. In the event that the Contractor obtains funds in cases where recoupment or withhold is prohibited under this section, the Contractor shall return the funds to the provider.

12.8 Recovery of Payments

12.8.1 The Contractor shall recover improper payments and overpayments attributable to claims paid by the Contractor as identified by the Contractor or the Agency.

12.8.2 The Contractor may retain overpayments attributable to claims paid by the Contractor.

12.8.3 *Reserved.*

12.8.4 The State shall transmit recovery of an overpayment attributable to claims paid by Contractor on or before the 60th day following receipt of the overpayment.

12.8.5 The Contractor shall report improper payments and overpayments in accordance with Section 12.3.

12.8.6 The provisions above do not apply to any amount of recovery to be retained under the False Claims Act cases or through other investigations.

12.9 Contractor Reporting Obligations for Adverse Actions Taken on Provider Applications for Program Integrity Reasons 42 C.F.R. §1002.3

The Contractor shall not permit the provider into the provider network if the Agency or 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 CHIP, or if the Agency or the Contractor determine that the provider did not fully and accurately make any disclosure required pursuant to 42 C.F.R. § 1001.1001(a)(1).

12.10 Termination of Providers

The Contractor shall comply with all requirements for provider disenrollment and termination as required by 42 C.F.R. §455.416.

12.11 Enforcement of Iowa Medicaid Program Rules

The Contractor shall vigorously pursue fraud, waste and abuse in the Medicaid Program and notify the Agency PI of any provider activity which would incur a sanction under 441 Iowa Administrative Code § 79.2(249A).

12.12 Referral for Sanction

The Contractor and the Agency shall develop a process for referral of providers to the Agency for Sanction under 441 Iowa Administrative Code § 79.2. The Contractor shall vigorously pursue fraud, waste and abuse in the Medicaid Program and notify the Agency PI of any provider activity which would incur a sanction under 441 Iowa Administrative Code § 79.2(249A).

13 Information Technology

13.1 Information Services and System

The Contractor shall maintain a fully integrated Information System (IS) sufficient to support program requirements, including but not limited to: (i) care coordination functions; (ii) utilization management; (iii) claims payment; (iv) service authorization; (v) provider network management; (vi) credentialing; (vii)

grievance and appeals processing; (viii) quality management; (ix) utilization management; and (x) encounter data. The Contractor shall be prepared to submit all required data and reports in the format specified by the Agency. The Contractor shall maintain an IS with capabilities to perform the data receipt, transmission, integration, management, assessment and system analysis tasks described in this Contract. Further, the Contractor shall comply with the requirements of 42 C.F.R. § 438.242 as described below.[27]

[28](a) *General rule.* Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of 42 C.F.R. part 438. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.

(b) *Basic elements of a health information system.* Contractor shall comply with the following:

(1) Section 6504(a) of the Affordable Care Act, 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.

(2) Collect data on member and provider characteristics as specified by the Agency, and on all services furnished to members through an encounter data system or other methods as may be specified by the Agency.

(3) Ensure that data received from providers is accurate and complete by—

(i) Verifying the accuracy and timeliness of reported data, including data from network providers the Contractor is compensating on the basis of capitation payments.

(ii) Screening the data for completeness, logic, and consistency.

(iii) Collecting 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.

(4) Make all collected data available to the Agency and upon request to CMS.

(c) *Member encounter data.* Contractor shall:

(1) Collect and maintain sufficient member encounter data to identify the provider who delivers any item(s) or service(s) to members.

(2) Submit member encounter data to the Agency at a frequency and level of detail to be specified by CMS and the Agency, based on program administration, oversight, and program integrity needs.

(3) Submit all member encounter data that the Agency as required to report to CMS under § 438.818.

(4) Specifications for submitting encounter data to the Agency in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate.

13.1.1 *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:

13.1.1.1 Member Database

Maintain a 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;

13.1.1.2 County of Legal Residency

County of legal residency for 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;

13.1.1.3 Clinical Information

Maintain a database which incorporates required clinical information described in Section 13.1.13;

13.1.1.4 Reporting

Maintain information and generate reports required by the performance indicators established to assess the Contractor's performance;

13.1.1.5 Claims Processing

Conduct claims processing and payment;

13.1.1.6 Medication Management

Maintain data to support medication management activities;

13.1.1.7 Capitation Payment

Maintain data documenting receipt and distribution of the capitation payment;

13.1.1.8 Incurred Claims

Maintain data on incurred but not yet reimbursed claims;

13.1.1.9 Third Party Liability

Maintain data on third party liability payments and receipts;

13.1.1.10 Claims Processing Timeliness

Maintain data on the time required to process and mail claims payment;

13.1.1.11 Critical Incident Data

Maintain critical incident data;

13.1.1.12 Clinical Data

Maintain clinical and functional outcomes data and data to support quality activities;

13.1.1.13 Grievance and Appeals

Maintain data on clinical reviews, appeals, grievances and complaints and their outcomes;

13.1.1.14 Utilization Management

Maintain data on services requested, authorized, provided and denied;

13.1.1.15 Ad Hoc Reporting

Maintain the capacity to perform ad hoc reporting on an "as needed" basis, with a turnaround time to average no more than five (5) business days;

13.1.1.16 Service Referrals

Maintain data on all service referrals;

13.1.1.17 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;

13.1.1.18 Age Specific Information

Maintain all data in such a manner as to be able to generate information on members by age;

13.1.1.19 Encounter Data

Provide encounter data to the Agency in a format specified by the Agency. Encounter data shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and privacy standards and shall be submitted with complete and accurate data that meets requirements for Agency submission of data to the Centers for Medicare and Medicaid Services' Medicaid Statistical Information System or successor system; and

13.1.1.20 Reserved.

13.1.2 *General Systems Requirements*

The IS implemented by the Contractor shall conform to the following general system 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 member, provider, prior authorization and claims to be processed; and (v) weekly file updates of reference files and claim payments.

13.1.2.1 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.

13.1.2.2 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.

13.1.2.3 Back-Up of Processing and Transaction Files

The Contractor shall employ the following back-up timelines: (i) twenty-four (24) 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.

13.1.3 *Data Usage*

13.1.3.1 Data Management

The Contractor shall utilize the clinical data it receives to appropriately manage the care being provided to members. As described in Section 14, 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 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.

13.1.3.2 Data Accessibility

The Contractor shall make data available to the Agency and, upon request, to CMS.

13.1.4 *System Adaptability*

In the event the Agency's technical requirements require amendment during the term of the Contract, the Agency will work with the Contractor in establishing the new technical requirements. 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.

13.1.5 *Information System Plan*

In any Work Plan required by Section 2.13, the Contractor shall submit a plan 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:

13.1.5.1 Planning, developing, testing and implementing new operating rules, new or updated versions of electronic transaction standards, and new or updated national standard code sets;

13.1.5.2 Concurrent use of multiple versions of electronic transaction standards and codes sets;

13.1.5.3 Registration and certification of new and existing trading partners;

13.1.5.4 Creation, maintenance and distribution of transaction companion guides for trading partners;

13.1.5.5 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;

13.1.5.6 Compliance with all aspects of HIPAA Privacy and Security rules;

13.1.5.7 Strategies for maintaining up-to-date knowledge of HIPAA-related mandates with defined or expected future compliance deadlines.

13.1.6 *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.

13.1.7 *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).

13.1.8 *Electronic Mail Encryption*

The Contractor's electronic mail encryption software for HIPAA security purposes shall be compatible with the Agency's email encryption software.

13.1.9 *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 Medicaid Management Information System (MMIS); (ii) the Agency's Title XIX eligibility system.

13.1.9.1 The Agency MMIS

The Contractor shall have the capacity to submit encounter data, as described in Section 13.5, to the MMIS in the manner and timeframe specified by the Agency.

13.1.9.2 The Agency Title XIX Eligibility System

The Contractor's IS shall have the capacity to electronically receive enrollment information through a file transfer process.

13.1.9.3 Reserved

13.1.10 *Use of Common Identifier*

The Contractor may use a common identifier, including 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 members.

13.1.11 *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.

13.1.12 *Electronic Visit Verification System*

In any Work Plan required by Section 2.13, if the use of an Electronic Visit Verification (EVV) System is proposed, the Contractor shall develop and describe the system that will be in place within a timeframe determined by the Agency and the Contractor to ensure compliance with state and federal regulations[29].

If an EVV System is not proposed, 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.

13.1.13 *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:

13.1.13.1 Diagnosis

Documentation of the diagnosis and functional assessment score;

13.1.13.2 Level of Functioning

Determination of and Documentation of the levels of functioning;

13.1.13.3 Services Authorized

Documentation of clinical services requested, services authorized, services substituted, services provided; Documentation shall reflect the application of utilization management criteria;

13.1.13.4 Services Denied

Documentation of services not authorized, reasons for the non-authorization based on Iowa Administrative Code citations, and substitutions offered;

13.1.13.5 Missed Appointments

Documentation of missed appointments, and subsequent attempts to follow up with the member;

13.1.13.6 Emergency Room

Follow-up on members discharged from the emergency room without an admission for inpatient treatment or observation;

13.1.13.7 Treatment Planning

Documentation of joint treatment planning, clinical consultation, or other interaction with the member or providers and/or funders providing or seeking to provide services to the member;

13.1.13.8 Medication Management

Documentation of the member's medication management done by the Contractor's clinical staff;

13.1.13.9 Inpatient Data

Documentation of assessment and determination of level at admission, continued service and discharge criteria;

13.1.13.10 Joint Treatment Planning

Name(s) of persons key to the treatment planning of members who access multiple services; and

13.1.13.11 Discharge Planning

Documentation of the discharge plan for each member discharged from twenty-four (24) hour services reimbursed through the Contractor; this shall include the destination of the member upon discharge.

13.1.14 *System Problem Resolution*

In any Work Plan required by Section 2.13, the Contractor shall develop plans for system problem resolution that do not rise to the level of disaster. 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.

13.1.15 *Escalation Procedures*

In any Work Plan required by Section 2.13, the Contractor shall develop and implement 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 13.2.1.

13.1.16 *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) calendar days prior to the installation or implementation of "minor" software and hardware upgrades, modifications or replacements and ninety (90) calendar 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 which 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. In any Work Plan required by Section 2.13, the Contractor shall develop and submit the plan required under this section.

13.1.17 *Environment Management*

The Contractor shall ensure the environment for development, system testing and User Acceptance Testing (UAT) is separate from the production environment.

13.2 Contingency and Continuity Plan

13.2.1 *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. For purposes of this Contract, "disaster" means 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. Disasters may include natural disasters, human error, computer virus or malfunctioning hardware or electrical supply. 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.

13.2.2 *General Responsibilities*

In any Work Plan required by Section 2.13, the Contractor shall develop and submit contingency and continuity planning documents. 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:

13.2.2.1 Notifying the Agency of any disruptions in normal business operations with a plan for resuming normal operations.

13.2.2.2 Ensuring participants continue to receive services with minimal interruption.

13.2.2.3 Ensuring data is safeguarded and accessible.

13.2.2.4 Training Contractor staff and stakeholders on the requirements of the information system contingency and continuity plans.

13.2.2.5 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.

13.2.3 *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. In any Work Plan required by Section 2.13, the Contractor shall include the plan required by this section. 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.

13.2.4 *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 13.1.2.3. 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.

13.3 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.

13.3.1 *Member Enrollment Data*

13.3.1.1 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 member data for use in eligibility verification, claims processing, and other functions that rely on 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 member identifiers, eligibility categories, or other member data elements without written approval from the Agency.

13.3.1.2 Reconciliation Process

The Contractor shall reconcile member eligibility data and capitation payments for each eligible 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) calendar days of discovering the discrepancy via procedures determined by the Agency. If the Contractor receives either enrollment information or capitation for a member, the Contractor is financially responsible for the member unless the Contractor has not received capitation for that 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 members determined to be ineligible or for whom the Contractor has not received capitation.

13.3.2 *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.

13.4 Claims Processing

13.4.1 *Claims Processing Capability*

The Contractor shall process and pay provider claims for services rendered to the Contractor's 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 paper claims, to the extent that paper claims are still allowed within the Iowa Medicaid program. 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 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 develop and implement 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 15 days of execution of the Contract. 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 6.1.2 and shall be no more than 180 days from the date of service.

13.4.2 *Claims Disputes*

In any Work Plan required by Section 2.13, the Contractor shall develop and implement written policies and procedures for registering and responding to claim disputes, including a process for out-of-network providers.

13.4.3 *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 441 Chapter 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 protected health information (PHI). Contractor shall require each physician providing services to enrollees 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.

13.4.4 *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.

13.4.5 *Coordination among Contractors*

Successful Contractor(s) 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.

13.4.6 *Claims Payment Timeliness*

The Contractor shall pay providers for covered medically necessary services rendered to the Contractor's members in accordance with Law. The Contractor shall pay or deny ninety percent (90%) of all clean claims within thirty (30) calendar days of receipt, ninety-five percent (95%) of all clean claims within

forty-five (45) calendar days of receipt and ninety-nine percent (99%) of all claims within ninety (90) calendar days of receipt. A "clean claim" is one in which all information required for processing is present. If a claim is denied because more information was required to process the claim, the claim denial notice shall specifically describe all information and supporting documentation needed to evaluate the claim for processing. As provided in 42 C.F.R. § 447.46(c)(2), the Contractor may, by mutual agreement, establish an alternative payment schedule with in-network providers. The alternative payment schedule shall be outlined in the provider contract. In accordance with 42 C.F.R. §447.45(d), the date of receipt of a claim is the date the Contractor receives the claim, as indicated by its date stamp on the claim, and the date of payment is the date of the check or other form of payment.

13.4.7 *Claims Reprocessing and Adjustments*

The Contractor shall adjudicate ninety percent (90%) of all clean provider-initiated adjustment requests within thirty (30) business days of receipt. 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 claims 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.

13.4.8 *Member Financial Participation and Cost Sharing*

Some members, as described in Section 5.4, including LTSS recipients who are receiving facility or community based care, must contribute a predetermined financial participation to the cost of services prior to Medicaid reimbursement. Providers bill members for their portion of the client participation. The Agency will notify the Contractor of a member's financial participation amount. The Contractor shall process claims in accordance with the liability amount and pay providers net of the applicable financial participation amount. In the event the sum of any applicable third-party payment and a member's financial participation equals or exceeds the reimbursement amount established for services, the Contractor shall make no payment. Additionally, some members, as described in Section 5.3 may be subject to cost sharing. The Contractor shall reduce the payment it makes to a provider, by the amount of the member's cost sharing obligation. The Contractor shall implement a mechanism, with Agency prior approval, to notify providers of a member's financial participation or cost sharing requirement.

13.4.9 *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.

13.5 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) business days prior to effective date.

13.5.1 *Definition of Uses of Encounter Claims*

The Contractor shall submit an encounter claim to the Agency, or its designee, for every service rendered to a 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 Contractor shall support the Agency's intent to use the encounter claims to make programmatic decisions and to monitor Contractor compliance and quality. 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 any liquidated damages assessed to the Contractor.

13.5.2 *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 every other week for adjudicated claims in support of the IME's drug rebate invoicing process identified in section 3.2.6.11. Encounter data shall be submitted by the 20th of the month 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 cannot 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.

13.5.3 *Encounter Claims Policies*

In any Work Plan required by Section 2.13, the Contractor shall develop written policies and procedures to address its submission of encounter claims to the State.

13.5.3.1 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 implement a quarterly Encounter Utilization Monitoring report and review process to be implanted in the first quarter following the contract effective date. 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.

13.5.3.2 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.

13.5.3.3 Patient Encounter Date Maintenance

The Contractor shall maintain sufficient patient encounter data to identify the physician who delivers services to patients, in compliance with 42 U.S.C. § 1396b(m)(2)(A)(xi).

13.6 Third Part Liability (TPL) Processing

13.6.1 *TPL Responsibility*

Pursuant to law, the Agency is the payer of last resort for all covered services. 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 members under the Contract and cost avoid and/or recover any such liability from the third party. The Contractor shall develop and implement policies and procedures, subject to Agency review and approval, to meet its obligations regarding third party liability when the third party pays a cash benefit to the member, regardless of services used, or does not allow the member to assign his/her benefits. When there is third party liability, the Contractor shall pay the 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.

13.6.1.1 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; (ii) worker's compensation; (iii) homeowner's insurance; (iv) automobile liability insurance; (v) non-custodial parents or their insurance carriers; or (vi) any individual responsible for a Medicaid participant's injury (for example, a person who committed an assault on a participant). Contractor shall be able to identify trauma and accident cases where funds expended can be recovered from liable third parties and recover the funds.

13.6.1.2 TPL Data

The Contractor shall share information regarding its 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 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.[30] The Agency will provide information to the Contractor on member TPL that was collected at the time of Medicaid application and through ongoing TPL identification processes. The Contractor shall report weekly any new TPL to the Agency to retain in the TPL system. The information collected 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.

13.6.2 *Cost Avoidance*

If a 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.

13.6.2.1 Provider Education

The Contractor shall educate network providers, and include in detailed written billing procedures, the process for submitting claims with third party liability 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.

13.6.2.2 Cost Avoidance Requirements

If insurance coverage information is not available or if one 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 a member from receiving medically necessary services in a timely manner.

13.6.2.3 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 prenatal care for a pregnant woman; (ii) the claim is for coverage derived from a parent whose obligation to pay support is being enforced by the State Title IV-D Agency and the provider of service has not received payment from the third party within thirty (30) calendar days after the date of service; or (iii) 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.

13.6.3 *Collection and Reporting*

The Contractor shall identify, collect, and report third party liability 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 third party liability 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 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 members who have newly discovered health insurance, in the timeframe and manner required by the Agency. The Contractor shall provide 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:

1. Monthly amounts billed and collected, current and year-to-date.
2. Recoveries and unrecoverable amounts by carrier, type of coverage, and reason (quarterly).
3. TPL activity reports (quarterly).
4. Internal reports used to investigate possible third-party liability when paid claims contain a TPL amount and no resource information is on file.
5. Monthly quality assurance sample to the Department verifying the accuracy of the TPL updated applied during the previous month.
6. Monthly pay-and-chase carrier bills.

13.6.4 *Reserved*

13.6.5 *Health Insurance Premium Payment Program*

The Contractor shall identify members with third party coverage who may be appropriate for enrollment in the Health Insurance Premium Payment (HIPP) program. The Contractor shall report members identified as potentially eligible for HIPP to the Agency in the timeframe and manner to be determined by the Agency. The Agency maintains full and final authority for determining if an individual is eligible for HIPP.

13.7 Health Information Technology

The use of Health Information Technology (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 Contractor shall obtain Agency approval of HIT initiatives and interfaces with IHIN. The Contractor shall leverage IHIN fully once it becomes fully operational. The Agency reserves the right to require the Contractor to establish additional HIT initiatives in the future.

14 Performance Targets and Reporting Requirements

14.1 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 members. The Agency will use various performance targets, industry standards, national benchmarks and program-specific standards in

monitoring the Contractor's performance and outcomes. The Agency reserves the right to publish Contractor performance. Failure to meet performance targets shall subject the Contractor to the corrective actions as outlined in Exhibit E. Refer to Exhibit F for information on the pay-for-performance program.

[31]The Contractor shall comply with the following data, information and documentation requirements in accordance with 42 C.F.R. § 438.604:

(a) *Specified data, information, and documentation.* Contractor shall submit to the Agency the following data:

(1) Encounter data in the form and manner described in 42 C.F.R. § 438.818.

(2) Data on the basis of which the Agency certifies the actuarial soundness of capitation rates to the Contractor under 42 C.F.R. § 438.4, including base data described in 42 C.F.R. § 438.5(c) that is generated by the Contractor.

(3) Data on the basis of which the Agency determines the compliance of the Contractor with the medical loss ratio requirement described in 42 C.F.R. § 438.8.

(4) Data on the basis of which the Agency determines that the Contractor has made adequate provision against the risk of insolvency as required under 42 C.F.R. § 438.116.

(5) 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, as set forth in 42 C.F.R. § 438.206.

(6) Information on ownership and control described in 42 C.F.R. § 455.104 from Contractor, and subcontractors as governed by 42 C.F.R. § 438.230.

(7) The annual report of overpayment recoveries as required in 42 C.F.R. § 438.608(d)(3).

(b) *Additional data, documentation, or information.* In addition to the data, documentation, or information specified in paragraph (a) of this section, Contractor must submit any other data, documentation, or information relating to the performance of the entity's obligations under 42 C.F.R. part 438 required by the Agency or the Secretary.

14.1.1 *Reporting Requirements*

The Contractor shall comply with all reporting requirements 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. The Contractor shall comply with the following certification requirements in accordance with 42 C.F.R. §438.606:

(a) *Source of certification.* For the data, documentation, or information specified in 42 C.F.R. § 438.604, Contractor shall certify the data, documentation or information the Contractor submits to the Agency by either the Contractor's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.

(b) *Content of certification.* The certification provided by the individual in paragraph (a) of this section must attest that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 C.F.R. § 438.604 is accurate, complete, and truthful.

(c) Timing of certification. Contractor shall submit the certification concurrently with the submission of the data, documentation, or information required in 42 C.F.R. § 438.604(a) and (b).

14.1.2 *Audit Rights and Remedies*

The Agency reserves the right to audit the Contractor's self-reported data at any time. The Agency may require corrective action or other remedies as specified in Exhibit E for Contractor non-compliance with these and other subsequent reporting requirements and performance standards.

14.1.3 *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. [32]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.

14.1.4 *Implementation Reporting*

The Agency reserves the right to require more frequent reporting at the beginning of the Contract 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.

14.1.5 *Other Reporting and Changes*

The Agency will provide at least thirty (30) calendar 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, which shall be provided following the Contract award date, will detail reporting requirements and the full list of required reports.

14.2 Financial Reports and Performance Targets

Financial reports assist the Agency in monitoring the Contractor's financial trends to assess its stability and its ability to offer health care services to its members. The financial reports include but are not limited to the reports described in Section 14.2.1 through Section 14.2.7.

14.2.1 *Third Party Liability Collections*

The Contractor shall report all third party liability collections to the Agency in the timeframe and format determined by the Agency.

14.2.2 *Iowa Insurance Division Reporting*

The Contractor shall comply with all reporting requirements at Iowa Admin. Code r. 191-40.14(514B) and copy the Agency on all required filings with the Iowa Insurance Division.

14.2.3 *Annual Independent Audit*

The Contractor shall complete an annual independent audit as described in Section 2.3.5.

14.2.4 *Physician Incentive Plan Disclosure*

The Contractor shall submit information on physician incentive plans, in the manner prescribed by the Agency, with sufficient detail to permit the Agency to determine compliance with 42 C.F.R. § 422.208 and 42 C.F.R. § 422.210.

14.2.5 *Insurance Premium Notice*

The Contractor shall submit certificates of insurance for required insurance no less than thirty (30) calendar days after the policy renewal effective date.

14.2.6 *Reinsurance*

The Contractor shall provide to the Agency all contracts of reinsurance or a summary of the plan of self-insurance which meet the requirements as set forth in Section 2.3.2. As applicable, the Contractor shall report to the Agency, in the manner dictated by the Agency, all health care claims costs paid by the Contractor's commercial reinsurer due to meeting the reinsurance attachment point.

14.2.7 *Medical Loss Ratio*

The Contractor shall maintain, at minimum, a medical loss ratio as set forth in Attachment 2.7.[33]

14.3 Member Services Reports and Performance Targets

Member services reports identify the methods the Contractor uses to communicate to members about health care and program services and monitor member satisfaction. Examples of member services reports to be submitted by the Contractor, in accordance with the terms of the Reporting Manual, include but are not limited to the reports described in Sections 14.3.1 through Section 14.3.10.

14.3.1 *Completion of Initial Health Risk Screening*

As described in Section 9.1.1, the Contractor shall complete an initial health risk screening no later than ninety (90) calendar days after member enrollment with the Contractor. Each quarter, at least seventy percent (70%) of the Contractor's new 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 member who does not obtain an initial health risk screening, the Contractor shall document at least three (3) attempts to conduct the screening.

14.3.2 *Completion of Comprehensive Health Risk Assessment*

As described in Section 9.1.2, the Contractor shall complete a comprehensive health risk assessment, in the timeframe mutually determined by the Agency.

14.3.3 *Care Plan Development*

Ninety-eight percent (98%) of members identified by the Contractor through the comprehensive health risk assessment as having a potential special healthcare care need shall have a care plan developed. Ninety-eight percent (98%) of care plans shall be updated, at minimum, annually.

14.3.4 *Member Helpline Performance Report*

The Contractor shall demonstrate the following: maintain a service level of 99% of calls answered by an individual or an electronic device without receiving a busy signal, and 80% of all calls will be answered in 30 seconds or less. The average speed for answering calls will be 30 seconds or less.[34]

14.3.5 *Member Enrollment*

The Contractor shall report total member enrollment count for the reporting period.

14.3.6 *Member Grievances Report*

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. The Contractor shall maintain and report to the Agency a member grievance log, which shall include the current status of all grievances.

14.3.7 *Member Hearing and Appeals Report*

The Contractor shall resolve one hundred percent (100%) of appeals within thirty (30) calendar days of receipt, or within 72 hours of receipt for expedited appeals. Further, one hundred percent (100%) of appeals shall be acknowledged within three (3) business days. The Contractor shall maintain and report to the Agency a member appeal log, which shall include the current status of all appeals.

14.3.8 *Summary of Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*

The Contractor shall annually provide to the Agency the survey results from its independent CAHPS survey.

14.3.9 *Member Website Utilization Report*

The Contractor shall have the capability to track and report to the Agency member website utilization data, including EOB and quality information hits.

14.3.10 *Member PCP Assignment Report*

The Contractor shall report: (i) total member enrollment count for those members under a Value Based Purchasing arrangement for the reporting period; (ii) the total member disenrollment count for those members disenrolled from a Value Based Purchasing arrangement for the reporting period; and (iii) a separate, detail report showing each member assignment to their PCP, including, but not limited to the individual PCP (name, NPI), physical location, affiliated organizational NPI(s), organizational name and organizational tax ID. This report will be in the format and frequency determined by the Department.

14.4 Provider Network Reports and Performance Targets

Provider network reports assist the Agency in monitoring the Contractor's provider services, network composition and geo-access ratios in order to assess member access, network capacity and provider relations. The Contractor shall identify current enrollment, gaps in network services and the corrective actions that the Contractor is taking to resolve any potential problems relating to network access and capacity. The provider network reports and performance targets include but are not limited to the reports described in Section 14.4.1 through Section 14.4.5.

14.4.1 *Network Geographic Access Reports for Providers*

The Contractor shall demonstrate access within the requirements set forth in Exhibit B or additional network adequacy standards developed by the Agency. the Agency reserves the right to request more frequent Network Geographic Access Assessment reporting at the beginning of the Contract, until the Contractor demonstrates that the network access standards have been met.

14.4.2 *Twenty four (24) Hour Availability Audit*

One hundred percent (100%) of Contractor's network primary care providers shall be available to member's twenty-four (24) hours-a-day, seven (7) days-a-week, and the Contractor shall implement corrective actions for network providers identified through the audit as failing to meet this standard.

14.4.3 *Provider Credentialing Report*

The Provider Credentialing Report details the timeliness and effectiveness of the Contractor provider credentialing processes. Credentialing of all providers applying for network provider status shall be completed as follows: (i) eighty-five percent (85%) within thirty (30) calendar days; and (ii) ninety-eight percent (98%) within forty-five (45) calendar days. The start time begins when the Contractor has received all necessary credentialing materials from the provider. Completion time ends when written communication is mailed or faxed to the provider notifying them of the Contractor's decision.

14.4.4 *Subcontractor Compliance Summary Report*

The Contractor shall conduct quarterly formal reviews of all subcontractors and provide summary reports to the Agency, in the prescribed format, of all key findings and any applicable corrective action plans implemented.

14.4.5 *Provider Helpline Performance Report*

99% of calls will be answered by an individual or an electronic device without receiving a busy signal. 80% of all calls will be answered in 30 seconds or less. The average speed for answering calls will be 30 seconds or less.

14.5 Quality Management Reports & Performance Targets

Quality management reports document the methods and processes the Contractor uses to identify program and clinical improvements that enhance the appropriate access, level of care, quality and utilization of program services by its members and providers. These reports assist the Agency in monitoring the Contractor's quality management and improvement activities. The quality management reports include but are not limited to the reports described in Section 14.5.1 through Section 14.5.5.

14.5.1 *Quality Management and Improvement Program Work Plan*

In the Work Plan required by 2.13, the Contractor shall develop a work plan for the Quality Management and Improvement Program to identify the goals the Contractor has set to address its strategy for

improving the delivery of health care benefits and services to its members (QMIP Plan). In the QMIP Plan, the Contractor shall identify the steps to be taken and include a timeline with target dates. The plan shall be submitted prospectively for each year, with quarterly updates and a final evaluation of the prior year. As a part of this work plan, the Contractor shall include its proposal to align with the SIM project, including specific detail for the value based purchasing requirements described in section 6.1.2. The Contractor shall incorporated use of the Value Index Score (VIS) in the QMIP plan.

14.5.2 *Quality Management Committee Meeting Minutes*

The Contractor shall report Quality Management Committee meeting minutes, document the actions of the Contractor's Quality Management Committee, and shall be provided in the reporting cycle following the meeting.

14.5.3 *Care Coordination Report*

The Contractor shall submit the Care Coordination Report to summarize all members engaged in care coordination programs developed by the Contractor, in accordance with Section 9, including summary information on active participation, number of contacts, disenrollment and outcomes.

14.5.4 *HEDIS Report*

The Contractor shall conduct an annual HEDIS audit survey and submit the compliance auditor's final audit report along with the same audited data provided to NCQA. The Agency will establish baseline performance targets for all HEDIS measures.

14.5.5 *Quarterly Health Outcomes and Clinical Reports*

The Agency intends to establish quarterly clinical reports and baseline rates to monitor healthcare services utilization and quality outcomes. Priority areas for monitoring which the Contractor shall report on include, but are not limited to:

14.5.5.1 Behavioral Health. (i) Follow-up after inpatient hospitalization for mental illness; (ii) readmission rates for psychiatric hospitalizations; (iii) anti-depression medication management; (iv) follow-up care for children prescribed attention deficit hyperactivity disorder (ADHD) medication; (v) diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medication; (vi) adherence to antipsychotic medications; (vii) number and percentage of members receiving mental health services; and (viii) number and percent of members receiving substance use disorder services; (ix) report that identifies foster children by a common identifier, their age, diagnosis, prescribed medications; and (x) a report that identifies foster children by a common identifier who are on two (2) or more prescribed psychotropic medications, psychotropic prescriptions, and diagnoses to support prescribing pattern.

14.5.5.2 Children's Health. (i) EPSDT screening rate; (ii) well-child visits; (iii) adolescent well-care visits; (iv) childhood immunization status; (v) adolescent immunization status; (vi) developmental screening for children age 0-3; and (vii) report that identifies foster children that receive EPSDT screenings.

14.5.5.3 Prenatal and Birth Outcomes. (i) Number of infants born between thirty-four (34) and

thirty-six (36) weeks gestation; (ii) percentage of deliveries that received recommended prenatal and postpartum visit; (iii) cesarean rate; and (iv) frequency of ongoing prenatal care.

14.5.5.4 Chronic Condition Management. These reports shall include measures that report on the effectiveness of services for members with chronic conditions, including but not limited to: (i) diabetes; (ii) cardiovascular conditions; (iii) HIV/AIDS; (iv) COPD; (v) asthma; (vi) chronic kidney disease; and (vii) other chronic conditions prevalent among enrolled program membership identified by the Contractor or the Agency.

14.5.5.5 Hospitalization and ER. (i) potentially preventable admissions; (ii) hospital readmission rates; (iii) potentially preventable ER visits; and (iv) emergency room diversion.

14.5.5.6 Adult Preventive Care. (i) cervical cancer screening; (ii) breast cancer screening; (iii) colorectal cancer screening; and (iv) adult access to preventive/ambulatory health services.

14.6 LTSS Reports and Performance Targets

LTSS reports document the Contractor's quality and management outcomes for individuals residing in an institutional setting or receiving HCBS. These reports document the Contractor's effectiveness in implementing institutional diversion strategies and promoting the provision of HCBS include but are not limited to the reports described in this section.

14.6.1 *Nursing Facilities Admission Rates*

The Nursing Facilities Admission Rates Report shall document the nursing facility, ICF/ID, and PMIC admission rate. The Agency will establish a baseline rate and the Contractor shall demonstrate a decrease in the number of nursing facility, ICF/ID, and PMIC days used by eligible members.

14.6.2 *Nursing Facility Days of Care*

The Nursing Facility Days of Care report shall document the number of nursing facility, ICF/ID, and PMIC days used by members. The Agency will establish a baseline rate and the Contractor shall demonstrate a decrease in the number of nursing facility, ICF/ID, and PMIC days used by eligible members.

14.6.3 *Return to Community*

The Return to Community report shall document the percentage of members who return to the community following nursing facility, ICF/ID, and PMIC admission. The Agency will establish a baseline rate and the Contractor shall demonstrate an increase in the number of members returning to the community.

14.6.4 *ICF/ID and PMIC Report*

The ICF/ID and PMIC report shall document measures for ICF/ID and PMIC services to be determined by the Agency.

14.6.5 *Fall Risk Management*

The Fall Risk Management report shall document the percentage of members in long-term care who are at risk for falling who receive fall risk intervention.

14.6.6 *Hospital Admission after Nursing Facility Discharge*

The Hospital Admission after Nursing Facility Discharge Report shall document the percentage of members discharged from a nursing facility who had a hospital admission within thirty (30) days. The Agency will establish a baseline rate and the Contractor shall demonstrate a decrease in the admission rate.

14.6.7 *Self-Direction*

The Self-Direction report shall document the number of members who are self-directing eligible HCBS as described in Section 4.4.8. The Agency will establish a baseline rate and the Contractor shall demonstrate an increase in self-directed services.

14.6.8 *Timeliness of Level of Care*

The Timeliness of Level of Care Report shall document the Contractor's timely completion of level of care reassessments. Ninety-five percent (95%) of reassessments shall be completed within twelve (12) months of the previous assessment. The Agency also reserves the right to audit the application of level of care criteria to ensure the accurate and appropriate application of criteria.

14.6.9 *Timeliness of Needs Assessment and Reassessments*

The Timeliness of Needs Assessment and Reassessments report shall document the Contractor's timely completion of needs assessments and reassessments for 1915(c) HCBS waiver enrollees. Ninety-five percent (95%) of needs assessment shall be completed within the timeframe mutually agreed upon between the Contractor and the Agency in the course of Contract negotiations.

14.6.10 *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 1915(c) HCBS waiver care plans and case notes to determine Contractor compliance with: (i) timely completion; (ii) care plan addressing the member's assessed health and safety risks, and personal goals; (iii) 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 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 members; (ix) percentage of new members starting ongoing services within the required timeframe; (x) 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.

14.6.11 *Critical Incident Reporting*

This report shall document, at minimum, the number, percent and frequency of critical incidents and the number and percent reported within the required timeframes. The Agency will monitor critical incident reports submitted by the Contractor to identify potential performance improvement activities.

14.6.12 *Out of State Placements*

This report shall include information regarding the members receiving out of state placements and providers for adults and children.

14.6.13 *Oral Health*

The Contractor shall ensure coordination of preventative oral health for the LTSS populations, including members residing in a facility.

14.7 Quality of Life Reports and Performance Targets

The Agency intends to develop reports, baseline data and performance targets surrounding quality of life outcomes for members. Potential areas for measurement include but are not limited to: (i) increased life expectancy; (ii) number and percentage of members who gain and maintain competitive employment; (iii) number and percentage of members engaged in volunteer work; (iv) satisfaction; and (v) reduction in homelessness. The Agency may require the Contractor to conduct a member survey to measure key experience and quality of life indicators using best practices for reaching populations with special healthcare needs. The Agency will analyze the findings of the survey to identify required performance improvement activities, shall make the findings available to stakeholders and shall have the EQRO validate the findings.

14.8 Utilization of Reports and Performance Targets

Utilization reports assist the Agency in monitoring the Contractor's utilization trends to assess its stability and continued ability to offer health care services to its members. The Contractor shall submit these reports to the Agency. The utilization reports and performance targets include but are not limited to the reports described in this section.

14.8.1 *Program Integrity Plan*

The Program Integrity Plan shall be updated annually and submitted to the Agency for review. Quarterly high-level progress reports shall be submitted to the Agency outlining key activities, findings and progress toward meeting goals and objectives. Quarterly recoupment totals shall also be provided. All plan updates shall be approved by the Agency.

14.8.2 *Prior Authorization Report*

Ninety-nine percent (99%) of standard authorization decisions shall be rendered within fourteen (14) calendar days of the request for service, or 72 hours for expedited authorization decisions. For pharmacy prior authorization one hundred percent (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. Pharmacy Rebate Reporting

In accordance with Section 3.2.6, the Contractor shall submit reports to facilitate pharmacy rebate collection in the manner and timeframe required by the Agency.

14.8.3 *Pharmacy Reporting*

The Contractor shall provide additional reporting specific to the pharmacy program, including, but not limited to: Pharmacy help desk performance; Prior authorization performance; Prior Authorization request turnaround time; Number of claims submitted as a 72-hour emergency supply; Denials (name of drug, number of requests, number of denials); Pharmacy network access; Grievance and appeals and Medication therapy management initiatives.

14.9 Claims Reports and Performance Targets

The Claims Reports assist the Agency in monitoring the Contractor's claims processing activities to ensure appropriate member access to services and payments to providers. 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 below & submit the data and reports described in Section 14.9.1 and Section 14.9.2.

14.9.1 *Adjudicated Claims Summary, Claims Aging Summary, and Claims Lag Report*

The Contractor shall pay or deny ninety percent (90%) of clean claims within thirty (30) calendar days of receipt, ninety-five percent (95%) of clean claims within forty-five (45) calendar days of receipt and ninety-nine percent (99%) of claims within ninety (90) calendar days of receipt.

14.9.2 *Claims Denials Reasons*

The Contractor shall report to the Agency the top ten (10) most common reasons for claim denial.

14.10 CMS Reporting

The Contractor shall be required to submit data necessary to support and report on federal waiver requirements and as requested by CMS in the manner and timeframe required by the Agency and CMS. This includes, but is not limited to, data related to the Iowa Health and Wellness Plan, HCBS waiver programs and members, the hawk-i program, and the SIM grant.

Reserved

15 Termination

15.1 Contractor's Termination Duties

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. In the event of Contract termination, the Agency reserves the right to require the Contractor to continue to serve or arrange for provision of services to members for up to forty-five (45) calendar days from the Contract Termination Date or until the members can be transferred to another program contractor, whichever is longer. During this transition period, the Agency will continue to make payments under the terms of the Contract. The Agency reserves the right to withhold some or all retroactive capitation adjustment payments due and owing to the Contractor in the event the Contractor fails to comply with the responsibilities set forth in this section. Upon receipt of notice of termination or upon request of the Agency, Contractor shall conduct the following activities to minimize the disruption of services to members and providers:

15.1.1 *Duties*

15.1.1.1 Agree to comply with all duties and/or obligations, including provider reimbursement, incurred prior to the actual termination date of the Contract.

15.1.1.2 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.

15.1.1.3 Appoint a liaison for post-transition concerns and provide for sufficient claims payment staff, member services staff, care coordination staff and provider services staff to ensure a smooth transition.

15.1.1.4 Submit a written Transition Plan to the Agency for approval within 60 days of Contract execution. The Contractor shall agree to revise the plan as necessary in order to obtain approval by the Agency. In the event of Contract termination, the Transition Plan shall be due within the timeframe set forth by the Agency in the Notice of Termination from the Agency. In the event of Contract expiration, the Transition Plan shall be due at least one hundred and eighty (180) calendar days before expiration of the Contract. 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. The

Agency will withhold the Contractor's final capitation payment until the Contractor has: (i) received the Agency approval of its Transition Plan; and (ii) 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. Designation of satisfactory completion of the Contractor's transition responsibilities pursuant to the Agency-approved Transition Plan shall be made at the sole discretion of the Agency.

15.1.1.5 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) calendar days of the request. Such records shall be provided at no expense to the Agency or its designated entity.

15.1.1.6 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 members' completion of Healthy Behaviors Program requirements as described in Section 5.2.

15.1.1.7 Provide the Agency, or its designated entity, all performance data with a due date following the termination or expiration of the Contract, but covering a reporting period before termination or expiration of the Contract, including but not limited to CAHPS and HEDIS.

15.1.1.8 Participate in the External Quality Review, as required by 42 C.F.R. Part 438, Subpart E, for the final year of the Contract.

15.1.1.9 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.

15.1.1.10 Submit reports to the Agency every thirty (30) calendar 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, then the Agency will require the Contractor to submit a revised final report. The Agency will, in writing, notify the Contractor once the Contractor has submitted a revised final report evidencing to the satisfaction of the Agency that the Contractor has fulfilled its continuing obligations.

15.1.1.11 Be responsible for resolving 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.

15.1.1.12 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.

15.1.1.13 Be financially responsible for all claims with dates of service through the day of termination or expiration of the Contract, including those submitted within established time limits after the day of termination or expiration of the Contract.

15.1.1.14 Be financially responsible for services rendered through the day of termination or expiration of the Contract, for which payment is denied by the Contractor and subsequently approved upon appeal or State fair hearing.

15.1.1.15 Be financially responsible for inpatient services for patients hospitalized on or before the day of Contract termination or expiration through the date of discharge, including the diagnosis related group (DRG) payment and any outlier payments.

15.1.1.16 Be responsible for submitting encounter data to the Agency for all claims incurred before the Contract expiration date according to established timelines and procedures and for a period of at least fifteen (15) months after termination or expiration of the Contract.

15.1.1.17 Arrange for the orderly transfer of patient care and patient records to those providers who will assume care for the member. For those 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 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.

15.1.1.18 In the event that the Agency assigns members or responsibility to another program Contractor, the Contractor shall work cooperatively with, and supply program information to, any successor program Contractors. Both the program information and the working relationship among the Contractor and successor program Contractors will be defined by the Agency.

15.1.1.19 Reserved.

15.1.1.20 Coordinate the continuation of care for members who are undergoing treatment for an acute condition.

15.1.1.21 Notify all providers about the Contract termination and the process by which 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.

15.1.1.22 Report any capitation or other overpayments made by the Agency to the Contractor within thirty (30) calendar 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) calendar days of reporting the overpayment to the Agency.

15.1.1.23 Take whatever other actions are necessary in order to ensure the efficient and orderly transition of members from coverage under this Contract to coverage under any new arrangement developed by the Agency.

EXHIBIT A

DEFINITIONS

340B Program. The federal 340B Drug Pricing program managed by Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA). The program allows certain designated facilities to purchase prescription medications at discounts, so 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 professional recognized standards for health care. It also includes recipient practices that result in unnecessary cost of the Medicaid program (see 42 C.F.R. § 455.2).

ADHD. Attention Deficit Hyperactivity Disorder.

Adverse Benefit Determination.[35] In the case of Contractor any of the following:

(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

(2) The reduction, suspension, or termination of a previously authorized service.

(3) The denial, in whole or in part, of payment for a service.

(4) The failure to provide services in a timely manner, as defined by the Agency.

(5) The failure of 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.

(6) Reserved.

(7) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

The Agency (Agency/the Agency). The Iowa Department of Human Services.

Appeal. Review by Contractor of an adverse benefit determination. No appeal is granted when a request for an exception to policy (such as requests that exceed service or reimbursement limits) has been denied by the Contractor.[36]

ARRA. The America Recovery and Reinvestment Act.

BCCEDP. Breast and Cervical Cancer Early Detection Program.

BCCT. Breast and Cervical Cancer Treatment.

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) long term care services that define the covered services available to members under the Contract.

BHIS. Behavioral and Health Intervention Services.

Bidder. An entity submitting a proposal to become a Contractor under an RFP.

BIP. Balancing Incentives Project.

BMI. Body Mass Index.

CAHPS. Consumer Assessment of Healthcare Providers and Systems.

Capitated Payment. A monthly payment to the Contractor on behalf of each member for the provision of health services under the Contract. Payment is made regardless of whether the member receives services during the month.

Care Coordination. Care coordination is the overall system of medical and psychosocial management encompassing, but not limited to: utilization management, disease management, discharge planning following restrictive levels of care, continuity of care, care transition, quality management and service verification.

CCD. Continuing Care Document.

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 the Health Care Financing Administration (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.

CMH. Children's Mental Health.

CMHC. Community Mental Health Centers.

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.

Community-Based Case Management. Community-Based Case Management is a collaborative process of planning, facilitation, and advocacy for options and services to meet a member's needs through communication and available resources to promote high quality, cost-effective outcomes. Qualified staff provides community-Based Case Management services to assist members in gaining timely access to the full range of needed services. For the purpose of this scope of work, Targeted Case Management activities are to be conducted through Community-Based Case Management. The Center for Medicare and Medicaid Services State Medicaid Directors' letter # 10-024 includes services definitions and provider standards that describes best practices and characteristics of integrated health homes (IHH). The Contractor is encouraged to implement these practices and characteristics into community-based case management. The Agency intends to require these IHH characteristics and practices in the future.

Co-Payment. A cost-sharing arrangement in which a 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.

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 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.

Current Enrollees. Enrollees who are known to be eligible for enrollment with the Contractor as of the start date of operations. After start date of operations, current enrollees shall mean the members who are enrolled in a given managed care program.

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 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.

~~**Director Decision.** The Agency Director's Final Decision is the final agency action on any Member appeal. The Agency will defend final Agency action on petition for judicial review filed by the member. The Contractor does not have the right of judicial review.~~

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. May include natural disasters, human error, computer virus or malfunctioning hardware or electrical supply.

Discharge Planning. The process, begun at admission, of determining a members continued need for treatment services and of developing a plan to address ongoing needs.

Disenrollment. The removal of a member from the Contractor's enrollment either through loss of eligibility or some other cause.

Dispensing Fee. Payment provided for the costs incurred by a pharmacy to dispense a drug. The fee reflects the pharmacist's professional services and costs associated with ensuring that possession of the appropriate covered outpatient drug is transferred to a Medicaid member.

DRA. The Deficit Reduction Act.

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 nine 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.

Duplicate Claim. A claim that is either a total or a partial duplicate of services previously paid.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT). A federally-required Medicaid benefit for individuals under the age of twenty-one (21) years that expands coverage for children and adolescents beyond adult limits to ensure availability of: (i) screening and diagnostic services to determine physical or mental defects; and (ii) health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered. EPSDT requirements help ensure access to all medically necessary health care services within the federal definition of "medical assistance."

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.

Emergent Care. Means the existence of conditions due to an illness or injury which are not life threatening but which require expeditious treatment because of the prospect of the condition worsening without immediate clinical intervention (441 Iowa Administrative Code § 88.21)

EMTALA. Emergency Medical Treatment and Active Labor Act.

Encounter Data. Records of medically-related services rendered by a provider to a member on a specified date of service. This data is inclusive of all services for which the Contractor has any financial liability to a provider.

Enrollee. A person who has been determined eligible by the Agency for Medicaid or a recipient of services provided under the State Children's Health Insurance Program operated by the Agency and who has been enrolled in either program in the Iowa Medicaid Management Information System (see Member, also).

Enrollment. The process by which an enrollee becomes a member of the Contractor.

EOB. Explanation of Benefits

EQRO. External Quality Review Organization.

ETL. Extraction, Transformation, and Load.

FBR. SSI Federal Benefit Rate.

FFS. Fee-for-Service.

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 him or some other person. It includes any act that constitutes fraud under applicable federal or State law. Fraud may include deliberate misrepresentation of need or eligibility, providing false information concerning costs or conditions to obtain reimbursement or certification, or claiming payment for services which were never delivered or received (see 42 C.F.R. § 455.2).

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

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.[37]

Gross Base LTSS Capitation. The column on the LTSS Gross Capitation rate chart that sets forth the total gross capitation rate applicable to a given capitation rate cell for LTSS services before risk adjustment and before removal of any withhold permitted under Exhibit F. The illustrated capitation rate is applicable to all rate cells within a single LTSS blended rate group, which immediately precede the illustrated capitation rate.[38]

Gross Base Risk Adjusted LTSS Capitation. The column on the LTSS Gross Capitation rate chart that sets forth the total gross capitation rate applicable to a given capitation rate cell for LTSS services after risk adjustment but before removal of any withhold permitted under Exhibit F. The illustrated capitation rate is applicable to all rate cells within a single LTSS blended rate group, which immediately precede the illustrated capitation rate.[39]

Gross Total State Plan plus 1915(b)(3). The total gross capitation rate applicable to a given capitation rate cell for medical services that is inclusive of all medical rate components included in the medical rate (i.e., risk adjustment, payment for 1915(b)(3) services, GME supplemental payments, UIHC supplemental payments, risk adjustment, and rebalancing). The values provided for the Gross Total State Plan plus 1915(b)(3) rates are provided before removal of any withhold permitted under Exhibit F.[40]

***hawk-i* Board.** The seven-member board appointed by the Governor to make policy for and provide direction to the Agency for the administration of the *hawk-i* program.

***hawk-i* 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.

Healthcare Effectiveness Data and Information Set (HEDIS). A set of performance measures developed by the National Committee for Quality Assurance (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.

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 nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) or to delay or prevent placement in a nursing facility.

HRSA. Health Resources Services Administration.

IAC. Iowa Administrative Code.

IDPH. Iowa Department of Public Health.

IHH. Integrated Health Homes.

Iowa Health Information Network (IHIN). Iowa's Health Information Exchange, located in the Iowa Department of Public Health.

IVR. Interactive Voice Response.

Long Term Care (LTC) or Long Term Services and Supports (LTSS). The services of a nursing facility (NF), an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/ID), State Resource Centers or services funded through 1915(c) home and community based services waivers.

LTSS Gross Capitation. Contract attachment rate charts that provide capitation rate cells for LTSS services before removal of any withhold provided for in Exhibit F.

LTSS Net Capitation. Contract attachment rate charts that provide capitation rate cells for LTSS services after removal of any withhold provided for in Exhibit F.

MAC. Maximum Allowable Cost.

MBHO. Managed Behavioral Healthcare Organization.

MED. Medicare Exclusion Database.

Medicaid. A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving eligible individuals.

Medicaid Administrative Fund: A fund established by the Contractor based on the percentage of administration expenses allowed within the capitation payments.

Medicaid Claims Fund. A fund established based on the MLR required within the capitated rate structure.

Medicaid Management Information System (MMIS). 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 enrollees.

Medical Gross Capitation. Contract attachment rate charts that provide capitation rate cells for medical services before removal of any withhold provided for in Exhibit F.

Medical Net Capitation. Contract attachment rate charts that provide capitation rate cells for medical services after removal of any withhold provided for in Exhibit F.

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 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 Necessary Services. Those Covered Services that are, under the terms and conditions of the Contract, determined through Contractor utilization management to be:

(1) Appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the member;

(2) Provided for the diagnosis or direct care and treatment of the condition of member enabling the member to make reasonable progress in treatment;

(3) Within standards of professional practice and given at the appropriate time and in the appropriate setting;

(4) Not primarily for the convenience of the member, the member's physician or other provider; and

(5) The most appropriate level of Covered Services, which can safely be provided.

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.

Medicare. A nationwide federally administered health insurance program which covers the cost of hospitalization, medical care and some related services. Medicare has two 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.

MEPD. Medicaid for Employed People with Disabilities.

MFCU. Medicaid Fraud Control Unit.

MHDS. Mental Health and Disability Services.

MHPAEA. Mental Health Parity and Addiction Equity Act.

Money Follows the Person Rebalancing Demonstration (MFP). A federal grant that will assist Iowa in transitioning individuals from a nursing facility or ICF/ID into the community and in rebalancing long-term care expenditures.

MTM. Medication Therapy Management.

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. 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. The term "provider network" is also used.

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 members without unreasonable delay. Adequacy is determined by a number of factors, including, but not limited to, provider/member ratios, geographic accessibility and travel distance, waiting times for appointments, and hours of agency operations.

NF. Nursing Facility.

NFMI. Nursing Facilities for Persons with Mental Illnesses.

NMHPA. The Newborn and Mothers Health Protection Act.

Notice. Notice means a written statement of the action the Contractor has taken or intends to take, the reasons for the action, the 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.

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.

PASRR. Preadmission Screening and Resident Review.

PA. Pharmacy Prior Authorization.

PACE. Program for All Inclusive Care for the Elderly.

Patient Liability. The amount of a member's income, as determined by the Agency, to be collected each month to help pay for the enrollee's long-term care services.

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 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.

Pharmaceutical and Therapeutics (P&T) Committee. A committee of nine members appointed by the Governor that is charged with developing and providing ongoing review of the Preferred Drug List pursuant to Iowa Code section 249A.20A.

Pharmacy Benefit Manager (PBM). An entity responsible for the provision and administration of pharmacy services.

Physician-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 services.
(a) Physician-administered drugs are administered by a medical professional in a physician's office or other outpatient clinical setting.
(b) Physician-administered drugs are incident to a physician's services that are separately billed to Medicaid or its designee.
(c) Reimbursement for physician-administered drugs is allowed only if the drug qualifies for rebate in accordance with 42 USC 1396r-8.

PMIC. Psychiatric Medical Institutions for Children.

Policies and Procedures Manual. The document to be released by the Agency following Contract award detailing the policies and procedures of the program.

POS. Point of Sale.

PPACA. The Patient Protection and Affordable Care Act.

PPS. Prospective Payment System.

Preferred Drug. A drug on the Preferred Drug List that provides medical equivalency to the Medicaid member in a cost-effective manner (by virtue of OBRA '90 and Supplemental Rebate) and does not require a prior authorization. A preferred drug is designated "P" on the Preferred Drug List.

Preferred Drug List (PDL). A list comprised of drugs recommended to the Iowa Department of Human Services by the Iowa Medicaid Pharmaceutical and Therapeutics Committee that have been identified as being therapeutically equivalent within a drug class and that provide cost benefit to the Medicaid program.

Preferred Drug with Conditions. A drug has "preferred" agents but before getting the drug a patient must meet medical criteria and guidelines that coincide with current prior authorization guidelines. A preferred drug with conditions is designated "P" on the Preferred Drug List and has a number in the comments column to indicate a prior authorization is required, as defined on the first page of the Preferred Drug List (PDL).

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 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. The process of obtaining prior approval as to the appropriateness of a service or medication; prior authorization does not guarantee coverage.

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.

Potential Enrollee. Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee.

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 his or her profession, or as other professionals in the same discipline would in the same or similar circumstances.

Program. The high quality healthcare initiative to be implemented under the Contract resulting from this Contract.

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

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. A health care provider who has entered into a contract with the Contractor to provide covered services to members.

Provider Preventable Conditions. Situations in which Medicaid payment is prohibited for services that should have been avoidable as defined in 42 C.F.R. § 447.26.

Psychosocial Necessity. The clinical, rehabilitative, or supportive mental health services that meet all of the following conditions: (i) are appropriate and necessary to the symptoms, diagnoses or treatment of a mental health diagnosis; (ii) are provided for the diagnosis or direct care and treatment of a mental disorder; (iii) are within standards of good practice for mental health treatment; (iv) are required to meet the mental health needs of the member and not primarily for the convenience of the member, the provider, or the Contractor; and (v) are the most appropriate type of service which would reasonably meet the needs of the member in the least costly manner after consideration of: (a) the member's clinical history including the impact of previous treatment and service interventions; (b) services being provided concurrently by other delivery systems; (c) the potential for services/supports to avert the need for more intensive treatment; (d) the potential for services/supports to allow the member to maintain functioning improvement attained through previous treatment; (e) unique circumstances which may impact the accessibility or appropriateness of particular services for an individual member (e.g., availability of transportation, lack of natural supports including a place to live); and (f) the member's choice of provider or treatment location.

QHP. Qualified Health Plan

RAC. Recovery Audit Contractor

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 Human Services by the Iowa Medicaid Pharmaceutical and Therapeutics Committee that informs prescribers of cost-effective alternatives that do not require a prior authorization.

Reporting Manual. The document to be distributed by the Agency after Contract award detailing the reporting requirements for the program.

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.

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). See definition for urban herein.

SAM. System for Award Management.

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. As outlined at 42 C.F.R. § 438.210, the review and consistent authorization or denial of a request by the member, or the member's authorized representative, for a service covered under this Contract to be provided.

SIM. State Innovation Model.

SIU. Special Investigations Unit.

SRC. State Resource Centers.

Start Date of Operations. The date, as determined by the Agency, when the Contractor shall begin providing services to members.

State. The State of Iowa, including, but not limited to, any entity or agency of the state, such as the Iowa Department of Human Services, the Department of Public Health, the Medicaid Fraud Control Unit, the Division of Insurance, and the Office of the Attorney General.

State Fair Hearing. The process set forth in 42 C.F.R. 431 subpart E.[41]

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 principal contractor or another subcontractor to perform a portion of the duties in the Scope of Work. This does not include providers who solely provide medical services to members pursuant to a provider agreement.

SSA. Social Security Administration.

SSI. Supplemental Security Income.

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 Chapter 225C.20 of the Code of Iowa with standards set forth in the Iowa Administrative Code 441 Chapter 24 and Chapter 90.

Total Paid LTSS Rate. The column on the LTSS net Capitation rate chart that sets forth the total net capitation rate applicable to a given capitation rate cell that is inclusive of all LTSS rate components included in the LTSS rate. The values provided for in the Total Paid LTSS Rate column represent capitation rates after removal of any withhold permitted under Exhibit F. The illustrated capitation rate is applicable to all rate cells within a single LTSS blended rate group, which immediately precede the illustrated capitation rate. The Agency will pay Contractor the monthly capitation rate provided for pursuant to Section 1.3.3 of the Contract's Special Terms based on the values represented in the Total Paid LTSS Rate as set forth in the applicable Contract attachment as compensation for all LTSS services provided to patients identified in the corresponding rate cells when the patient is identified as receiving LTSS services.[42]

Total Paid Medical Rate. The column on the Medical Net Capitation rate chart that sets forth the total net capitation rate applicable to a given capitation rate cell that is inclusive of all medical rate components included in the medical rate including risk adjustment, payment for 1915(b)(3) services, GME supplemental payments, and UIHC supplemental payments. The values provided for in the Total Paid Medical Rate column represent capitation rates after removal of any withhold permitted under Exhibit F. The Agency will pay Contractor the monthly capitation rate provided for pursuant to Section 1.3.3 of the Contract's Special Terms based on the values represented in the Total Paid Medical Rate as set forth in the applicable Contract attachment as compensation for all medical goods and services provided to patients identified in the corresponding rate cells. When a patient receives both medical and LTSS services, the Total Paid Medical Rate is combined with the Total Paid LTSS Rate to arrive at a total amount to be paid the Contractor for that patient's managed care coverage for the month.[43]

TPL. Third Party Liability.

UAT. User Acceptance Testing.

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 utilization management, 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 and industry standards. Utilization review is done at the individual member level as well as a system level.

Urban. A Metropolitan Statistical Area (MSA) as defined by the federal Executive Office of Management and Budget.

Urgent, nonemergency need. The existence of conditions due to an illness or injury which are not life threatening but which require expeditious treatment because of the prospect of the condition worsening without immediate clinical intervention.

Value Based Purchasing (VBP). Linking provider payment to improved performance by health care providers is called Value Based Purchasing. 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.

Value Index Score (VIS). The 3M Value Index Score (VIS) is a single score that represents how well a primary care physician (PCP) cares for his or her patients, regardless of their health status (i.e., healthy to chronically ill). While there are many quality measures available, not all consider health outcomes or how elements of the health system affect those outcomes. The VIS measures provider quality by encompassing all the moving pieces of primary care. This allows for a better understanding of overall provider and system performance, which can help accelerate care improvement and serve as the basis for value-based payment. VIS is comprised of claims-based measures from six key domains of care that take into account patient conditions, processes of care and outcomes of care. One additional domain is based on member experience surveys. Because it is strongly correlated with total cost-of care, the 3M VIS complements cost measures when defining true value within a primary care system.

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.

1915(c) HCBS Waiver. Refers to the seven (7) 1915(c) HCBS waivers operated by the Agency as of the release date of this Contract. Includes: (i) AIDS/HIV; (ii) Brain Injury; (iii) Child 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.

EXHIBIT B

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 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 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 members are met within the Contractor's provider network. The Contractor shall also have a system to refer members to, and pay for, non-network providers when medically necessary. The Contractor shall also pay for non-network providers when a 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) neonatology; (viii) nephrology; (ix) neurology; (x) neurosurgery; (xi) obstetrics and gynecology; (xii) occupational therapy; (xiii) oncology/hematology; (xiv) ophthalmology; (xv) orthopedics; (xvi) otolaryngology; (xvii) pathology; (xviii) physical therapy; (xix) pulmonology; (xx) psychiatry; (xxi) radiology; (xxii) reconstructive surgery; (xxiii) rheumatology; (xxiv) speech therapy; (xxv) urology; and (xxvi) 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:*
   i. Sixty (60) minutes or sixty (60) miles from the personal residence of members for at least seventy-five percent (75%) of non-dual members.

ii. Ninety (90) minutes or ninety (90) miles from the personal residence of members for ALL non-dual members.

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

C. Hospital and Emergeney Services Aceess 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*:
   i. *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 6.2.2.6. 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.

   ii. *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 6.2.2.6. 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*:
   i. Transport distance to providers shall be the usual and customary not to exceed thirty (30) minutes or thirty (30) miles for members in urban areas and not to exceed sixty (60) minutes or sixty (60) miles for members in rural areas except where community standards and Documentation shall apply.

E. Reserved

F. Behavioral Health Access Standards

a. *Time and Distance:*
   i. Outpatient services: Thirty (30) minutes or thirty (30) miles from the personal residence of members except where community standards and Documentation shall apply.

ii. Inpatient, residential, intensive outpatient and partial hospitalization: Sixty (60) minutes or sixty (60) miles from the personal residence of members in urban areas and ninety (90) minutes or ninety (90) miles from the personal residence of 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 member appointments in accordance with the following requirements:

i. Emergency: Members with emergency needs shall be seen within fifteen (15) minutes of presentation at a service delivery site.

ii. Mobile Crisis: Members in need of mobile crisis services shall receive services within one (1) hour of presentation or request.

iii. Urgent: Members with urgent non-emergency needs shall be seen by 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.

iv. Persistent symptoms: Members with persistent symptoms shall be seen by an appropriate provider within forty-eight (48) hours or reporting symptoms.

v. Routine: Members with need for routine services shall be seen by an appropriate provider within three (3) weeks of the request for an appointment.

vi. Substance Use Disorder & Pregnancy: Members who are pregnant women in need of routine substance use disorder services must be admitted within forty-eight (48) hours of seeking treatment.

vii. 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*:

i. *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.

ii. *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.

   i. *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.

   ii. *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 a member's residence in each county, excluding pharmacies participating in the Specialty Pharmacy Program

EXHIBIT C

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 Breast and Cervical Cancer Early Detection Program (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 19	Children ages 1-18 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.
hawk-i	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.
Home and Community-Based Services	Individuals eligible for one of the following seven (7) 1915(c) HCBS waivers: • AIDS/HIV • Brain Injury • Children's Mental Health • Elderly • Health and Disability • Intellectual Disabilities • Physical Disability Individuals eligible for the 1915(i) Habilitation program.

POPULATION	DESCRIPTION
Independent Foster Care Adolescents	Individuals under age twenty-one (21) who were in state-sponsored foster care on their eighteenth birthday with income under 254% FPL.
Infants under Age 1	Infants under age one (1) 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, nursing facility, 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 SSI federal benefit rate (FBR).
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 exeeeding I33% FPL.
Kids with Special Needs	Children under age 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 I50% 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.

POPULATION	DESCRIPTION
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 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 supplemental security income (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.

EXHIBIT D

COVERED BENEFITS

The Contractor shall provide medically necessary covered benefits as described in Section 3.2 of the Scope of Work. Medicaid covered services are outlined in Iowa Admin. Code r. 441-78, within the State Plan, and all CMS approved waivers.

Table D1: 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 may only be authorized in the following situations: • If the pregnancy is the result of an act of rape or incest; or • In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. No other abortions, regardless of funding, can be provided as a benefit under this Contract.
ALLERGY TESTING AND INJECTIONS	Contractor to use utilization management guidelines established.
ANESTHESIA	Contractor to use utilization management guidelines established.
B3 SERVICES	Contractor to use utilization management guidelines established and approved by the Agency. Contractor shall use The ASAM Criteria as the utilization management guidelines for substance use disorder residential treatment.
BARIATRIC SURGERY	Contractor to use utilization management guidelines established.
BHIS (INCLUDING ABA)	Contractor to use utilization management guidelines established.
BREAST RECONSTRUCTION	Contractor to use utilization management guidelines established.
BREAST REDUCTION	Contractor to use utilization management guidelines established.
CARDIAC REHABILITATION	Contractor to use utilization management guidelines established.

CHEMOTHERAPY	Contractor to use utilization management guidelines established.
CHIROPRACTIC CARE (THERAPEUTIC ADJUSTIVE MANIPULATION)	• X-ray- payment for documenting x-rays is limited to one 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 categories based off the patient's condition / diagnosis. A diagnosis or combination of diagnoses within category i generally required short-term treatment of 12 per 12-month period. A diagnosis or combination of diagnoses with category ii generally required moderate-term treatment of 18 per 12-month period. A diagnosis or combination of diagnoses within category iii generally required long-term treatment of 24 per 12-month period. For diagnostic combinations between categories, 28 treatments are generally required per 12-month period.
COLORECTAL CANCER SCREENING	Contractor to use utilization management guidelines established.
CONGENITAL ABNORMALITIES CORRECTION	Contractor to use utilization management guidelines established.
DAIBETIES EQUIP AND SUPPLIES	Contractor to use utilization management guidelines established.
DIAGNOSTIC GENGETIC TESTING	Contractor to use utilization management guidelines established.
DIALYSIS	Contractor to use utilization management guidelines established.
DURABLE MEDICAL EQUIPMENT AND SUPPLIES	• Medical supplies are not to exceed a three-month supply. Diabetic supplies are covered as follows: blood glucose test or reagent strips 6 units per month (1 unit equals 50 strips); urine glucose test strips 3 units per month (1 unit equals 100 strips), lancets 4 units per month (1 unit equals 100 lancets), and needles 500 units per month (1 unit equals 1 needle). Reusable insulin pens are allowed once every six months. Diapers and disposable under pads are covered and can be provided in a 90-day period. Diaper/brief 1,80 per 90-day supply, liner/shield/guard/pad 450 per 90-day supply, pull-on 450 per 90-day supply, disposable under pads 600 per 90-day supply, reusable under pads 48- per 12 months. Maximum units can very when combinations of incontinence products are used. Hearing aid batteries are covered up to 30 batteries per aid in a 90-day period. Ostomy supplies and accessories are covered one unit per day of regular wear or three units per month of extended wear are allowed. Services are limited to members in a medical facility. No payment is made to medical suppliers for medical supplies or durable medical equipment for members receiving inpatient or outpatient care in a hospital. • No payment is made for medical supplies or durable medical equipment for 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 members • In an intermediate care facility for intellectual disability or a facility receiving • Nursing facility 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 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 utilization management guidelines established.
EPSDT	Contractor to use utilization management guidelines established.
FAMILY PLANNING	Contractor to use utilization management guidelines established.
FOOT CARE	Contractor to use utilization management guidelines established.
GENERAL INPATIENT HOSPITAL CARE	Contractor to use utilization management guidelines established.
GENETIC COUNSELING	Contractor to use utilization management guidelines established.
GYNOCOLOGICAL EXAMS	Contractor to use utilization management guidelines established.
HEARING AIDS	Contractor to use utilization management guidelines established.
HEARING EXAMS	• Prior authorization is required for replacement of a hearing aid less than 4 years old, except when member is a child under 21 years of age.

HOME HEALTH	• Skilled nursing is limited to five visits per week. • Home health aide is limited to visits that do not exceed 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 utilization management guidelines established.
ICF/ID	Must meet level of care.
IMAGING/DIAGNOSTICS (MRI, CT, PET)	Contractor to use utilization management guidelines established.
IMMUNIZATIONS	Contractor to use utilization management guidelines established.
INFERTILITY DIAGNOSIS AND TREATMENT	Contractor to use utilization management guidelines established.
INHALATION THERAPY	Contractor to use utilization management guidelines established.
INPATIENT PHYSICIAN SERVICES	Contractor to use utilization management guidelines established.
INPATIENT SURGICAL SERVICES	Contractor to use utilization management guidelines established.
IV INFUSION SERVICES	Contractor to use utilization management guidelines established.
LAB TESTS	Contractor to use utilization management guidelines established.
MATERNITY AND PREGNANCY SERVICES	Contractor to use utilization management guidelines established.
MEDICAL TRANSPORTATION	Contractor to use utilization management guidelines established.
MENTAL HEALTH/BEHAVIORAL HEALTH OUTPATIENT TREATMENT	Contractor to use utilization management guidelines established.
MENTAL/BEHAVIORAL HEALTH INPATIENT TREATMENT	Contractor to use utilization management guidelines established.
MIDWIFE SERVICES	Contractor to use utilization management guidelines established.
NEMT	Contractor to use utilization management guidelines established.

NEWBORN CHILD COVERAGE	Contractor to use utilization management guidelines established.
NON-COSMETIC RECONSTRUCTIVE SURGERY	Contractor to use utilization management 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 16 hours per day.
NUTRITIONAL COUNELING	Contractor to use utilization management guidelines established.
OCCUPATIONAL THERAPY	• Total Medicaid payment for services provided by an independently practicing occupational therapist shall not exceed the therapy cap as disclosed by the centers of Medicare and Medicaid services (CMS). April 1, 2014, law was signed protecting access to Medicare act of 2014. This new law extends the exceptions process for outpatient therapy caps through March 31, 2015. The statutory Medicare Part B outpatient therapy cap for occupational therapy (OT) is $1,920.
ORTHOTICS	• Payment for orthopedic shoes and inserts and therapeutic shoes for members with diabetes are limited as follows: only two pairs of depth shoes per member are allowed in a 12-month period, three pairs of inserts in addition to the non-customized removable inserts provided with depth shoes are allowed in a 12-month period, only two pairs of custom-molded shoes per member are allowed in a 12-month period, two additional pair of inserts for custom-molded shoes are allow in in a 12-month period.
OUTPATIENT SURGERY	Contractor to use utilization management guidelines established.
PATHOLOGY	Contractor to use utilization management guidelines established.
PHARMACY	• Prior authorization is required as specified in the Preferred Drug List 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 Code of Federal Regulations (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 a 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 441 Iowa Administrative Code § 78.2(5) and at http://www.iowamedicaidpdl.com/sites/default/files/ghs-files/nonprescription-drugs/2011-11-09/otclistbythercategory20111101.pdf And http://www.iowamedicaidpdl.com/sites/default/files/ghs-files/2014-12-12/Non-Drug%20Product%20List%20Effective%201-1-15.pdf. • Quantity: up to 31 day supply at a time except contraceptives at 90 day; otcs at minimum quantity of 100 units per prescription or currently available consumer package. Some drugs are limited to an initial 15 day supply, list at: http://www.iowamedicaidpdl.com/sites/default/files/ghs-files/quantity-limits/2014-11-24/15-days-supply-list-effective-01-01-15.pdf • Monthly quantity limits by drug list at: http://www.iowamedicaidpdl.com/sites/default/files/ghs-files/quantity-limits/2014-11-24/quantity-limits-list-1-1-15.pdf • Reimbursement at lower of Iowa AAC (WAC if no AAC), FUL or U&C.
PHYSICAL THERAPY	• Total Medicaid payment for services provided by an independently practicing physical therapist shall not exceed the therapy cap as disclosed by the Centers of Medicare and Medicaid services (CMS). April 1, 2014, law was signed protecting access to Medicare act of 2014. The statutory Medicare Part B outpatient therapy cap for physical therapy (PT) is $1,920.
PMIC	Contractor to use utilization management guidelines established.
PRIMARY CARE ILLNESS/INJURY PHYSICIAN SERVICES	Contractor to use utilization management guidelines established.
PROSTATE CANCER SCREEING	Contractor to use utilization management guidelines established.
PROSTETICS	Contractor to use utilization management guidelines established.
PULMONARY REHABILITATION	Contractor to use utilization management guidelines established.
RADIATION THERAPY	Contractor to use utilization management guidelines established.
SCREEING PAP TESTS	Contractor to use utilization management guidelines established.
SCREENING MAMMOGRAPHY	Contractor to use utilization management guidelines established.
SECOND SURGICAL OPTION	Contractor to use utilization management guidelines established.
SKILLED NURSING	Contractor to use utilization management guidelines established.

SERVICES	
SLEEP STUDIES	Contractor to use utilization management guidelines established.
SPECIALTY PHYSICIAN SERVICES	Contractor to use utilization management guidelines established.
SPEECH THERAPY	• Total Medicaid payment for services provided by an independently practicing speech therapist shall not exceed the therapy cap as disclosed by the Centers of Medicare and Medicaid Services (CMS). April 1, 2014, law was signed protecting access to Medicare act of 2014. The statutory Medicare Part B outpatient therapy cap for speech therapy (ST) is $1,920.
SUBSTANCE USE DISORDER INPATIENTTREATMENT	Contractor shall use The ASAM Criteria as the utilization management guidelines for substance use disorder services.
SUBSTANCE USE DISORDER OUTPATIENT TREATMENT	Contractor shall use The ASAM Criteria as the utilization management guidelines for substance use disorder services.
TMJ TREATMENT	Contractor to use utilization management guidelines established.
TOBACCO CESSATION	Contractor to use utilization management guidelines established.
TOBACCO CESSATION FOR PREGNANT WOMEN	Contractor to use utilization management guidelines established.
TRANSPLANT - ORGAN AND TISSUE	Contractor to use utilization management guidelines established.
URGENT CARE CENTERS/FACILITIES EMERGENCY CLINICS (NON-HOSPITAL BASED)	Contractor to use utilization management guidelines established.
VISION CARE EXAMS	• Routine eye examinations are covered once in a 12-month period.
VISION FRAMES AND LENSES	• Frame services are limited up to 3 times for children up to 1 year of age, up to 4 times per year for children 1 through 3 years of age, one frame every 12 months for children 4-7 years of age and once every 24 months after 8 years of age. Safety frames are allowed for children through 7 years of age. • Single vision and multifocal lens services are limited up to 3 times for children up to 1 year of age, up to 4 times per year for children 1-3 years of age, once every 12 months for children 4-7 years of age, once every 24 months after 8 years of age. • Gas permeable contact lenses are limited as follow: up to 16 lenses for children up to 1 year of age, up to 8 lenses every 12 months for children 1-3 years of age, up to 6 lenses every 12 months for children 4-7 years of age, two lenses every 24 months for members 8 years of age and over. • Replacement of glasses that have been lost or damaged beyond repair are covered for adults age 21

	and over is limited to once every 12 months. Replacement for lost or damaged glasses for children less than 21 years of age is not limited.
WALK-IN CENTER SERVICES	Contractor to use utilization management guidelines established.
X-RAYS	Contractor to use utilization management 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 utilization management guidelines established.

TABLE D2: 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
Chiropractic Care therapeutic adjustive manipulative	✓		

Service Category	Covered	Duration, Scope, exclusions, and Limitations	Excluded Coding
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.	
Genetic Counseling	✓	Prior authorization required. Must be an appropriate candidate and outcome is expected to determine a covered course of tx and not just informational.	
2. Emergency Services			
Emergency Room Services	✓		
Emergency Transportation-Ambulance and Air Ambulance	✓	Reviewed for medical necessity prior to payment.	

Service Category	Covered	Duration, Scope, exclusions, and Limitations	Excluded Coding
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 mechanical or non-human organs, transplant services and supplies not listed in this section including complications.	
Congenital Abnormalities Correction	✓		
Anesthesia	✓		
Hospice Care - Inpatient	✓		
Hospice Respite - Inpatient	✓	Limited to 15 days per lifetime for inpatient respite care. 15 days per lifetime for outpatient hospice respite care. Hospice respite care must be used in increments of not more than 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	✓	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.	

Service Category	Covered	Duration, Scope, exclusions, and Limitations	Excluded Coding
Substance Use Disorder Inpatient Treatment	✓	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
Substance Use Disorder Outpatient Treatment	✓	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 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 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 60 visits in a 12 month period.	N/A

Service Category	Covered	Duration, Scope, exclusions, and Limitations	Excluded Coding
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 prescription.	
Orthotics	✓		
Prosthetics	✓		
Cardiac Rehabilitation	✓		
Pulmonary Rehabilitation	✓		
Skilled Nursing Services	✓	Covered in nursing facilities, skilled nursing facilities and hospital swing beds.	This service is limited to 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	

Service Category	Covered	Duration, Scope, exclusions, and Limitations	Excluded Coding
Pathology	✓		
9. Preventive Wellness Chronic Disease Management			
Preventive Care	✓	Limited to ACA required preventive services.	
Nutritional Counseling	✓	Max 40 units allowed for 12 month period	Not covered: 97802, 97803, G0270
Nutritional Counseling	✓	Max 20 units allowed for 12 month period	Not covered: 97804 & G0271
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 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 per year 77057, 77052, G0202	
Hearing Exam (Adult)	✓	Limit of one 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,

Service Category	Covered	Duration, Scope, exclusions, and Limitations	Excluded Coding
			V5210, V5220, V5230, V5240, V5264, V5266, V5267, V5298, V5299
Diabetes - med necessary equip & supplies Education	✓		
Screening Pap tests	✓		
Gynecological exam	✓	One per year	
Prostate cancer screening	✓	One per year for men age 50-64 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 19-20	
Benefits Not Provided			
Acupuncture	**X**	Not covered	
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 tx, and tubal/vasectomy reversals, fertility drugs.	

Service Category	Covered	Duration, Scope, exclusions, and Limitations	Excluded Coding
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 members determined Medically Exempt.	Covered only for members determined Medically Exempt.
Tobacco Cessation	**X**	Not covered	
TMJ	**X**	Not covered	Not covered for primary diagnosis of: 524.60, 524.61, 524.62, 524.63, 524.64, or 524.69
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 D3: Reserved.

TABLE D4: Reserved

TABLE D5: *HAWK-I* 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)

EXHIBIT E

CONTRACT COMPLIANCE

NON-COMPLIANCE REMEDIES

It is the Agency's primary goal to ensure that the Contractor is delivering quality care to 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 sixty (60) 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.

CORRECTIVE ACTIONS

In accordance with 42 C.F.R. Part 438, Subpart I, the Agency may require corrective action(s) and implement intermediate sanctions when the Contractor has failed to provide the requested services. The nature of the corrective action(s) will depend upon the nature, severity and duration of the Deficiency and repeated nature of the non-compliance. The non-compliance corrective actions may be instituted in any sequence and include, but are not limited to, any of the following:

- Written Warning: the Agency may issue a written warning and solicit a response regarding the Contractor's corrective action.

- 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.

- 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.

- 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.

- Assigning the Contractor's Membership and Responsibilities to Another Contractor: The Agency may assign the Contractor's 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 members and responsibility for those members to another contractor at least ten (10) business days prior to transferring any members.

- Appointing Temporary Management of the Contractor's Plan: The Agency may assume management of the Contractor's plan or may assign temporary management of the Contractor's plan to the Agency's agent, if at any time the Agency determines that the Contractor can no longer effectively manage its plan and provide services to members.

- 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. For more information see RFP Exhibit E: Sample Contract Section 2.5.1.

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 subsections and subject to the limitations provided in 42 USC Chapter Seven, Subchapter XIX, Section 1396u-2 (e).

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 following subsections. 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 this Exhibit. 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.

ATED DAMAGES

	Requirement	Liquidated Damages
ior	Contractor fails to honor one hundred percent (100%) of outstanding prior authorizations for a new member for ninety (90) days during year one (1) of the Contract, a minimum of thirty (30) days after year one (1) of the Contract -or- the required timeframe for individuals with an institutional level of care as described in Section 3.3.4 and Section 3.3.5.	$157 per occurrence
15(i) l care ent	Contractor fails to 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 mutually agreed upon between the Contractor and the Agency in the course of Contract negotiations.	$315 per occurrence.
ns	Contractor violates requirements of Contractor's obligations with respect to member and/or provider communication or education materials as set forth in Section 8.2 and Section 6.1.6. For illustration purposes only, a violation will be determined to exist if Contractor promulgated or distributed, directly or indirectly through any agent or independent contractor, member and/or provider communication or education materials that have not been approved by the Agency or that contain inaccurate, false or misleading information. For further illustration, a violation will be determined to exist if the Contractor distributes any member or provider communication, including member or provider letters, bulletins, alerts, press releases or other press communications, bulletins and forms, without prior approval by the Agency.	$625 per occurrence.

Topic	Requirement	Liquidated Damages
Marketing	The Contractor engages in prohibited marketing practices as set forth in Section 8.1 and 42 C.F.R. § 438.104. For illustration purposes only, a violation will be determined to exist if Contractor distributed, directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Agency or that contain inaccurate, false or misleading information.	$625 per occurrence.
Member Services Helpline	The Contractor fails to meet performance requirements for the member services helpline as set forth in Section 8.3.3.	$796 per reporting period in which any standard is not met
Timely Prior Authorization Processing	The Contractor fails to process a prior authorization request within fourteen (14) calendar days of the request for service, or 72 hours for expedited authorization decisions or with twenty-four (24) hours for pharmacy prior authorizations.	$542 per occurrence
Grievance Resolution	The Contractor fails to resolve one hundred percent (100%) of grievances within thirty (30) calendar days of receipt, or within 72 hours of receipt for expedited grievances.	$157 per occurrence
Appeals Resolution	The Contractor fails to resolve one hundred percent (100%) of appeals within 30 calendar days of receipt, or within 72 hours of receipt for expedited appeals.	$157 per occurrence
Reporting	The Contractor fails to submit a report as required in the Reporting Manual, by the required deadline or in a complete and accurate manner.	$315 per instance
Provider Enrollment File	The Contractor fails to submit a provider enrollment file that meets the Agency Specifications.	$2500 per occurrence

Topic	Requirement	Liquidated Damages
Timely Claims Processing	The Contractor fails to pay or deny ninety percent (90%) of clean claims within thirty (30) calendar days of receipt, ninety-five percent (95%) of clean claims within forty-five (45) calendar days of the date of receipt or ninety-nine percent (99%) of all claims within ninety (90) calendar days of receipt.	$5,474 per reporting period
Encounter Submission	The Contractor fails to comply in any way with encounter data submission requirements as described in Section 13.5.	$8,100 per accounting period
Provider Credentialing	The Contractor fails to credential eighty-five percent (85%) of providers within thirty (30) days and ninety-eight percent (98%) of providers within forty-five (45) days as outlined in Section 6.1.3.	$3,069 per month
Provider Agreements	The Contractor fails to maintain provider agreements in accordance with Section 6.1.2.	$1,136 per occurrence
Network Access	The Contractor fails to meet the network access standards as described in Section 6 or Exhibit B.	$5,131 per reporting period
Response to the Agency Inquiries	The Contractor fails to provide a timely and accurate response to the Agency inquiries within the timeframes set forth by the Agency in accordance with Section 2.16.	$240 for each incident of non-compliance.
Onsite Staff Attendance	The Contractor fails to have subject appropriate staff member(s) attend onsite meetings as requested and required by the Agency.	$485 per occurrence
Readiness Review	The Contractor fails to pass the readiness review at least thirty (30) calendar days prior to scheduled member enrollment.	$2,168 per day

Topic	Requirement	Liquidated Damages
Corrective Action Plan Compliance	The Contractor fails to provide a timely and acceptable corrective action plan or comply with corrective action plan timeline agreed upon with the Agency.	$284 per day

NON-COMPLIANCE WITH DISASTER RECOVERY REQUIREMENTS

In accordance with Section 13.2, the Contractor is responsible for executing 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. If the Contractor's failure to restore operations requires the Agency to transfer 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 members or reassignment of operational duties.

NON-COMPLIANCE WITH REPORTING REQUIREMENTS

In addition to the liquidated damages for reporting non-compliance as described in Table E1, 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 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 member transfer. In addition, the Contractor shall pay any costs the Agency incurs to accomplish the transfer of members. Further, the Agency will withhold all capitation payments or require corrective action until the Contractor provides satisfactory financial data.

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 administered drugs as set forth in Section 3.2.6.1. 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.

NON-COMPLIANCE WITH PROVIDER NETWORK REQUIREMENTS

In addition to the liquidated damages for provider network requirements as described in Table E1, 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 shall be made following a review of the Contractor's Network Geographic Access Assessment Report. 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 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.

NON-COMPLIANCE WITH ACCREDITATION REQUIREMENTS

As described in Section 2.1.2, the Contractor shall be required to attain and maintain accreditation through NCQA or URAC. 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.

NON-COMPLIANCE WITH READINESS REVIEW REQUIREMENTS

In addition to the liquidated damages for readiness review non-compliance as described in Table E1, if the Contractor fails to satisfactorily pass the readiness review at least thirty (30) calendar 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.

[44]Exhibit F

PAY FOR PERFORMANCE

PROGRAM ESTABLISHMENT AND ELIGIBILITY

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.

INCENTIVE PAYMENT POTENTIAL

During each measurement year, the Ageney will withhold a portion of the approved capitation payments from Contractor. In the first year of the Contract, the withheld amount shall be two percent (2%). The Agency reserves the right to change or increase the withhold amount in future years of the Contract term. Changes shall be made through the Contract amendment process. In the first year of the Contract, the Contractor may be eligible to receive some or all of the withheld funds based on the Contractor's performance in the areas outlined in Table F1 of this Exhibit.

YEAR ONE OUTCOME MEASURES AND INCENTIVE PAYMENT STRUCTURE

The outcome measures, targets and incentive payment opportunities for the first Contract year are set forth in Table F1 below. Operational performance measures have been selected to measure the Contractor's performance during implementation and initial member transition. These performance standards require the Contractor to exceed the minimum performance standard required for Contract compliance and incentivize the Contractor to perform at a higher level in five (5) areas determined by the Agency to be critical for successful program implementation. Measures will be paid based on custom Specifications developed by the Agency and performance will be determined by the Agency or its designee. The Contractor shall submit information to the Agency, in the format and timeframe specified by the Agency, with respect to each performance measure set forth below. Incentive payments will be payable in the form of release of funds withheld.

TABLE F1: YEAR ONE OPERATIONAL PAY FOR PERFORMANCE MEASURES

Performance Measure	Required Contractual Standard	Standard Required to Receive Incentive Payment	Amount of Performance Withhold at Risk
Timely Claims Processing	The Contractor shall pay or deny ninety percent (90%) of clean claims within fourteen (14) calendar days of receipt, ninety-nine point five percent (99.5%) of clean claims within twenty-one (21) calendar days of receipt and one hundred percent (100%) of all claims within ninety (90) calendar days of receipt.	If the Contractor processes ninety-five percent (95%) of all clean claims within fourteen (14) calendar days of receipt, Contractor is eligible to receive an incentive payment equal to twenty-five percent (25%) of the amount of the Performance Withhold at risk. If the Contractor processes ninety-seven percent (97%) of all clean claims within fourteen (14) calendar days of receipt, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk. If the Contractor processes one hundred percent (100%) of all clean claims within fourteen (14) calendar days of receipt, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.	20%
Prior Authorization Processing	The Contractor shall process one hundred percent (100%) of prior authorization requests within seven (7) calendar days of the request for service, or three (3) business days for expedited authorization decisions, and one hundred percent (100%) of pharmacy prior authorization requests within twenty-four (24) hours of the request for service	If the Contractor processes ninety-five percent (95%) of prior authorization requests within four (4) calendar days of the request for services and two (2) business days for expedited authorizations and ninety-five percent (95%) of pharmacy prior authorization requests within twelve (12) hours of the request for service, Contractor is eligible to receive an incentive payment equal to twenty-five percent (25%) of the amount of the Performance Withhold at risk. If the Contractor processes ninety-seven percent (97%) of prior authorization requests within four (4) calendar days of the request for services and two (2) business days for expedited authorizations and ninety-seven percent (97%) of pharmacy prior authorization requests within twelve (12) hours of the request for service, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk. If the Contractor processes one hundred percent (100%) of prior authorization requests within four (4) calendar days of the request for services and two (2) business days for expedited authorizations and one hundred percent (100%) of pharmacy prior authorization requests within twelve (12) hours of the request for service, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.	20%

Performance Measure	Required Contractual Standard	Standard Required to Receive Incentive Payment	Amount of Performance Withhold at Risk
Completion of Initial Health Screening	Each quarter, at least seventy percent (70%) of the Contractor's new 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.	If Contractor completion of initial health screening is at or above seventy-three percent (73%) screened and below seventy-six percent (76%) screened, Contractor is eligible to receive an incentive payment equal to twenty-five percent (25%) of the amount of the Performance Withhold at risk. If Contractor completion of initial health screening is at or above seventy-six percent (76%) screened and below seventy-nine percent (79%) screened, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk. If Contractor completion of the initial health screening is at or above seventy-nine percent (79%) screened, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.	20%
Provider Credentialing	Credentialing of all providers applying for network provider status shall be completed as follows: (i) ninety percent (90%) within thirty (30) calendar days; and (ii) one hundred percent (100%) within forty-five (45) calendar days.	Contractor completes: (i) eighty percent (80%) within twenty (20) calendar days; and (ii) ninety percent (90%) within thirty (30) calendar days, Contractor is eligible to receive an incentive payment equal to twenty-five percent (25%) of the amount of the Performance Withhold at risk. Contractor completes: (i) eighty-five percent (85%) within twenty (20) calendar days; and (ii) ninety-five percent (95%) within thirty (30) calendar days, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk. Contractor completes: (i) ninety percent (90%) within twenty (20) calendar days; and (ii) one hundred percent (100%) within thirty (30) calendar days, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.	20%

Performance Measure	Required Contractual Standard	Standard Required to Receive Incentive Payment	Amount of Performance Withhold at Risk
Provider Network	Contractor shall develop a provider network that meets the following distance requirements from the personal residence of members: (i) primary care physician within thirty (30) miles or thirty (30) minutes; and (ii) behavioral health provider within thirty (30) miles or thirty (30) minutes. Additionally, the Contractor shall contract with at least two (2) HCBS providers per county for each covered HCBS in the benefit package for each 1915(c) and 1915(i) HCBS waiver. For areas of the State where provider availability is insufficient to meet any of these three (3) standards, the access standards shall meet the usual and customary standards for the community, which are documented and justified to the State.	Within (6) months of the Contract effective date, the Contractor develops a provider network that meets the following distance requirements from the personal residence of members: (i) primary care physicians within twenty (20) miles or twenty (20) minutes; (ii) behavioral health provider within twenty (20) miles or twenty (20) minutes. Additionally, the Contractor contracts with at least three (3) HCBS providers per county for each covered HCBS in the benefit package for each 1915(c) and 1915(i) HCBS waiver. For areas of the State where provider availability is insufficient to meet any of these three (3) standards, the access standards shall meet the usual and customary standards for the community, which are documented and justified to the State.	20%

YEAR TWO AND BEYOND OUTCOME MEASURES AND INCENTIVE PAYMENT STRUCTURE

The Agency has identified priority clinical performance measures for inclusion in the pay for performance program beginning in Contract year two (2) at which time sufficient clinical data is anticipated to be available to establish a baseline and target for each measure. The Agency reserves the right to change year two (2) measures based on information and data gathered during year one (1) or to better align with the Agency priorities and CMS initiatives. Performance measures and targets may change on a year-to-year basis as program priorities shift and as necessary to support continuous quality improvement. The performance measures and targets applicable during each Contract year shall be established annually by the Agency and reflected in an amendment to the Contract.

Except as otherwise set forth in Table F2, Contractor performance shall be calculated based on care delivered during the measurement year. For example, year two (2) performance measures are tied to performance in Contract year (2). Incentive payments for any measure will be

conditioned upon the Contractor improving outcomes on that individual measure from the previous year.

The Contractor is required to collect performance data for all of the pay for performance measures listed in Table F2 in Contract year one (1) to serve as baseline data. The Agency expects to achieve continuous improvement in this program. The Agency reserves the right to tie performance improvement program requirements to pay for performance indicators where the Contractor has failed to meet the benchmark or improvement standard.

TABLE F2: YEAR TWO OPERATIONAL PAY FOR PERFORMANCE MEASURES

<table>
<tr><th colspan="4">Pay for Performance Tied to Medical Capitation Payments</th></tr>
<tr><th>Performance Measure</th><th>Required Contractual Standard</th><th>Standard Required to Receive Incentive Payment</th><th>Amount of 2.5% Medical Performance Withhold at Risk</th></tr>
<tr><td>Value Based Purchasing</td><td>The Contractor must have at least 40% of the population defined by the Agency in a value based purchasing (VBP) arrangement (use of VIS and TCOC or MLR) with the healthcare delivery system by end of calendar year 2018a date determined by the department.</td><td>If the Contractor is able to reach 25% of designated membership covered by value based purchasing contracts by June 30, 2018a date determined by the department, inclusive of use of the VIS and TCOC or MLR, seventy-five percent (75%) of the amount of the Performance Withhold at risk.

If the Contractor is able to reach 30% of designated membership covered by value based purchasing contracts by June 30, 2018a date determined by the department, inclusive of use of the VIS and TCOC or MLR, one hundred percent (100%) of the amount of the Performance Withhold at risk.</td><td>20%</td></tr>
<tr><td>Children's Access to Care</td><td>No required contract standard. This NCQA measure assesses access to care and preventative health utilization.</td><td>Total (all sub-measures)<table><tr><th>Rate</th><th>Percent of Performance Withhold at Risk</th></tr><tr><td>70</td><td>50%</td></tr><tr><td>80</td><td>75%</td></tr><tr><td>85</td><td>100%</td></tr></table></td><td>20%</td></tr>
<tr><td>Adult Access to Care</td><td>No required contract standard. This NCQA measure assesses access to care and preventative health utilization.</td><td>Total (all sub-measures)<table><tr><th>Rate</th><th>Percent of Performance Withhold at Risk</th></tr><tr><td>65</td><td>50%</td></tr><tr><td>70</td><td>75%</td></tr><tr><td>85</td><td>100%</td></tr></table></td><td>20%</td></tr>
</table>

Pay for Performance Tied to Medical Capitation Payments			
Performance Measure	**Required Contractual Standard**	**Standard Required to Receive Incentive Payment**	**Amount of 2.5% Medical Performance Withhold at Risk**
Provider Network	Contractor shall develop a provider network that meets the following distance requirements from the personal residence of members (i) primary care physician within thirty (30) miles or thirty (30) minutes; and (ii) behavioral health provider within thirty (30) miles or thirty (30) minutes. For areas of the State where provider availability is insufficient to meet standards, the access standards shall meet the usual and customary standards for the community, which are documented and justified to the State.	Contractor develops a provider network where providers accepting new patients (open panel) are within the following distance requirements of the personal residence of members: (i) primary care physicians within twenty (20) miles or twenty (20) minutes; (ii) behavioral health provider within twenty (20) miles or twenty (20) minutes. For areas of the State where provider availability is insufficient to meet standards, the access standards shall meet the usual and customary standards for the community, which are documented and justified to the State. Provider network gaps that have been approved by the Agency shall be excluded for purposes of determining whether the Contractor has met the standard required to receive an incentive payment.	20%
Appeals	The Contractor shall make a decision on standard, non-expedited appeals within thirty (30) calendar days of receipt of the appeal. The Contractor shall make a decision on an expedited appeal within seventy-two (72) hours of receipt of the expedited Appeal.	If the Contractor makes decisions on ninety percent (90%) of standard, non-expedited appeals within twenty-five (25) calendar days of receipt, the Contractor is eligible to receive an incentive payment equal to seventy-five percent (75%) of the amount of the Performance Withhold at risk in relation to Appeals. If the Contractor makes decisions on ninety-five percent (95%) of standard non-expedited appeals within twenty-five (25) calendar days of receipt, the Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk in relation to Appeals. Appeals with Agency approved extensions will be excluded from these calculations.	20%
Pay for Performance Tied to LTSS Capitation Payments			

Pay for Performance Tied to Medical Capitation Payments			
Performance Measure	**Required Contractual Standard**	**Standard Required to Receive Incentive Payment**	**Amount of 2.5% Medical Performance Withhold at Risk**
Performance Measure	**Required Contractual Standard**	**Standard Required to Receive Incentive Payment**	**Amount of 0.5% LTSS Performance Withhold at Risk**
Provider Network	The Contractor shall contract with at least two (2) HCBS providers per county for each covered HCBS in the benefit package for each 1915(c) and 1915 (i) HCBS waiver. For areas of the State where provider availability is insufficient to meet standards, the access standards shall meet the usual and customary standards for the community, which are documented and justified to the State.	The Contractor contracts with at least three (3) HCBS providers per county for each covered HCBS in the benefit package for each 1915(c) and 1915(i) HCBS waiver. For areas of the State where provider availability is insufficient to meet standards, the access standards shall meet the usual and customary standards for the community, which are documented and justified to the State. Provider network gaps that have been approved by the Agency shall be excluded for purposes of determining whether the Contractor has met the standard required to receive an incentive payment.	100%

TABLE F3: YEAR THREE PAY FOR PERFORMANCE MEASURES (SFY 2019)[45]

With respect to each of the performance measures listed in Table F3 below, the parties agree to work diligently and in good faith to establish the specifications that will be used to determine whether a standard has been achieved by August 15, 2018.

Pay for Performance Tied to Medical Capitation Payments			
Performance Measure	**Required Contractual Standard**	**Standard Required to Receive Incentive Payment**	**Amount of 2% Medical Performance Withhold at Risk**
Encounter Data Correction	The Contractor shall have in placee 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.	The Contractor shall achieve a +/- 2% reconciliation measurement between the encounters submitted to the Agency when compared to required quarterly financial reports.	

Pay for Performance Tied to Medical Capitation Payments			
Performance Measure	**Required Contractual Standard**	**Standard Required to Receive Incentive Payment**	**Amount of 2% Medical Performance Withhold at Risk**
Claims Reprocessing and Adjustments	The Contractor shall adjudicate ninety percent (90%) of all clean provider-initiated adjustment requests within thirty (30) business days of receipt. The Contractor shall also reprocess all claims processed in error within thirty (30) business days of identification of the error or, in the event system configuration is necessary, 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 claims 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.	The Contractor shall adjudicate ninety-five percent (95%) of all clean provider-initiated adjustment requests within thirty (30) business days of receipt. 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 claims 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.	

Pay for Performance Tied to Medical Capitation Payments			
Performance Measure	**Required Contractual Standard**	**Standard Required to Receive Incentive Payment**	**Amount of 2% Medical Performance Withhold at Risk**
Home and Community Based Services 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 1915(c) HCBS waiver care plans and case notes to determine Contractor compliance with: (i) timely completion; (ii) care plan addressing the member's assessed health and safety risks, and personal goals; (iii) 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 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 members; (ix) percentage of new members starting ongoing services within the required timeframe; (x) 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.	Ninety-eight percent (98%) of care plans reviewed by the Agency shall meet the requirements for compliance with: (i) care plan addressing the member's assessed health and safety risks, and personal goals; (ii) member signature on the care plan; and (iii) plan for supports available to the member in the event of an emergency are documented.	

Pay for Performance Tied to Medical Capitation Payments			
Performance Measure	**Required Contractual Standard**	**Standard Required to Receive Incentive Payment**	**Amount of 2% Medical Performance Withhold at Risk**
Home and Community Based Services	The Agency intends to develop reports, baseline data and performance targets surrounding quality of life outcomes for members. Potential areas for measurement include but are not limited to: (i) increased life expectancy; (ii) number and percentage of members who gain and maintain competitive employment; (iii) number and percentage of members engaged in volunteer work; (iv) satisfaction; and (v) reduction in homelessness. The Agency may require the Contractor to conduct a member survey to measure key experience and quality of life indicators using best practices for reaching populations with special healthcare needs. The Agency will analyze the findings of the survey to identify required performance improvement activities, shall make the findings available to stakeholders and shall have the EQRO validate the findings.	Ninety percent (90%) of members surveyed using the Iowa Participant Experience Survey report that they feel they are a part of service planning. Sample size shall be approved by the Agency and met to qualify for incentive payment.	

Pay for Performance Tied to Medical Capitation Payments			
Performance Measure	**Required Contractual Standard**	**Standard Required to Receive Incentive Payment**	**Amount of 2% Medical Performance Withhold at Risk**
Employment	The Agency intends to develop reports, baseline data and performance targets surrounding quality of life outcomes for members. Potential areas for measurement include but are not limited to: (i) increased life expectancy; (ii) number and percentage of members who gain and maintain competitive employment; (iii) number and percentage of members engaged in volunteer work; (iv) satisfaction; and (v) reduction in homelessness. The Agency may require the Contractor to conduct a member survey to measure key experience and quality of life indicators using best practices for reaching populations with special healthcare needs. The Agency will analyze the findings of the survey to identify required performance improvement activities, shall make the findings available to stakeholders and shall have the EQRO validate the findings.	Contractor shall increase participation in employment activities for LTSS members by five percent (5%).	
Well Visits	The Agency intends to establish quarterly clinical reports and baseline rates to monitor healthcare services utilization and quality outcomes.	Contractor shall increase rate of Well Child Visits in the Third, Fourth, Fifth and Six years of life by five percent (5%).	

Pay for Performance Tied to Medical Capitation Payments			
Performance Measure	**Required Contractual Standard**	**Standard Required to Receive Incentive Payment**	**Amount of 2% Medical Performance Withhold at Risk**
Behavioral Health	The Agency intends to establish quarterly clinical reports and baseline rates to monitor healthcare services utilization and quality outcomes.	Contractor shall increase the rate of follow up after hospitalization for mental illness within seven (7) days by five percent (5%).	
Health Outcomes	The Agency intends to establish quarterly clinical reports and baseline rates to monitor healthcare services utilization and quality outcomes.	Contractor shall increase the rate of HbA1c testing by three percent (3%).	
Emergency Department Usage	The Agency intends to establish quarterly clinical reports and baseline rates to monitor healthcare services utilization and quality outcomes.	Contractor shall reduce the rate of use of the emergency department by five percent (5%).	

Exhibit G[46]

Pharmaceuticals excluded from capitation payments

(to be billed to the Agency by MCO via invoice)

NDC	Drug Name
00944305302	ADVATE
00944305402	ADVATE
00944304510	ADVATE
00944305102	ADVATE
00944304610	ADVATE
00944304710	ADVATE
00944305202	ADVATE
00944425602	ADYNOVATE
00944462401	ADYNOVATE
00944462701	ADYNOVATE
00944425802	ADYNOVATE
00944462501	ADYNOVATE
00944425202	ADYNOVATE
00944462201	ADYNOVATE
00944462801	ADYNOVATE
00944425402	ADYNOVATE
00944462301	ADYNOVATE
00944462601	ADYNOVATE
69911047602	AFSTYLA
69911047702	AFSTYLA
69911047402	AFSTYLA
69911047802	AFSTYLA
69911047502	AFSTYLA

68516460101	ALPHANATE/VON WILLEBRAND
68516460501	ALPHANATE/VON WILLEBRAND
68516460201	ALPHANATE/VON WILLEBRAND
68516460601	ALPHANATE/VON WILLEBRAND
68516460302	ALPHANATE/VON WILLEBRAND
68516460702	ALPHANATE/VON WILLEBRAND
68516460402	ALPHANATE/VON WILLEBRAND
68516460802	ALPHANATE/VON WILLEBRAND
68516460902	ALPHANATE/VON WILLEBRAND
68516461002	ALPHANATE/VON WILLEBRAND
68516360202	ALPHANINE SD
68516360502	ALPHANINE SD
68516360302	ALPHANINE SD
68516360602	ALPHANINE SD
68516360102	ALPHANINE SD
68516360402	ALPHANINE SD
64406092201	ALPROLIX
64406093301	ALPROLIX
64406096601	ALPROLIX
64406094401	ALPROLIX
64406097701	ALPROLIX
64406091101	ALPROLIX
64193044502	BEBULIN
58394063503	BENEFIX
58394063603	BENEFIX
58394063303	BENEFIX
58394063703	BENEFIX
58394063403	BENEFIX

64406080401	ELOCTATE
64406080501	ELOCTATE
64406080601	ELOCTATE
64406080101	ELOCTATE
64406080701	ELOCTATE
64406080801	ELOCTATE
64406080901	ELOCTATE
64406080201	ELOCTATE
64406081001	ELOCTATE
64406080301	ELOCTATE
60923028410	EXONDYS 51
60923036302	EXONDYS 51
64193042302	FEIBA
64193042402	FEIBA
64193042502	FEIBA
00053813302	HELIXATE FS
00053813402	HELIXATE FS
00053813102	HELIXATE FS
00053813502	HELIXATE FS
00053813202	HELIXATE FS
00944394402	HEMOFIL M
00944394602	HEMOFIL M
00944394002	HEMOFIL M
00944394202	HEMOFIL M
63833061702	HUMATE-P
63833061502	HUMATE-P
63833061602	HUMATE-P
69911086602	IDELVION

69911086702	IDELVION
69911086402	IDELVION
69911086502	IDELVION
53270027105	IXINITY
53270027106	IXINITY
53270027205	IXINITY
53270027206	IXINITY
53270027005	IXINITY
76125067650	KOATE
76125025620	KOATE
76125066830	KOATE
76125066750	KOATE-DVI
76125067250	KOATE-DVI
76125067351	KOATE-DVI
76125025020	KOATE-DVI
76125050030	KOATE-DVI
76125066730	KOATE-DVI
00026379550	KOGENATE FS BIO-SET
00026378550	KOGENATE FS
00026378555	KOGENATE FS
00026379660	KOGENATE FS BIO-SET
00026378660	KOGENATE FS
00026378665	KOGENATE FS
00026379220	KOGENATE FS BIO-SET
00026378220	KOGENATE FS
00026378225	KOGENATE FS
00026379770	KOGENATE FS BIO-SET
00026378770	KOGENATE FS

00026378775	KOGENATE FS
00026379330	KOGENATE FS BIO-SET
00026378330	KOGENATE FS
00026378335	KOGENATE FS
00026382425	KOVALTRY
00026382650	KOVALTRY
00026382125	KOVALTRY
00026382850	KOVALTRY
00026382225	KOVALTRY
00053763302	MONOCLATE-P
00053763402	MONOCLATE-P
00053623302	MONONINE
00169781001	NOVOEIGHT
00169781501	NOVOEIGHT
00169782001	NOVOEIGHT
00169782501	NOVOEIGHT
00169783001	NOVOEIGHT
00169785001	NOVOEIGHT
00169720101	NOVOSEVEN RT
00169720201	NOVOSEVEN RT
00169720501	NOVOSEVEN RT
00169720801	NOVOSEVEN RT
68982014401	NUWIQ
68982014601	NUWIQ
68982014001	NUWIQ
68982014201	NUWIQ
68982014301	NUWIQ
68982014501	NUWIQ

68982013901	NUWIQ
68982014101	NUWIQ
00944500101	OBIZUR
00944500105	OBIZUR
00944500110	OBIZUR
68516320202	PROFILNINE
68516320502	PROFILNINE SD
68516320302	PROFILNINE
68516320602	PROFILNINE SD
68516320101	PROFILNINE
68516320401	PROFILNINE SD
00944284410	RECOMBINATE
00944284510	RECOMBINATE
00944284110	RECOMBINATE
00944284210	RECOMBINATE
00944284310	RECOMBINATE
00944303002	RIXUBIS
00944303202	RIXUBIS
00944302602	RIXUBIS
00944303402	RIXUBIS
00944302802	RIXUBIS
64406005801	SPINRAZA
00944755302	VONVENDI
00944755102	VONVENDI
67467018201	WILATE
67467018202	WILATE
68982018201	WILATE
68982018202	WILATE

58394001401	XYNTHA
58394001501	XYNTHA
58394001201	XYNTHA
58394001301	XYNTHA
58394002403	XYNTHA SOLOFUSE
58394002503	XYNTHA SOLOFUSE
58394001603	XYNTHA SOLOFUSE
58394002303	XYNTHA SOLOFUSE
58394002203	XYNTHA SOLOFUSE
00944292102	ADVATE
00944294210	ADVATE
00944294310	ADVATE
00944294810	ADVATE
00944296410	ADVATE
00944296510	ADVATE

Attachment 2.7 Medical Loss Ratio

PART A: Applicable to Contractor Medical Loss Ratio ("MLR") reporting submitted after the end of the State Fiscal Year 2018 (June 30, 2018).

(a) Applicability. 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.

(b) *Definitions.* As used in this section, the following terms have the indicated meanings:

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.

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.

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.

MLR reporting year means a period of 12 months consistent with the State fiscal year.

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.

Non-claims costs means those expenses for administrative services that are not: Incurred claims (as defined in paragraph (e)(2) of this section); expenditures on activities that improve health care quality (as defined in paragraph (e)(3) of this section); or licensing and regulatory fees, or Federal and State taxes (as defined in paragraph (f)(2) of this section).

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.

(c) *MLR requirement.* A minimum MLR of 88% must be reported for each MLR reporting year by the Contractor, consistent with this section.

(d) *Calculation of the MLR.* The MLR experienced for Contractor in a MLR reporting year is the ratio of the numerator (as defined in paragraph (e) of this section) to the denominator (as defined in paragraph (f) of this section). A MLR may be increased by a credibility adjustment, in accordance with paragraph (h) of this section.

(e) *Numerator*—(1) *Required elements.* The numerator of Contractor's MLR for a MLR reporting year is the sum of the Contractor's incurred claims (as defined in (e)(2) of this section); the Contractor's expenditures for activities that improve health care quality (as defined in paragraph (e)(3) of this section); and fraud reduction activities (as defined in paragraph (e)(4) of this section).

(2) *Incurred claims.* (i) 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.

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

(A) Overpayment recoveries received from network providers.

(B) Prescription drug rebates received and accrued.

(iii) 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 paragraph (e)(4) of this section.

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

(v) Amounts that must be excluded from incurred claims:

(A) Non-claims costs, as defined in paragraph (b) of this section, which include the following:

(*1*) Amounts paid to third party vendors for secondary network savings.

(*2*) Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management.

(*3*) 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 (3) 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.

(*4*) Fines and penalties assessed by regulatory authorities.

(B) Amounts paid to the Agency as remittance under paragraph (j) of this section.

(C) Amounts paid to network providers under to 42 C.F.R.
§ 438.6(d).

(vi) 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.

(3) *Activities that improve health care quality.* Activities that improve health care quality are limited to 2% of capitation payments and must be in one of the following categories:

(i) 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).

(ii) A Contractor activity related to any EQR-related activity as described in 42 C.F.R. § 438.358(b) and (c).

(iii) 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, as defined in paragraph (e)(2) of this section.

(4) *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 paragraph must not include expenses for fraud reduction efforts in paragraph (e)(2)(iii)(B) of this section.

(f) *Denominator*—(1) *Required elements.* 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 (as defined in paragraph (f)(2) of this section) minus the Contractor's Federal, State, and local taxes and licensing and regulatory fees (as defined in paragraph (f)(3) of this section) and is aggregated in accordance with paragraph (i) of this section.

(2) *Premium revenue.* Premium revenue includes the following for the MLR reporting year:

(i) 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).

(ii) Agency-developed one time payments, for specific life events of members.

(iii) Other payments to the Contractor approved under 42 C.F.R. § 438.6(b)(3).

(iv) 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.

(v) All changes to unearned premium reserves.

(vi) 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.

(3) *Federal, State, and local taxes and licensing and regulatory fees.* Taxes, licensing and regulatory fees for the MLR reporting year include:

(i) Statutory assessments to defray the operating expenses of any State or Federal department.

(ii) Examination fees in lieu of premium taxes as specified by State law.

(iii) Federal taxes and assessments allocated to Contractor, excluding Federal income taxes on investment income and capital gains and Federal employment taxes.

(iv) 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.

(v) 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 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.

(4) *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 paragraph for that year may be reported by Contractor.

(g) *Allocation of expense*—(1) *General requirements.* (i) 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.

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

(2) *Methods used to allocate expenses.* (i) Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results.

(ii) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.

(iii) 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.

(h) *Credibility adjustment.* (1) 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.

(2) Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

(3) If Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards in this section.

(4) On an annual basis, CMS will publish base credibility factors for MCOs, PIHPs, and PAHPs that are developed according to the following methodology:

(i) 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 I year of experience.

(ii) 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 would be expected to experience a loss ratio less than 85 percent 1 out of every 4 years, or 25 percent of the time.

(iii) 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 10 percent 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.

(iv) 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. Any MCO, PIHP, or PAHP with enrollment greater than this number of member months will be determined to be fully credible.

(v) 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.

(vi) 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 1,000 or a different degree of rounding as appropriate to ensure that the credibility thresholds are consistent with the objectives outlined herein.

(i) *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 as noted in subsection (a) above. MCOs will additional aggregate data for the Title XIX and Title XXI populations for application of the minimum MLR of 88%.[47]

(j) *Remittance to the Agency if specific 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. Contractor shall remit payment to the Agency within 90 days of submission of the MLR report for any MLR falling below the MLR standard.

(k) *Reporting requirements.* (1) Contractor shall submit a report to the Agency that includes at least the following information for each MLR reporting year:

(i) Total incurred claims with IBNR reported separately.

(ii) Expenditures on quality improving activities.

(iii) Expenditures related to activities compliant with 42 C.F.R. § 438.608(a)(1) through (5), (7), (8) and (b).

(iv) Non-claims costs.

(v) Premium revenue.

(vi) Taxes, licensing and regulatory fees.

(vii) Methodology(ies) for allocation of expenditures.

(viii) Any credibility adjustment applied.

(ix) The calculated MLR.

(x) Any remittance owed to the Agency, if applicable.

(xi) A comparison of the information reported in this paragraph with the audited financial report required under 42 C.F.R. § 438.3(m).

(xii) A description of the aggregation method used under paragraph (i) of this section.

(xiii) The number of member months.

(2) Contractor must submit the report required in paragraph (k)(1) of this section in a timeframe and manner determined by the Agency, which must be within 12 months of the end of the MLR reporting year.

(3) Contractor must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

(l) *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 Contractor's 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 12 months.

(m) *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 paragraph (k) of this section.

(n) *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 paragraph (k) of this section.

PART B: Medical Loss Ratio Provision Applicable through the end of State Fiscal Year 2017 (6/30/17)

The existing Medical loss ratio definitions and calculation methodology set forth below are applicable only to MLR reports submitted through the end of State Fiscal Year 2017 (6/30/2017) (for the first contract period from April 1, 2016 to June 30, 2017); thereafter, Part A of this attachment applies.

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.

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, taxes, and regulatory fees due from and or received from the Agency for services provided during the Coverage Year. Capitation payments will be determined on a gross basis without regard to whether the health plan recovers the performance withhold. 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 88% minimum loss ratio.

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

- 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.
- 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.
- Provider Incentive Payments. Provider incentive payments shall be made within Contract requirements set forth in Section 10.3.2. 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.
- 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.
- Supplemental Payments. Supplemental payments shall be excluded from the Benefit Expense.

Data Submission. Contractor shall submit data to the Agency, in the form and manner prescribed by the Agency in Section I3 of the Contract. The Contractor shall submit information to the State within 30 days following the six (6) month claims run-out period.

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 15 days of the end of the third calendar quarter of each Coverage Year.

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.

Risk Corridor for Iowa Health and Wellness Plan.

In addition, the parties to the Contract agree to impose a risk corridor for the Iowa Health and Wellness Plan population. The risk corridor shall be based on a Risk Corridor Medical Loss Ratio (RCMLR) of 89.5% and shall be applicable only to the first contract period from April1, 2016 to June 30, 2017. Risk corridors are defined as follows:

IA Health Link Risk Corridor for Iowa Health and Wellness Plan (IHAWP)	
Target Risk Corridor Medical Loss Ratio (RCMLR) 89.5%	
+ 2% RCMLR	Contractor is responsible for 100% of losses between 89.5% RCMLR and less than or equal to 91.5% RCMLR
+ 2% to 4.5% RCMLR	Contractor is responsible for 50% of losses greater than 91.5% RCMLR and less than or equal to 94% RCMLR and Agency is responsible for 50% of losses greater than 91.5% RCMLR and less than or equal to 94% RCMLR
≥ + 4.5% RCMLR	Agency is responsible for 100% of losses greater than 94% RCMLR
- 2% RCMLR	Contractor retains 100% of gains greater than or equal to 87.5% RCMLR and less than 89.5% RCMLR
- 2% to 4.5% RCMLR	Contractor retains 50% of gains greater than or equal to 85% RCMLR and less than 87.5% RCMLR and Agency retains 50% of gains greater than or equal to 85% RCMLR and less than 87.5% RCMLR
≤ - 4.5% RCMLR	Agency retains 100% of gains less than 85% RCMLR

The following terms and conditions will apply to the RCMLR:

The RCMLR is established on a medical loss ratio basis using incurred Benefit expense and gross capitation rates (premium revenue). The RCMLR shall apply to claims incurred and premium revenue earned during the first contract year from April 1, 2016 through June 30, 2017.

Capitation revenue shall be the Capitation payments made by the Agency to each Contractor. The revenue used in the RCMLR calculation shall consist of the Capitation payments made to each Contractor adjusted to exclude any supplemental payments, taxes, and regulatory fees due from and or received from the Agency for services provided during the Coverage Year including amounts withheld.

Capitation payments shall be determined on a gross basis without regard to whether the Agency recovers the performance withhold.

Benefit Expense. The Agency shall determine the Benefit Expense for the RCMLR using the following data:

- 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 to the Agency's Medicaid fee-for-service equivalent rates.
- 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.
- Incurred expenditures will reflect the application of any member copayments specific to IHAWP, without regard to whether the Contractor collects these amounts.
- Provider Incentive Payments. Provider incentive payments shall be made within Contract requirements set forth in Section 10.3.2. 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.
- 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.
- Supplemental Payments. Supplemental payments shall be excluded from the Benefit Expense.

Data Submission. Contractor shall submit data to the Agency, in the form and manner prescribed by the Agency in Section 13 of the Contract. The Contractor shall submit information to the State within 30 days following the six (6) month claims run-out period.

RCMLR Calculation and Payment. Within ninety (90) days following data submission, the Agency shall calculate the RCMLR by dividing the Benefit Expense by the Revenue. The RCMLR shall be expressed as a percentage rounded to the second decimal point. Contractor shall have sixty (60) days to review the Agency's RCMLR Calculation. The Agency and Contractor shall have the right to review all data and methodologies used to calculate the RCMLR payment obligation.

The payments are due to either the Agency or the Contractor plan October 15, 2018.

Risk Corridor for Long Term Services and Supports.

In addition, the parties to the Contract agree to impose a LTSS risk corridor (LTSS RC). This risk corridor shall be based on a per member per month basis using incurred expenditures specific to the LTSS categories of service (Institutional & Waiver) and shall be applicable only to the first contract period from April 1, 2016 to June 30, 2017.

The risk corridor amounts utilized as the benchmark shall be the risk-adjusted LTSS gross capitation rates by rate cell for the April to June 2016 and July 2016 to June 2017 time periods excluding the administrative component and member participation component of each rate cell. This benchmark is defined as the target LTSS RC rates.

Risk corridors are defined as follows:

IA Health Link Risk Corridor for LTSS	
Target LTSS RC rate values are presented in Attachment 3.2-04	
+ 2% of target LTSS RC rate	*Contractor is responsible for 100% of losses greater than target LTSS RC rate and less than or equal to 102% of target LTSS RC rate.*
+ 2% to 4% of target LTSS RC rate	*Contractor is responsible for 75% of losses greater than 102% of target LTSS RC rate and less than or equal to 104% of target LTSS RC rate.* *Agency is responsible for 25% of losses greater than 102% of target LTSS RC rate and less than or equal to 104% of target LTSS RC rate*
+ 4% to 6% of target LTSS RC rate	*Contractor is responsible for 50% of losses greater than 104% of target LTSS RC rate and less than or equal to 106% of target LTSS RC rate.* *Agency is responsible for 50% of losses greater than 104% of target LTSS RC rate and less than or equal to 106% of target LTSS RC rate.*
+ 6% to 8% of target LTSS RC rate	*Contractor is responsible for 25% of losses greater than 106% of target LTSS RC rate and less than or equal to 108% of target LTSS RC rate.* *Agency is responsible for 75% of losses greater than 106% to target LTSS RC rate and less than or equal to 108% of target LTSS RC rate.*
+ 8% to 12.5% of target LTSS RC rate.	*Agency is responsible for 100% of losses greater than 108% of target LTSS RC rate and less than or equal to 112.5% of target LTSS RC rate.*
≥+ 12.5% of target LTSS RC rate	*Contractor is responsible for 100% of losses greater than 112.5% of target LTSS RC rate.*
- 2% of the LTSS cost component	*Contractor retains 100% of gains less than target LTSS RC rate and greater than or equal to 98% of target LTSS RC rate.*
- 2% to 4% of target LTSS RC rate	*Contractor retains 75% of gains less than 98% of target LTSS RC rate and greater than or equal to 96% of target LTSS RC rate.* *Agency retains 25% of gains less than 98% of target LTSS RC rate and greater than or equal to 96% of target LTSS RC rate.*
- 4% to 6% of target LTSS RC rate	*Contractor retains 50% of gains less than 96% of target LTSS RC rate and greater than or equal to 94% of target LTSS RC rate.* *Agency retains 50% of gains less than 96% of target LTSS RC rate and greater than or equal to 94% of target LTSS RC rate.*
- 6% to 8% of target	*Contractor retains 25% of gains less than 94% of target LTSS RC rate*

LTSS RC rate	*and greater than or equal to 92% of target LTSS RC rate.* *Agency retains 75% of gains less than 94% of target LTSS RC rate and greater than or equal to 92% of target LTSS RC rate.*
- 8% to 12.5% of target LTSS RC rate	*Agency retains 100% of gains less than 92% of target LTSS RC rate and greater than or equal to 87.5% of target LTSS RC rate.*
≤-12.5% of target LTSS RC rate	*Contractor retains 100% of gains less than 87.5% of target LTSS RC rate.*

The following terms and conditions will apply to the LTSS risk corridor:

The LTSS Risk Corridor shall apply to claims incurred and premium revenue earned during the first contract year from April 1, 2016 through June 30, 2017. The calculation of the LTSS risk corridor shall be a comparison of the claims cost component of the capitation rates to actual incurred expenditures. The calculation of the LTSS risk corridor shall not be a medical loss ratio calculation.

The risk corridor amounts utilized as the benchmark are the risk-adjusted LTSS gross capitation rates by rate cell for the April to June 2016 and July 2016 to June 2017 time periods excluding the administrative component. The risk-adjusted LTSS gross capitation rates by rate cell to be utilized for the LTSS risk corridor calculation are presented in Attachment 3.2-04. The LTSS risk corridor calculation shall reflect a blend of the April to June 2016 and July 2016 to June 2017 gross capitation rates based on actual enrollment for the 15-month rating period. The LTSS risk corridor is specific to the LTSS component of the capitation rates and shall be performed on a composite basis across all LTSS rate cells.

Capitation revenue used in the LTSS risk corridor calculation shall be the LTSS component of the capitation rates inherent in capitation payments made by the Agency to Contractor adjusted to exclude any supplemental payments, taxes, and regulatory fees, due from and or received from the Agency for services provided during the Coverage Year including amounts withheld. Capitation payments shall be determined on a gross basis without regard to whether the Agency recovers the performance withhold.

Benefit Expense. The Agency shall determine the Benefit Expense for the LTSS RC using the following data:

- 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 LTSS RC, 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 subcapitated arrangements. Incurred expenditures may, at the discretion of the Agency, be repriced to the Agency's Medicaid fee-for-service equivalent rates.
- 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.

- Incurred expenditures shall include costs for services rendered for long term services and supports. Services identified as long term services and supports shall be consistent with capitation rate setting methodology. Incurred expenditures shall not include costs related to acute care, behavioral health, short term institutional, or short term home and community based services.
- Incurred expenditures will not include quality improvement expenses, case management expenses, or other administrative expenses.
- Incurred expenditures shall be net of patient participation amounts without regard to whether the Contractor collects these amounts. Incurred expenditures will reflect the application of any member copayments specific to LTSS, without regard to whether the Agency collects these amounts.
- Provider Incentive Payments. Provider incentive payments shall be made within Contract requirements set forth in Section 10.3.2. 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.
- Supplemental Payments. Supplemental payments shall be excluded from the Benefit Expense.

Data Submission. Contractor shall submit data to the Agency, in the form and manner prescribed by the Agency in Section 13 of the Contract. The Contractor shall submit information to the State within 30 days following the six (6) month claims run-out period.

LTSS risk corridor Calculation and Payment. Within ninety (90) days following data submission, the Agency shall calculate the LTSS risk corridor by comparing actual benefit expense to capitation revenue across the applicable services and populations. The capitation revenue used in the risk corridor calculation shall reflect a weighted average of the Target LTSS RC rate values effective April 1, 2016 and July 1, 2016 using actual enrollment for the Contractor for the evaluation period (i.e., April 1, 2016 to June 30, 2017). A sample calculation illustrating the LTSS risk corridor calculation is presented in Attachment 3.2-05.

Contractor shall have sixty (60) days to review the Agency's LTSS risk corridor calculation. The Agency and Contractor shall have the right to review all data and methodologies used to calculate the LTSS RC payment obligation.

The payments are due to either the Agency or the Contractor plan no later than October 15, 2018.

Acceptance by Contractor of any Agency risk corridor payment for either the RCMLR or the LTSS RC 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 reasonableness of the associated RCLMR or LTSS RC calculation and/or payment.

Special Terms Attachment 3.2-0X – Rate Exhibit[48]