First Amendment to the IA Health Link Contract MED-20-001

This First Amendment to Contract Number MED-20-001 between the Iowa Department of Human Services (Agency) and Iowa Total Care, Inc. (Contractor) hereby amends the Contract as set forth below. To the extent that there is a conflict between any provision of this First Amendment and the Contract, this First Amendment shall control. This First Amendment is effective as of July 1, 2019.

Section 1: Amendment to Contract Language

The Contract is amended as follows:

Revision 1. Contract Declarations and Execution Page. The following fields in the Contract Declarations and Execution Page(s) are modified as set forth below:

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:** Mary Tavegia 611 5th Avenue Des Moines, IA 50309 **Phone:** 515-256-4645
Agency Contract Manager (hereafter "Contract Manager") /Address ("Notice Address"): Mary Tavegia 611 5th Avenue Des Moines, IA 50309	**Agency Contract Owner (hereafter "Contract Owner") / Address:** Michael Randol 611 5th Avenue Des Moines, IA 50309
E-Mail: mtavegi@dhs.state.ia.us	**E-Mail:** mrandol@dhs.state.ia.us
Phone: 515-256-4645	
Contractor: (hereafter "Contractor")	
Legal Name: **Iowa Total Care, Inc.**	**Contractor's Principal Address:** 1080 Jordan Creek Parkway, Suite 100 South West Des Moines, Iowa 50266
Tax ID #: [redacted]	**Organized under the laws of:** State of Iowa

Revision 2. The document attached to this First Amendment as Attachment 3.2-01 is hereby incorporated into the Contract as Special Contract Attachment 3.2-01.

Revision 3. Section 1.3.3.1 of the Special Terms is hereby amended to read as follows:

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 will 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.

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.

The parties agree to work diligently and in good faith to establish and agree to capitation rates before the expiration of any rate period. If the parties are unable to establish new annual capitation rates for a subsequent rate period due to delays or disagreements, the Agency or Contractor may terminate the Contract upon ninety (90) days written notice. Effective date of the termination shall be no sooner than ninety (90) days from expiration of the current rate period and contract amendment term or, if notice is given after the expiration of the current rate period, ninety (90) days written notice from the date of the notice.

Examples:

Example 1: Current agreed rates expire June 30, 2020. The MCO determines that it does not want to agree to continue with the managed care contract and provides notice of termination on January 1, 2020. Because the parties are currently performing under agreed rates that run through June 30, 2020, the first day of the 90-day notice period is July 1, 2020 – the first day of the new rate period. The effective date of contract termination is September 30, 2020 – the last day of the month that is 90-days from the first day of the notice period.

Example 2: Rates expired on June 30, 2019. The Agency and MCO are unable thereafter to come to terms on new rates after expiration of the current rates. The MCO provides

notice of termination on August 1, 2019. The first day of the 90-day notice period is August 1, 2019. The last day of the notice period is October 31, 2019 – the last day of the month that is 90-days from the beginning of the notice period.

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

The Agency will conduct a mid-year review using emerging data to reassess the SFY2020 capitation rates and rating assumptions to determine if updates are necessary for material changes that yield greater than 0.7% trend above the original implied trend net of efficiencies identified as appropriate by the Agency. The Agency agrees to update the rates prospectively, for the January 1, 2020 – June 30, 2020 contract period, due to any of the following:

1. If the updated emerging trend identified for SFY2019 through updated MRT data and supporting encounter data on a statewide basis exceeds the ~~rate~~-assumed trend associated with the payment rate chosen by the Agency for the SFY2020 capitation rates in a material manner as defined above.
2. Emerging experience is materially worse than predicted due to unforeseeable or unaccounted for events outside the control of the Agency or the Contractor at the time of rate development. Examples may include, but are not limited to:

    a. Pharmacy unit cost increases (as measured by AWP, NADAC, or similar metric),

    b. Legislative, Agency (IME, DHS, CMS, etc.) taking action to loosen or remove prior authorization requirements, thereby increasing utilization,

    c. Changes to the membership eligibility, verification/re-verification requirements, or program changes disrupting the normal membership processes,

    d. Introduction of new therapies or pharmacological solutions (including technology) to low incidence populations (e.g. specialty drugs) which may occur as a pharmacy or medical (J-code) benefit, or

    e. Administrative requirements not considered elsewhere in the Contract.
3. Costs determined to be inappropriately allocated to the Iowa Medicaid program costs through an independent audit.
4. Inefficiencies in care identified through the Prometheus tool.

The Agency agrees to update the rates retroactively for all the sample reasons above. If it is found that the final member attribution has impacted the assumed MCO LTSS mix and/or the assumed relativity factors. If the assumed attribution is similar to the final attribution and therefore there are no updates needed to the MCO LTSS mix or relativity factors, the Agency will evaluate the rates on a prospective basis as described above.

Except as agreed to, this Contract does not preclude the Agency's discretion to maintain the capitation rates at the amount agreed upon through the end of the First Amendment.

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.

Beginning July 1 2019, the Agency will exclude from the capitation rates the select prescription drugs and treatments as set forth in Exhibit G. Contractor shall continue to provide coverage for these Exhibit G pharmaceuticals and treatments, and the Agency will reimburse the Contractor based on Contractor's invoice to the Agency for Exhibit G pharmaceuticals or treatments paid. Contractor may only invoice for the actual pharmaceutical or treatment 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 or treatments within six (6) months from the Contractor's receipt date of the claim and explanation of benefits from a primary carrier. The Agency will pay Contractor the lesser of the amount that would be paid under the fee-for-service system for the pharmaceutical or treatment, or the amount the Contractor actually paid for the pharmaceutical or treatment. Contractor must include with the invoice details as required by the Agency to document that the claim was appropriately paid, as well as verification regarding oversight to ensure appropriate utilization of these drugs. At minimum, Contractor's invoice must include claim level detail sufficient to support the invoices. The selected prescription drugs and treatments included in Exhibit G are intended to be those which are new, emerging, high cost, and/or not accounted for in capitation rate development. Exhibit G is subject to change upon Agency approval, and Agency may remove any previously included prescription drug or treatment from Exhibit G when its financial impact has been quantified and incorporated into the capitation rates.

Revision 4. Section 1.3.3.3 is amended to read as follows:

1.3.3.3 Graduate Medical Education (GME) Payments and other supplemental 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.

1.3.3.3.2 Other Supplemental Payments.
The Plan shall pass through these payments to designated providers as directed by the Agency. All supplemental payment minimums shall be distributed in accordance with requirements in 42 C.F.R § 438.6.

Revision 5. Section 2.5.7 of the General Terms for Service Contracts is hereby amended to read as follows:

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 one-hundred and eighty (180) days of the Agency's receipt of the Contractor's written notice of breach.

Revision 6. The title to Section 2.2.6 is hereby amended to read as follows:

2.2.6 *Protecting Members Against Liability for Payment*

Revision 7. Section 2.5.9.1 is hereby amended to read as follows:

2.5.9.1 Who must provide disclosures. The Contractor must obtain disclosures from disclosing entities, fiscal agents, and network Providers, unless otherwise directed by the Agency.

Revision 8. The title to Section 2.5.13 is hereby amended to read as follows:

2.5.13. Prohibited Affiliations

Revision 9. Section 2.15 Confidentiality of Member Medical Records and Other Information. The third paragraph of the section is amended as follows:

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 three (3) business days upon discovery of a non-HIPAA-related breach.

Revision 10. Section 3.2.5 subsection heading (f) is amended to read as follows:

(f) Availability

Revision 11. Section 3.2.8.13.2 amended to read as follows:

3.2.8.13.2 For Members Over Age 21 and Under Age 65

Notwithstanding provisions of 3.2.8.13.1, the Contractor shall pay for inpatient psychiatric treatment in an institution for mental disease (IMD) that is approved by the Agency 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.

Revision 12. Section 3.2.11.2.2 is hereby amended to read as follows:

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 and level of care assessments in accordance with the following requirements:

a) Members shall have the ability to have others present of their choosing;
b) Members and chosen team members shall receive notice to schedule no less than 14 days prior to current assessment end date;
c) Members and chosen team members shall receive a copy of the completed assessment within three (3) business days of the assessment;
d) Members and chosen team members shall receive information related to the assessment results in a manner that is meaningful to the team;
e) Assessments shall be conflict-free and firewalled from case management and utilization management functions;
f) Assessors shall be trained either by the organization that developed the assessment tool or by an individual directly trained by the organization that developed the assessment tool;
g) Assessors shall be trained in appropriate administration of the identified assessment tool in line with best practice for the tool administered;
h) Assessment results shall be drawn using a valid sample size to evaluate the inter-rater reliability of the assessment administration; and
i) Any assessment determined to be inappropriately derived during evaluation shall be re-administered within 30 days of findings.

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.

Revision 13. Section 3.2.15.3 is hereby amended to read as follows:

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 shall not charge members for missed appointments.

Revision 14. Section 4.2.2.2 is hereby amended to read as follows:

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.

The Contractor shall administer all level of care assessments in accordance with the following requirements:

a) Members shall have the ability to have others present of their choosing;

b) Members and chosen team members shall receive notice to schedule no less than 14 days prior to current assessment end date;
c) Members and chosen team members shall receive a copy of the completed assessment within three (3) business days of the assessment;
d) Members and chosen team members shall receive information related to the assessment results in a manner that is meaningful to the team;
e) Assessments shall be conflict-free and firewalled from case management and utilization management functions;
f) Assessors shall be trained either by the organization that developed the assessment tool or by an individual directly trained by the organization that developed the assessment tool;
g) Assessors shall be trained in appropriate administration of the identified assessment tool in line with best practice for the tool administered;
h) Where applicable, assessment results shall be drawn using a valid sample size to evaluate the inter-rater reliability of the assessment administration; and
i) Any assessment determined to be inappropriately derived during evaluation shall be re-administered within 30 days of findings.

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.

Revision 15. Section 4.3.8.14 is hereby amended to read as follows:

4.3.8.14 Service limits are monitored and appropriate action is taken if a member is nearing or exceeds needs-based service limits outlined in the service plan. Appropriate action includes assessment of whether the service plan requires revision to allocate additional units of waiver services or if other non-waiver resources are available to meet the member's needs in the community.

Revision 16. Section 5.1.1 is hereby deleted and marked reserved as follows:

5.1.1 Reserved

Revision 17. Section 6.1.2 is hereby amended to read as follows:

6.1.2 *Provider Agreements*

In accordance with 42 C.F.R. § 438.206, the Contractor shall establish written agreements with all network providers. The Contractor shall identify and incorporate the

applicable terms of its Contract with the Agency and any incorporated documents in the Contractor's provider agreements. Under the terms of the provider agreement, the provider must agree that all applicable terms and conditions set out in the Contract, the Contract, any incorporated documents and all applicable State and Federal laws, as amended, govern the duties and responsibilities of the provider with regard to the provision of services to members. The Contractor shall attest that all applicable State and Federal laws and contractual requirements are met in the provider agreement templates.

The Contractor shall also include in all of its provider agreements provisions to ensure continuation of benefits. The Contractor shall ensure that providers are enrolled with the Agency as a condition for participation in the Contractor's network. The Contractor shall require a signed Business Associates Agreement as part of the provider agreement when required. In addition, the provider agreement shall specify the provider's responsibility regarding 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 calendar year 2020. The VBP arrangement shall recognize population health outcome improvement as measured through Agency approved metrics combined with a total cost of care measure for the population in the VBP arrangement. Driving population health through delivery system reform under VBP means that providers need a clear understanding of the specific lives for which they are accountable. As such, any 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. The Contractor shall also require that all contracted hospitals report admission and discharge information to support this exchange and coordination. Contractor shall use an Agency approved tool, to provide a consistent, real-time notification platform for hospitals to uniformly report inpatient and ED events for Medicaid members to the Contractor and care teams participating in VBP agreements. The Contractor shall notify the Agency of any risk sharing agreements it has arranged with a provider and require in the provider agreement for any providers who are paid on a capitated basis the submission of encounter data within ninety (90) days of the date of service. As applicable, the provider agreements shall comply with the requirements set forth 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.

Revision 18. The internal reference in the last sentence of subsection 6.2.2.7 is changed from 3.2.6.9.1.1 to 3.2.6.8.1.1.

Revision 19. Section 9.1.1 and its subsections are hereby amended to read as follows:

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 standardized questions that tie to social determinants of health. Contractor tools will be compared against the current approach by the Agency, and a uniform tool is preferred across managed care entities.

9.1.1.2 Subsequent Screenings

The Contractor shall also 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, or every twelve (12) months, whichever is sooner. Subsequent screenings shall include standardized questions that tie to social determinants of health. Such evidence may be available through methods such as claims review or provider notification.

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.

Revision 20. Section 10.1.2.14 is hereby amended to read as follows:

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 measures within Agency-approved value based purchasing contracts;

Revision 21. Section 10.2.5 is hereby amended to read as follows:

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 Agency-approved metrics 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.

Revision 22. Section 12 is hereby amended to read as follows:

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 12.7 and 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) Direct the activities of Special Investigation Unit staff;

(ii) Attend meetings with the State, including meeting with the State as the State directs, but no less than meeting on a monthly basis;

(iii) Act as a subject matter expert for Medicaid program integrity; and

(iv) Reduce or eliminate 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 of the identification of suspected fraud or abuse activity as defined by the Agency. 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 Contractor 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

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.

12.7.3.4 Audits by the Agency or its Designee. The Agency or its designee may audit Contractor's provider claims and recover from the Contractor the identified provider overpayments by following the procedures below.

12.7.3.4.1 Audit Procedure.

a. Notice of Overpayment. If the Agency identifies a provider overpayment owed to the Contractor, the Department shall send notice to the Contractor identifying the overpayment.

b. Response to Notice. On or before the 90th day following the date of the notice, the Contractor shall either shall pay the Agency the amount identified as a provider overpayment or shall dispute the overpayment in writing to the Program Integrity Director or other Agency representative designated by the Agency.

c. Dispute Procedures. If the Contractor disputes the overpayment, the Program Integrity Director or other Agency representative designated by the Agency will consider the Contractor's dispute and shall notify the Contractor of its final decision on or before the 60th day following the date the written dispute is received. The Agency has the sole discretion to uphold, overturn, or amend an identified overpayment. If the Contractor disputes the overpayment and the Agency's final decision identifies an overpayment, the Contractor shall pay the Agency the identified overpayment on or before the tenth day following the final decision or the 90th day following the original notice of overpayment, whichever is later.

d. Extension of time. If the Contractor makes a written request on or before the due date for the payment of the overpayment, the Agency, through its Program Integrity Director or other Agency representative, may, in its sole discretion, grant an extension of the time within which the Contractor must pay the overpayment

e. Contractor Recovery. Where an overpayment has been identified by the Agency and the Contractor has been required to pay the amount of the overpayment to the Agency, the Contractor shall recover the overpayment from the provider and may retain the overpayment recovered.

f. Offset. If the Contractor fails to repay an overpayment identified under these procedures, the Agency may offset the amount of the overpayment owed by the Contractor against any payments owing to Contractor under this Agreement.
g. If the Agency identifies an overpayment within two (2) years of the date the claim was paid, the Agency will contact the Contractor prior to recovering the overpayment.

12.8 Recovery of Payments

12.8.1 Except as otherwise provided in Section 12.7.3 and 12.8.4, the Contractor shall recover improper payments and overpayments attributable to claims paid by the Contractor as identified by the Contractor or the Agency for up to five (5) years from the date the claim was paid.
12.8.2 Except as otherwise provided in Section 12.7.3 and 12.8.4, the Contractor may retain overpayments attributable to claims paid by the Contractor.
12.8.3 *Reserved.*
12.8.4 Where a provider overpayment owed to a Contractor is recovered by the RAC, the state, or the federal government, by any means, the Agency, in consultation with the recovering entity, shall determine, in its sole discretion, if any portion of the recovered payment will be returned to the Contractor. If the Agency determines that a portion will be returned to the Contractor, 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 Reserved.

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).

Revision 23. Section 13.1.12 is hereby amended to the following.

13.1.12 *Electronic Visit Verification System*

The Contractor shall participate in Agency EVV planning activities and use the Agency EVV system that will be in place within a timeframe determined by the Agency to ensure compliance with state and federal regulations. The Contractor shall develop and describe what methodologies will be used to monitor member receipt and utilization of personal care, Home Health Services, and other services using the Agency EVV system.

Revision 24. Section 13.4.1 is hereby amended to read as the follows:

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. 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 update provider reimbursement rates in its claims processing system and adjudicate claims using the new rates no later than 30 calendar days from notification by the Agency, or as otherwise directed by the Agency. Except as otherwise specified in law, or as otherwise directed by the agency, rate updates shall be implemented prospectively.

The Contractor shall develop 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.

Revision 25: Subsection 13.6.2.3 Cost Avoidance Exceptions – Pay and Chase Activities is amended to read as follows:

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 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 (ii) the claim is for preventive pediatric services (including EPSDT) that are covered by the Medicaid program. Following reimbursement to the provider in these cost avoidance exception cases, the Contractor shall actively seek reimbursement from responsible third parties and adjust claims accordingly.

Revision 26. Section 13.6.5 is hereby deleted and marked reserved as follows:

13.6.5 *Reserved*

Revision 27. Section 14.3.11 is hereby added to read as follows:

14.3.11 *Completion of Subsequent Health Risk Screening*

As described in Section 9.1.1.2, the Contractor shall complete a subsequent health risk screening no later than twelve (12) months from the last initial or comprehensive health risk screening, or last health risk screening attempt. Each quarter, at least seventy percent (70%) of the Contractor's members who are due for subsequent health risk screening, who have been assigned to the Contractor for a continuous period of at least twelve (12) months, shall complete an initial health risk screening within twelve (12) months of the last initial or comprehensive health risk screening or last health risk screening attempt. For any member who does not obtain a subsequent health risk screening, the Contractor shall document at least three (3) attempts to conduct the screening. Demonstrated good faith efforts of these three (3) attempts which result in the unsuccessful completion of a member's Health Risk Screening will be excluded from the 70% threshold calculation.

Revision 28. Section 14.3.12 is hereby added to read as follows:

14.3.12 *Value Added Services Management and Evaluation*

In the Work Plan required by 2.13, the Contractor shall develop a plan for value added services to identify the goals the Contractor has set to address its strategy for improving the health and wellbeing of its members. In the Work 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 identify methods to (i) track participation in the program; (ii) establish standards and health status targets; and (ii) evaluate the effectiveness of the program. In addition to the annual plan and evaluation, value added service participation shall be reported quarterly.

Revision 29. Section 14.5.1 is hereby amended to read as follows:

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.

Revision 30. Section 14.5.5 and subsections are hereby amended to read as follows:

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 will be established by the Agency on an annual basis.

Revision 31. Section 14.6 and subsections are hereby amended to read as follows:

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. Documentation of outcomes for the LTSS population include, but are not limited to, the reports described in this section.

14.6.1 *LTSS Admission to an Institution from the Community*

The LTSS Admission to an Institution from the Community shall document the number of MLTSS plan member admissions to an institution (nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/ID) from the community that result in a short-term, medium-term, or long-term stay during the measurement year per 1,000 member months in accordance with Centers for Medicare and Medicaid Services (CMS) measure specifications. The Agency will establish a baseline rate for this report and the Contractor shall demonstrate a decrease in the number of institutional facility admissions by eligible members.

14.6.2 *LTSS Supports Minimizing Institutional Length of Stay*

The LTSS Minimizing Institutional Length of Stay report shall document the proportion of admissions to an institutional facility for LTSS members that result in successful discharge to the community within 100 days of admission in accordance with Centers for Medicare and Medicaid Services (CMS) measure specifications. The Agency will establish a baseline rate for this report and the Contractor shall demonstrate an increase in the number of eligible members successfully discharged to the community within 100 days of admission.

14.6.3 *LTSS Successful Transition after Long-Term Institutional Stay*

The LTSS Successful Transition after Long-Term Institutional Stay report shall document the proportion of MLTSS plan members who are long-term residents (101 days or more) of institutional facilities who are successfully transitioned to the community in accordance with Centers for Medicare and Medicaid Services (CMS) measure specifications. The Agency will establish a baseline rate for this report 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.

Revision 32. Exhibit A – Definitions is amended as follows:

Delete the definition for "Emergent care" and replace with:

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.

Revision 33. Table 1 of Exhibit E is hereby amended to read as follows:

Honoring outstanding prior authorizations	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
1915(c) and 1915(i) HCBS waiver assessment and care plan development	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.

Communications	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.
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. Requests for extensions approved in accordance with previous sections of this Contract shall be removed from this timeliness measure.	$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

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 file submission
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.	$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

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
Prior Authorization and Claims Payment system issues	Any prior authorization or claims payment system issue that was reported by the Contractor as corrected but reoccurred within 60 days of the reported correction.	$542 per occurrence
Complete provider credentialing and accurately load provider rosters and rates.	If Contractor fails to complete provider credentialing including loading of rosters and rates as required in Section 13.4.1	$542 per occurrence

Revision 34. Exhibit F is hereby amended to read as follows:

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 Agency 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 six (6) 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: SFY 2020 OPERATIONAL PAY FOR PERFORMANCE MEASURES

Performance Measure	**Required Contractual Standard**	**Standard Required to Receive Incentive Payment**	**Amount of Performance Withhold at Risk**
Encounter Data	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	Within ninety days (90) of the end of each quarter the Contractor's accepted encounter data shall match the Contractor's submitted financial information within ninety-eight percent (98%) using reporting criteria set forth in the F1 reporting template.	20%

	one percent (1%). For every service provided, providers must submit corresponding claim or encounter data with claim detail identical to that required for fee-for-service claims submissions		
Timely Claims Processing	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 all claims within ninety (90) calendar days of receipt.	If the Contractor processes ninety-five percent (95%) of all clean claims within thirty (30) 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 ninety-seven percent (97%) of all clean claims within thirty (30) 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 ninety-nine percent (99%) of prior authorization requests within fourteen (14) calendar days of the request for service, or 72 hours for	If the Contractor processes ninety-five percent (95%) of prior authorization requests within eight (8) calendar days of the request for services 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.	20%

	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	If the Contractor processes ninety-seven percent (97%) of prior authorization requests within eight (8) calendar days of the request for services 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 ninety-nine percent (99%) of prior authorization requests within eight (8) calendar days of the request for services and ninety-nine percent (99%) 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.	
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 and subsequent health screenings is at or above seventy-three percent (73%) 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 initial and subsequent health screenings is at or above seventy-six percent (76%) 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) eighty-five percent (85%) within thirty (30) calendar days; and (ii) ninety-eight percent (98%) 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) ninety-seven percent (97%) within thirty (30) calendar days and ninety-nine percent (99%) within forty-five calendar days (45), Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.	10%

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	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 ninety percent (90%) 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.	10%

	customary standards for the community, which are documented and justified to the State.		

Revision 35. Exhibit G and table are hereby amended to read as follows:

Exhibit G

Beginning July 1, 2019 the Agency will exclude from the capitation rates the select prescription drugs and treatments as set forth in Exhibit G. Contractor shall continue to provide coverage for these Exhibit G pharmaceuticals and treatments, and the Agency will reimburse the Contractor based on Contractor's invoice to the Agency for Exhibit G pharmaceuticals or treatments paid. Contractor may only invoice for the lower of (1) actual cost to the Contractor, (2) actual cost to Contractor's PBM, or (3) the actual cost paid for the drug.

Pharmaceuticals excluded from capitation payments (to be billed to the Agency by MCO via invoice)

NDC	Drug Name
71894-120-02	Zolgensma
71894-121-03	Zolgensma
71894-122-03	Zolgensma
71894-123-03	Zolgensma
71894-124-04	Zolgensma
71894-125-04	Zolgensma
71894-126-04	Zolgensma
71894-127-05	Zolgensma
71894-128-05	Zolgensma
71894-129-05	Zolgensma
71894-130-06	Zolgensma
71894-131-06	Zolgensma
71894-132-06	Zolgensma
71894-133-07	Zolgensma
71894-134-07	Zolgensma
71894-135-07	Zolgensma
71894-136-08	Zolgensma
71894-137-08	Zolgensma
71894-138-08	Zolgensma
71894-139-09	Zolgensma
71894-140-09	Zolgensma
71894-141-09	Zolgensma

Section 2: Ratification & Authorization
Except as expressly amended and supplemented herein, the Contract shall remain in full force and effect, and the parties hereby ratify and confirm the terms and conditions thereof. Each party to this Amendment represents and warrants to the other that it has the right, power, and authority to enter into and perform its obligations under this Amendment, and it has taken all requisite actions (corporate, statutory, or otherwise) to approve execution, delivery and performance of this Amendment, and that this Amendment constitutes a legal, valid, and binding obligation.

Section 3: CMS Contingency.
This Amendment is contingent on the approval of CMS.

Section 4. Federal Funds. The following federal funds information is provided

Contract Payments include Federal Funds? Yes **The contractor for federal reporting purposes under this contract is a:** Vendor **DUNS #:** 809245525 **The Name of the Pass-Through Entity:** Iowa Department of Human Services	
CFDA #: 93.778 **Grant Name:** Medical Assistance Program	**Federal Awarding Agency Name:** Department of Health and Human Services/Centers for Medicare and Medicaid Services
CFDA #: 93.767 **Grant Name:** Children's Health Insurance Program	**Federal Awarding Agency Name:** Department of Health and Human Services/Centers for Medicare and Medicaid Services

Section 5: Execution
IN WITNESS WHEREOF, in consideration of the mutual covenants set forth above and for other good and valuable consideration, the receipt, adequacy and legal sufficiency of which are hereby acknowledged, the parties have entered into the above Amendment and have caused their duly authorized representatives to execute this Amendment.

Contractor, Iowa Total Care, Inc.		**Agency, Iowa Department of Human Services**	
Signature of Authorized Representative:	Date: 7/2/19	Signature of Authorized Representative:	Date: 7-3-19
Printed Name: Mitch Wasden		Printed Name: Gerd W. Clabaugh	
Title: Plan President and CEO		Title: Interim Director	

Special Contract
Attachment 3.2-01

Rate Cell	Iowa Total Care SFY20 Rates, Gross Withhold Final SFY18 Proxy MCO Enrollment	SFY20 Rates Net Additional Payments	GME PMPM	ACR PMPM	GEMT PMPM	SFY20 Rates Gross Additional Payments
Children 0-59 days M&F	14,417	$ 2,239.86	$ 5.28	$ 136.63	$ 4.18	$ 2,385.94
Children 60-364 days M&F	79,988	$ 306.29	$ 5.28	$ 23.54	$ 1.31	$ 336.42
Children 1-4 M&F	297,975	$ 148.62	$ 5.28	$ 6.50	$ 0.99	$ 161.39
Children 5-14 M&F	573,189	$ 157.66	$ 5.28	$ 4.78	$ 0.55	$ 168.27
Children 15-20 F	95,333	$ 261.01	$ 5.28	$ 6.96	$ 2.94	$ 276.19
Children 15-20 M	89,769	$ 189.88	$ 5.28	$ 4.62	$ 1.55	$ 201.33
CHIP - Hawk-i	252,609	$ 143.74	$ -	$ -	$ -	$ 143.74
Non-Expansion Adults 21-34 F	132,314	$ 395.25	$ 5.28	$ 9.38	$ 4.37	$ 414.28
Non-Expansion Adults 21-34 M	29,414	$ 251.89	$ 5.28	$ 6.45	$ 2.80	$ 266.42
Non-Expansion Adults 35-49 F	71,817	$ 566.36	$ 5.28	$ 15.36	$ 5.07	$ 592.07
Non-Expansion Adults 35-49 M	29,304	$ 427.77	$ 5.28	$ 10.74	$ 4.15	$ 447.94
Non-Expansion Adults 50+ M&F		$ 662.01	$ 5.28	$ 17.05	$ 4.45	$ 688.80

	15,257					
Pregnant Women	30,982	$ 438.00	$ 5.28	$ 16.40	$ 4.01	$ 463.68
WP 19-24 F (Medically Exempt)	4,814	$ 741.31	$ -	$ 18.91	$ 11.44	$ 771.66
WP 19-24 M (Medically Exempt)	3,468	$ 621.38	$ -	$ 11.71	$ 10.20	$ 643.28
WP 25-34 F (Medically Exempt)	10,945	$ 931.53	$ -	$ 14.23	$ 14.47	$ 960.22
WP 25-34 M (Medically Exempt)	10,144	$ 855.45	$ -	$ 16.32	$ 19.41	$ 891.19
WP 35-49 F (Medically Exempt)	16,993	$ 1,262.92	$ -	$ 28.87	$ 18.10	$ 1,309.89
WP 35-49 M (Medically Exempt)	14,539	$ 1,179.78	$ -	$ 28.81	$ 26.16	$ 1,234.75
WP 50+ M&F (Medically Exempt)	26,056	$ 1,527.58	$ -	$ 38.13	$ 22.46	$ 1,588.18
WP 19-24 F (Non-Medically Exempt)	76,310	$ 244.55	$ -	$ 6.75	$ 2.75	$ 254.05
WP 19-24 M (Non-Medically Exempt)	62,272	$ 202.18	$ -	$ 5.28	$ 2.95	$ 210.41
WP 25-34 F (Non-Medically Exempt)	93,878	$ 332.54	$ -	$ 8.38	$ 3.05	$ 343.97
WP 25-34 M (Non-Medically Exempt)	74,594	$ 287.63	$ -	$ 9.60	$ 4.89	$ 302.12
WP 35-49 F (Non-Medically Exempt)	93,699	$ 514.65	$ -	$ 12.37	$ 4.15	$ 531.16
WP 35-49 M (Non-Medically Exempt)	80,810	$ 481.68	$ -	$ 15.03	$ 6.12	$ 502.83
WP 50+ M&F (Non-Medically Exempt)	147,722	$ 805.35	$ -	$ 23.33	$ 5.74	$ 834.41
ABD Non-Dual <21 M&F	38,499	$ 990.80	$ 5.28	$ 42.92	$ 5.47	$ 1,044.47
ABD Non-Dual 21+ M&F	91,618	$ 1,592.79	$ 5.28	$ 37.43	$ 23.40	$ 1,658.89
Residential Care Facility		$ 3,399.59	$ 5.28	$ 34.12	$ 17.06	$ 3,456.04

	1,767					
Breast and Cervical Cancer	598	$ 1,901.79	$ -	$ 44.54	$ 1.53	$ 1,947.86
Dual Eligible 0-64 M&F	127,884	$ 475.38	$ -	$ -	$ -	$ 475.38
Dual Eligible 65+ M&F	33,741	$ 206.58	$ -	$ -	$ -	$ 206.58
Custodial Care Nursing Facility <65	8,108	$ 4,290.50	$ 5.28	$ 41.36	$ 22.60	$ 4,359.74
Custodial Care Nursing Facility 65+	51,092	$ 3,398.60	$ -	$ -	$ -	$ 3,398.60
Elderly HCBS Waiver	34,359	$ 3,398.60	$ -	$ -	$ -	$ 3,398.60
Non-Dual Skilled Nursing Facility	764	$ 4,290.50	$ 5.28	$ 53.82	$ 7.54	$ 4,357.14
Dual HCBS Waivers: PD; H&D	5,624	$ 4,290.50	$ -	$ 34.49	$ 7.55	$ 4,332.54
Non-Dual HCBS Waivers: PD; H&D; AIDS	5,411	$ 4,290.50	$ 5.28	$ 66.68	$ 23.72	$ 4,386.18
Brain Injury HCBS Waiver	6,155	$ 4,290.50	$ 5.28	$ 34.30	$ 7.27	$ 4,337.35
ICF/ID	6,295	$ 6,382.78	$ 5.28	$ 12.94	$ 4.88	$ 6,405.87
State Resource Center	1,804	$ 6,382.78	$ 5.28	$ 1.73	$ 3.00	$ 6,392.79
Intellectual Disability HCBS Waiver	52,435	$ 6,382.78	$ 5.28	$ 14.77	$ 2.86	$ 6,405.68
PMIC	1,136	$ 3,471.07	$ 5.28	$ 7.47	$ 5.32	$ 3,489.15
Children's Mental Health HCBS Waiver	3,045	$ 3,471.07	$ 5.28	$ 7.15	$ 2.26	$ 3,485.77
CHIP - Children 0-59 days M&F	20	$ 2,239.86	$ -	$ -	$ -	$ 2,239.86
CHIP - Children 60-364 days M&F	737	$ 306.29	$ -	$ -	$ -	$ 306.29
CHIP - Children 1-4 M&F		$ 148.62	$ -	$ -	$ -	$ 148.62

	67					-
CHIP - Children 5-14 M&F	58,784	$ 157.66	$ -	$ -	$ -	$ 157.66
CHIP - Children 15-20 F	9,586	$ 261.01	$ -	$ -	$ -	$ 261.01
CHIP - Children 15-20 M	9,822	$ 189.88	$ -	$ -	$ -	$ 189.88
TANF Maternity Case Rate	2,987	$ 6,378.36	$ -	$ -	$ -	$ 6,378.36
Pregnant Women Maternity Case Rate	3,513	$ 5,844.09	$ -	$ -	$ -	$ 5,844.09
Total - Final Proxy MCO Mix	**2,977,961**	**$ 643.03**	**$ 2.97**	**$ 10.39**	**$ 3.36**	**$ 659.76**