Third Amendment to the MED-20-001 Contract

This Third Amendment to Contract Number MED-20-001 is effective as of July 1, 2020, between the Iowa Department of Human Services (Agency) and Iowa Total Care, Inc. (Contractor).

Section 1: Amendment to Contract Language
The Contract is amended as follows:

Revision 1. Contract Section 1.3.3.4 is amended to read as follows:

1.3.3.4 Payment for Services & GME Only. No payment will be made to a network provider other than by the Contractor for services covered under the Contract, except when these payments are specifically required to be made by the State in Title XIX of the Social Security Act, in 42 C.F.R., or when the State agency makes direct payments to network providers for graduate medical education costs approved under the State plan. See: 42 C.F.R. § 438.60.

Revision 2. Contract Section 2.5.5 in the Scope of Work is amended to read as follows:

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

Revision 3. Contract Section 3.2.6.12 is added as follows:

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

Revision 4. Contract Section 3.2.6.13 is added as follows:

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

a) Safety edit on days' supply, early refills, duplicate fills, and quantity limitations on opioids and a claims review automated process that indicates fills of opioids in excess of limitations identified by the State;
b) Safety edits on the maximum daily morphine equivalent for treatment of pain and a claims review automated process that indicates when an individual is prescribed the morphine milligram equivalent for such treatment in excess of any limitation that may be identified by the State;
c) A claims review automated process that monitors when an individual is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics;
d) A program to monitor and manage the appropriate use of antipsychotic medications by all children including foster children enrolled under the State plan;
e) Fraud and abuse identification processes that identifies potential fraud or abuse of controlled substances by beneficiaries, health care providers, and pharmacies;
All of the above SUPPORT Act requirements are satisfied by Contractor's compliance with the obligation to adhere to the Agency's DUR Board recommendations as implemented by the Agency.

Revision 5. Contract Section 3.2.8.13.2, is amended to read as follows:

3.2.8.13.2 IMD Exclusion & In Lieu Of Services.
Notwithstanding provisions of 3.2.8.13.1, the State will only make a monthly capitation payment to the Contractor for an Enrolled Member aged 21–64 receiving inpatient treatment in an Institution for Mental Diseases (IMD), as defined in 42 C.F.R. § 435.1010, so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services, and length of stay in the IMD is for a short term stay of no more than 15 days during the period of the monthly capitation payment. See: 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. Contractor may cover services or settings for Enrolled Members that are in lieu of those covered under the State plan if:

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

See: 42 C.F.R. § 438.3(e)(2)(i) - (iii); 42 C.F.R. § 457.1201(e).

Revision 6. Contract Section 3.2.8.13.2, that begins with the text "For stays exceeding the 15 days in a calendar month..." is amended by renumbering the clause to 3.2.8.13.2.1.

Revision 7. Contract Section 3.2.9 is amended to read as follows:

3.2.9 Health Homes.
The Contractor shall administer and fund the State's Health Home services within the approved Chronic Condition Health Home and Integrated Health Home State Plan Amendments. The Contractor shall provide oversight that includes but not limited to documentation reviews and provider self-assessment reviews to ensure that Health Home Providers are meeting all of the requirements of the Health Home State Plan Amendments, Health Home Manual and Administrative Rules. The Contractor shall provide guidance to Health Home Providers to ensure the requirements of the Health Home State Plan Amendments, Health Home Manual and Administrative Rules are being met. The Contractor shall be responsible for any identified deficiencies. In accordance with federal requirements, the Contractor shall ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) HCBS waivers, other forms of community-based case management, or value-based purchasing arrangements.

Revision 8. Contract Section 5.3.1 is amended to read as follows:

5.3.1 Exempt Populations
The Contractor shall ensure, in accordance with 42 C.F.R § 447.56, that copayments are not imposed on any of the following populations:

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

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

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

5.3.1.4 Children for whom child welfare services are made available under Part B of title IV of the Social Security Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age;

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

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

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

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

5.3.1.9 An Indian (as defined at Section 7.5) who is currently receiving or has ever received an item or service furnished by an Indian health care provider (IHCP) or through referral under contract health services. See 42 C.F.R. § 447.52(h); 42 C.F.R. § 447.56(a)(1)(x); ARRA 5006(a); 42 C.F.R. § 447.51(a)(2); SMDL 10-001; and

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

Revision 9. Contract Section 6.1 General Provisions is amended to include the following:

6.1 General Provisions
The Agency will screen and enroll, and periodically revalidate all Contractor network providers as Medicaid providers. See: 42 C.F.R. § 438.602(b)(1); 42 C.F.R. § 457.1285.

Revision 10. Contract Section 6.1.2 is amended 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 may execute network provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to 120 days but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the provider, and notify affected enrollees. (See: 42 C.F.R. § 438.602(b)(2); 42 C.F.R. § 457.1285.) 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 11. Contract Section 6.1.3(d) is amended to read as follows:

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

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

See: Section 1903(i) of the Social Security Act, final sentence; section 1903(i)(2)(A) - (C) of the Social Security Act; section 1903(i)(16) - (17) of the Social Security Act.

Revision 12. Contract Section 6.1.3.8 is added as follows:

6.1.3.8 Screening and Enrollment of Providers
The Agency will screen and enroll, and periodically revalidate all Contractor network providers as Medicaid providers. See: 42 C.F.R. § 438.602(b)(1); 42 C.F.R. § 457.1285.

Revision 13. Contract Section 6.1.3.9 is added as follows:

6.1.3.9 Agreements Pending Outcome of Screening.
Contractor may execute network provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to 120 days but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one 120-day period without enrollment of the provider, and notify affected enrollees. See: 42 C.F.R. § 438.602(b)(2); 42 C.F.R. § 457.1285.

Revision 14. Contract Section 6.1.6.6 is added as follows:

6.1.6.6 Quality Provider Assistance
The Contractor shall develop a provider assistance program that focuses on the needs of the provider. The Contractor shall develop and implement quality measures to provide excellent provider service in all areas of assistance. Focus should be given to anticipate needs and

reduce administrative burden for all providers. The Agency shall approve all quality measures.

Revision 15. Contract Section 6.3.6 is amended to read as follows:

6.3.6 Health Homes
The Contractor shall develop a network of Integrated Health Homes and Chronic Condition Health Homes. The Contractor shall develop strategies to encourage additional participation, particularly in areas of the State where participation has been low. In developing the Integrated Health Home and Chronic Condition Health Home networks, the Contractor shall ensure all providers meet the minimum requirements for participation as defined in the State Plan and the Agency policy. Refer to Section 3.2.9 for additional detail on all health home requirements.

Revision 16. Contract Section 8.3.2 is amended to read as follows:

8.3.2 Helpline Staff and Knowledge.
The Contractor's member services helpline staff shall be prepared to efficiently respond to member concerns or issues, including but not limited to: (i) how to access health care services; (ii) identification or explanation of covered services; (iii) procedures for submitting a grievance or appeal; (iv) reporting fraud or abuse; (v) locating a provider; (vi) health crises, including but not limited to, suicidal callers; (vii) balance billing issues; (viii) cost-sharing and patient liability inquiries; and (ix) incentive programs.

The Contractor shall respond to all urgent requests within four (4) hours if received prior to 1:00 pm. If received after 1:00 pm, urgent requests will be responded to by 11:00 am the next business day.

Revision 17. Contract Section 8.3.3 is amended to read as follows:

8.3.3 Helpline Performance Metrics
Contractor shall comply with the call center performance metrics as set forth in Section 14.11.

Revision 18. Contract section 9.1(d) is amended to read as follows:

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

Revision 19. Contract Section 13.4.6 is amended to read as follows:

13.4.6 Claims Reprocessing and Adjustments.
The Contractor shall adjudicate ninety percent (90%) of all clean provider-initiated adjustment requests within thirty (30) calendar days of receipt. The Contractor shall also

reprocess all claims processed in error within thirty (30) calendar days of identification of the error or upon a scheduled approved by the Agency. Except in cases in which system configuration is necessary, the start time begins when the Contractor identifies, or is made aware of the error, and has received all necessary information to validate the error; identification of the error could be brought forward by a provider, the Agency, or internal Contractor staff. In the event the Contractor requests clarification from the Agency regarding a claims reprocessing project, the time for reprocessing will begin to run on the day the Contractor receives all information necessary to accurately reprocess the claims. In cases in which a system configuration is necessary, the Contractor shall make corrections to the system and reprocess claims within sixty (60) calendar days unless an extension is approved by the Agency. The Contractor shall reprocess mass adjustments of claims upon a schedule approved by the Agency and the Contractor.

Revision 20. The following is added to the Contract as new subsection 13.5.4

13.5.4 Attestation under Penalty of Perjury
The Contractor shall ensure that the designated individual who submits data to the State shall provide a certification, which attests, based on best information, knowledge and belief that the data, documentation and information are accurate, complete and truthful, under penalty of perjury in accordance with 42 C.F.R. § 438.604 and 42 C.F.R. § 438.606(b).

Revision 21. Contract Section 14.3.4 is amended to read as follows:

14.3.4 Member Helpline Performance Report
Contractor shall comply with the call center performance metrics as set forth in Section 14.11.

Revision 22. Contract Section 14.4.5 is amended to read as follows

14.4.5 Provider Helpline Performance Report
Contractor shall comply with the call center performance metrics as set forth in Section 14.11.

Revision 23. Contract Section 14.6.8 is amended to read as follows:

14.6.8 Timeliness of Level of Care Assessments and Reassessments
The Timeliness of Level of Care Report shall document the Contractor's timely completion of level of care reassessments. One hundred percent (100%) 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. 42 C.F.R.§483.20, and 42 C.F.R.§413.343.

Revision 24. Contract Section 14.6.9 is amended to read as follows:

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(i) State Plan HCBS Habilitation enrollees. One hundred percent (100%) of needs assessment shall be completed within twelve (12) months of the previous assessment.. 42 C.F.R. §441.720.

Revision 25. Contract Section 14.11 is added as follows:

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

a) Abandonment rates must be five percent or less. Calls are considered abandoned if the caller hangs up after 30 seconds and does not talk with a Customer Service Representative.
b) Service levels must be at least 80% for incoming calls. The service level is calculated by the following formula:
   Service Level = ((T – (A + B)/T) * 100, where:
   T = all calls that enter the queue
   A = calls that are answered after 30 seconds
   B = calls that are abandoned after 30 seconds
c) 90% of telephone inquiries, excluding billing inquiries, must be responded to during the initial call.
d) 99% of calls will be answered by an individual or an electronic device without receiving a busy signal.
e) 90% of written, faxed, or e-mailed inquires must be responded to within three business days of receipt excluding bill inquiries. If a complete response cannot be made within three business days, an interim response shall be provided within the first three business days and every three days thereafter until resolved. All inquiries must be resolved within 15 business days.
f) 95% of all bill inquiries will be responded to by phone or in writing within two business days. 100% of bill inquiries will be responded to by phone or in writing within three business days.

Revision 26. Contract Exhibit D (D1 and D2) is amended to include the following table row below the "Occupational Therapy" row:

ORGAN TRANSPLANTS	• Contractor shall not pay for organ transplants unless the State plan provides, and the Contractor follows, written standards that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high-quality care to Enrolled

	Members. See: Section 1903(i) of the Social Security Act, final sentence; section 1903(i)(1) of the Social Security Act.

Revision 27. Contract Exhibit E is amended to add a new section immediately before the "Liquidated Damages" headline, which reads as follows:

SANCTION AUTHORITY

Additional State Sanctions. The State may impose additional sanctions provided for under State statutes or regulations to address noncompliance. See: 42 C.F.R. § 438.702(b); 42 C.F.R. § 457.1270.

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

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

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

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

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

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

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

Offsets – Premiums or Excess Amounts. If the State imposes a civil monetary penalty on the Contractor for charging premiums or charges in excess of the amounts permitted under Medicaid, the State will deduct the amount of the overcharge from the penalty and return it to the affected Enrolled Member. See: 42 C.F.R. § 438.704(c); 42 C.F.R. § 457.1270.

Temporary Management – Enrollee Right to Terminate. If the State imposes temporary management because an MCO has repeatedly failed to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 C.F.R. § 438, the State will notify affected Enrolled Members of their right to terminate enrollment without cause. See: 42 C.F.R. § 438.706(b); 42 C.F.R. § 457.1270.

Notice to Enrolled Members. After Contractor is notified that the State intends to terminate the Contract, the State may:

a) Give the Contractor's Enrolled Members notice of the State's intent to terminate the Contract.
b) Allow Enrolled Members to dis-enroll immediately without cause.

See: Section 1932(e)(4) of the Social Security Act; 42 C.F.R. § 438.722(a) - (b); 42 C.F.R. § 457.1270.

Revision 28. Contract Exhibit E, Table E1 is amended to change the table row that previously was titled "Member Services Helpline" to read as follows:

All Call Centers	The Contractor fails to meet performance requirements as set forth in Section 14.11	$796 per reporting period, per call center, in which any standard is not met

Revision 29. Contract Exhibit F is amended to read as follows:

Exhibit F
PAY FOR PERFORMANCE

Withhold Arrangement. The Agency will implement a withhold arrangement to reward the Contractor's efforts to improve quality and outcomes as described in the relevant yearly rate certification. See: Special Contract Attachment Section 3.2 (Rate Sheets).

General. For all withhold arrangements authorized by this Contract:

a) The arrangement is for a fixed period of time.
b) The withhold amount shall be two percent (2%) of capitation payments.
c) That performance is measured during the rating period under the Contract in which the withhold arrangement is applied.
d) The arrangement is not to be renewed automatically.
e) The arrangement is made available to both public and private contractors under the same terms of performance.

f) The arrangement does not condition Contractor participation in the withhold arrangement on the Contractor entering into or adhering to intergovernmental transfer agreements.
g) The arrangement is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the State's quality strategy.
h) The measurements are related to dates of service covering the performance period of July 1, 2020 through June 30, 2021, including a minimum of six (6) months of claims run-out before making the calculations.

See: 42 C.F.R. § 438.6(b)(3)(i) - (v); 42 C.F.R. § 438.340.

Table F1: SFY 2021 PAY FOR PERFORMANCE MEASURES

Performance Measure 1	Amount of Performance Withhold at Risk
Encounter Data	10%
Required Contractual Standard	
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. 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 45 days from the date the initial error report for the month was sent to the Contractor or 59 days from the date the initial encounter data were due. The error rate for encounter data cannot exceed 1%. For every service provided, providers must submit corresponding claim or encounter data with claim detail identical to that required for fee-for-service claims submissions	
Standard Required to Receive Incentive Payment	
Within 90 days of the end of each quarter the Contractor's accepted encounter data shall match the Contractor's submitted financial information within 98% using reporting criteria set forth in the F1 reporting template.	

Performance Measure 2	Amount of Performance Withhold at Risk
Timely Claims Reprocessing	10%
Required Contractual Standard	
The Contractor shall also reprocess all claims processed in error within thirty (30) calendar days of identification of the error or upon a schedule approved by the Agency. Except in cases in which system configuration is necessary, the start time begins when the Contractor identifies, or is made aware of the error, and has received all necessary information to validate the error; identification of the error could be brought forward by a provider, the Agency, or internal Contractor staff. In the event the Contractor requests clarification form the Agency regarding a claims reprocessing project, the time for reprocessing will begin to run on the day the Contractor receives all information necessary to accurately reprocess the claims. In cases in which a system configuration is necessary, the Contractor shall make corrections to the system and reprocess claims within sixty (60) calendar days unless an extension is approved by the Agency.	

Standard Required to Receive Incentive Payment
The Contractor will achieve a measure of ninety percent (90%) of all reprocessed claims within fifteen (15) business days of discovery of an error not related to a system configuration and ninety-five percent (95%) of all claims reprocessed within thirty (30) business days when a system configuration change is required.

Performance Measure 3	Amount of Performance Withhold at Risk
Follow-up After Hospitalization for Mental Illness (ages 6+)	30%
Standard Description	
Percent of discharges for children and adults who were hospitalized for treatment of selected diagnoses who had a follow up visit with a MH practitioner within 7 days of discharge and within 30 days of discharge.	
CMS Core Set Measure #3-1	Amount of Performance Withhold at Risk
Follow-up After Hospitalization for Mental Illness	7.5%
Standard Description – Core Set Measure #3-1	
Percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. • Percentage of discharges for which the child received follow-up within 7 days after Discharge. (CMS Core Health Care Quality Measure "FUH" (child, 7-days).)	
Standard Required to Receive Incentive Payment #3-1	
For hospitalization for mental illness for children ages 6 to 17 who are discharged and have a follow up within 7 days after discharge, the Contractor must meet or exceed 49.7%.	
CMS Core Set Measure #3-2	Amount of Performance Withhold at Risk
Follow-up After Hospitalization for Mental Illness	7.5%
Standard Description – Core Set Measure #4-2	
Percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner: • Percentage of discharges for which the child received follow-up within 30 days after Discharge. (CMS Core Health Care Quality Measure "FUH" (child, 30-days).)	
Standard Required to Receive Incentive Payment #3-2	
For hospitalization for mental illness for children ages 6 to 17 who are discharged and have a follow-up within 30 days of discharge, the Contractor must meet or exceed 72.1%	
CMS Core Set Measure #3-3	Amount of Performance Withhold at Risk
Follow-up After Hospitalization for Mental Illness	7.5%
Standard Description – Core Set Measure #3-3	
Percentage of discharges for beneficiaries age 18 to 64 who were hospitalized for	

treatment of selected mental illness diagnoses or intentional self-harm and who had a follow up visit with a mental health practitioner. • Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge (CMS Core Health Care Quality Measure "FUH" (adult, 7-days).)
Standard Required to Receive Incentive Payment #3-3
For hospitalization for mental illness for beneficiaries age 18 to 64 who are discharged and have a follow-up within 7 days of discharge, the Contractor must meet or exceed 43.0%.

CMS Core Set Measure #3-4	Amount of Performance Withhold at Risk
Follow-up After Hospitalization for Mental Illness	7.5%

Standard Description – Core Set Measure #3-4
Percentage of discharges for beneficiaries age 18 – 64 who were hospitalized for treatment of selected mental illness diagnoses or intentional self-harm and who had a follow up visit with a mental health practitioner. (CMS Core Health Care Quality Measure "FUH" (adult, 30-days).) • Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge
Standard Required to Receive Incentive Payment #3-4
For hospitalization for mental illness for beneficiaries age 18 - 64 who are discharged and have a follow-up within 30 days of discharge, the Contractor must meet or exceed 63.6%.

Performance Measure 4	Amount of Performance Withhold at Risk
Follow-up After Emergency Department Visit for Mental Health	30%

Standard Description
Percentage of emergency department (ED) visits for beneficiaries age 18 to 64 with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported.

CMS Core Set Measure #4-1	Amount of Performance Withhold at Risk
Follow-up After Emergency Department Visit for Mental Health	15%

Standard Description – Core Set Measure #4-1
Percentage of emergency department (ED) visits for beneficiaries age 18 - 64 with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days) (CMS Core Health Care Quality Measure "FUM" (7-days).)
Standard Required to Receive Incentive Payment #4-1

For ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days) the Contractor must meet or exceed 43.4%.	
CMS Core Set Measure #4-2	Amount of Performance Withhold at Risk
Follow-up After Emergency Department Visit for Mental Health	15%
Standard Description – Core Set Measure #4-2	
Percentage of emergency department (ED) visits for beneficiaries age 18 - 64 with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) (CMS Core Health Care Quality Measure "FUM" (30-days).)	
Standard Required to Receive Incentive Payment #4-2	
For ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) the Contractor must meet or exceed 59.5%.	

Performance Measure 5	Amount of Performance Withhold at Risk
Long Term Services and Support: Balancing Toward Community-Based Services	20%
Standard Description	
Percentage of all members qualifying for the Long Term Services and Support who are with the same MCO for six consecutive months in community based services (those on an HCBS waiver and therefore not in a facility). (CMS Core Health Care Quality Measure "PPC")	
Standard Required to Receive Incentive Payment	
For those in HCBS services as compared to facilities as of June 30, 2021, the Contractor must meet or exceed a rate of 66.5%. Baseline is June 30, 2020.	

* If applicable, subsequent to the release of new measurement criteria from NCQA in 2020, parties agree to review and update to align the measurement criteria to the revised NCQA standards.

Revision 30. The document attached to this Amendment as Exhibit 1 is hereby incorporated into the Contract as Special Contract Attachment 3.2-02.

Revision 31. Section 1.3.3.1 of Section 1 of the Contract entitled "Pricing" is amended by deleting paragraphs 9 through 11. Paragraph 9 begins with the text, "The Agency will conduct a mid-year review . . . ." Paragraph 11 begins with the text, "Except as agreed to, this Contract does not preclude . . . ." The clauses as edited have been moved to Attachment 3.2-02.

Revision 32. Special Attachment 2.7 of the Contract entitled "Attachment 2.7 Medical Loss Ratio" is amended to incorporate as a new paragraph the following language after the paragraph beginning "Acceptance by Contractor... :

Notwithstanding the above, for a period beginning July 1, 2020 through December 31, 2020 the minimum medical loss ratio (MLR) will be 89%.

Revision 33. Federal Funds. The following federal funds information is provided:

Contract Payments include Federal Funds? Yes **DUNS #:** 809245525 **The Name of the Pass-Through Entity:** Iowa Department of Human Services	
CFDA #: 93.778 Title XIX: The Medical Assistance Program	**Federal Awarding Agency Name:** Centers for Medicare and Medicaid Services (CMS)
CDFA #: 93.767 Children's Health Insurance Program	**Federal Awarding Agency Name:** Centers for Medicare and Medicaid Services (CMS)

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: 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: 6.29.2020	Signature of Authorized Representative:	Date: 6.30.20
Printed Name: Mitch Wasden		Printed Name: Kelly Garcia	
Title: Plan President and CEO		Title: Director	

Exhibit 1

Special Contract Attachment 3.2-02

	Iowa Total Care SFY21 Rates, Net Withhold							
Rate Cell	SFY18 Proxy Enrollment	SFY21 Rates Net Additional Payments	Withhold PMPM	SFY21 Rates Net Withhold, Net Additional Payments	GME PMPM	ACR PMPM	GEMT PMPM	SFY21 Rates, Net Withhold Gross Additional Payments
Children 0-59 days M&F	14,417	$2,239.86	$44.80	$2,195.06	$5.28	$136.63	$4.18	$2,341.15
Children 60-364 days M&F	79,988	$306.29	$6.13	$300.16	$5.28	$23.54	$1.31	$330.29
Children 1-4 M&F	297,975	$148.62	$2.97	$145.65	$5.28	$6.50	$0.99	$158.42
Children 5-14 M&F	573,189	$157.66	$3.15	$154.50	$5.28	$4.78	$0.55	$165.11
Children 15-20 F	95,333	$261.01	$5.22	$255.79	$5.28	$6.96	$2.94	$270.97
Children 15-20 M	89,769	$189.88	$3.80	$186.08	$5.28	$4.62	$1.55	$197.53
CHIP - Hawk-i	252,609	$143.74	$2.87	$140.86	$0.00	$0.00	$0.00	$140.86
Non-Expansion Adults 21-34 F	132,314	$395.25	$7.90	$387.34	$5.28	$9.38	$4.37	$406.38
Non-Expansion Adults 21-34 M	29,414	$251.89	$5.04	$246.85	$5.28	$6.45	$2.80	$261.38
Non-Expansion Adults 35-49 F	71,817	$566.36	$11.33	$555.03	$5.28	$15.36	$5.07	$580.74
Non-Expansion Adults 35-49 M	29,304	$427.77	$8.56	$419.22	$5.28	$10.74	$4.15	$439.39

Non-Expansion Adults 50+ M&F	15,257	$662.01	$13.24	$648.77	$5.28	$17.05	$4.45	$675.56
Pregnant Women	30,982	$438.00	$8.76	$429.24	$5.28	$16.40	$4.01	$454.92
WP 19-24 F (Medically Exempt)	4,814	$741.31	$14.83	$726.48	$0.00	$18.91	$11.44	$756.84
WP 19-24 M (Medically Exempt)	3,468	$621.38	$12.43	$608.95	$0.00	$11.71	$10.20	$630.85
WP 25-34 F (Medically Exempt)	10,945	$931.53	$18.63	$912.90	$0.00	$14.23	$14.47	$941.59
WP 25-34 M (Medically Exempt)	10,144	$855.45	$17.11	$838.34	$0.00	$16.32	$19.41	$874.08
WP 35-49 F (Medically Exempt)	16,993	$1,262.92	$25.26	$1,237.67	$0.00	$28.87	$18.10	$1,284.63
WP 35-49 M (Medically Exempt)	14,539	$1,179.78	$23.60	$1,156.19	$0.00	$28.81	$26.16	$1,211.16
WP 50+ M&F (Medically Exempt)	26,056	$1,527.58	$30.55	$1,497.03	$0.00	$38.13	$22.46	$1,557.63
WP 19-24 F (Non-Medically Exempt)	76,310	$244.55	$4.89	$239.66	$0.00	$6.75	$2.75	$249.16
WP 19-24 M (Non-Medically Exempt)	62,272	$202.18	$4.04	$198.13	$0.00	$5.28	$2.95	$206.36
WP 25-34 F (Non-Medically Exempt)	93,878	$332.54	$6.65	$325.88	$0.00	$8.38	$3.05	$337.32
WP 25-34 M (Non-Medically Exempt)	74,594	$287.63	$5.75	$281.88	$0.00	$9.60	$4.89	$296.37
WP 35-49 F (Non-Medically Exempt)	93,699	$514.65	$10.29	$504.35	$0.00	$12.37	$4.15	$520.87
WP 35-49 M (Non-Medically Exempt)	80,810	$481.68	$9.63	$472.05	$0.00	$15.03	$6.12	$493.20
WP 50+ M&F (Non-Medically Exempt)	147,722	$805.35	$16.11	$789.24	$0.00	$23.33	$5.74	$818.31
ABD Non-Dual <21 M&F	38,499	$990.80	$19.82	$970.98	$5.28	$42.92	$5.47	$1,024.66
ABD Non-Dual 21+ M&F	91,618	$1,592.79	$31.86	$1,560.93	$5.28	$37.43	$23.40	$1,627.04

Residential Care Facility	1,767	$3,399.59	$67.99	$3,331.60	$5.28	$34.12	$17.06	$3,388.05
Breast and Cervical Cancer	598	$1,901.79	$38.04	$1,863.76	$0.00	$44.54	$1.53	$1,909.83
Dual Eligible 0-64 M&F	127,884	$475.38	$9.51	$465.87	$0.00	$0.00	$0.00	$465.87
Dual Eligible 65+ M&F	33,741	$206.58	$4.13	$202.45	$0.00	$0.00	$0.00	$202.45
Custodial Care Nursing Facility <65	8,108	$4,290.50	$85.81	$4,204.69	$5.28	$41.36	$22.60	$4,273.93
Custodial Care Nursing Facility 65+	51,092	$3,398.60	$67.97	$3,330.63	$0.00	$0.00	$0.00	$3,330.63
Elderly HCBS Waiver	34,359	$3,398.60	$67.97	$3,330.63	$0.00	$0.00	$0.00	$3,330.63
Non-Dual Skilled Nursing Facility	764	$4,290.50	$85.81	$4,204.69	$5.28	$53.82	$7.54	$4,271.33
Dual HCBS Waivers: PD; H&D	5,624	$4,290.50	$85.81	$4,204.69	$0.00	$34.49	$7.55	$4,246.73
Non-Dual HCBS Waivers: PD; H&D; AIDS	5,411	$4,290.50	$85.81	$4,204.69	$5.28	$66.68	$23.72	$4,300.37
Brain Injury HCBS Waiver	6,155	$4,290.50	$85.81	$4,204.69	$5.28	$34.30	$7.27	$4,251.54
ICF/ID	6,295	$6,382.78	$127.66	$6,255.12	$5.28	$12.94	$4.88	$6,278.22
State Resource Center	1,804	$6,382.78	$127.66	$6,255.12	$5.28	$1.73	$3.00	$6,265.13
Intellectual Disability HCBS Waiver	52,435	$6,382.78	$127.66	$6,255.12	$5.28	$14.77	$2.86	$6,278.02
PMIC	1,136	$3,471.07	$69.42	$3,401.65	$5.28	$7.47	$5.32	$3,419.73
Children's Mental Health HCBS Waiver	3,045	$3,471.07	$69.42	$3,401.65	$5.28	$7.15	$2.26	$3,416.34
CHIP - Children 0-59 days M&F	20	$2,239.86	$44.80	$2,195.06	$0.00	$0.00	$0.00	$2,195.06
CHIP - Children 60-364 days M&F	737	$306.29	$6.13	$300.16	$0.00	$0.00	$0.00	$300.16

CHIP - Children 1-4 M&F	67	$148.62	$2.97	$145.65	$0.00	$0.00	$0.00	$145.65
CHIP - Children 5-14 M&F	58,784	$157.66	$3.15	$154.50	$0.00	$0.00	$0.00	$154.50
CHIP - Children 15-20 F	9,586	$261.01	$5.22	$255.79	$0.00	$0.00	$0.00	$255.79
CHIP - Children 15-20 M	9,822	$189.88	$3.80	$186.08	$0.00	$0.00	$0.00	$186.08
TANF Maternity Case Rate	2,987	$6,378.36	$127.57	$6,250.79	$0.00	$0.00	$0.00	$6,250.79
Pregnant Women Maternity Case Rate	3,513	$5,844.09	$116.88	$5,727.20	$0.00	$0.00	$0.00	$5,727.20
Total (MCO Mix)	**2,977,961**	**$643.03**	**$12.86**	**$630.17**	**$2.97**	**$10.39**	**$3.36**	**$646.90**

The Agency will conduct a mid-year review using emerging data to reassess the SFY2021 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 to reflect a full actuarially sound rate development, for the January 1, 2021 through June 30, 2021.