Fifth Amendment to the MED-20-001 Contract

This Fifth Amendment to Contract Number MED-20-001 is effective as of January 1, 2021, 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 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 1305 E. Walnut Des Moines, IA 50319-0114 **Phone:** 515-782-0310
Agency Contract Manager (hereafter "Contract Manager") /Address ("Notice Address"): Mary Tavegia 1305 E. Walnut Des Moines, IA 50319-0114	**Agency Contract Owner (hereafter "Contract Owner") / Address:** Julie Lovelady 1305 E. Walnut Des Moines, IA 50319-0114
E-Mail: mtavegi@dhs.state.ia.us	**E-Mail:** jlovela@dhs.state.ia.us
Phone: 515-782-0310	

Revision 2. Contract Section 1.3.3.3 is amended to read as follows:

1.3.3.3 Other Payments.

1.3.3.3.1 Pay out GME as directed in the rate sheet applicable to each payment period.

1.3.3.3.2 Pay other supplemental payments to providers as directed by the Agency when supplements are built into the rates and to the extent the supplements are permissible under federal law.

Revision 3. Contract Appendix 1 (Scope of Work), Section 3.2.6.13 is amended to read 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;
f) Implementation of retrospective reviews on opioid prescriptions exceeding above limitations on an ongoing basis.

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

Revision 4. Contract Appendix 1 (Scope of Work), Section 5.3.4 is amended as follows. The subparagraphs 5.3.4.1 through 5.3.4.4 remain unchanged:

5.3.4 Nonemergency Use of Emergency Room (ER)

The Contractor shall impose an eight dollar ($8) copayment for Iowa Health and Wellness Plan member's nonemergency use of an ER and a twenty-five dollar ($25) copayment for Hawk-i member's non-emergency use of an ER. A copayment shall not be imposed on Hawk-i enrolled members whose family income is less than one-hundred and eighty-one percent (181%) of the federal poverty level. To impose cost-sharing for non-emergency use of the ER, the hospital providing the care must first conduct an appropriate medical screening pursuant to 42 C.F.R. § 489.24 to determine the individual does not need emergency services. The Contractor shall instruct its provider network of the ER services co-payment policy and procedure, such as the hospital's notification responsibilities, outlined below, and the circumstances under which the hospital must waive or return the co-payment. Before providing non-emergency treatment and imposing cost-sharing for such services on an individual, the hospital must:

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

5.3.4.2 Provide the individual with the name and location of an available and accessible alternative non-emergency services provider. If geographical or other circumstances prevent the hospital from meeting this requirement, cost-sharing may not be imposed;

5.3.4.3 Determine that the alternative provider can provide services to the

individual in a timely manner with the imposition of a lesser cost sharing amount. The assessment of access to timely services shall be based on the medical needs of the enrollee; and

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

Revision 5. Contract Appendix 1 (Scope of Work), Section 8.15.1(3)(ii) is amended to read as follows:

(ii) *Appeal.* The member may request an appeal either orally or in writing. Further, unless the member requests an expedited resolution, an oral appeal can be followed by a written, signed appeal but is not required. The Contractor shall direct the member to the Agency Appeal and Request for Hearing form as an option for submitting a request for an appeal.

Member eligibility and eligibility related grievances and appeals (including but not limited to long-term care eligibility and enrollment), including termination of eligibility, effective dates of coverage, and the determination of premium, copayment, and patient liability responsibilities shall be directed to the Agency.

Revision 6. Contract Appendix 1 (Scope of Work), Section 13.1.12 is amended to read as follows:

13.1.12 *Electronic Visit Verification System*

The Contractor shall participate in EVV planning activities and use the Contractor-proposed, Agency-approved EVV system that will be in place within a timeframe determined by the Agency to ensure compliance with state and federal regulations, including Section 12006 of the Cures Act (42 U.S.C. § 1396b(l)). Beginning on January 1, 2021, the Contractor shall require personal care providers to use the Contractor EVV system or another EVV system complying with Section 12006 of the Cures Act. Beginning on January 1, 2023, the Contractor shall require home health services to use the Contractor EVV system or another EVV system complying with Section 12006 of the Cures Act. The Contractor shall develop and describe what methodologies will be used to monitor member receipt and utilization of personal care, Home Health Services, and other services using the EVV system. All EVV data that originates in or passes through the Contractor EVV system will be provided to the Agency in a format and timeframe subject to Agency approval.

Revision 7. Contract Appendix 1 (Scope of Work), Section 13.4.7 is amended to read as follows:

13.4.7 *Claims Reprocessing and Adjustments*

The Contractor shall adjudicate ninety percent (90%) of all clean identified adjustments including Reprocessed Claims within thirty (30) business days of receipt and ninety-nine

percent (99%) of all clean identified adjustments including Reprocessed Claims within ninety (90) business days of receipt. The Contractor shall also reprocess all claims processed in error within thirty (30) business days of identification of the error or upon a scheduled approved by the Agency. Except in cases in which system configuration is necessary, the start time begins when the Contractor identifies, or is made aware of the error, and has received all necessary information to validate the error; identification of the error could be brought forward by a provider, the Agency, or internal Contractor staff. In the event the Contractor requests clarification from the Agency regarding a claims reprocessing project, the time for reprocessing will begin to run on the day the Contractor receives all information necessary to accurately reprocess the claims. The Contractor shall reprocess mass adjustments of claims upon a schedule approved by the Agency and the Contractor.

Revision 8. Exhibit A of the Contract is amended to include the following definition inserted after "Reporting Manual"

Reprocessed Claim. The adjustment of certain already-processed claims until the claim is correct or no further changes are required. The re-processing process includes all activities identified to pay or deny the claim after its initial adjudication through the claims payment system. This includes payment of the claim once adjustments have been completed.

Revision 9. Exhibit E of the Contract is modified by replacing all text under the heading "SANCTION AUTHORITY" with the following:

SANCTION AUTHORITY

Medically Necessary Services. If Contractor fails to substantially provide Medically Necessary Services to an Enrolled Member that the Contractor is required to provide under law or under this Contract, the State may impose a civil monetary penalty of up to $25,000 for each failure to provide services. The State may also:

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

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

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

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

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

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

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

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

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

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

See: 42 C.F.R. § 438.700(b)(4); 42 C.F.R. § 438.702(a); 42 C.F.R. § 438.704(b)(2); sections 1932(e)(1)(iv); 1903(m)(5)(A)(iv)(l); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(I); 1932(e)(2)(A)(ii) of the Social Security Act; 42 C.F.R. § 457.1270. {From CMSC J.5.04}.

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

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

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

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

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

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

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

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

a) Grant Enrolled Members the right to dis-enroll without cause.
b) Suspend all new enrollments to the Contractor after the date the Secretary or the State notifies the Contractor of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.

c) Suspend payments for all new enrollments to the Contractor until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

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

Additional State Sanctions. The State may impose additional sanctions provided for under State statutes or regulations to address noncompliance. See: 42 C.F.R. § 438.702(b); 42 C.F.R. § 457.1270. {From CMSC J.5.10}.

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

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

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

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

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. {From CMSC J.5.18}.

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

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

Revision 10. Exhibit E Table E1 is modified to remove the following two topics in the table: 1) topic labeled “Communication” and 2) topic labeled “Complete provider credentialing and accurate load provider rosters and rates”.

Revision 11. Table F1 of Exhibit F of the Contract is amended to read as follows:

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+)	0%
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	0%
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	0%
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	0%

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	0%

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	0%

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	0%
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	0%
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	0%
Standard Description	
Percentage of all members qualifying for the Long Term Services and Support who are with the same MCO for six 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.	

Performance Measure 6	Amount of Performance Withhold at Risk

<table>
<tr><td>Social Determinants of Health Project (SDOH): Data Accuracy</td><td>80%</td></tr>
<tr><td colspan="2">Standard Description</td></tr>
<tr><td colspan="2">The monthly SDOH data submitted by the contractor will be reviewed by the Agency each month, and a Quality Control (QC) report will be returned to the contractor. The first month’s report will set a baseline expectation of QC feedback from the Agency. Each report shall meet standards set by the Agency.
For the five (5) subsequent active months (February 2021 – June 2021) as defined by the SDOH Business Requirements Document (BRD), the Contractor will make good faith efforts to have all issues satisfactorily addressed and compliant. Within two (2) weeks of the Agency’s submission to the QC report, there shall be a discussion between the Agency and the contractor which will result in action to resolve the identified issue(s) by the Contractor. The Contractor will submit data within the timeframe required by the SDOH BRD.</td></tr>
<tr><td colspan="2">Standard Required to Receive Incentive Payment</td></tr>
<tr><td colspan="2">Any of the five (5) months where the data submission is incomplete, missing or QC issues are not satisfactorily addressed timely will reduce the performance withhold by 16 percentage points (out of the identified 80% withhold).</td></tr>
</table>

Revision 12: **Special Contract Attachment 2.7 entitled “Attachment 2.7 Medical Loss Ratio” is amended by removing “Risk Corridor for Iowa Health and Wellness Plan”, “Risk Corridor for Long Term Service and Supports”, and “LTSS risk corridor Calculation and Payment” and adding the following:**

Risk Corridor

Agency shall perform a settlement of the payments made by the MCO to Agency or by Agency to the MCO for the rate period beginning January 1, 2021, and running through June 30, 2021. The settlement is the calculated gain or loss determined when comparing the actual MLR developed from the emerging experience to the risk sharing corridor percentages in the table below. The actual MLR is calculated as the total adjusted medical expenditures divided by the total capitation rate for all populations. The total capitation rate excludes taxes and fees, as well as amounts related to the Physician ACR payment, GEMT payment, GME, and NF CRR payments.

Adjusted medical expenditures shall be determined by Agency/Agency’s-contracted actuaries based on encounter data and plan financial data submitted by the MCO.

Adjusted medical expenditures only include services covered by the Agency and the MCO and will exclude all expenditures associated with carve-out services such as Zolgensma and the administrative costs of COVID-19 vaccinations. Administrative expenditures included in the pharmacy claims expenditures will be removed from the pharmacy claims for purposes of this Risk Corridor. Adjusted medical expenditures will not include quality improvement expenses, case management expenses, or other administrative expenses. Adjusted medical expenditures will not include amounts related to the Physician ACR payment, GEMT payment, GME, and NF CRR payments.

The Agency reserves the right to audit claims expenditures. For purposes of the Risk Corridor, the State will limit the overall level of reimbursement to 103% of the fee schedule target and will sample the submitted encounter data to ensure compliance with that target. The data used by the Agency and its actuaries for the reconciliation will be the MMIS encounter data. The Agency and the MCO agree that to the extent there are differences between claims expenditures as reflected in the encounter data and the financial data submitted by the MCO, the Agency and MCO will confer and make a good faith effort to reconcile those differences before the calculation of the final settlement as described below.

The Risk Corridor Percentage is calculated as the total adjusted medical expenditures divided by the total capitation rate. The total capitation rate excludes applicable taxes for the January – June 2021 period.

The Risk Sharing Corridor is defined as follows:

Risk Corridor Minimum Percentage	Risk Corridor Maximum Percentage	MCO Share	State/Fed Share
0.0%	89.8%	0%	100%
89.8%	92.3%*	100%	0%
92.3%*	94.8%	100%	0%
94.8%	94.8% +	0%	100%

**The target MLR of 92.3% is based on the weighted average of total non-medical load amounts built into SFY21b rates using the CY19 enrollment distribution. The actual target used for the final reconciliation may vary slightly based on the actual population distribution for the MCO during the six-month contract period. To the extent the target MLR varies from 92.3% using the actual enrollment mix during the contract period, the risk corridor bands will still be +/- 2.5% from the revised target.*

Within 230 days following the end of the contract period, the MCO shall provide Agency with a complete and accurate report of actual medical expenditures, by category of service, for enrollees, based on claims incurred for the contract period including six (6) months of claims run-out, and its best estimate of any claims incurred but not reported (IBNR) for claims run-out beyond six (6) months, and any applicable IBNR completion factors. The report will be a detailed claim-level record.

Prior to 9 months following contract period, Agency shall provide the MCO with a final settlement under the risk share program for the contract period. Any balance due between

Agency and the MCO, as the case may be, will be paid within 60 days of receiving the final reconciliation from Agency.

For the January – June 2021 contract period, the capitation rates have been determined to be actuarially sound by an actuary that meets the qualifications and standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board.

The MCO may provide services to enrollees that are in addition to those covered under the State plan although, the cost of these services cannot be included when determining rates or risk corridor.

Revision 13: Special Contract Attachment 2.7 entitled "Attachment 2.7 Medical Loss Ratio" is amended by revising the last sentence to read as follows:

> Notwithstanding the above, for a period beginning July 1, 2020 through June 30, 2021 the minimum medical loss ratio (MLR) will be 89%.

Revision 14. The document attached to this Amendment as Exhibit 1 is hereby incorporated into the Contract as Special Contract Attachment 3.2-03.

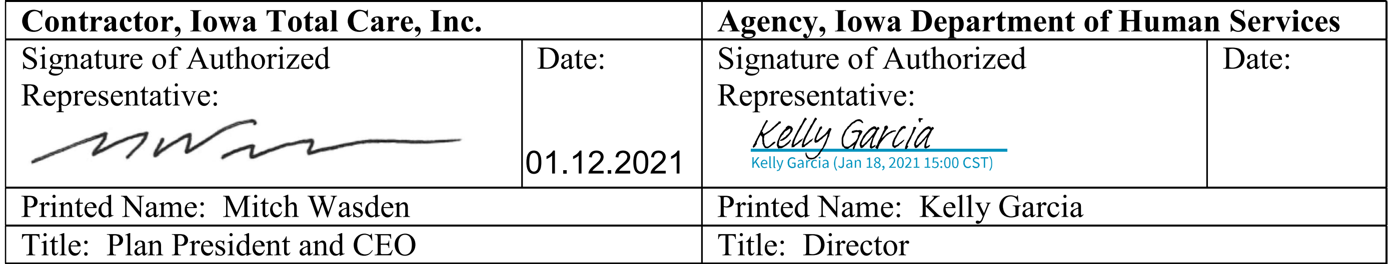
Revision 15. Federal Funds. The following federal funds information is provided:

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: 01.12.2021	Signature of Authorized Representative: Kelly Garcia Kelly Garcia (Jan 18, 2021 15:00 CST)	Date:
Printed Name: Mitch Wasden		Printed Name: Kelly Garcia	
Title: Plan President and CEO		Title: Director	

Exhibit 1

Special Contract Attachment 3.2-03

	Iowa Total Care Rates, Net Withhold								
Rate Cell	**CY19 Proxy MMs**	**SFY21b Rates Net Additional Payments**	**Withhold PMPM**	**SFY21b Rates Net Withhold, Net Additional Payments**	**GME PMPM**	**ACR PMPM**	**GEMT PMPM**	**NF CRR PMPM**	**SFY21b Rates, Net Withhold Gross Additional Payments**
Children 0-59 days M&F	24,001	$ 2,225.84	$ 44.52	$ 2,181.32	$ 5.28	$ 217.32	$ 4.27	$ -	$ 2,408.19
Children 60-364 days M&F	92,450	$ 311.56	$ 6.23	$ 305.32	$ 5.28	$ 34.96	$ 1.42	$ -	$ 346.98
Children 1-4 M&F	294,566	$ 153.28	$ 3.07	$ 150.21	$ 5.28	$ 7.98	$ 0.77	$ -	$ 164.24
Children 5-14 M&F	605,647	$ 159.58	$ 3.19	$ 156.39	$ 5.28	$ 5.41	$ 0.46	$ -	$ 167.54
Children 15-20 F	102,703	$ 262.89	$ 5.26	$ 257.63	$ 5.28	$ 8.74	$ 2.29	$ -	$ 273.93
Children 15-20 M	95,041	$ 206.42	$ 4.13	$ 202.29	$ 5.28	$ 5.40	$ 1.53	$ -	$ 214.50
CHIP - Hawk-i	208,401	$ 155.33	$ 3.11	$ 152.23	$ -	$ -	$ 0.34	$ -	$ 152.57
Non-Expansion Adults 21-34 F	141,222	$ 403.48	$ 8.07	$ 395.41	$ 5.28	$ 12.09	$ 3.74	$ -	$ 416.52
Non-Expansion Adults 21-34 M	30,609	$ 242.64	$ 4.85	$ 237.79	$ 5.28	$ 5.71	$ 2.46	$ -	$ 251.23
Non-Expansion Adults 35-49 F	79,511	$ 586.84	$ 11.74	$ 575.11	$ 5.28	$ 15.41	$ 4.16	$ -	$ 599.96
Non-Expansion Adults 35-49 M	32,124	$ 421.25	$ 8.43	$ 412.83	$ 5.28	$ 12.13	$ 2.89	$ -	$ 433.13

Non-Expansion Adults 50+ M&F	15,339	$ 730.46	$ 14.61	$ 715.85	$ 5.28	$ 13.76	$ 4.30	$ -	$ 739.19
Pregnant Women	34,789	$ 396.82	$ 7.94	$ 388.88	$ 5.28	$ 28.81	$ 3.60	$ -	$ 426.58
WP 19-24 F (Medically Exempt)	4,082	$ 795.50	$ 15.91	$ 779.59	$ -	$ 15.16	$ 13.59	$ -	$ 808.35
WP 19-24 M (Medically Exempt)	3,530	$ 902.57	$ 18.05	$ 884.52	$ -	$ 12.55	$ 8.69	$ -	$ 905.76
WP 25-34 F (Medically Exempt)	11,920	$ 981.46	$ 19.63	$ 961.83	$ -	$ 17.42	$ 11.80	$ -	$ 991.05
WP 25-34 M (Medically Exempt)	12,146	$ 969.25	$ 19.38	$ 949.86	$ -	$ 21.40	$ 17.52	$ -	$ 988.79
WP 35-49 F (Medically Exempt)	17,772	$ 1,312.44	$ 26.25	$ 1,286.19	$ -	$ 31.69	$ 14.47	$ -	$ 1,332.36
WP 35-49 M (Medically Exempt)	16,236	$ 1,165.57	$ 23.31	$ 1,142.26	$ -	$ 28.45	$ 19.50	$ -	$ 1,190.22
WP 50+ M&F (Medically Exempt)	24,392	$ 1,575.95	$ 31.52	$ 1,544.43	$ -	$ 38.31	$ 18.93	$ -	$ 1,601.67
WP 19-24 F (Non-Medically Exempt)	96,350	$ 241.84	$ 4.84	$ 237.00	$ -	$ 7.99	$ 2.29	$ -	$ 247.28
WP 19-24 M (Non-Medically Exempt)	82,426	$ 189.11	$ 3.78	$ 185.33	$ -	$ 5.79	$ 2.53	$ -	$ 193.65
WP 25-34 F (Non-Medically Exempt)	110,052	$ 317.94	$ 6.36	$ 311.58	$ -	$ 9.16	$ 2.34	$ -	$ 323.07
WP 25-34 M (Non-Medically Exempt)	98,648	$ 286.95	$ 5.74	$ 281.21	$ -	$ 9.84	$ 3.87	$ -	$ 294.92
WP 35-49 F (Non-Medically Exempt)	106,870	$ 520.46	$ 10.41	$ 510.05	$ -	$ 14.88	$ 3.36	$ -	$ 528.29
WP 35-49 M (Non-Medically Exempt)	101,627	$ 474.79	$ 9.50	$ 465.29	$ -	$ 13.90	$ 4.89	$ -	$ 484.08
WP 50+ M&F (Non-Medically Exempt)	175,113	$ 843.63	$ 16.87	$ 826.75	$ -	$ 20.68	$ 4.82	$ -	$ 852.25
ABD Non-Dual <21 M&F	39,711	$ 927.29	$ 18.55	$ 908.74	$ 5.28	$ 54.85	$ 3.98	$ -	$ 972.86
ABD Non-Dual 21+ M&F	92,818	$ 1,693.49	$ 33.87	$ 1,659.62	$ 5.28	$ 37.62	$ 17.58	$ -	$ 1,720.10

Residential Care Facility	1,482	$ 4,139.36	$ 82.79	$ 4,056.58	$ 5.28	$ 34.77	$ 7.65	$ -	$ 4,104.27
Breast and Cervical Cancer	743	$ 2,144.05	$ 42.88	$ 2,101.17	$ -	$ 66.11	$ 0.91	$ -	$ 2,168.19
Dual Eligible 0-64 M&F	125,436	$ 503.91	$ 10.08	$ 493.83	$ -	$ -	$ 1.01	$ -	$ 494.84
Dual Eligible 65+ M&F	39,325	$ 210.10	$ 4.20	$ 205.90	$ -	$ -	$ 0.86	$ -	$ 206.76
Custodial Care Nursing Facility <65	8,396	$ 4,403.04	$ 88.06	$ 4,314.98	$ 5.28	$ 36.26	$ 8.51	$ 7.47	$ 4,372.51
Custodial Care Nursing Facility 65+	54,273	$ 3,461.33	$ 69.23	$ 3,392.10	$ -	$ -	$ 0.92	$ 7.47	$ 3,400.49
Elderly HCBS Waiver	37,754	$ 3,461.33	$ 69.23	$ 3,392.10	$ -	$ -	$ 2.67	$ -	$ 3,394.77
Non-Dual Skilled Nursing Facility	796	$ 4,403.04	$ 88.06	$ 4,314.98	$ 5.28	$ 52.55	$ 19.14	$ 7.47	$ 4,399.42
Dual HCBS Waivers: PD; H&D	6,341	$ 4,403.04	$ 88.06	$ 4,314.98	$ -	$ -	$ 2.90	$ -	$ 4,317.88
Non-Dual HCBS Waivers: PD; H&D; AIDS	5,645	$ 4,403.04	$ 88.06	$ 4,314.98	$ 5.28	$ 72.61	$ 14.30	$ -	$ 4,407.16
Brain Injury HCBS Waiver	6,241	$ 4,403.04	$ 88.06	$ 4,314.98	$ 5.28	$ 49.38	$ 5.20	$ -	$ 4,374.84
ICF/ID	5,852	$ 6,584.68	$ 131.69	$ 6,452.99	$ 5.28	$ 15.03	$ 2.12	$ -	$ 6,475.41
State Resource Center	1,680	$ 6,584.68	$ 131.69	$ 6,452.99	$ 5.28	$ 0.47	$ 0.41	$ -	$ 6,459.15
Intellectual Disability HCBS Waiver	54,164	$ 6,584.68	$ 131.69	$ 6,452.99	$ 5.28	$ 17.01	$ 2.51	$ -	$ 6,477.78
PMIC	1,395	$ 2,904.48	$ 58.09	$ 2,846.39	$ 5.28	$ 14.23	$ 8.89	$ -	$ 2,874.79
Children's Mental Health HCBS Waiver	3,223	$ 2,904.48	$ 58.09	$ 2,846.39	$ 5.28	$ 12.07	$ 4.52	$ -	$ 2,868.26
CHIP - Children 0-59 days M&F	191	$ 2,225.84	$ 44.52	$ 2,181.32	$ -	$ -	$ -	$ -	$ 2,181.32
CHIP - Children 60-364 days M&F	1,076	$ 311.56	$ 6.23	$ 305.32	$ -	$ -	$ 0.31	$ -	$ 305.63

CHIP - Children 1-4 M&F	2	$ 153.28	$ 3.07	$ 150.21	$ -	$ -	$ -	$ -	$ 150.21
CHIP - Children 5-14 M&F	61,681	$ 159.58	$ 3.19	$ 156.39	$ -	$ -	$ 0.38	$ -	$ 156.77
CHIP - Children 15-20 F	9,536	$ 262.89	$ 5.26	$ 257.63	$ -	$ -	$ 1.24	$ -	$ 258.86
CHIP - Children 15-20 M	9,687	$ 206.42	$ 4.13	$ 202.29	$ -	$ -	$ 1.29	$ -	$ 203.58
TANF Maternity Case Rate	3,257	$ 6,527.16	$ 130.54	$ 6,396.62	$ -	$ -	$ -	$ -	$ 6,396.62
Pregnant Women Maternity Case Rate	3,081	$ 5,734.87	$ 114.70	$ 5,620.17	$ -	$ -	$ -	$ -	$ 5,620.17
Total	**3,185,014**	**$ 660.33**	**$ 13.21**	**$ 647.13**	**$ 2.93**	**$ 12.71**	**$ 2.89**	**$ 0.15**	**$ 665.81**