First Amendment to the Iowa Health Link Contract

This Amendment to Contract Number MED-16-020 is effective as of January 1, 2016, between the Iowa Department of Human Services (Agency) and UnitedHealthcare Plan of the River Valley Inc. (Contractor).

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

Revision 1. The "Start Date" Contract Information on the Contract Declarations and Executions page is modified to read as follows:

Start Date: 4/1/2016.

Revision 2. The "End Date of Base Term of Contract" and "End Date of Contract" in Contract Information on the Contract Declarations and Executions page is modified to read as follows:

End Date of Base Term of Contract: 3/31/2019
End Date of Contract: DELETE

Revision 3. The "Possible Extension(s)" in Contract Information on the Contract Declarations and Executions page is modified to read as follows:

Possible Extension(s): This Contract may be extended for two (2) additional two-year terms.

Revision 4. Section 1.3.3.1 of the Special Terms of the Contract is modified 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 to begin providing managed care services to its assigned Medicaid population on March 1, 2016. However, if the implementation date is delayed for any reason, Contractor shall not be entitled to payments pursuant to this Contract until Contractor begins providing managed care services for its patient population consistent with the Scope of Work as set forth in this Contract. The Agency has sole discretion to determine the implementation date.

For each capitated rate period, the parties will agree on a matrix specifying the payment for each enrollee by the categories determined by the Agency to be appropriate. These categories will be determined by the Agency. Nothing in this Contract shall limit the ability of the Agency to require the determination of a state-wide average even if the Contractor is not providing services

for members in all counties in the State. The rate-setting methodology will be in compliance with federal requirements and approved by CMS before the parties may contractually agree to the established rates.

For the initial rate period spanning from April 1, 2016 to June 30, 2017, the parties agree to the rates set forth in Special Contract Attachment 3.2-01. Note, the capitation rates shown in the Attachment will be subject to risk adjustment as outlined in Appendix 1 Section 2.3.3 Risk Adjustment. In each subsequent rate period, the Agency's actuarial contractor will analyze data to determine actuarially sound rates to be offered to Contractor. The Agency and Contractor may discuss proposed capitation rates, but the Agency's actuarial contractor will ultimately be responsible for establishing the actuarially-sound rates to be offered and attesting to the capitation rates to be presented to CMS. Following CMS approval of the final rates, the Agency will present the approved capitation rates to the Contractor in Contract Amendment form. After the first rate period, subsequent capitated rates will be added to the Contract in sequentially numbered Special Contract Attachments (i.e., Attachment 3.2-02, Attachment 3.2-03, etc.). Contractor and the Agency must mutually agree to the capitation rates and signify this agreement by executing the Contract amendment. Capitation rates within any rate period are subject to amendment, which shall only occur through formal Contract amendment and only after the proposed rate changes have been approved by CMS.

The parties agree to work diligently and in good faith to establish and agree to capitation rates before the expiration of any rate period. If the parties are unable to establish new capitation rates for a subsequent rate period due to delays or disagreements, the Agency will either terminate the Contract or continue paying Contractor based on the last rates from the then expired rate period until such time as the newly established capitation rates are incorporated into the Contract. Upon agreement to the capitation rates, the Agency will perform a reconciliation between the capitation rates paid and the newly agreed upon rates for the rate period. Any discrepancy will be reconciled through the capitation rate payment process.

By agreeing to the rates offered to Contractor through the Contract amendment process, Contractor irrevocably and unconditionally releases, acquits, and forever discharges the State of Iowa, the Agency, and all of the Contractor'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 forty-five (45) 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 forty-five (45) 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 120 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.

Revision 5. Section 1.3.3.2 of the Special Terms of the Contract is modified to read as follows:

The Agency will make capitated payments to the Plan as early in the month as possible, but no later than the 10th Day of each month. The Agency will pay all other approved invoices in conformance with Contract Section 1.3.3.6.

Revision 6. Section 1.3.3.3 of the Special Terms of the Contract is modified to read as follows:

1.3.3.3 Pass Through Payments.
To the extent that the Agency includes pass through payments in capitated payments, including but not limited to GME payments, the Plan will shall comply with Agency policy and process regarding distribution of such pass through 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 will 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.

Revision 7. Section 2.5.5 2 of the Contract's Special Terms Appendix 1 -- Scope of Work is hereby removed from the contract and shall be indicated as "Reserved".

Revision 8. The paragraph under Section 2.5 of the General Terms for Services Contracts, which begins "The provisions for termination stated in this Section 2.5…," is modified to read as noted below. All subsections under Section 2.5 remain unchanged.

2.5 *Termination.*

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

Revision 9. Subsection 3.1.1.2 of the Contract's Special Terms Appendix 1 -- Scope of Work, is modified to read as noted below

3.1.1.2 *Excluded Populations*

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

Revision 10. Subsection 3.1.1.3 of the Contract's Special Terms Appendix 1 -- Scope of Work, is modified to read as noted below

3.1.1.3 *Excluded Services*

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

Revision 11. Subsection 3.2.5 of the Contract's Special Terms Appendix 1 -- Scope of Work, is modified to read as noted below. All subsections under 3.2.5 remain unchanged.

3.2.5 *Emergency Services*

Emergency services shall be available twenty-four (24) hours a day, seven (7) days a week. In accordance with 42 C.F.R. § 438.114, the Contractor shall cover emergency services without the need for prior authorization and may not limit reimbursement to in-network providers. Contractor shall cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with Contractor. Contractor shall pay non-contracted providers for emergency services at the amount that would have been paid if the service had been provided under the State's fee-for-service Medicaid program. The Contractor shall cover the medical screening examination, as defined by the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations, provided to a member who presents to an emergency department with an emergency medical condition. The Contractor may not deny payment for treatment obtained under either of the following circumstances: (i) the member had an emergency medical condition, defined as a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part. This includes cases in which the absence of immediate medical attention would not have resulted in such impairment or dysfunction; or (ii) a representative of the Contractor instructs the member to seek emergency services.

Contractor shall not deny payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. Contractor shall not deny payment for treatment obtained when a representative of Contractor instructs the enrollee to seek Emergency Medical Services.

Revision 12. Subsection 3.2.6.9.1 of the Contract's Special Terms Appendix 1 -- Scope of Work, is modified to read as follows:

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

Revision 13. Subsection 3.2.6.9.2 of the Contract's Special Terms Appendix 1 -- Scope of Work, is modified to read as follows:

3.2.6.9.2 Dispensing Fee:

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

Revision 14. Subsection 3.2.8.5 of the Contract's Special Terms Appendix 1 -- Scope of Work, is modified to read as follows:

3.2.8.5 Scope of Covered Mental Health Services

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

(i) Outpatient therapy provided by a licensed qualified provider including family therapy and in-home family therapy as medically necessary to address the needs of the child or other members in the family;
(ii) Medication management provided by a professional licensed to prescribe medication;
(iii) In-patient hospital psychiatric services including, except as limited, services in the state mental health institutes;
(iv) Services that meet the concurrent substance use disorder and mental health needs of individuals with co-occurring condition;
(v) Community-based and facility based sub-acute services;
(vi) Crisis Services including, but not limited to:
a. 24 hour crisis response;
b. Mobile crisis services;
c. Crisis assessment and evaluation;
d. Non-hospital facility based crisis services;
e. Twenty-three (23) hour observation in a twenty-four (24) hour treatment facility;
(vii) Care consultation by a psychiatric physician to a non-psychiatric physician;
(viii) Integrated health home mental health services and supports;
(ix) Intensive psychiatric rehabilitation services;
(x) Peer support services for persons with serious mental illness;
(xi) Community support services including, but not limited to:
a. Monitoring of mental health symptoms and functioning/reality orientation,
b. Transporting to and from behavioral health services and placements,
c. Establishing and building supportive relationship,
d. Communicating with other providers,
e. Ensuring member attends appointments and obtains medications, crisis intervention and developing a crisis plan, and
f. Developing and coordinating natural support systems for mental health support;
(xii) Habilitation program services;
(xiii) Children's mental health waiver services;
(xiv) Stabilization services;
(xv) In-home behavioral management services;
(xvi) Behavioral interventions with child and with family including behavioral health intervention services (BHIS) and both Medicaid and non-Medicaid funded applied behavior analysis (ABA) services for children with autism; and
(xvii) Psychiatric Medical Institutions for Children (PMIC).

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

Revision 15. Subsection 3.2.11.2.2 of the Contract's Special Terms Appendix 1 -- Scope of Work, is modified to read as noted below.

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 average aggregate limits established in each 1915(i) Habilitation Program and 1915(c) Children's Mental Health Waiver. 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 not perform needs-based eligibility reassessments more frequently than annually or as 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 and/or waiver budget caps.

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

In any Work Plan required by Section 2.13, the Contractor shall develop policies and procedures

(a) identifying a timeline in which all needs assessments shall be completed: (i) upon initial enrollment with the Contractor; and (ii) when the Contractor becomes aware of a change in the member's circumstances which necessitates a new assessment;

(b)providing that reassessments shall be conducted, at least every twelve (12) months; and

(c) identifying a mechanism for completing needs assessments in an appropriate and timely manner.

Revision 16. Subsection 4.2.2.2 of the Contract's Special Terms Appendix 1 -- Scope of Work, is modified to read as noted below.

4.2.2.2 *Initial Assessment and Annual Support Assessment*

The Contractor shall ensure level of care and assessment for members potentially eligible for 1915(c) HCBS waiver enrollment shall 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

limits established in each 1915(c) HCBS waiver. 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 not perform needs-based eligibility reassessments more frequently than annually or as 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 residing in a nursing facility or ICF/ID or 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 and/or waiver budget caps.

In any Work Plan required by Section 2.13, the Contractor shall develop and implement the mechanism in which the needs assessments shall be administered in a conflict free manner consistent with BIP requirements. The Contractor shall include in that mechanism a timeline in which all needs assessments shall be completed: (i) upon initial enrollment with the Contractor; and (ii) when the Contractor becomes aware of a change in the member's circumstances which necessitates a new assessment. The Contractor shall conduct reassessments at least every twelve (12) months.

Revision 17. Subsection 4.3.12.7 of the Contract's Special Terms Appendix 1 -- Scope of Work, is hereby removed from the contract and shall be indicated as "Reserved".

Revision 18. Subsection 6.1.2 of the Contract's Special Terms Appendix 1 -- Scope of Work, is modified to read as noted below. All subsections under Section 6.1.2 remain unchanged.

6.1.2 *Provider Agreements*

In accordance with 42 C.F.R. § 438.206, the Contractor shall establish written agreements with all network providers. Contractors shall obtain Agency approval of all template provider agreements. The Contractor shall identify and incorporate the applicable terms of its Contract with the Agency and any incorporated documents in the Contractor's provider agreements. Under the terms of the provider agreement, the provider must agree that all applicable terms and conditions set out in the Contract, the Contract, any incorporated documents and all applicable State and Federal laws, as amended, govern the duties and responsibilities of the provider with regard to the provision of services to members.

The Contractor shall also include in all of its provider agreements provisions to ensure continuation of benefits. The Contractor shall include in its agreement that all providers enrolled with the Contractor must first enroll with Iowa Medicaid. 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 its total assigned population in a value based purchasing (VBP) arrangement with the healthcare delivery system by calendar year 2018. The VBP arrangement shall recognize population health outcome improvement as measured through the VIS combined with a decrease in total cost of care for the population in the VBP arrangement. Driving population health through delivery system reform under VBP means that providers need a clear understanding of the specific lives for which they are accountable. As such, any members that are part of a VBP must be assigned by the Contractor to a designated primary care provider (PCP). This PCP information shall be immediately reported by the Contractor for use in system wide coordination enhancements as specified by the Agency, such as provider alerts through the Iowa Health Information Network (IHIN); the Contractor shall also require that all contracted hospitals report admission and discharge information to support this exchange and coordination. Contractors shall use the State-wide Alert Notification (SWAN) system, or other processes as approved by the Agency, to satisfy hospital inpatient reporting requirements for Medicaid members. The Contractor shall use the SWAN system, or other Agency approved tool, to provide a consistent, real-time notification platform for hospitals to uniformly report inpatient and ED events for Medicaid members to the Contractor and care teams participating in VBP agreement. The Contractor shall notify the Agency of any risk sharing agreements it has arranged with a provider and require in the provider agreement for any providers who are paid on a capitated basis the submission of encounter data within ninety (90) days of the date of service. As applicable, the provider agreements shall comply with the requirements set forth for subcontracts as outlined in Section 2.2 and in accordance with 42 C.F.R. § 434.6. The Contractor shall maintain all provider agreements in accordance with the provisions specified in 42 C.F.R. § 438.12, 438.214 and this Contract. The Agency reserves the right to direct the Contractor to terminate or modify any provider agreement when the Agency determines it to be in the best interest of the State.

Revision 19. Subsection 6.2.2.7 of the Contract's Special Terms Appendix 1 -- Scope of Work, is modified to read as follows:

6.2.2.7 For all provider types, not described in Section 6.2.2.6, in developing the provider network during the first six (6) months of the Contract, the Contractor shall extend contract offers, at minimum, at the current Agency defined Iowa Medicaid floor. During and after this six month time period, for in-network providers the Contractor shall reimburse these provider types at a rate that is equal to or exceeds the current Agency defined Iowa Medicaid floor, or as otherwise mutually agreed upon by the Contractor and the provider. Pharmacy providers shall be reimbursed in accordance with Section 3.2.6.9.1.1;

Revision 20. Subsection 6.2.4 of the Contract's Special Terms Appendix 1 -- Scope of Work, is modified to read as noted below. With the exception of the subsection noted in Revision 14, all subsections under Subsection 6.2.4 remain unchanged.

6.2.4 *Out of Network Providers*

With the exception of family planning, emergency services and continuity of care requirements described in Section 3.3, once the Contractor has met the network adequacy standards set forth in Exhibit B, the Contractor may require all of its members to seek covered services from in-network providers. Prior to closing its network, the Contractor shall seek the Agency approval. The Agency retains sole authority for determining if network access standards have been met and whether the network may be closed. If the Contractor is unable to provide medically necessary covered services to a particular member using contract providers, the Contractor shall adequately and timely cover these services for that member using non-contract providers for as long as the Contractor's provider network is unable to provide them.

For services delivered on or after April 1, 2016, the Contractor shall negotiate and execute written single-case agreements or arrangements with non-network providers, when necessary, to ensure access to covered services. With the exception of single case agreements and other arrangements established with non-network providers, out-of-network providers shall coordinate with the Contractor with respect to payment at 90% of the rate of reimbursement to in-network providers.

The Contractor shall ensure that no provider bills a member for all or any part of the cost of a treatment service, except as allowed for Title XIX cost sharing and patient liability as further described in Section 5. The Contractor shall coordinate payment with out-of-network providers and ensure that the cost to the enrollee is no greater than it would be if services were provided within the network.

Revision 21. Subsection 6.2.4.1.1 of the Contract's Special Terms Appendix 1 -- Scope of Work, is modified to read as follows:

6.2.4.1.1 The ordered service requires prior authorization AND the service will be delivered on or after April 1, 2016;

Revision 22. Subsection 11.2.1.1 is added as a new subsection to the Contract's Special Terms Appendix 1 – Scope of Work, with the following language:

11.2.1.1 For services provided before April 1, 2016, the Contractor shall not deny payment for services lacking a prior authorization except as otherwise directed by the Agency. Within 90 days of claim payment, the Contractor shall perform retrospective review of claims for services normally requiring a prior authorization in a manner approved by the Agency. The Contractor shall report the number and outcome of these reviews to the Agency each month for the first 180 days of the Contract. The Contractor shall adhere to claims payment parameters set forth in Section 13.4.6 of the Contract and shall not suspend payments for review prior to adjudication except as otherwise directed by the Agency. If it is determined during retrospective review that claims were paid for services not medically necessary, the Contractor may recover payments from the provider. For services provided on or after April 1, 2016, the Contractor shall implement Agency-approved policies and procedures in accordance with 11.2.1.

Revision 23. Subsection 13.4.1 of the Contract's Special Terms Appendix 1 -- Scope of Work, is modified to read as 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 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 180 days from the date of service.

Revision 24. Subsection 13.4.6 of the Contract's Special Terms Appendix 1 -- Scope of Work, is modified to read as follows:

13.4.6 *Claims Payment Timeliness*

The Contractor shall pay providers for covered medically necessary services rendered to the Contractor's members in accordance with Law. The Contractor shall pay or deny ninety percent (90%) of all clean claims within fourteen (14) calendar days of receipt, ninety-nine point five percent (99.5%) of all clean claims within twenty-one (21) calendar days of receipt and one hundred percent (100%) of all claims within ninety (90) calendar days of receipt. A "clean claim" is one in which all information required for processing is present. If a claim is denied because more information was required to process the claim, the claim denial notice shall specifically describe all information and supporting documentation needed to evaluate the claim for processing. As provided in 42 C.F.R. § 447.46(c)(2), the Contractor may, by mutual agreement, establish an alternative payment schedule with in-network providers. The alternative payment schedule shall be outlined in the provider contract. In accordance with 42 C.F.R. §447.45(d), the date of receipt of a claim is the date the Contractor receives the claim, as indicated by its date stamp on the claim, and the date of payment is the date of the check or other form of payment. In compliance with Section 6.3.13.4 and Section 5006(d) of the American Recovery and Reinvestment Act of 2009, Contractor shall meet the requirements of timely payment for all Indian Tribe, Tribal Organization, or Urban Indian Organization ("I/T/U") providers in its network, including the paying of 90% of all I/T/U clean claims from such practitioners (i.e., those who are in individual or group practice or who practice in shared health facilities) within 30 days of the date of receipt; and paying 99% of all clean claims from such

practitioners (who are in individual or group practice or who practice in shared health facilities) within 90 days of the date of receipt.

Revision 25. The Contract Attachment 2.7, Medical Loss Ratio, is modified to read as follows:

Coverage Year. The Coverage Year will initially be considered an fifteen (15) month period followed by subsequent twelve (12) month periods. The Medical Loss Ratio Calculation shall be prepared using all data available from the Coverage Year, including IBNP and six (6) months of run-out for Benefit Expense.

Revision 26. The Contract Attachment 3.2-01, is modified to read as follows:

See Attached document.

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.

UnitedHealthcare Plan of the River Valley Inc.
Signature of Authorized Representative:
Date: 7/21/2016
Printed Name: Kimberly Stoltz
Title: CEO

Iowa Department of Human Services
Signature of Authorized Representative:
Date: 7/21/2016
Printed Name: Charles Palmer
Title: Director

Iowa Department of Public Health
Signature of Authorized Representative:
Date:
Printed Name: Kathy Stone
Title: Director, Division of Behavioral Services