Seventh Amendment to the Iowa Health Link Contract MED-16-020

This Seventh Amendment to Contract Number MED-16-020 between the Iowa Department of Human Services (Agency) and UnitedHealthcare Plan of the River Valley, Inc. (Contractor) is hereby amended as set forth below. To the extent that there is a conflict between any provision of this Seventh Amendment and the Contract or previous amendments, this Seventh Amendment shall control. This Seventh Amendment is effective as of July 1, 2018.

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

Revision 1. Section 1.3.3.1 of the Special Terms is hereby amended to read as follows:

1.3.3.1. Pricing In accordance with the payment terms outlined in this section and the Contractor's completion of the Scope of Work as set forth in this Contract, the Agency will make capitation payments to the Contractor on a monthly basis or upon occurrence of a qualifying maternity delivery. The capitation payments include both per member per month capitation rates and maternity case rate payments. The capitation payments and any Case rate shall be payment in full for goods and services provided pursuant to this Contract. Retroactive adjustments to reflect the actual cost of goods and services provided pursuant to the Contract are prohibited.

The parties anticipate Contractor 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. After the first rate period, subsequent capitated rates will be added to the Contract in sequentially numbered Special Contract Attachments (i.e., Attachment 3.2-02, Attachment 3.2-03, etc.). Contractor and the Agency must mutually agree to the capitation rates and signify this agreement by executing the Contract amendment. Capitation rates within any rate period are subject to amendment, which shall only occur through formal Contract amendment and only after the proposed rate changes have been approved by CMS.

The parties agree to work diligently and in good faith to establish and agree to capitation rates before the expiration of any rate period. If the parties are unable to establish new annual capitation rates for a subsequent rate period due to delays or disagreements, the Agency or Contractor may terminate the Contract upon ninety (90) days written notice from expiration of the current rate period and contract amendment term or, if notice is given after the expiration of the current rate period, ninety (90) days written notice from the date of the notice. Upon agreement to the capitation rates, the Agency will perform a reconciliation between the capitation rates paid and the newly agreed upon rates for the rate period. Any discrepancy will be reconciled through the capitation rate payment process.

Based on emerging experience or updated programs, the Agency may use discretion to review the capitation rates for the managed care program. The Agency agrees to collaboratively review the capitation rates mid-year with the Contractor. This agreement does not preclude the Agency's discretion to maintain the capitation rates at the amount agreed upon through the end of the Seventh Amendment. To ensure that all parties work expediently towards timely implementation of the cost interventions identified in the Agency's actuary rate certification for SFY19, all questions critical to implementation must be submitted by the Contractor to the Agency no later than 30 days prior to implementation of the specific Cost Intervention target date, and in the event changes to the capitation rates are required, such changes can only take effect through a formal Contract amendment..

By agreeing to the rates offered to Contractor through the Contract amendment process, Contractor irrevocably and unconditionally releases, acquits, and forever discharges the State of Iowa, the Agency, and all of the Agency's officers, directors, employees, agents, and attorneys, from any and all liability whatsoever from any and all claims, demands and causes of action of every nature whatsoever that Contractor may have or may ever claim to have now existing or hereafter arising that relate to or arise out of any assertion regarding the actuarial soundness of the agreed rates.

The Agency will make capitation payments to the Contractor based on the Contractor's Medicaid-member enrollment as reflected on the monthly HIPAA 834 file (full positive file). Contractor shall reconcile Contractor's HIPAA 820 capitation file with the monthly HIPAA 834 file (full positive file) on a monthly basis. Any discrepancies found between these two files shall be reported to the Agency within ninety (90) Days from the date the Contractor receives the HIPAA 820 capitation file. No adjustments to the capitation payment may be claimed by Contractor for any discrepancies reported after the ninety (90) Day period. The capitation payments will be subject to retroactive changes to the Medicaid-member eligibility criteria. This may include, but is not limited to, Medicaid-members moving from Medicaid-only eligibility to Medicare and Medicaid eligibility. The Agency will adjust payments to Contractor to reflect the Member enrollment changes.

In addition to the monthly capitation payment made to Contractor, the Agency will also make a payment to Contractor when a Medicaid member assigned to the Contractor gives birth and the member is in the population designated in the Contract's then current rate sheet as subject to a payment for giving birth. The amount of this payment, commonly referred to as a "maternity case rate payment," shall be in an amount established as part of the capitation rate-setting process and included in the rate matrix applicable to the given Contract period. The Contractor shall supply documentation of the birth in a form and format determined by the Agency. Upon verification by the Agency of the birth, the Agency shall cause the maternity case rate payment to be made separately and apart from the usual capitation payment for contracted services.

Contractor shall diligently monitor births in its assigned Medicaid population and claim a maternity case rate payment for each birth in the assigned Medicaid population for which a maternity case rate payment is available no later than 60 Days following the date on which the Contractor was made aware of the birth. The Agency shall have no obligation to pay a maternity case rate payment for a birth that occurred more than 210 Days prior to Contractor's claim for a maternity case rate payment.

The capitation rates will be subject to a withhold amount as shown in the capitation rate matrix. The withhold will be retained by the Agency until the period for determination of return of the withhold to the Contractor. The determination of the return of the withhold is outlined in Appendix 1 Exhibit F, Pay-for-Performance requirements.

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

For the rating period July 1, 2017 through June 30, 2018, the Agency will implement a risk pool for the Home Based Habilitation services (H2016 U4-U9) for the Habilitation program members that are not otherwise enrolled in an LTSS program. The Contractor will continue to manage the Habilitation program and authorize services as appropriate using practice guidelines. The Contractor will submit claims paid to providers for H2016 U4-U9 (non-LTSS members) on a quarterly basis to the Agency for reimbursement. The agency will reimburse the health plans at a rate of 75% of the Iowa Medicaid fee-for-service fee schedule amount for the submitted claims. The Agency will not reimburse the Contractor for claims submitted that are duplicate submissions, for members not eligible for the Habilitation program, or for other reasons that are consistent with correct coding standards.

A reconciliation process will occur upon completion of SFY 2018 to maintain budget neutrality of the habilitation services risk pool to the state. The final risk pool amount will be determined using SFY 2018 enrollment and the habilitation risk pool PMPMs specified in the contract. The habilitation risk pool PMPMs applied will be gross of the withhold; no withhold reduction will be applied. The final risk pool amount will be allocated to the MCOs proportionally based on the aggregated Iowa Medicaid fee-for-service fee schedule amount for the submitted and accepted habilitation claims. The reconciliation payment amount will calculated as the MCO-specific habilitation services risk pool amount minus the interim amounts paid to the MCO.

All habilitation services claims must be submitted to the state by February 1, 2019. The reconciliation amounts for each amount MCO will be calculated by March 1, 2019 and paid or recouped from the MCOs by April 1, 2019. The Agency and the Contractor will establish an agreed upon policy for claims submitted by providers for correction after January 1, 2019 for dates of service during SFY18.

Beginning in SFY2018, the Agency will exclude from the capitation rates the select prescriptions drugs as set forth in Exhibit G from the pharmacy and/or the medical benefits included in the capitation rates. Contractor shall continue to provide coverage for these Exhibit G pharmaceuticals, and the Agency will reimburse the Contractor based on Contractor's invoice to

the Agency for Exhibit G pharmaceuticals paid for. Contractor may only invoice for the actual pharmaceutical cost incurred by Contractor. All such invoices must be submitted by Contractor within 12 months of the date of service, with the exception of coordination of benefits situations, in which Contractor shall invoice for Exhibit G pharmaceuticals within six (6) months from the Contractor's receipt date of the claim and explanation of benefits from a primary carrier. The Agency will pay Contractor the lesser of the amount that would be paid under the fee-for-service system for the pharmaceutical or the amount the Contractor actually paid for the pharmaceutical. Contractor must include with the invoice detailed as required by the Agency to document that the claim was appropriately paid, as well as an attestation from the Contractor that authorization criteria and medication adherence management were applied appropriately.

Revision 2. Section 3.2.1 is hereby amended to read as follows:

The Contractor shall provide, at minimum, all benefits and services deemed medically necessary services that are covered under the Contract with the Agency in accordance with 42 C.F.R. § 438.210. In accordance with 42 C.F.R. § 438.210(a)(3), the Contractor shall furnish covered services in an amount, duration and scope reasonably expected to achieve the purpose for which the services are furnished. The Contractor may not arbitrarily deny or reduce the amount, duration and scope of a required service solely because of diagnosis, type of illness, or condition of the Member. The Contractor may place appropriate limits on a service on the basis of medical necessity criteria for the purpose of utilization control, provided the services can reasonably be expected to achieve their purpose. Further information on allowable and required utilization control measures is outlined in Section 11. The Contractor shall not avoid costs for services covered in the Contract by referring members to publicly supported health care resources. The Contractor shall ensure services are provided consistent with the United States Supreme Court's *Olmstead* decision and shall promote the Agency's goal of serving individuals in community integrated settings. The Contractor shall work collaboratively with mental health and disability services regions in supporting intensive residential service homes and Access Centers.

Revision 3. Section 3.2.8.11 is hereby amended to read as follows:

3.2.8.11 Court-Ordered Mental Health Services

The Contractor shall provide all covered and required mental health services ordered for members through a court action pursuant to chapter 125 or chapter 229 for a period of at least three days, regardless of medical necessity. Notwithstanding this provision, the Contractor may only end funding of court ordered services under chapter 125 or chapter 229 after giving the provider and the Agency and, as appropriate, the Juvenile Court Officer twenty-four (24) hour written notice of the Contractor's offer of adequate, available, and accessible mental health services and supports that can meet the member's needs in a lower level of care.

The Contractor shall fund all placements mandated by the court pursuant to Iowa Code chapter 812 (not competent to stand trial) or Iowa Rule of Criminal Procedure 2.22 (not guilty by reason of insanity for Medicaid enrollees except as limited by 3.2.8.13.2.

Revision 4. Section 3.2.8.12 is hereby amended to read as follows:

3.2.8.12 Court-Ordered Substance Use Disorder Services

The Contractor shall provide all substance use disorder services ordered for members through a court action, for a period of three days regardless of medical necessity, when: (i) except for

evaluations, the services ordered by the court meet the ASAM Criteria after the initial three days; (ii) the court offers treatment with a substance use disorder licensed program, and (iii) for IDPH Participants, the court orders treatment and it is provided by a network provider contracted to serve IDPH Participants. The Contractor shall work with the courts to examine the appropriateness of court-ordered placements and identify specific appropriate alternatives for the courts to consider. The Contractor has the right to establish policies that require providers of court-ordered substance use disorder services to provide notification and Documentation of court-ordered treatment.

Revision 5. Section 3.2.8.13 and subsections are hereby amended to read as follows:

3.2.8.13 Services at a State Mental Health Institute and other Institutions for Mental Disease

The Contractor shall authorize payment for inpatient treatment at state mental health institutes and other institutions for mental disease based on the member's age in accordance with the following:

3.2.8.13.1 For Members Age 21 and Under or 65 and Older
The Contractor shall authorize and pay for all inpatient treatment for members twenty-one (21) years of age and under or sixty-five (65) years of age and older at state mental health institutes that falls within the Agency approved Contractor's Utilization Management Guidelines. If the member is a resident of inpatient treatment on their 21st birthday, the Contractor shall authorize and pay for treatment until their 22nd birthday if medically necessary. The Contractor also shall implement policies to assure reimbursement for up to five (5) days, regardless of whether the Contractor's Utilization Management Guidelines are met, when a member age twenty-one (21) and under or age sixty-five (65) and older is court-ordered for an inpatient mental health evaluation at a state mental health institute. If a member's clinical condition falls within the Contractor's Utilization Management Guidelines for inpatient care, inpatient services shall be authorized as long as Guidelines are met. The Contractor may establish policies to limit reimbursement to no more than one (1) evaluation per inpatient episode.

3.2.8.13.2 For Members Over Age 21 and Under Age 65
Notwithstanding provisions of 3.2.8.13.1, the Contractor may pay for inpatient psychiatric treatment in an inpatient psychiatric hospital that is an institution for mental disease (IMD) for stays that are 15 days or less in a calendar month in lieu of similar services covered by the state plan for individuals between 22 and 65 years of age consistent with the provisions of 42 C.F.R. § 438.6(e). During the first 15 IMD member days, the member will remain enrolled in the Plan, and the Plan will continue to provide care coordination services and reimburse all covered services for the member. Contractor may utilize other services to assist the member and is not required to utilize the IMD psychiatric hospital except when constrained by court order. The member must be given the option to utilize other Medicaid services as opposed to the IMD psychiatric hospital except when constrained by court order.

3.2.8.13.3
For stays exceeding the 15 days in a calendar month as allowed under Section 3.2.8.13.2, the member will remain enrolled in the Plan and the Plan will continue to provide care coordination services and reimburse all covered services. The Plan must submit data related to IMD stays as outlined in the Reporting Manual

3.2.8.13.4

When the member is served in an IMD for 15 days or less in a calendar month pursuant to Section 3.2.8.13.2, the Contractor shall reimburse the IMD for the IMD member days using the current weighted average inpatient hospitalization rate, and the Contractor shall be entitled to the full capitation payment attributable to the member for that month.
For IMD stays that exceed the 15 member days permitted under Section 3.2.8.13.2, the Contractor will not reimburse the IMD for any of the IMD member days in that month, and Contractor shall be entitled to retain only the capitation payment associated with days the member did not spend in the IMD using an average daily value of monthly capitation paid for the member month.

Revision 6. Section 3.2.11.2.6 is hereby amended to the following.

3.2.11.2.6 Service Plan Development

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

Revision 7: Section 3.2.11.2.15 is hereby amended to read as follows:

3.2.11.2.15 Frequency of Care Coordination Contact

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

Revision 8. Section 3.3 is hereby amended to read as follows. All subsection under Section 3.3 remain unchanged:

The Contractor shall implement mechanisms to ensure the continuity of care of members transitioning in and out of the Contractor's enrollment pursuant to all requirements in 42 C.F.R. § 438.62. The Contractor must demonstrate the following components are implemented to ensure continuity of care during transitions:

(i) The member has access to services consistent with the access they previously had, and is permitted to retain their current provider for a period of time if that provider is not in the Contractor's network.
(ii) The member is referred to appropriate providers of services that are in the network.
(iii) The entity (Contractor or Agency) previously serving the member, fully and timely complies with requests for historical utilization data from the new entity in compliance with Federal and State law.
(iv) Consistent with Federal and State law, the member's new provider(s) are able to obtain copies of the member's medical records, as appropriate.
(v) Any other necessary procedures as specified by the Centers for Medicare and Medicaid Services to ensure continued access to services to prevent serious detriment to the member's health or reduce the risk of hospitalization or institutionalization.

Possible transitions include, but are not limited to: (i) initial program implementation; (ii) initial enrollment with the Contractor; (iii) transitions between program Contractors during the first

ninety (90) days of a member's enrollment; and (iii) at any time for cause as described in the Section 7.4.

Revision 9. Section 4.1 is hereby amended to read as follows:

The Contractor shall ensure that services are provided in a manner that facilitates maximum community placement and participation for members that require LTSS. The Contractor shall ensure services are provided consistent with the United States Supreme Court's *Olmstead* decision and shall promote the Agency's goal of serving individuals in community integrated settings. Funding decisions by the Contractor shall consider individual member choice and community-based alternatives within available resources to promote the Agency's goal of maximum community integration. The Contractor shall support and enhance person-centered care. When members reside in nursing facilities or ICF/IDs, those facilities are primarily responsible for the care and treatment of those individuals, and for addressing health and safety needs. Members residing in these facilities may receive additional care coordination and quality oversight from the Contractor. When members with health and long-term care needs live in their own homes or other community-based residential settings, the Contractor, in accordance with 42 C.F.R. § 438.208(c)(3)(i) – (v), shall, with the member's participation and in consultation with the member's provider(s), develop a person-centered care plan to address the member's care and treatment needs, providing assurances for health and safety, and proactively address potential risks related to members' desire to live as independently as possible. For members who require individualized, enhanced staffing patterns to support them in a less-restrictive setting, the Contractor shall not reduce the enhanced staffing arbitrarily or without supporting documentation.

Revision 10: Section 4.4.6 is hereby amended to the following:

4.4.6 Frequency of Community-Based Case Manager Contact

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

Revision 11. Section 6.1.3.3 is hereby amended to the following.

6.1.3.3 Timeliness

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

Revision 12. Section 6.1.1 is hereby amended to the following.

6.1.1 *Provider Network*

The Contractor shall provide all covered services specified in the Contract and as required by 42 C.F.R. § 438.206. In addition, per 42 C.F.R. § 438.207, the Contractor shall submit an electronic file of provider information to the Agency, in a format specified by the Agency, to demonstrate to the State that it, and that it offers an appropriate range of preventive, primary care, specialty services, and long term care services that is adequate for the anticipated number of enrollees for the service area (1) at the time it enters into the Contract with the Agency, and (2) any time there is a significant change (as defined by the Agency) in the Contractor's operations that impacts services. The Contractor shall: (i) adequately serve the expected enrollment; (ii) offer an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled; and (iii) maintain a sufficient number, mix and geographic distribution of providers in accordance with the general access standards set forth in Exhibit B. These minimum requirements shall not release the Contractor from the requirement to provide or arrange for the provision of any medically necessary covered service required by its members, whether specified above or not.

Revision 13. Section 6.2.3 is hereby amended to read as follows:

The Contractor shall document adequate network capacity at the time it enters into the Contract with the Agency, during the Agency's readiness review, at any time there is a significant change in the Contractor's operation or the program, changes in services, changes in benefits, changes in payments, enrollment of a new population, or as otherwise requested by the Agency. The Documentation of network adequacy shall be signed by the Contractor's Chief Executive Officer (CEO) and submitted at the required frequency and in the required format as determined by the Agency. Network adequacy is addressed through different performance indicators specified in the Contract that focus on specific time and distance measures and the provider number, mix and geographic distribution, including the general access standards set forth in Exhibit B and as designated in 42 CFR § 438.206. The Contractor shall provide the Agency written notice at least ninety (90) calendar days in advance of the Contractor's inability to maintain a sufficient network in any county.

(a)Delivery network. The Contractor shall meet the following requirements:

(1) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities.

(2) Provides female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.

(3) Provides for a second opinion from a network provider, or arranges for the member to obtain one outside the network, at no cost to the member.

(4) If the provider network is unable to provide necessary services, covered under the contract, to a particular member, the Contractor must adequately and timely cover these services out of network for the member, for as long as the Contractor's provider network is unable to provide them.

(5) The Contractor shall coordinate with out-of-network providers for payment and ensure the cost to the member is no greater than it would be if the services were furnished within the network.

(6) Demonstrate that its network providers are credentialed as required by 42 C.F.R. § 438.214.

(7) Demonstrate that its network includes sufficient family planning providers to ensure timely access to covered services.

(b)Furnishing of services. The Contractor shall comply with the following requirements.

(1)Timely access. The Contractor must do the following:

(i) Meet and require its network providers to meet Agency standards for timely access to care and services, taking into account the urgency of the need for services.

(ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid FFS, if the provider serves only Medicaid members.

(iii) Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.

(iv) Establish mechanisms to ensure compliance by network providers.

(v) Monitor network providers regularly to determine compliance.

(vi) Take corrective action if there is a failure to comply by a network provider.

(2)Access and cultural considerations. The Contractor shall participate in the Agency's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

(3)Accessibility considerations. The Contractor shall ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

(c)Nature of supporting documentation. The Contractor shall submit documentation to the State, in a format specified by the Agency, to demonstrate that it complies with the following requirements:

(1) Offers an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of enrollees for the service area.

(2) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

(d)Timing of documentation. The Contractor shall submit the documentation described in paragraph (c) of this section as specified by the Agency, but no less frequently than the following:

(1) At the time it enters into a contract with the Agency.

(2) On an annual basis.

(3) At any time there has been a significant change (as defined by the Agency) in the Contractor's operations that would affect the adequacy of capacity and services, including -

(i) Changes in the Contractor's services, benefits, geographic service area, composition of or payments to its provider network; or

(ii) Enrollment of a new population.

Revision 14. Section 6.2.4 is hereby amended to read as follows:

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 80% of the rate of reimbursement to in-network providers.

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

Revision 15. Section 13.4.7 is hereby amended to read as follows:

13.4.7 Claims Reprocessing and Adjustments

The Contractor shall adjudicate ninety percent (90%) of all clean provider-initiated adjustment requests within thirty (30) business days of receipt. The Contractor shall also reprocess all claims processed in error within thirty (30) business days of identification of the error or, in the event system configuration is necessary, upon a scheduled approved by the Agency. Except in cases in which system configuration is necessary, the start time begins when the Contractor identifies, or is made aware of the error, and has received all necessary information to validate the error;

identification of the error could be brought forward by a provider, the Agency, or internal Contractor staff. In the event the Contractor requests clarification from the Agency regarding a claims reprocessing project, the time for reprocessing will begin to run on the day the Contractor receives all information necessary to accurately reprocess the claims. The Contractor shall reprocess mass adjustments of claims upon a schedule approved by the Agency and the Contractor.

Revision 16. Section 13.1.1.19 is hereby amended to read as follows:

Provide encounter data to the Agency in a format specified by the Agency. Encounter data shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and privacy standards and shall be submitted with complete and accurate data that meets requirements for Agency submission of data to the Centers for Medicare and Medicaid Services' Medicaid Statistical Information System or successor system; and

Revision 17. Section 13.3.1.2 is hereby amended to read as follows:

13.3.1.2 Reconciliation Process

The Contractor shall reconcile member eligibility data and [1]capitation payments for each eligible member. The Contractor shall reconcile its eligibility and capitation records monthly. If the Contractor discovers a discrepancy in eligibility or capitation, the Contractor shall notify the Agency in accordance with the requirements at Section 12.12. The Contractor shall return any capitation or overpayments to the Agency within sixty (60) calendar days of discovering the discrepancy via procedures determined by the Agency. If the Contractor receives either enrollment information or capitation for a member, the Contractor is financially responsible for the member unless the Contractor has not received capitation for that member ninety (90) days following notification to the Agency that a capitation was not received. Nothing in this section prohibits the Contractor from recovering payments to providers, in accordance with Agency policy, for services rendered to members determined to be ineligible or for whom the Contractor has not received capitation.

Revision 18. Section 14.3.6 is hereby amended to read as follows:

14.3.6 *Member Grievances Report*

The Contractor shall resolve one hundred percent (100%) of grievances within thirty (30) calendar days of receipt, or within seventy-two (72) hours of receipt for expedited grievances. The Contractor shall maintain and report to the Agency a member grievance log, which shall include the current status of all grievances.

Revision 19. Exhibit F is amended by adding the following Table F3 at the end of Exhibit F:

TABLE F3: YEAR THREE PAY FOR PERFORMANCE MEASURES (SFY 2019)

With respect to each of the performance measures listed in Table F3 below, the parties agree to work diligently and in good faith to establish the specifications that will be used to determine whether a standard has been achieved by August 15, 2018.

[1] Amend. 3, Rev. 100.

Pay for Performance Tied to Medical Capitation Payments			
Performance Measure	**Required Contractual Standard**	**Standard Required to Receive Incentive Payment**	**Amount of 2% Medical Performance Withhold at Risk**
Encounter Data Correction	The Contractor shall have in place a system for monitoring and reporting the completeness of claims and encounter data received from providers. For every service provided, providers must submit corresponding claim or encounter data with claim detail identical to that required for fee-for-service claims submissions. The Contractor shall also have in place a system for verifying and ensuring that providers are not submitting claims or encounter data for services that were not provided. The Contractor shall demonstrate its internal standards for measuring completeness, the results of any completeness studies, and any corrective action plans developed to address areas of non-compliance. The Agency may require the Contractor to demonstrate, through report or audit, that this monitoring system is in place and that the Contractor is regularly monitoring the completeness of claims and encounter data and ensuring that the Contractor is meeting the Agency completeness requirements.	The Contractor shall achieve a +/- 2% reconciliation measurement between the encounters submitted to the Agency when compared to required quarterly financial reports.	

Pay for Performance Tied to Medical Capitation Payments			
Performance Measure	**Required Contractual Standard**	**Standard Required to Receive Incentive Payment**	**Amount of 2% Medical Performance Withhold at Risk**
Claims Reprocessing and Adjustments	The Contractor shall adjudicate ninety percent (90%) of all clean provider-initiated adjustment requests within thirty (30) business days of receipt. The Contractor shall also reprocess all claims processed in error within thirty (30) business days of identification of the error or, in the event system configuration is necessary, upon a scheduled approved by the Agency. Except in cases in which system configuration is necessary, the start time begins when the Contractor identifies, or is made aware of the error, and has received all necessary information to validate the error; identification of the error could be brought forward by a provider, the Agency, or internal Contractor staff. In the event the Contractor requests clarification from the Agency regarding a claims reprocessing project, the time for reprocessing will begin to run on the day the Contractor receives all information necessary to accurately reprocess the claims. The Contractor shall reprocess mass adjustments of claims upon a schedule approved by the Agency and the Contractor.	The Contractor shall adjudicate ninety-five percent (95%) of all clean provider-initiated adjustment requests within thirty (30) business days of receipt. The Contractor shall also reprocess all claims processed in error within thirty (30) business days of identification of the error or upon a scheduled approved by the Agency. Except in cases in which system configuration is necessary, the start time begins when the Contractor identifies, or is made aware of the error, and has received all necessary information to validate the error; identification of the error could be brought forward by a provider, the Agency, or internal Contractor staff. In the event the Contractor requests clarification from the Agency regarding a claims reprocessing project, the time for reprocessing will begin to run on the day the Contractor receives all information necessary to accurately reprocess the claims. The Contractor shall reprocess mass adjustments of claims upon a schedule approved by the Agency and the Contractor.	

Pay for Performance Tied to Medical Capitation Payments			
Performance Measure	**Required Contractual Standard**	**Standard Required to Receive Incentive Payment**	**Amount of 2% Medical Performance Withhold at Risk**
Home and Community Based Services Care Plan and Case Notes Audit	The Agency reserves the right to conduct an audit, or to utilize a subcontractor to conduct an audit, of 1915(c) HCBS waiver care plans and case notes to determine Contractor compliance with: (i) timely completion; (ii) care plan addressing the member's assessed health and safety risks, and personal goals; (iii) member signature on the care plan; (iv) all providers are listed on the care plan; (v) all funding sources are listed on the care plan; (vi) plan for supports available to the member in the event of an emergency are documented; (vii) provision of services as delineated in the care plan; (viii) discussion of advanced directives with members; (ix) percentage of new members starting ongoing services within the required timeframe; (x) member and/or guardian participation in care plan development; and (xi) number and percentage of in-person visits that were on time, late or missed.	Ninety-eight percent (98%) of care plans reviewed by the Agency shall meet the requirements for compliance with: (i) care plan addressing the member's assessed health and safety risks, and personal goals; (ii) member signature on the care plan; and (iii) plan for supports available to the member in the event of an emergency are documented.	

Pay for Performance Tied to Medical Capitation Payments			
Performance Measure	**Required Contractual Standard**	**Standard Required to Receive Incentive Payment**	**Amount of 2% Medical Performance Withhold at Risk**
Home and Community Based Services	The Agency intends to develop reports, baseline data and performance targets surrounding quality of life outcomes for members. Potential areas for measurement include but are not limited to: (i) increased life expectancy; (ii) number and percentage of members who gain and maintain competitive employment; (iii) number and percentage of members engaged in volunteer work; (iv) satisfaction; and (v) reduction in homelessness. The Agency may require the Contractor to conduct a member survey to measure key experience and quality of life indicators using best practices for reaching populations with special healthcare needs. The Agency will analyze the findings of the survey to identify required performance improvement activities, shall make the findings available to stakeholders and shall have the EQRO validate the findings.	Ninety percent (90%) of members surveyed using the Iowa Participant Experience Survey report that they feel they are a part of service planning. Sample size shall be approved by the Agency and met to qualify for incentive payment.	

Pay for Performance Tied to Medical Capitation Payments			
Performance Measure	**Required Contractual Standard**	**Standard Required to Receive Incentive Payment**	**Amount of 2% Medical Performance Withhold at Risk**
Employment	The Agency intends to develop reports, baseline data and performance targets surrounding quality of life outcomes for members. Potential areas for measurement include but are not limited to: (i) increased life expectancy; (ii) number and percentage of members who gain and maintain competitive employment; (iii) number and percentage of members engaged in volunteer work; (iv) satisfaction; and (v) reduction in homelessness. The Agency may require the Contractor to conduct a member survey to measure key experience and quality of life indicators using best practices for reaching populations with special healthcare needs. The Agency will analyze the findings of the survey to identify required performance improvement activities, shall make the findings available to stakeholders and shall have the EQRO validate the findings.	Contractor shall increase participation in employment activities for LTSS members by five percent (5%).	
Well Visits	The Agency intends to establish quarterly clinical reports and baseline rates to monitor healthcare services utilization and quality outcomes.	Contractor shall increase rate of Well Child Visits in the Third, Fourth, Fifth and Six years of life by five percent (5%).	

Pay for Performance Tied to Medical Capitation Payments			
Performance Measure	**Required Contractual Standard**	**Standard Required to Receive Incentive Payment**	**Amount of 2% Medical Performance Withhold at Risk**
Behavioral Health	The Agency intends to establish quarterly clinical reports and baseline rates to monitor healthcare services utilization and quality outcomes.	Contractor shall increase the rate of follow up after hospitalization for mental illness within seven (7) days by five percent (5%).	
Health Outcomes	The Agency intends to establish quarterly clinical reports and baseline rates to monitor healthcare services utilization and quality outcomes.	Contractor shall increase the rate of HbA1c testing by three percent (3%).	
Emergency Department Usage	The Agency intends to establish quarterly clinical reports and baseline rates to monitor healthcare services utilization and quality outcomes.	Contractor shall reduce the rate of use of the emergency department by five percent (5%).	

Revision 20. The document attached to this Seventh Amendment as Attachment 3.2-06 is hereby incorporated into the Contract by reference and replaces former Attachment 3.2-05.

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

Section 3: CMS Contingency.

This Amendment is contingent on the approval of CMS.

Section 4: 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, UnitedHealthcare Plan of the River Valley, Inc.		**Agency, Iowa Department of Human Services**	
Signature of Authorized Representative:	Date: 8/22/2018	Signature of Authorized Representative:	Date: 8-23-18
Printed Name: Bror Hultgren		Printed Name: Jerry Foxhoven	
Title: CEO		Title: Director	