# Third Amendment to the Iowa Health Link Contract

This Third Amendment to Contract Number MED-16-018 between the Iowa Department of Human Services (Agency) and Amerigroup Iowa, Inc. (Contractor) amends the Contract as set forth below. This Third Amendment is effective as of as of July 1, 2017.

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

**Revision 1.** The Contract Contract Declarations and Execution page of the contract is amended by adding the following detail concerning the Agency and the Contractor:

| **Agency of the State (hereafter "Agency")** | |
|---|---|
| **Name/Principal Address of Agency:**<br>Iowa Department of Human Services<br>1305 E. Walnut<br>Des Moines, IA 50319-0114 | **Agency Billing Contact Name / Address:**<br>Elizabeth Matney<br>100 Army Post Rd.<br>Des Moines, IA 50315<br>**Phone:** 515-974-3204 |
| **Agency Contract Manager (hereafter "Contract Manager" ) /Address ("Notice Address"):**<br>Elizabeth Matney<br>100 Army Post Rd.<br>Des Moines, IA 50315 | **Agency Contract Owner (hereafter "Contract Owner") / Address:**<br>Mikki Stier<br>100 Army Post Rd.<br>Des Moines, IA 50315 |
| **E-Mail:** ematney@dhs.state.ia.us | **E-Mail:** mstier@dhs.state.ia.us |
| **Phone:** 515-974-3204 | |

| **Contractor: (hereafter "Contractor")** | |
|---|---|
| **Legal Name:** Amerigroup Iowa, Inc. | **Contractor's Principal Address:**<br>4800 Westown Parkway, Suite 200<br>West Des Moines, IA 50266 |
| **Tax ID #:** 47-3863197 | **Organized under the laws of:** State of Iowa |
| **Contractor's Contract Manager Name/Address ("Notice Address"):**<br>Anna J. Dey<br>Regulatory Oversight Manager<br>Amerigroup Iowa, Inc.<br>4800 Westown Parkway, Suite 200<br>West Des Moines, IA 50266<br><br>Copy to:<br><br>Cynthia MacDonald<br>Plan President<br>Amerigroup Iowa, Inc.<br>4800 Westown Parkway, Suite 200<br>West Des Moines, IA 50266<br>Cynthia.MacDonald@amerigroup.com | **Contractor's Billing Contact Name/Address:**<br><br>Leslie K. Carpenter<br>Mgr. Southern Region, Premium Reconciliation<br>Anthem, Inc.<br>4425 Corporation Lane<br>Virginia Beach, VA 23462<br><br>Phone: 757-473-2737, ext. 32116 |
| **Phone:** 515-327-7012, ext. 47005 | |
| **E-Mail:** anna.dey@anthem.com | |

**Revision 2**: Section 1.3.3.1 of the Contract is 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 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 Agency's officers, directors, employees, agents, and attorneys, from any and all liability whatsoever from any and all claims, demands and causes of action of

every nature whatsoever that Contractor may have or may ever claim to have now existing or hereafter arising that relate to or arise out of any assertion regarding the actuarial soundness of the agreed rates.

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

In addition to the monthly capitation payment made to Contractor, the Agency will also make a payment to Contractor when a Medicaid member assigned to the Contractor gives birth and the member is in the population designated in the Contract's then current rate sheet as subject to a payment for giving birth. The amount of this payment, commonly referred to as a "maternity case rate payment," shall be in an amount established as part of the capitation rate-setting process and included in the rate matrix applicable to the given Contract period. The Contractor shall supply documentation of the birth in a form and format determined by the Agency. Upon verification by the Agency of the birth, the Agency shall cause the maternity case rate payment to be made separately and apart from the usual capitation payment for contracted services. Contractor shall diligently monitor births in its assigned Medicaid population and claim a maternity case rate payment for each birth in the assigned Medicaid population for which a maternity case rate payment is available no later than 60 Days following the date on which the Contractor was made aware of the birth. The Agency shall have no obligation to pay a maternity case rate payment for a birth that occurred more than 210 Days prior to Contractor's claim for a maternity case rate payment.

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

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

Beginning 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 verification regarding oversight to ensure appropriate utilization of these drugs. At minimum, Contractor's invoice must include claim level detail sufficient to support the invoices

**Revision 3:** Section 1.3.3.3 of the Contract is amended to read as follows:

**1.3.3.3 Graduate Medical Education (GME) Payments.**
The Contractor shall comply with Agency policy and process regarding distribution of GME payments.

**Revision 4:** Section 1.3.3.3.1 of the Contract is amended to read as follows:

**1.3.3.3.1 University of Iowa Health Care Physician Supplemental**
To the extent that the Agency includes University of Iowa Health Care Physician Supplemental payments in capitated payments, the Plan shall pass through these payments to University of Iowa Health Care as early in the month as possible, but no later than the 15th Day of each month.

**Revision 5:** Section 2.13.25.1 of the Contract's General terms is amended to read as follows. All subsections under Section 2.13.25.1 remain unchanged:

**2.13.25.1 Financial Records.** The Contractor shall maintain accurate, current, and complete records of the financial activity of this Contract which sufficiently and properly document and calculate all charges billed to the Agency during the entire term of this Contract, which includes any extensions or renewals thereof, and for a period of at least ten (10) years following the date of final payment or completion of any required audit (whichever is later). If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the ten (10) year period, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular ten (10) year period, whichever is later. The Contractor shall permit the Agency, the Auditor of the State of Iowa or any other authorized representative of the State and where federal funds are involved, the Comptroller General of the United States or any other authorized representative of the United States government, to access and examine, audit, excerpt and transcribe any directly pertinent books, documents, papers, electronic or optically stored and created records, or other records of the Contractor relating to orders, Invoices or payments, or any other Documentation or materials pertaining to this Contract, wherever such records may be located. The Contractor shall not impose a charge for audit or examination of the Contractor's books and records. Based on the audit findings, the Agency reserves the right to address the Contractor's board or other managing entity regarding performance and expenditures. When state or federal law or the terms of this Contract require compliance with OMB Circular A-87, A-110, or other similar provision addressing proper use of government funds, the Contractor shall comply with these additional records retention and access requirements:

**Revision 6:** Section 2.13.25.2 of the Contract's General Terms is amended to read as follows:

**2.13.25.2** The Contractor shall retain all non-medical and medical client records for a period of ten (10) years from the last date of service for each patient; or in the case of a minor patient or client, for a period consistent with that established by Iowa Code § 614.1(9), whichever is greater.

**Revision 7:** Section 2.1.2 of the Contract's Scope of Work is amended to read as follows:

2.1.2 Accreditation

The Contractor shall attain and maintain accreditation from the National Committee for Quality Assurance (NCQA) or URAC. If not already accredited, the Contractor shall demonstrate it has initiated the accreditation process as of the Contract effective date. The Contractor shall achieve accreditation at the earliest date allowed by NCQA or URAC. Accreditation shall be maintained throughout the life of the Contract at no additional cost to the Agency. When accreditation standards conflict with the standards set forth in the Contract, the Contract prevails unless the accreditation standard is more stringent.
The Contractor shall comply with the following requirements in accordance with 42 C.F.R. § 438.332:

(a) Contractor shall inform the Agency whether it has been accredited by a private independent accrediting entity.

(b) If Contractor has received accreditation by a private independent accrediting entity, Contractor hereby authorizes the private independent accrediting entity to provide the Agency a copy of its most recent accreditation review, including:

(1) Accreditation status, survey type, and level (as applicable);

(2) Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and

(3) Expiration date of the accreditation.

(c) Reserved.(1) Reserved.

(2) Reserved.

**Revision 8:** Section 2.2 of the Contract's Scope of Work is amended to read as follows:

2.2 Subcontracts

The Contractor shall comply with the terms of this section, pursuant to 42 C.F.R. § 438.230.

(a) *Applicability.* The requirements of this section, and those below, apply to any contract or written arrangement that Contractor has with any subcontractor.

(b) *General rule.*

(1) Notwithstanding any relationship(s) that Contractor may have with any subcontractor, Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract with the Agency; and

(2) All contracts or written arrangements between the Contractor and any subcontractor must meet the requirements of paragraph (c) of this section.

(c) Each contract or written arrangement described in paragraph (b)(2) of this section must specify that:

(1) If any of Contractor's activities or obligations under its Contract with the Agency are delegated to a subcontractor—

(i) The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.

(ii) The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the Contractor's contract obligations.

(iii) The contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the Agency or the Contractor determine that the subcontractor has not performed satisfactorily.

(2) The subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions;

(3) The subcontractor agrees that—

(i) The Agency, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's Contract with the Agency.

(ii) The subcontractor will make available, for purposes of an audit, evaluation, or inspection under paragraph (c)(3)(i) of this section, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members.

(iii) The right to audit under paragraph (c)(3)(i) of this section will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

(iv) If the Agency, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the Agency, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

In addition, pursuant to 42 C.F.R. 438.3(k), all of Contractor's subcontracts must fulfill the requirements of 42 C.F.R. part 438 for the service or activity delegated under the subcontract in accordance with 42 C.F.R. § 438.230.

**Revision 9:** Section 2.2.1 of the Contract's Scope of Work is amended to read as follows:

2.2.1 *Subcontractor Qualifications*

The Contractor is accountable for any functions and responsibilities that are delegated to a subcontractor, and is required to certify and warrant all subcontractor work. Prior to delegation, the Contractor shall evaluate the prospective subcontractor's ability to perform the activities to be delegated, including firm and staff qualifications. The Contractor shall ensure that Business Associates Agreements are in place as necessary. The Contractor shall notify the Agency in writing of all subcontracts relating to Deliverables to be provided under this Contract prior to the time the subcontract(s) become effective. The Contractor shall submit for Agency review and approval subcontractor agreements for any subcontractor whose payments are equal to or greater than five percent (5%) of capitation payments under the Contract. However, the Agency reserves the right to review and approve any subcontracts, and all subcontracts shall be accessible to the Agency and provided within three (3) business days of request. All material changes to the subcontractor agreement previously approved by the Agency shall be submitted in writing to the Agency for approval at least sixty (60) days prior to the effective date of the proposed subcontract agreement amendment. The Agency shall have the right to request the removal of a subcontractor for good cause. Subcontractors shall be bound to the same contractual terms and conditions as the Contractor.

**Revision 10:** Section 2.3.5 of the Contract's Scope of Work is amended to read as follows:

2.3.5 *Annual Independent Audit*

In accordance with 42 C.F.R. §438.3(m) the Contractor shall submit audited financial reports specific to the Medicaid contract on an annual basis. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards. The Contractor shall submit to the Agency a copy of the annual audited financial report required by the Iowa Insurance Division. This report shall specify the Contractor's financial activities under the Contract within six (6) months following the end of each calendar year. The report, prepared using Statutory Accounting Principles as designated by the NAIC, shall be prepared by an independent Certified Public Accountant on a calendar year basis. The auditor shall be on the Iowa Insurance Division's list of approved auditors. The Contractor is responsible for the cost of the audit. The Contractor's audit format and contents shall include at a minimum: (i) third party liability payments made by other third-party payers; (ii) receipts received from other insurers; (iii) a breakdown of the costs of service provision, administrative support functions, plan management and profit; (iv) assessment of the Contractor's compliance with financial requirements of the Contract including compliance with requirements for insolvency protection, surplus funds, working capital, and any additional requirements established in Administrative Rules for organizations licensed as HMOs; and (v) a separate letter from the independent Certified Public Accountant addressing non-material findings, if any.

**Revision 11:** Section 2.4 of the Contract's Scope of Work is amended to read as follows:

*2.4 Maintenance of Records*

In accordance with 42 C.F.R. §438.3(u), Contractor shall retain, and require subcontractors to retain, as applicable, the following information: member grievance and appeal records in 42 C.F.R. § 438.416, base data in 42 C.F.R. § 438.5(c), MLR reports in 42 C.F.R. § 438.8(k), and the data, information, and documentation specified in 42 C.F.R. §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

*2.4.1 Financial Records*

See General Terms for Service Contracts, Section 2.13.25 Records Retention and Access.

*2.4.2 Medical Records*

The Contractor shall maintain records that fully disclose the extent of services provided to individuals under the Contract for a period of ten (10) years, or for the duration of contested case proceedings, whichever is longer.

*2.4.3 Response to Record Requests*

In accordance with 42 C.F.R. 438.3(h), the Agency, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the Contractor, or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. The Contractor and its subcontractors shall furnish duly authorized and identified agents or representatives of the State and Federal governments, with such information as they may request regarding payments claimed for Medicaid services. The Contractor must timely provide copies of the requested records to the Agency, the Agency's designee, or the Iowa Medicaid Fraud Control Unit (MFCU) within ten (10) business days from the date of the request unless the Agency may, at its sole discretion, sets a time period greater than 10 days. If such original Documentation is not made available as requested, the Contractor must provide transportation, lodging and subsistence at no cost, for all State and/or Federal representatives to carry out their audit functions at the principal offices of the Contractor or other locations of such records. Additionally, the Contractor shall grant the Agency, the Agency's designee, or MFCU access during the Contractor's regular business hours to examine health service and financial records related to a health service billed to the program. The Agency will notify the Contractor no less than twenty-four (24) hours before obtaining access to a health service or financial record, unless the Contractor waives the notice. The Agency shall access records in accordance with 45 C.F.R. Parts 160 through 164.

**Revision 12:** Subsections 2.5.3 through 2.5.5 of the Contract's Scope of Work are amended by deleting the text and reserving the subsections 2.5.3 through 2.5.5.

**Revision 13:** Subsection 2.5.8 of the Contract's Scope of Work is amended by deleting the text and reserving the subsection.

**Revision 14:** Subsection 2.5.16 of the Contract's Scope of Work is amended by deleting the text and reserving the subsection.

**Revision 15:** Section 2.7 of the Contract's Scope of Work is amended to read as follows:

2.7 *Medical Loss Ratio*

The Contractor shall maintain, at minimum, an annual Medical Loss Ratio (MLR) as set forth in Attachment 2.7 – Medical Loss Ratio. In the event the MLR falls below the established target, the Agency shall recoup excess capitation paid to the Contractor.

**Revision 16:** Subsection 2.9.2.3(e)(xv of the Contract's Scope of Work is amended to read as follows:

(xv) Program Integrity Manager: Shall ensure oversight of the Contractor's special investigations unit (SIU) activity. The Program Integrity Manager will serve as the liaison between the Contractor and state agencies, law enforcement, and federal agencies. The Program Integrity Manager shall be informed of current trends in fraud, waste, and abuse as well as mechanisms to detect such activity. The Program Integrity Manager shall be in the Iowa offices. The position shall be dedicated at least ninety percent (90%) of the time to the oversight and management of the program integrity efforts required under the Contract. The Program Integrity Manager shall have open and immediate access to all claims, claims processing data and any other electronic or paper information sufficient to meet the requirements of the Agency. The duties shall include, but not be limited to: (i) oversight of the program integrity function under the Contract; (ii) liaison with the IME in all matters regarding program integrity; (iii) development and operations of a fraud control program within the Contractor claims payment system; (iv) liaison with Iowa's MFCU and/or the Office of the Attorney General; (v) assure coordination of efforts with the Agency and other agencies with regards to program integrity issues.

**Revision 17:** Section 2.9.6 of the Contract's Scope of Work is amended to read as follows:

2.9.6 *Out of State Operations*

The Contractor shall ensure the location of any staff or operational functions outside of the State of Iowa does not compromise the delivery of integrated services and a seamless experience for enrollees and providers. Additionally, the Contractor shall assure availability of personnel to the Agency to address out-of-state operations during normal Agency hours of operation. In accordance with 42 C.F.R. § 438.602(i), Contractor shall not be located outside of the United States, and no claims paid by Contractor to a network provider, out-of-network provider, subcontractor or financial institution located outside of the U.S. may be considered in the development of actuarially sound capitation rates.

**Revision 18:** Section 2.9.7 of the Contract's Scope of Work is amended to read as follows:

2.9.7 *Staff Training and Qualifications*

The Contractor shall ensure on an ongoing basis that all staff has the appropriate credentials, education, experience and orientation to fulfill the requirements of their position. The Contractor shall provide initial and ongoing training and shall ensure all staff is trained in the major components of the Contract. As applicable based on the scope of services provided under subcontract, the Contractor shall ensure all subcontractor staff is trained in accordance with this section. Staff training shall include: (i) Contract requirements and State and Federal requirements specific to job functions; (ii) in accordance with 42 C.F.R. § 422.128, training on the Contractor's policies and procedures on advance directives; (iii) initial and ongoing training on identifying and handling quality of care concerns; (iv) cultural sensitivity training; (v) training on fraud and abuse and the False Claims Act as further described in Section 12.2.3; (vi) HIPAA training; (vii) clinical protocol training for all clinical staff; (viii) ongoing training, at least quarterly, regarding interpretation and application of utilization management guidelines for all utilization management staff; (ix) assessment processes, person-centered planning and population specific training relevant to the enrolled populations for all care managers; and (x) training and education to understand abuse, neglect, exploitation and prevention including the detection, mandatory reporting, investigation and remediation procedures and requirements. Training material shall be updated on a regular basis to reflect any program changes. The Contractor shall maintain documentation to confirm staff training, curriculum, schedules and attendance. The Agency

reserves the right to request the Contractor to implement additional staff training in the event that performance issues are identified by the Agency.

**Revision 19:** Section 2.15 of the Contract's Scope of Work is amended to read as follows:

2.15 *Confidentiality of Member Medical Records and Other Information*

The Contractor shall develop, implement, and adhere to written policies and procedures, subject to Agency review and approval, pertaining to maintaining the confidentiality of all medical records and other pertinent information, including, but not limited to, health and enrollment information.

In compliance with 42 C.F.R. § 438.224, for medical records and any other health and enrollment information that identifies a particular Member, Contractor shall only use and disclose such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable.

The Contractor shall also comply with all other applicable State and Federal privacy and confidentiality requirements. The Contractor shall protect and maintain the confidentiality of mental health information by implementing policies for staff and through contract terms with network providers which allow release of mental health information only as allowed by Iowa Code § 228. Further, the Contractor shall protect and maintain the confidentiality of substance use disorder information, allowing the release of substance use disorder information only in compliance with policies set forth in 42 C.F.R. Part 2 and other applicable State and Federal law and regulations. The Contractor shall notify the Agency of a HIPAA-related breach in accordance with the terms of Section 1.5 of the Contract's Special Terms. The Contractor shall notify the Agency within one (1) Business Day upon discovery of a non-HIPAA-related breach.

**Revision 20:** Section 2.18 of the Contract's Scope of Work is amended to read as follows:

2.18 *Agency Ongoing Monitoring*

The Agency will conduct ongoing monitoring of the Contractor, in accordance with 42 C.F.R. §438.66, to ensure compliance with Contract requirements and performance standards. The method and frequency of monitoring is at the discretion of the Agency and may include, but is not limited to, both scheduled and unannounced onsite visits, review of policies and procedures and performance reporting. Reporting requirements are detailed further in Section 14. The reviews will identify and make recommendations for areas of improvement, monitor the Contractor's progress towards implementing mandated programs or operational enhancements, and provide the Contractor with technical assistance when necessary. In preparation for planned onsite reviews, the Contractor shall cooperate with the Agency by forwarding in advance policies, procedures, job descriptions, contracts, records, logs and other material upon request. Documents not requested in advance shall be made available during the course of the review. Contractor personnel shall be available at all times during review activities. The Contractor shall have available work space and access to staff and systems for the Agency staff while onsite.

**Revision 21:** Section 3.1.1 of the Contract's Scope of Work is amended to read as follows:

3.1.1 *Eligible Members*

The majority of Medicaid and CHIP members will be enrolled in the program unless specifically excluded as described in Section 3.1.1.2. Refer to Exhibit C for a detailed description of the eligibility categories enrolled in the Contract.

3.1.1.1 *Iowa Department of Public Health Participants*

In addition to covering Medicaid and CHIP enrollees, the Contractor shall provide substance use disorder services, as described in Exhibit D, to persons meeting the eligibility criteria to receive IDPH funded substance use disorder services ("IDPH Participants"). The Contractor is required to provide services to a minimum number of IDPH Participants annually based on requirements established by IDPH and subject to annual adjustments at the discretion of IDPH.

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 for full Medicaid benefits; (vii) persons presumed eligible for services (i.e. Presumptive Eligibility); (viii) persons residing in the Iowa Veteran's Home; (ix) effective July 1, 2017, beneficiaries who are eligible only for the Family Planning Waiver; and (x) persons eligible only for the Medicare Savings Program. Alaskan Native and American Indian populations shall be enrolled voluntarily.

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 22:** Section 3.2.1 is amended to read as follows:

3.2.1 *General*

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 not deny reimbursement of covered services based on the presence of a pre-existing condition. The Contractor shall ensure that the principles of the Americans with Disabilities Act (ADA) and Olmstead Act principles are incorporated into the delivery and approval of all services.

In compliance with 42 C.F.R. § 438.3(l), Contractor shall allow each Member to choose his or her network provider to the extent possible and appropriate.

**Revision 23:** Subsection 3.2.2.2 of the Contract's Scope of Work is amended by deleted the text and marking the subsection "Reserved."

**Revision 24:** Section 3.2.6 of the Contract's Scope of Work is amended to read as follows. Note that this revision does not amend any subsections under Section 3.2.6:

3.2.6 *Pharmacy Services*

Prescription drugs shall be covered and reimbursed by the Contractor. In accordance with 42 C.F.R. § 438.3(s), the Contractor shall administer pharmacy benefits in compliance with the following requirements:

(1) Contractor shall provide coverage of covered outpatient drugs as defined in section 1927(k)(2) of the Social Security Act, in a manner that meets the standards for such coverage imposed by section 1927 of the Social Security Act as if such standards applied directly to Contractor.

(2) Contractor shall report drug utilization data that is necessary for States to bill manufacturers for rebates in accordance with section 1927(b)(1)(A) of the Social Security Act in accordance with subsection 3.2.6.11.1 below. Such utilization information must include, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code of each covered outpatient drug dispensed or covered by the Contractor.

(3) Contractor shall establish procedures to report all utilization data for covered outpatient drugs, specifically identifying drugs subject to discounts under the 340B drug pricing program so as to prevent duplicate discounts on such drugs as set forth in subsections 3.2.6.11.2 through 3.2.6.11.4 below.

(4) Contractor shall operate a drug utilization review program that complies with the requirements described in section 1927(g) of the Social Security Act and 42 C.F.R. part 456, subpart K, as if such requirement applied to the Contractor instead of the Agency. Contribution to and participation in the Agency's DUR Board (Commission) meetings and activities, as well as adherence to DUR oversight conducted on the fee-for-service population, as described in these authorities will satisfy those specific drug utilization review program requirements. No DUR initiatives can be implemented without review and recommendation from the FFS DUR Board.

(5) Contractor shall provide a detailed description of its drug utilization review program activities to the Agency on an annual basis in a format, content, and timeline as required by CMS.

(6) Contractor shall conduct a prior authorization program that complies with the requirements of section 1927(d)(5) of the Social Security Act, as if such requirements applied to the Contractor instead of the Agency.

**Revision 25:** Reserved.

**Revision 26:** Subsections 3.2.6.3.1 and 3.2.6.3.2 of the Contract's Scope of Work are amended by deleting the text and marking the subsections "Reserved."

**Revision 27:** Subsection 3.2.6.4 and its subparts of the Contract's Scope of Work is amended to read as follows:

3.2.6.4.1 Prospective DUR (proDUR): The Contractor is responsible for ensuring the implementation of the Medicaid FFS proDUR edits through its point-of-sale pharmacy claims processing system and/or vendor.

3.2.6.4.1.1 The Contractor shall implement all Medicaid FFS Prospective DUR edits.

3.2.6.4.2 Retrospective DUR (retroDUR): The Contractor shall participate and collaborate with the Agency's DUR Board (Commission) activities related to all aspects of retrospective DUR including but not limited to providing claims data, conducting the activity, following up (re-evaluation), and providing all associated reporting.

3.2.6.4.3 Educational Component: The Contractor shall participate and collaborate with the Agency's DUR Board (Commission) activities related to the education program/interventions for physicians and pharmacists as recommended by the DUR Board (Commission) including but not limited to providing claims data, conducting the activity, following up (re-evaluation) and providing all associated reporting.

3.2.6.4.4 Reporting: The Contractor shall report prospective and retrospective DUR activities and educational initiatives to the Department or its designee, quarterly, and assist in data collection and reporting to the Department of data necessary to complete the CMS DUR annual report.

3.2.6.4.5 DUR Board (Commission): Contractor shall collaborate with the Department on all federally required activities as well as development and review of prior authorization criteria and prospective drug utilization review edits, which will be forwarded for review and approval by the DUR Board (Commission) and Agency staff.

**Revision 28:** Subsection 3.2.6.7.2 of the Contract's Scope of Work is amended by deleting the text and marking the subsection "Reserved."

**Revision 29:** Subsection 3.2.6.10.2 of the Contract's Scope of Work is amended to read as follows:

3.2.6.10.2 Pursuant to requirements of the federal Patient Protection and Affordable Care Act (PPACA), P.L. 111-148 and Health Care and Education Reconciliation Act of 2010 (HCERA), P.L. 111-152, together called the Affordable Care Act, the Contractor shall provide information on drugs administered/dispensed to individuals enrolled in the MCO if the Contractor is responsible for coverage of such drugs. Specifically, Section 1927(b) of the Social Security Act, as amended by Section 2501(c) of PPACA, requires the Agency to provide utilization information for Contractor covered drugs in the quarterly rebate invoices to drug manufacturers and in quarterly utilization reports to the Centers for Medicare and Medicaid Services. The Contractor shall submit all drug encounters including physician administered drugs, with the exception of inpatient hospital drug encounters and any select prescription drugs reimbursed by the Contractor and invoiced separately to the Agency, to the Agency or its designee pursuant to

the requirements of this Contract. The Agency or its designee will submit these encounters for federal drug rebates from manufacturers.

**Revision 30:** Subsection 3.2.6.11.1 of the Contract's Scope of Work is amended to read as follows:

3.2.6.11.1 The Contractor shall submit a claim-level detail file once every two weeks of drug encounters to the Agency or its designee.

**Revision 31:** Subsection 3.2.6.11.2 of the Contract's Scope of Work is amended to read as follows:

3.2.6.11.2 The Contractor shall provide this reporting to the Agency in the manner and timeframe prescribed by the Agency, including, but not limited to, the submission of complete and accurate drug encounter data and a rebate file to the Agency or its designee. The Contractor shall comply with all file layout requirements including, but not limited to, format and naming conventions and submission of paid amounts. A complete listing of claim fields required will be determined by the Agency.

**Revision 32:** Subsection 3.2.8.20 of the Contract's Scope of Work is amended to read as follows:

3.2.8.20*Parity*

In accordance with 42 C.F.R. § 438.3(n), Contractor shall deliver services in compliance with the requirements of 42 C.F.R. part 438, subpart K insofar as those requirements are applicable.

This includes, but is not limited to: (i) ensuring medical management techniques applied to mental health or substance use disorder benefits are comparable to and applied no more stringently than the medical management techniques that are applied to medical and surgical benefits; (ii) ensuring compliance with MHPAEA for any benefits offered by the Contractor to members beyond those specified in Iowa's Medicaid State plan; (iii) making the criteria for medical necessity determinations for mental health or substance use disorder benefits available to any current or potential member, or contracting provider upon request; (iv) providing the reason for any denial of reimbursement or payment with respect to mental health or substance use disorder benefits to members; and (v) providing out-of-network coverage for mental health or substance use disorder benefits when made available for medical and surgical benefits.

**Revision 33:** Subsection 3.2.9 of the Contract's Scope of Work is amended to read as follows. Note that all subsections of subsection 3.2.9 are not altered by this revision:

3.2.9 *Health Homes*

The Contractor shall administer and fund the State's Health Home services within the approved State Plan Amendment. In accordance with federal requirements, the Contractor shall ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) HCBS waivers, other forms of community-based case management, or value-based purchasing arrangements. If supplemental services are required to ensure quality of Health Home services to members, the cost of such supplemental services provided to ensure quality may be deducted from Health Home payments.

**Revision 34:** Subsection 3.2.11.2.2 of the Contract's Scope of Work is amended to read as follows:

3.2.11.2.2 *Initial Assessment and Annual Support Assessment*

The Contractor shall ensure that level of care and needs-based assessments for members potentially eligible for 1915(i) Habilitation Program and 1915(c) Children's Mental Health Waiver enrollment include an assessment of the individual's ability to have his or her needs met safely and effectively in the community and at a cost that does not exceed the 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 perform needs-based eligibility reassessments annually and when the member's function or medical status has changed. The Contractor shall track level of care and needs-based eligibility expiration dates to ensure this requirement is met. This requirement applies to all members on a 1915(i) Habilitation Program and 1915(c) Children's Mental Health Waiver. The Contractor shall obtain Agency approval of timeframes in which reassessments shall occur for individuals identified as having a medical or functional status change. The Agency will establish timelines, which the Contractor shall adhere to, for the Contractor to promptly assess the member's needs and ensure member safety.

Once the assessment is completed, the Contractor shall submit the level of care or functional eligibility assessment to the Agency in the manner prescribed by the Agency. The Agency will retain all authority for determining Medicaid categorical, financial, level of care or needs-based eligibility and enrolling members into a Medicaid eligibility category. The Agency will notify the Contractor when a member has been enrolled in a 1915(i) Habilitation Program and 1915(c) Children's Mental Health Waiver eligibility category and any applicable patient liability amounts.

The Contractor shall administer all needs assessments 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 35:** Subsection 3.2.11.2.12 of the Contract's Scope of Work is amended to read as follows:

3.2.11.2.12 In accordance with 42 C.F.R. § 441.301(b)(1), the Contractor shall ensure waiver services are not furnished to individuals who are inpatient in a hospital, nursing facility, institution for mental diseases, or ICF/ID. Further, in accordance with 42 C.F.R. §438.3(o),

Contractor shall deliver any services covered under the Contract that could be authorized through a waiver under section 1915(c) of the Social Security Act or a State plan amendment authorized through sections 1915(i) or of the Social Security Act in settings consistent with 42 C.F.R. § 441.301(c)(4) and 42 C.F.R. § 441.710(a).

**Revision 36:** Section 3.4 of the Contract's Scope of Work is amended to read as follows:

3.4 *Coordination with Medicare*

The Contractor shall provide medically necessary covered services to members who are also eligible for Medicare if the service is not covered by Medicare. The Contractor shall ensure that services covered and provided under the Contract are delivered without charge to members who are dually eligible for Medicare and Medicaid. The Contractor shall coordinate with Medicare payers, Medicare Advantage Plans, and Medicare providers as appropriate to coordinate the care and benefits of members who are also eligible for Medicare. In compliance with 42 C.F.R. §438.3(t), the Contractor shall enter into a Coordination of Benefits Agreement with Medicare and participate in the automated claims crossover process. In any Work Plan required by Section 2.13, the Contractor shall develop a plan to coordinate care for duals.

**Revision 37:** Section 4.1 of the Contract's Scope of Work is amended to read as follows:

4.1 *General*

The Contractor shall ensure that services are provided in a manner that facilitates maximum community placement and participation for members that require LTSS. The Agency is dedicated to serving individuals in the communities of their choice within the resources available and to implementing the United States Supreme Court's mandate in *Olmstead v. L.C.*. 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 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 38:** Subsection 4.2.1 of the Contract's Scope of Work is amended to read as follows:

4.2.1 *Initial Determination for Non-Members*

The Agency has designated the tools that will be used to determine the level of care and comprehensively assessed supports needed for individuals wishing to access either community supports or facility care, as described. The intention of the multi-purpose evaluation is to provide uniformity and streamline the documents completed to determine the appropriate level of care and outline the assessed needs of the individual. The tool is also used to evaluate whether or not

the needs are being met and the provider's ability to perform the tasks as assigned. The tools currently designated by the department, notwithstanding future decisions or input from stakeholders, are as follows:

| Waiver/Service Type | Age | DHS Designated Assessment Tool |
|---|---|---|
| AIDS/HIV | 0 - 3 | Case Management (CM) Comprehensive Assessment |
| | 4 - 20 | interRAI - Pediatric Home Care (PEDS-HC) |
| | 21 + | interRAI - Home Care (HC) |
| AIDS/HIV with Habilitation | 16 - 18 | inter-RAI Child and Youth Mental Health (ChYMH) |
| AIDS/HIV with Habilitation | 19 + | interRAI - Community Mental Health (CMH) |
| Brain Injury (BI) | 0 - 3 | CM Comprehensive Assessment |
| | 4 - 20 | interRAI - Pediatric Home Care (PEDS-HC) |
| | 21 + | interRAI - Home Care (HC) |
| BI with Habilitation | 16 - 18 | inter-RAI Child and Youth Mental Health (ChYMH) |
| BI with Habilitation | 19 + | interRAI - Community Mental Health (CMH) |
| Children's Mental Health | 0 - 3 | CM Comprehensive Assessment (or modified PIHH) |
| | 4 - 20 | interRAI - Child and Youth Mental Health (ChYMH) |
| | 12 - 18 | interRAI - Adolescent Supplement (in addition to ChYMH) |
| Elderly | 65 + | interRAI - Home Care (HC) |
| Elderly with Habilitation | 65 + | interRAI - Community Mental Health (CMH) |
| Health and Disability (HD) | 0 - 3 | CM Comprehensive Assessment |
| | 4 - 20 | interRAI - Pediatric Home Care (PEDS-HC) |
| | 21 - 64 | interRAI - Home Care (HC) |
| HD with Habilitation | 16 - 18 | inter-RAI Child and Youth Mental Health (ChYMH) |
| HD with Habilitation | 19 + | interRAI - Community Mental Health (CMH) |
| Intellectual Disability (ID) | 0 - 4 | CM Comprehensive Assessment |
| | 5 - 15 | Supports Intensity Scale - Child (SIS-C) |
| | 16+ | Supports Intensity Scale - Adult (SIS-A) |
| ID with Habilitation | 16 + | Supports Intensity Scale - Adult (SIS-A) |
| Physical Disability (PD) | 18 - 20 | interRAI - Pediatric Home Care (PEDS-HC) |
| | 21 + | interRAI - Home Care (HC) |
| PD with Habilitation | 16 - 18 | inter-RAI Child and Youth Mental Health (ChYMH) |
| PD with Habilitation | 19 + | interRAI - Community Mental Health (CMH) |
| Habilitation Services | 16 - 18 | interRAI - Child and Youth Mental Health (ChYMH) |
| | 19 + | interRAI - Community Mental Health (CMH) |

The Contractor shall not revise or add to the tools without express approval from the Agency and may require consensus among all Contractors and stakeholder engagement.

The Contractor shall not be responsible for determining the initial level of care assessments for nursing facility or ICF/ID or 1915(c) HCBS waiver enrollment for individuals who are not

enrolled with the Contractor and are applying for initial Medicaid LTSS eligibility. This responsibility is maintained by the Agency or its designee. The Contractor shall refer all inquiries regarding Medicaid enrollment and initial level of care determinations to the Agency or its designee in the form and format developed by the Agency.

**Revision 39:** Subsection 4.2.2.1 of the Contract's Scope of Work is amended to read as follows:

4.2.2.1 *Identification*

In any Work Plan required by Section 2.13, the Contractor shall develop and implement policies and procedures for ongoing identification of members who may be eligible for LTSS, which includes, at minimum the following processes: (i) processing referrals from a member's provider(s); (ii) processing member self-referrals; (iii) incorporation of hospital admission notifications; and (iv) ongoing review of claims data. The Contractor shall conduct a comprehensive assessment in accordance with 42 C.F.R. § 438.208(c)(2), as described, using a tool and process prior approved by the Agency, for members who have been identified through any of these processes as potentially meeting an institutional level of care and in need of institutional placement or 1915(c) HCBS waiver enrollment. The Contractor shall refer individuals who are identified as potentially eligible for LTSS to the Agency or its designee for level of care determination, if applicable.

**Revision 40:** Subsection 4.2.2.2 of the Contract's Scope of Work is amended to read as follows:

4.2.2.2 *Initial Assessment and Annual Support Assessment*

The Contractor shall ensure that level of care and assessment for members potentially eligible for 1915(c) HCBS waiver enrollment includes an assessment of the individual's ability to have his or her needs met safely and effectively in the community and at a reasonable cost to the Agency. If a member's needs exceed limits established in Iowa Administrative Code or the approved 1915(c) waivers, the Contractor has discretion but is not required to authorize services that exceed those limits. If a member does not appear to meet enrollment criteria such as meeting the target population group, the Contractor shall comply with the requirements related to the appearance of ineligibility. The Contractor shall obtain Agency approval for timeframes in which the level of care assessment shall occur. The Agency will establish timelines which will promptly assess the member's needs and ensure member safety.

The Contractor shall conduct level of care reassessments, using the Agency designated tools by population annually and when the Contractor becomes aware that the member's functional or medical status has changed in a way that may affect level of care eligibility. The Contractor may perform needs-based eligibility reassessments annually and when the member's function or medical status has changed. The Contractor shall track level of care expiration dates to ensure this requirement is met. This requirement applies to all members eligible under a 1915(c) HCBS waiver. The Contractor shall obtain Agency approval for timeframes in which reassessments shall occur for individuals identified as having a change in medical or functional status. The Agency will establish timelines, which the Contractor shall adhere to, for the Contractor to promptly assess the member's needs and ensure member safety.

Once the assessment is completed, the Contractor shall submit the level of care/support needs assessment to the Agency in the manner prescribed by the Agency. The Agency will retain all authority for determining Medicaid categorical, financial and level of care eligibility and enrolling members into a Medicaid eligibility category. The Agency will notify the Contractor

when a member has been enrolled in nursing facility or ICF/ID or 1915(c) HCBS waiver eligibility category and any applicable patient liability amounts.

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 41:** Subsection 4.3.8.4 of the Contract's Scope of Work is amended to read as follows:

4.3.8.4 Care plans are developed in accordance with 42 C.F.R. § 438.208(c)(3)(i)-(v), by a person trained in person-centered planning using a person-centered process and plan, with enrollee participation and provider consultation; and updated on schedule and in compliance with the Contract;

**Revision 42:** Subsection 4.3.8.8 of the Contract's Scope of Work is amended to read as follows:

4.3.8.8 Services are appropriate to address the member's needs, and in accordance with 42 C.F.R. § 438.208(c)(4), Contractor allows members with special health care needs determined through an assessment in accordance with 42 C.F.R. § 438.208(c)(2) to need a course of treatment or regular care monitoring to directly access a specialist as appropriate for the enrollee's condition and identified needs;

**Revision 43:** Subsection 4.3.8.14 of the Contract's Scope of Work is amended to read as follows:

4.3.8.14 Service limits are monitored and appropriate action is taken if a member is nearing or exceeds needs-based limits outlined in the service plan. Appropriate action includes assessment of whether the service plan requires revision to allocate additional units of waiver services or if other non0waiver resources are available to meet the member's needs in the community.

**Revision 44:** Subsection 4.4.2 of the Contract's Scope of Work is amended to read as follows. Note that this revision does not alter the subsections under subsection 4.4.2:

4.4.2 *Service Plan Development*

The Contractor shall provide service plan development for each 1915(c) HCBS waiver enrollee. In any Work Plan required by Section 2.13, the Contractor shall include how they will ensure that all components of the service plan process will meet contractual requirements, as well as State and Federal regulations and policies, including 42 C.F.R. §438.208(c)(3)(i)-(v).

**Revision 45:** Subsection 4.4.5.2 of the Contract's Scope of Work is amended to read as follows:

4.4.5.2 *Service Needs*

The Contractor shall continually monitor 1915(c) HCBS waiver member's service needs are met to assist the member in remaining in the least restrictive setting of the member's choice. If the Contractor determines a member's needs cannot be safely met in the community and within the monthly costs and service limits defined in the 1915(c) HCBS waiver in which the member is

enrolled, the Contractor shall determine if additional services may be otherwise available through the Contractor's own Exception to Policy process as described in Section 8.15.10, to allow the member to continue to reside safely in the community.

**Revision 46:** Subsection 5.3.1.9 of the Contract's Scope of Work is amended to read as follows:

5.3.1.9 An Indian (as defined at Section 7.5) who is currently receiving or has ever received an item or service furnished by an Indian health care provider or through referral under contract health services; and

**Revision 47:** Subsection 6.1.2 of the Contract's Scope of Work is amended to read as follows. Note that this revision does not alter the subsections under subsection 6.1.2:

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 concurrently 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 the population defined by the Agency in a value based purchasing (VBP) arrangement with the healthcare delivery system by the end of calendar year 2018. The VBP arrangement shall recognize population health outcome improvement as measured through the VIS combined with a total cost of care measure for the population in the VBP arrangement. Driving population health through delivery system reform under VBP means that providers need a clear understanding of the specific lives for which they are accountable. As such, any members that are part of a VBP must be assigned by the Contractor to a designated primary care provider (PCP). This PCP information shall be immediately reported by the Contractor for use in system wide coordination enhancements as specified by the Agency, 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.

Contractor shall ensure compliance with the obligations set forth in 42 C.F.R. § 438.6(c) by showing that the VBP arrangement with providers:

(a) Is based on utilization and delivery of services;
(b) Directs expenditures equally, and using the same terms of performance, for a class of providers providing the service under the Contract;
(c) Expects to advance at least one of the goals and objectives in the quality strategy in 42 C.F.R. § 438.340;
(d) Has an evaluation plan that measures the degree to which the arrangement advances at least one of the goals and objectives in the quality strategy in 42 C.F.R. § 438.340;
(e) Does not condition network provider participation in contract arrangements under 42 C.F.R. § 438.6(c)(1)(I through (iii) on the network provider entering into or adhering to intergovernmental transfer agreements; and
(f) May not be renewed automatically.

If the Contract directs Contractor's expenditures under 42 C.F.R. §438.6(c)(1)(i) or (c)(1)(ii), the arrangement:

(a) Will make participation in the value-based purchasing initiative, delivery system reform or performance improvement initiative available, using the same terms or performance, to a class of providers providing services under the contract related to the reform or improvement initiative;
(b) Will use a common set of performance measures across all of the payers and providers;
(c) Will not set the amount or frequency o the expenditures; and
(d) Will not allow the State to recoup any unspent funds allocated for these arrangements from Contractor.

**Revision 48:** Subsection 6.1.3 of the Contract's Scope of Work is amended to read as follows. Note that this revision does not alter the subsections under Section 6.1.3:

6.1.3 *Provider Credentialing*

In accordance with 42 C.F.R. §438.214, the Contractor shall comply with the following requirements:

(a) *General rules.* Contractor shall implement written policies and procedures for selection and retention of network providers and ensure that those policies and procedures, at a minimum, meet the requirements of this section.

(b) *Credentialing and recredentialing requirements.* (1) The Contractor's credentialing and re-credentialing process for all contracted providers shall meet the guidelines and standards of the

accrediting entity through which the Contractor attains accreditation and in compliance with 441 Iowa Administrative Code Chapter 88 as well as all State and Federal rules and regulations.

(2) Contractor shall follow a documented process for credentialing and recredentialing of network providers.

(c) *Nondiscrimination.* Contractor network provider selection policies and procedures, consistent with 42 C.F.R. § 438.12, must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

(d) *Excluded providers.* (1) Contractor may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.

(c) Reserved

**Revision 49:** Subsection 6.1.5(a)(1) of the Contract's Scope of Work is amended to read as follows:

6.1.5 *Provider-Patient Communications*

(a) *General rules.*

(1) Pursuant to 42 C.F.R. § 438.102, Contractor shall not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient, for the following:

(i) The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

(ii) Any information the Member needs to decide among all relevant treatment options.

(iii) The risks, benefits, and consequences of treatment or non-treatment.

(iv) The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

**Revision 50:** Subsection 6.1.6.1.9 of the Contract's Scope of Work is amended to read as follows:

6.1.6.1.9 Policies and procedures for grievances and appeals in accordance with 42 C.F.R. § 438.414 and consistent with Section 8.2.1 and 8.15.

**Revision 51:** Subsection 6.1.8 of the Contract's Scope of Work is amended to read as follows:

6.1.8 *Notification of Provider Disenrollment*

In addition to the requirement to comply with Section 8.2.1 obligations regarding member notification of provider disenrollment, the Contractor shall notify the Department and the Office of the Inspector General of provider disenrollments for program integrity reasons and in compliance with 42 C.F.R. Part 1001.

**Revision 52:** Subsection 6.1.10 of the Contract's Scope of Work is amended by deleting the text and marking the subsection "Reserved."

**Revision 53:** Subsection 6.3.1 of the Contract's Scope of Work is amended to read as follows:

6.3.1 *Primary Care Providers*

The specific primary care provider (PCP) designation is required for those members under a value based purchasing arrangement described in section 6.1.2. If using a PCP model, in any Work Plan required by Section 2.13, the Contractor shall describe the types of physician's eligible to serve as a PCP, any panel size limits or requirements, and proposed policies and procedures to link members to PCPs. Contractor shall demonstrate compliance with 42 C.F.R. § 438.208.

**Revision 54:** Subsection 6.3.8 of the Contract's Scope of Work is amended to read as follows:

6.3.8 *Family Planning Clinics*

The Contractor shall make a reasonable and good faith attempt to contract with all local family planning clinics that are enrolled as such with Iowa Medicaid.

**Revision 55:** Subsection 6.3.13 of the Contract's Scope of Work is amended by deleting the text and marking the subsection "Reserved."

**Revision 56:** Subsection 7.2.2 of the Contract's Scope of Work is amended to read as follows:

7.2.2 *New Enrollees*

Applicants shall have the opportunity to select a Contractor at the time of application, based on the plan information provided to them at the time of application. New enrollees who do not select a Contractor at the time of application shall be auto-assigned to one in accordance with the auto-assignment process set forth in Section 7.2.3. Information shall be provided to new enrollees in accordance with Section 8.2.1.

7.2.2.1 Reserved

**Revision 57:** Subsection 7.2.3 of the Contract's Scope of Work is amended to read as follows:

7.2.3 *Auto Assignment*

The auto-assignment algorithm will be designed by the Agency and comply with the provisions at 42 C.F.R. § 438.54, including striving to preserve existing provider-beneficiary relationships, inclusive of long-term services and supports (LTSS) providers. To the extent this is not possible, the algorithm will distribute equitably among qualified Contractors excluding those subject to intermediate sanctions at 42 C.F.R. § 438.702(a)(4). The Agency reserves the right to modify the auto-assignment logic at any time throughout the Contract term. Per 42 C.F.R. § 438.56(c), the Agency will automatically reenroll with the Contractor beneficiaries who are disenrolled solely because of loss of eligibility for a time period of two (2) months or less.

**Revision 58:** Section 7.5 of the Contract's Scope of Work is amended to read as follows:

7.5 *Indian Medicaid Managed Care*

(a) *Definitions.* As used in this section, the following terms have the indicated meanings:

*Indian* means any individual defined at 25 U.S.C. §§ 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12. This means the individual:

(i) Is a member of a Federally recognized Indian tribe;

(ii) Resides in an urban center and meets one or more of the four criteria:

(A) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

(B) Is an Eskimo or Aleut or other Alaska Native;

(C) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(D) Is determined to be an Indian under regulations issued by the Secretary of Health and Human Services;

(iii) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(iv) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

*Indian health care provider (IHCP)* means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

(b) *Network and coverage requirements.* In accordance with 42 C.F.R. § 438.14(b) Contractor shall:

(1) Demonstrate that there are sufficient IHCPs participating in the provider network of the Contractor to ensure timely access to services available under the Contract from such providers for Indian members who are eligible to receive services.

(2) Pay IHCPs, whether participating or not, for covered services provided to Indian members who are eligible to receive services from such providers as follows:

(i) At a rate negotiated between the Contractor, and the IHCP, or

(ii) In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the Contractor would make for the services to a participating provider which is not an IHCP; and

(iii) Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 C.F.R. §§ 447.45 and 447.46.

(3) Permit any Indian member to receive services from a IHCP primary care provider participating as a network provider, to choose that IHCP as his or her primary care provider, as long as that provider has capacity to provide the services.

(4) Permit Indian members to obtain services covered under the Contract from out-of-network IHCPs from whom the member is otherwise eligible to receive such services.

(5) If at any point in time access to covered services cannot be ensured in the Agency due to few or no IHCPs, Contractor will be considered to have met the requirement in paragraph (b)(1) of this section if—

(i) Indian members are permitted by the Contractor to access out-of-State IHCPs; or

(ii) If this circumstance is deemed to be good cause for disenrollment from both Contractor and the State's managed care program in accordance with 42 C.F.R. § 438.56(c).

(6) Contractor must permit an out-of-network IHCP to refer an Indian member to a network provider.

(c) *Payment requirements.* (1) When an IHCP is enrolled in Medicaid as a FQHC but not a participating provider of Contractor, it must be paid an amount equal to the amount the Contractor would pay a FQHC that is a network provider but is not an IHCP, pursuant to Special Terms Appendix 1 – Scope of Work, Section 6.3.7.

(2) When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of Contractor or not, the Contractor shall reimburse the IHCP at its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State plan's FFS payment methodology.

(3) Reserved.

(d) Reserved.

**Revision 59:** Subsection 8.2.1 of the Contract's Scope of Work is amended to read as follows:

8.2.1 *General*

The Contractor shall comply with the information requirements at 42 C.F.R. § 438.10 as set forth below.

(a) *Definitions.* As used in this section, the following terms have the indicated meanings:

*Limited English proficient (LEP)* means potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

*Prevalent* means a non-English language determined to be spoken by a significant number or percentage of potential members and members that are limited English proficient.

*Readily accessible* means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

(b) *Applicability.* The provisions of this section apply to Contractor.

(c) *Basic rules.* (1) Contractor must provide all required information in this section to members and potential members in a manner and format that may be easily understood and is readily accessible by such members and potential members.

(2) Reserved.

(3) Reserved.

(4) For consistency in the information provided to members, the Agency will develop and require Contractor to use:

(i) Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care; and

(ii) Model member handbooks and member notices.

(5) Contractor shall provide the required information in this section to each member.

(6) Member information required in this section may not be provided electronically by the Agency, or Contractor unless all of the following are met:

(i) The format is readily accessible;

(ii) The information is placed in a location on the Agency or Contractor's Web site that is prominent and readily accessible;

(iii) The information is provided in an electronic form which can be electronically retained and printed;

(iv) The information is consistent with the content and language requirements of this section; and

(v) The member is informed that the information is available in paper form without charge upon request and provides it upon request within 5 business days.

(7) Contractor must have in place mechanisms to help members and potential members understand the requirements and benefits of the plan.

(d) *Language and format.* The Agency will:

(1) Reserved.

(2) Make oral interpretation available in all languages and written translation available in each prevalent non-English language. All written materials for potential members must include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free telephone number of the entity providing choice counseling services as required by 42 C.F.R. § 438.71(a). Large print means printed in a font size no smaller than 18 point.

(3) Require Contractor to make its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its particular service area. Written materials must also be made available in alternative formats upon request of the potential member or member at no cost. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost. Written materials must include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of Contractor's member/customer service unit. Large print means printed in a font size no smaller than 18 point.

(4) Make interpretation services available to each potential member and require Contractor to make those services available free of charge to each member. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language. Oral interpretation requirements apply to all non-English languages, not just those that the Agency identifies as prevalent.

(5) Notify potential members, and require Contractor to notify its members—

(i) That oral interpretation is available for any language and written translation is available in prevalent languages;

(ii) That auxiliary aids and services are available upon request and at no cost for members with disabilities; and

(iii) How to access the services in paragraphs (d)(5)(i) and (ii) of this section.

(6) Provide, and require Contractor to provide, all written materials for potential members and members consistent with the following:

(i) Use easily understood language and format.

(ii) Use a font size no smaller than 12 point.

(iii) Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency.

(iv) Include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. Large print means printed in a font size no smaller than 18 point.

(e) *Information for potential members.* (1) The Agency must provide the information specific in paragraph (e)(2) of this section not each potential member, either in paper or electronic form as follows:

(i) At the time the potential member first becomes eligible to enroll in a voluntary managed care program, or is first required to enroll in a mandatory managed care program; and

(ii) Within a timeframe that enables the potential member to use the information in choosing among available Contractors.

(2) The information for potential members must include, at a minimum, all of the following:

(i) Information about the potential member's right to disenroll consistent with the requirements of 42 C.F.R. § 438.56 and which explains clearly the process for exercising this disenrollment right, as well as the alternatives available to the potential member based on their specific circumstance;

(ii) The basic features of managed care;

(iii) Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program. For mandatory and voluntary populations, the length of the enrollment period and all disenrollment opportunities available to the member must also be specified;

(iv) The service area covered by each Contractor;

(v) Covered benefits including:

(A) Which benefits are provided by the Contractor; and

(B) Which, if any, benefits are provided directly by the Agency.

(C) For a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Agency must provide information about where and how to obtain the service;

(vi) The provider directory and Preferred Drug List (PDL) information required in paragraphs (h) and (i) of this section;

(vii) Any cost-sharing that will be imposed by the Contractor consistent with those set forth in the State plan;

(viii) The requirements for each Contractor to provide adequate access to covered services, including the network adequacy standards established in 42 C.F.R. § 438.68;

(ix) The Contractor's responsibilities for coordination of member care; and

(x) To the extent available, quality and performance indicators for each Contractor, including member satisfaction.

(3) The Contractor will comply requests for information submitted by the Agency or its contracted representative and required for the development of information specified in paragraph (e)(2) of this section.

(f) *Information for all members with Contractor: General requirements.* (1) Contractor must make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

(2) The Agency will notify all members of their right to disenroll consistent with the requirements of 42 C.F.R. § 438.56 at least annually. Such notification will clearly explain the process for exercising this disenrollment right, as well as the alternatives available to the member based on their specific circumstance.

(3) Contractor must make available, upon request, any physician incentive plans in place as set forth in 42 C.F.R. § 438.3(i).

(g) *Information for members with Contractor—Member handbook.* (1) Contractor must provide each member a member handbook, within seven days after receiving notice of the beneficiary's enrollment, which serves a similar function as the summary of benefits and coverage described in 45 C.F.R. § 147.200(a).

(2) The content of the member handbook must include information that enables the member to understand how to effectively use the managed care program. This information must include at a minimum:

(i) Benefits provided by Contractor.

(ii) How and where to access any benefits provided by the Agency, including any cost sharing, and how transportation is provided.

(A) In the case of a counseling or referral service that Contractor does not cover because of moral or religious objections, Contractor must inform members that the service is not covered by Contractor.

(B) Contractor must inform members how they can obtain information from the Agency about how to access the services described in paragraph (g)(2)(i)(A) of this section.

(iii) The amount, duration, and scope of benefits available under the Contract in sufficient detail to ensure that members understand the benefits to which they are entitled.

(iv) Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider.

(v) The extent to which, and how, after-hours and emergency coverage are provided, including:

(A) What constitutes an emergency medical condition and emergency services.

(B) The fact that prior authorization is not required for emergency services.

(C) The fact that, subject to the provisions of this section, the member has a right to use any hospital or other setting for emergency care.

(vi) Any restrictions on the member's freedom of choice among network providers.

(vii) The extent to which, and how, members may obtain benefits, including family planning services and supplies from out-of-network providers. This includes an explanation that Contractor cannot require a member to obtain a referral before choosing a family planning provider.

(viii) Cost sharing.

(ix) Member rights and responsibilities, including the elements specified in 42 C.F.R. § 438.100.

(x) The process of selecting and changing the member's primary care provider.

(xi) Grievance, appeal, and fair hearing procedures and timeframes, consistent with Special Terms Appendix 1 – Scope of Work, Section 8.15, in an Agency-developed or Agency-approved description. Such information must include:

(A) The right to file grievances and appeals.

(B) The requirements and timeframes for filing a grievance or appeal.

(C) The availability of assistance in the filing process.

(D) The right to request a State fair hearing after Contractor has made a determination on a member's appeal which is adverse to the member.

(E) The fact that, when requested by the member, benefits that Contractor seeks to reduce or terminate will continue if the member files an appeal or a request for Agency fair hearing within the timeframes specified for filing, and that the member may, consistent with Agency policy, be required to pay the cost of services furnished while the appeal or State fair hearing is pending if the final decision is adverse to the member.

(xii) How to exercise an advance directive, as set forth in 42 C.F.R. § 438.3(j).

(xiii) How to access auxiliary aids and services, including additional information in alternative formats or languages.

(xiv) The toll-free telephone number for member services, medical management, and any other unit providing services directly to members.

(xv) Information on how to report suspected fraud or abuse;

(xvi) Any other content required by the Agency including, but not limited to information listed in Special Terms Appendix 1 – Scope of Work, Section 8.2.6.

(3) Information required by this paragraph to be provided by Contractor will be considered to be provided if the Contractor:

(i) Mails a printed copy of the information to the member's mailing address;

(ii) Provides the information by email after obtaining the member's agreement to receive the information by email;

(iii) Posts the information on the Web site of Contractor and advises the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or

(iv) Provides the information by any other method that can reasonably be expected to result in the member receiving that information.

(4) The Contractor must give each member notice of any change that the Agency defines as significant including, but not limited to, those changes set forth at Special Terms Appendix 1 – Scope of Work, Section 8.2.8, in the information specified in this paragraph (g), at least 30 days before the intended effective date of the change.

(h) *Information for all members of Contractor—Provider Directory.* (1) Contractor must make available in paper form upon request and electronic form, the following information about its network providers:

(i) The provider's name as well as any group affiliation.

(ii) Street address(es).

(iii) Telephone number(s).

(iv) Web site URL, as appropriate.

(v) Specialty, as appropriate.

(vi) Whether the provider will accept new members.

(vii) The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.

(viii) Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

(2) The provider directory must include the information in paragraph (h)(1) of this section for each of the following provider types covered under the Contract:

(i) Physicians, including specialists;

(ii) Hospitals;

(iii) Pharmacies;

(iv) Behavioral health providers; and

(v) LTSS providers, as appropriate.

(3) Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.

(4) Provider directories must be made available on Contractor's Web site in a machine readable file and format as specified by the Secretary.

(i) *Information for all members of Contractor: Preferred Drug List.* Contractor must make available in electronic or paper form, the following information about its Preferred Drug List (PDL) as described at Special Terms Appendix 1 – Scope of Work, Section 3.2.6.2.1:

(1) Which medications are covered (both generic and name brand).

(2) What tier each medication is on.

(3) PDLs must be made available on Contractor's Web site in a machine readable file and format as specified by the Secretary, or through a link to the PDL on the Agency's Web site.

(j) Reserved.

**Revision 60:** Subsection 8.2.2 of the Contract's Scope of Work is amended to read as follows:

8.2.2 *Language Requirements*

The Contractor shall provide information to members who are limited English proficient through the provision of language services at no cost to the individual. All written materials shall be provided in English and Spanish, and any additional prevalent languages identified by the Agency in the future at no additional cost to the Agency. Per 42 C.F.R. § 438.340(b)(6), at the time of enrollment with the Contractor, the Agency will provide the primary language of each enrollee. The Contractor shall utilize this information to ensure communication materials are distributed in the appropriate language. The Contractor shall also identify additional languages that are prevalent among the Contractor's membership. For purposes of this requirement, prevalent language is defined as any language spoken by at least five percent (5%) of the general population in the Contractor's service area. Written information shall be provided in any such prevalent languages identified by the Contractor.

**Revision 61:** Subsection 8.2.3 of the Contract's Scope of Work is amended to read as follows:

8.2.3 *Alternative Formats*

The Contractor shall make written materials available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. This includes 508 compliance, Braille, large font, audiotape and verbal explanations of written materials.

**Revision 62:** Subsection 8.2.6 of the Contract's Scope of Work is amended to read as follows:

8.2.6 *New Member Communications*

The Contractor shall distribute enrollment materials to each member. All information in the enrollment materials shall meet the requirements set forth in Section 8.2 and shall be submitted for the Agency review and approval prior to distribution in accordance with the process established in Section 8.2.4. In addition to information set forth in Section 8.2.1, the enrollment materials shall include the following information:

8.2.6.1 Reserved;

8.2.6.2 Contractor's contact information, including address, telephone number, web site;

8.2.6.3 Reserved;

8.2.6.4 Contractor's office hours/days, including the availability of the Member Helpline and the 24-hour Nurse Call Line;

8.2.6.5 Reserved;

8.2.6.6 Reserved;

8.2.6.7 Description of how to complete a health risk screening, a process described in Section 9.1;

8.2.6.8 Reserved;

8.2.6.9 Reserved;

8.2.6.10Reserved;

8.2.6.11If applicable, any cost-sharing information, including patient liability responsibilities for 1915(c) HCBS waiver enrollees, 1915(i) program enrollees, ICF/ID, and nursing facility residents, and contact information where the member can ask questions regarding their cost-sharing obligations and consequences for failure to comply with cost sharing and patient liability requirements;

8.2.6.12Reserved;

8.2.6.13Reserved;

8.2.6.14Procedures for obtaining out-of-network services and any special benefit provisions (for example, co-payments, limits or rejections of claims) that may apply to services obtained outside the Contractor's network;

8.2.6.15Standards and expectations for receiving preventive health services;

8.2.6.16Procedures for changing Contractors and circumstances under which this is possible, as described in Section 7.4;

8.2.6.17Procedures for making complaints and recommending changes in policies and services;

8.2.6.18 Reserved;

8.2.6.19Information on how to contact the Iowa Medicaid Enrollment Broker;

8.2.6.20Information on alternative methods or formats of communication for visually and hearing-impaired and non-English speaking enrollees and how members can access those methods or formats at no expense;

8.2.6.21Information and procedures on how to report suspected abuse and neglect, including the phone numbers to call to report suspected abuse and neglect;

8.2.6.22Contact information and description of the role of the Ombudsman; and

8.2.6.23For members enrolled in a 1915(c) HCBS Waiver or 1915(i) State Plan, the Contractor shall also provide the following information:

8.2.6.23.1 A description of the community-based case management's or integrated health home care coordinator's roles and responsibilities;

8.2.6.23.2 Information on how to change community based case management or integrated health homes care coordination; and

8.2.6.23.3 When applicable, information on the option to self-direct, a process described in Section 4.4.8, including but not limited to: (i) the roles and responsibilities of the member; (ii) the ability of the member to select a representative; (iii) the services that can and cannot be self-directed; (iv) the member's right to participate and voluntarily withdraw; (v) how to select the self-direction option; and (vi) who can and cannot be hired by the member to perform the services; and information on estate recovery.

**Revision 63:** Subsection 8.2.7 of the Contract's Scope of Work is amended by deleting the text and marking the subsection "Reserved."

**Revision 64:** Section 8.5 of the Contract's Scope of Work is amended to read as follows:

8.5 *Electronic Communications*

The Contractor shall leverage technology to promote timely and effective communications with members. All electronic communications shall be in compliance with 42 C.F.R. §438.10, as further described in Section 8.2.1. The Contractor shall collect information on member's preferred mode of receipt of Contractor-generated communications and send materials in the selected format. Options shall include, but are not limited to, the ability to receive paper communications via mail or electronic communications through a secure web portal. When a member notifies the Contractor of selection to receive communications electronically, that choice shall be confirmed through regular mail with instructions on how to change the selection if

desired. Additionally, emails shall be sent to members alerting them anytime an electronic notice is posted to the portal; no confidential information shall be included in emails. In the event such a notification email is returned as undeliverable, the Contractor shall send the notice by regular mail within three (3) business days of the failed email. When applicable, the Contractor shall comply with a member's election to change the preferred mode of communication. The Contractor shall receive electronic communications from members via email and the member website. The Contractor shall respond to electronic inquiries within one (1) business day. The Contractor is also encouraged to utilize mobile technology, such as delivering medication and appointment reminders through personalized voice or text messaging.

**Revision 65:** Subsection 8.12.1 of the Contract's Scope of Work is amended to read as follows. Note that this revision does not alter the other subsections under subsection 8.12.1:

8.12.1 *Stakeholder Advisory Board*

The Contractor shall convene a Stakeholder Advisory Board in accordance with the following requirements of 42 C.F.R. §438.110:

(a) *General rule.* Contractor shall establish and maintain a stakeholder advisory board within 90 days of the effective date of the Contract.

(b) *Committee composition.* The committee required in paragraph (a) of this section must include at least a reasonably representative sample of the LTSS populations, or other individuals representing those members, covered under the Contract with the Contractor as further described at Section 8.12.1.2.

The purpose of the Stakeholder Advisory Board is to serve as a forum for members or their representatives and providers to advise the Contractor. The Stakeholder Advisory Board shall provide input on issues such as: (i) service delivery; (ii) quality of care; (iii) member rights and responsibilities; (iv) resolution of grievances and appeals; (v) operational issues; (vi) program monitoring and evaluation; (vii) member and provider education; and (viii) priority issues identified by members.

**Revision 66:** Section 8.15 of the Contract's Scope of Work is amended to read as follows:

8.15 *Grievance Appeals and State Fair Hearings*

8.15.1 *General*

Pursuant to 42 C.F.R. § 438.402, the following requirements shall apply:

(a) *The grievance and appeal system.* Contractor must have a grievance and appeal system in place for members.

(b) *Level of appeals.* Contractor may have only one level of appeal for members.

(c) *Filing requirements*—(1) *Authority to file.* (i) A member may file a grievance and request an appeal with the Contractor. A member may request a State fair hearing after receiving notice under 42 C.F.R. § 438.408, as described at Section 8.15.4, that the adverse benefit determination is upheld.

(A) *Deemed exhaustion of appeals processes.* In the case of Contractor failing to adhere to the notice and timing requirements in 42 C.F.R. § 438.408, as described at Section 8.15.4, the member is deemed to have exhausted the Contractor's appeals process. The member may initiate a State fair hearing.

(B) Reserved.

(ii) State law permits a provider or an authorized representative, with the written consent of the member, to request an appeal or file a grievance, or request a State fair hearing, on behalf of a member. When the term "member" is used throughout this section 8.15 and all its subsections, it includes providers and authorized representatives consistent with this paragraph, with the exception that providers cannot request continuation of benefits as specified in 42 C.F.R. § 438.420(b)(5).

(2) *Timing*—(i) *Grievance.* A member may file a grievance with Contractor at any time.

(ii) *Appeal.* Following receipt of a notification of an adverse benefit determination by Contractor, a member has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the managed care plan.

(3) *Procedures*—(i) *Grievance.* The member may file a grievance either orally or in writing with the Contractor.

(ii) *Appeal.* The member may request an appeal either orally or in writing. Further, unless the member requests an expedited resolution, an oral appeal must be followed by a written, signed appeal. 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.

8.15.2 *Notice of Adverse Benefit Determination*

In accordance with 42 C.F.R. §438.404, the following requirements shall apply:

(a) *Notice.* The Contractor must give members timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below and in 42 C.F.R. § 438.10.

(b) *Content of notice.* Pursuant to 42 C.F.R. § 438.10, the Contractor must use language developed by the Agency for the notice, with the only non-Agency developed language being permissible for content described at (1) - (2). The notice must explain the following:

(1) The adverse benefit determination the Contractor has made or intends to make.

(2) The reasons for the adverse benefit determination, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such

information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. Citation of the Iowa Code and/or Iowa Administrative Code sections supporting the adverse benefit determination shall also be provided.

(3) The member's right to request an appeal of the Contractor's adverse benefit determination, including information on exhausting the Contractor's one level of appeal described at 42 C.F.R. § 438.402(b) and the right to request a State fair hearing consistent with 42 C.F.R. § 438.402(c).

(4) The procedures for exercising the rights specified in this paragraph (b) of this subsection.

(5) The circumstances under which an appeal process can be expedited and how to request it.

(6) The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with Agency policy, under which the member may be required to pay the costs of these services.

(c) *Timing of notice.* The Contractor must mail the notice within the following timeframes:

(1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in 42 C.F.R. §§ 431.211, 431.213, and 431.214.

(2) For denial of payment, at the time of any action affecting the claim.

(3) For standard service authorization decisions that deny or limit services, within the timeframe specified in 42 C.F.R. § 438.210(d)(1).

(4) If Contractor meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with 42 C.F.R. § 438.210(d)(1)(ii), it must—

(i) Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and

(ii) Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

(5) For service authorization decisions not reached within the timeframes specified in 42 C.F.R. § 438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.

(6) For expedited service authorization decisions, within the timeframes specified in 42 C.F.R. § 438.210(d)(2).

8.15.3 *Handling of Grievances and Appeals*

In accordance with 42 C.F.R. §438.406, the following requirements shall apply:

(a) *General requirements.* In handling grievances and appeals, the Contractor must give members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(b) *Special requirements.* Contractor's process for handling member grievances and appeals of adverse benefit determinations must:

(1) Acknowledge receipt of each grievance and appeal within 3 business days.

(2) Ensure that the individuals who make decisions on grievances and appeals are individuals—

(i) Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

(ii) Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the Agency, in treating the member's condition or disease.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

(iii) Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

(3) Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the member or the provider requests expedited resolution.

(4) Provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 42 C.F.R. § 438.408(b) and (c) in the case of expedited resolution.

(5) Provide the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by Contractor (or at the direction of the Contractor) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 C.F.R. § 438.408(b) and (c).

(6) Include, as parties to the appeal—

(i) The member and his or her representative; or

(ii) The legal representative of a deceased member's estate.

8.15.4 *Grievance and Appeals Resolution and Notification*

In accordance with 42 C.F.R. § 438.408, the following requirements shall apply:(a) *Basic rule.* Contractor must resolve each grievance and appeal, and provide notice, as expeditiously as the member's health condition requires, within Agency-established timeframes that may not exceed the timeframes specified in this section.

(b) *Specific timeframes*—(1) *Standard resolution of grievances.* For standard resolution of a grievance, the Contractor shall resolve and provide notice to the affected parties within 30 calendar days from the day Contractor receives the grievance.

(2) *Standard resolution of appeals.* For standard resolution of an appeal, the Contractor shall resolve and provide notice to the affected parties within 30 calendar days from the day the Contractor receives the appeal. This timeframe may be extended under paragraph (c) of this subsection.

(3) *Expedited resolution of appeals.* For expedited resolution of an appeal, the Contractor shall resolve and provide notice to affected parties within 72 hours after the Contractor receives the appeal. This timeframe may be extended under paragraph (c) of this section.

(c) *Extension of timeframes.* (1) The Contractor may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if—

(i) The member requests the extension; or

(ii) The Contractor shows (to the satisfaction of the Agency, upon its request) that there is need for additional information and how the delay is in the member's interest.

(2) *Requirements following extension.* If Contractor extends the timeframes not at the request of the member, it must complete all of the following:

(i) Make reasonable efforts to give the member prompt oral notice of the delay.

(ii) Within 2 calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.

(iii) Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

(3) *Deemed exhaustion of appeals processes.* If Contractor fails to adhere to the notice and timing requirements in this section, the member is deemed to have exhausted the Contractor's appeals process. The member may initiate a State fair hearing.

(d) *Format of notice*—(1) *Grievances.* The Contractor must provide a member with written notice of the resolution of a grievance consistent with, at a minimum, the standards described at 42 C.F.R. § 438.10.

(2) *Appeals.* (i) For all appeals, the Contractor must provide written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 C.F.R. § 438.10.

(ii) For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice.

(e) *Content of notice of appeal resolution.* Pursuant to 42 C.F.R. §438.10, the Contractor must use language developed by the Agency for the notice, with the only non-Agency developed language being permissible for content described at (1). The written notice of the resolution must include the following:

(1) The results of the resolution process and the date it was completed.

(2) For appeals not resolved wholly in favor of the members—

(i) The right to request a State fair hearing, and how to do so.

(ii) The right to request and receive benefits while the hearing is pending, and how to make the request.

(iii) That the member may, consistent with Agency policy, be held liable for the cost of those benefits if the hearing decision upholds the Contractor's adverse benefit determination.

(f) *Requirements for State fair hearings*—(1) *Availability.* A member may request a State fair hearing only after receiving notice that the Contractor is upholding the adverse benefit determination.

(i) *Deemed exhaustion of appeals processes.* If Contractor fails to adhere to the notice and timing requirements in 42 C.F.R. § 438.408, the member is deemed to have exhausted the Contractor's appeals process. The member may initiate a State fair hearing.

(ii) Reserved.

(2) *State fair hearing.* The member must request a State fair hearing no later than 120 calendar days from the date of the Contractor's notice of resolution.

(3) *Parties.* The parties to the State fair hearing include the Contractor, as well as the member and his or her representative or the representative of a deceased member's estate.

8.15.5 *Expedited Resolution of Appeals*

In accordance with 42 C.F.R. § 438.410, the following requirements shall apply:

(a) *General rule.* Contractor must establish and maintain an expedited review process for appeals, when the Contractor determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

(b) *Punitive action.* Contractor must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.

(c) *Action following denial of a request for expedited resolution.* If Contractor denies a request for expedited resolution of an appeal, it must—

(1) Transfer the appeal to the timeframe for standard resolution in accordance with 42 C.F.R. § 438.408(b)(2).

(2) Follow the requirements in 42 C.F.R. § 438.408(c)(2).

8.15.6 *Information About the Grievance and Appeal Process*

In accordance with 42 C.F.R. § 438.414, the Contractor must provide information specified in 42 C.F.R. § 438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.

8.15.7 *Recordkeeping Requirements*

In accordance with 42 C.F.R. § 438.416, the following requirements shall apply:

(a) Contractor shall maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the Agency quality strategy.

(b) The record of each grievance or appeal must contain, at a minimum, all of the following information:

(1) A general description of the reason for the appeal or grievance.

(2) The date received.

(3) The date of each review or, if applicable, review meeting.

(4) Resolution at each level of the appeal or grievance, if applicable.

(5) Date of resolution at each level, if applicable.

(6) Name of the covered person for whom the appeal or grievance was filed.

(c) The record must be accurately maintained in a manner accessible to the Agency and available upon request to CMS.

8.15.8 *Continuation of Benefits*

In accordance with 42 C.F.R. §438.420, the following requirements shall apply to all members other than those members receiving coverage pursuant to Iowa Code ch. 514I:

(a) *Definition.* As used in this section—

*Timely files* means files for continuation of benefits on or before the later of the following:

(i) Within 10 calendar days of the Contractor sending the notice of adverse benefit determination.

(ii) The intended effective date of the Contractor's proposed adverse benefit determination.

(b) *Continuation of benefits.* The Contractor must continue the member's benefits if all of the following occur:

(1) The member files the request for an appeal timely in accordance with 42 C.F.R. § 438.402(c)(1)(ii) and (c)(2)(ii);

(2) The appeal involves the termination, suspension, or reduction of previously authorized services;

(3) The services were ordered by an authorized provider;

(4) The period covered by the original authorization has not expired; and

(5) The member timely files for continuation of benefits.

(c) *Duration of continued or reinstated benefits.* If, at the member's request, the Contractor continues or reinstates the member's benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of following occurs:

(1) The member withdraws the appeal or request for State fair hearing.

(2) The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal under 42 C.F.R. § 438.408(d)(2).

(3) A State fair hearing office issues a hearing decision adverse to the member.

(d) *Member responsibility for services furnished while the appeal or State fair hearing is pending.* If the final resolution of the appeal or State fair hearing is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of services furnished to the member while the appeal and State fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section. The Contractor shall not be required to continue benefits beyond any Agency defined benefit limits as outlined in Exhibit D.

8.15.9 *Effectuation of Reversed Appeal Resolutions*

In accordance with 42 C.F.R. § 438.424, the following requirements shall apply:

(a) *Services not furnished while the appeal is pending.* If the Contractor, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly

and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

(b) *Services furnished while the appeal is pending.* If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Contractor must pay for those services, in accordance with Agency policy and regulations.

8.15.10 *Exception to Contractor Policy Process*

The Contractor may operate an exception to policy process. Under the exception to policy process, a member can request an item or service not otherwise covered by the Agency or the Contractor. Exceptions to policy may be granted to Contractor policies, but they cannot be granted to federal or State law and regulations. An exception to policy is a last resort request and is not appealable as the request is for services outside of state plan or waiver benefits.

**Revision 67:** Section 9.1 of the Contract's Scope of Work is amended to read as follows:

9.1 *General Obligations Applicable to Care Coordination*

(a) *Basic requirement*—(1) *General rule.* The Contractor shall comply with the requirements of this section in accordance with 42 C.F.R. § 438.208.

(2) Reserved.

(3) Reserved.

(b) *Care and coordination of services for all members.* Contractor shall implement procedures to deliver care to and coordinate services for all Contractor members pursuant to Special Terms Appendix 1 – Scope of Work, Sections 4 and 9. These procedures must meet Agency requirements and must do the following:

(1) Ensure that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. The member must be provided information on how to contact their designated person or entity;

(2) Coordinate the services the Contractor furnishes to the member:

(i) Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays;

(ii) With the services the member receives from any other MCO, PIHP, or PAHP;

(iii) With the services the member receives in FFS Medicaid; and

(iv) With the services the member receives from community and social support providers.

(3) Provide that Contractor makes a best effort to conduct an initial screening of each member's needs, within 90 days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful;

(4) Share with the Agency or other MCOs, PIHPs, and PAHPs serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities;

(5) Ensure that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards; and

(6) Ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 C.F.R. parts 160 and 164 subparts A and E, to the extent that they are applicable.

(c) *Additional services for members with special health care needs or who need LTSS*—(1) Persons who need LTSS or persons with special health care needs will be identified by the Contractor through the initial screening described in paragraph (b)(3), through identification processes pursuant to Special Terms Appendix 1 – Scope of Work, Section 4.2.2 or by the Agency.

(i) Reserved.

(ii) Reserved.

(2) *Assessment.* Contractor shall implement mechanisms to comprehensively assess each member identified as needing LTSS or having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring pursuant to Special Terms Appendix 1 – Scope of Work, Section 4.2.2. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of the Agency or the Contractor as appropriate.

(3) *Treatment/service plans.* Contractor shall produce a treatment or service plan meeting the criteria in paragraphs (c)(3)(i) through (v) of this section and pursuant to Special Terms Appendix 1 – Scope of Work, Section 4.4.2 and 4.4.3 for members who require LTSS and, if the Agency requires, must produce a treatment or service plan meeting the criteria in paragraphs (c)(3)(iii) through (v) of this section for members with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan must be:

(i) Developed by an individual meeting LTSS service coordination requirements with member participation, and in consultation with any providers caring for the member;

(ii) Developed by a person trained in person-centered planning using a person-centered process and plan as defined in 42 C.F.R. §441.301(c)(1) and (2) for LTSS treatment or service plans;

(iii) Approved by the Contractor in a timely manner, if this approval is required by the Contractor;

(iv) In accordance with any applicable Agency quality assurance and utilization review standards; and

(v) Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the member's circumstances or needs change significantly, or at the request of the member per 42 C.F.R. § 441.301(c)(3).

(4) *Direct access to specialists.* For members with special health care needs determined through an assessment (consistent with paragraph (c)(2) of this section) to need a course of treatment or regular care monitoring, Contractor must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.

(d) Reserved.

**Revision 68:** New Section 9.2 is hereby added to the Contract's Scope of Work, and the clause reads as follows:

9.2 *LTSS Care Coordination*

The Contractor shall comply with Section 9.1 and Section 4 when providing LTSS care coordination services.

**Revision 69:** New Section 9.3 is hereby added to the Contract's Scope of Work, and the clause reads as follows:

9.3 *Non-LTSS Care Coordination*

The care coordination requirements in this section apply to non-LTSS services; see Section 4 for LTSS assessment, care plan and community-based case management requirements. For members receiving LTSS who are identified as eligible for services under the Contractor's care coordination program, as described in this section, the Contractor shall implement strategies to ensure the integration of LTSS case management and Contractor care coordination program services.

The Contractor shall implement a care coordination program in compliance with the requirements of this section. Care coordination programs shall also have a demonstrated record of: (i) improving quality outcomes; (ii) coordinating care across the healthcare delivery system; (iii) increasing member compliance with recommended treatment protocols; (iv) increasing member understanding of their healthcare conditions and prescribed treatment; (v) empowering members; (vi) coordinating care with other Contractors and/or Agencies; and (vii) providing flexible person-centered care.

**9.3.1 Initial Screening**

The Contractor shall conduct initial health risk screenings for: (i) new members, within ninety (90) days of enrollment for the purpose of assessing need for any special health care or care coordination services; (ii) members who have not been enrolled in the prior twelve (12) months; and (iii) members for whom there is a reasonable belief they are pregnant. During the initial health risk screening process, members shall be offered assistance in arranging an initial visit with their PCP (as applicable) for a baseline medical assessment and other

preventive services, including an assessment or screening of the member's potential risk, if any, for specific diseases or conditions.

#### 9.3.1.1 Tool

The Contractor shall obtain Agency approval of an initial health risk screening tool. At minimum, information collected shall assess the member's physical, behavioral, social, functional and psychological status and needs. The tool shall determine the need for care coordination, behavioral health services, or any other health or community services. The tool shall also comply with NCQA standard for health risk screenings and contain questions that can tie to social determinants of health.

#### 9.3.1.2 Subsequent Screenings

The Contractor shall also be required to conduct a subsequent health screening if a member's health care status is determined to have changed since the original screening. Such evidence may be available through methods such as claims review or provider notification.

#### 9.3.1.3 Screening Method

The initial health risk screening may be conducted: (i) in person; (ii) by phone; (iii) electronically through a secure website; or (iv) by mail. The Contractor shall develop methods to maximize contacts with members in order to complete the initial health screening.

### 9.3.2 Comprehensive Health Risk Assessment

The initial health screening described in Section 9.1.1 shall be followed by a comprehensive health risk assessment when a member is identified in the initial screening process as having a special health care need, or when there is a need to follow-up on problem areas identified in the initial screening.

#### 9.3.2.1 Tool

The Contractor shall obtain Agency approval for use of an initial health risk assessment tool. At minimum, information collected shall assess the member's physical, behavioral, social, functional and psychological status and needs. The tool shall determine the need for care coordination, behavioral health services, or any other health or community services. The tool must also comply with NCQA standard for health risk screenings and contain questions that can tie to social determinants of health.

#### 9.3.2.2 Timeline for Completion

The Contractor shall obtain Agency approval for the timeframe in which all comprehensive health risk assessments shall be completed. The Contractor shall implement and adhere to the Agency-approved timeline. Changes to this timeline must receive the Agency's prior approval.

### 9.3.3 Care Coordination

The Contractor shall design and operate a care coordination program, subject to the Agency review and approval, to monitor and coordinate the care for members identified as having a special health care need. Minimum requirements for the Contractor's care coordination program include: (i) catastrophic case management; (ii) disease management; (iii) programs to target members overusing and/or abusing services; (iv) discharge planning; and (v) transition planning.

### 9.3.4 Risk Stratification

The Contractor shall utilize risk stratification levels, subject to the Agency review and approval, to determine the intensity and frequency of follow-up care that is required for each member participating in the care coordination program.

### 9.3.5 Member Identification

In addition to identifying members eligible for the care coordination program through the initial health risk screening and comprehensive health risk assessment, the Contractor shall utilize, at minimum: (i) industry standard predictive modeling; (ii) claims review; (iii) member and caregiver requests; and (iv) physician referrals.

### 9.3.6 Care Plan Development

The Contractor shall develop a care plan for all members eligible for the care coordination program. The care plan shall be individualized and person-centered based on the findings of the initial health risk screening, comprehensive health risk assessment, available medical records, and other sources needed to ensure that care for members is adequately coordinated and appropriately managed. The care plan shall: (i) establish prioritized goals and actions; (ii) facilitate seamless transitions between care settings; (iii) create a communication plan with providers and members; and (iv) monitor whether the member is receiving the recommended care.

#### 9.3.6.1 Involved Parties

When developing the care plan, in addition to working with a multidisciplinary team of qualified health care professionals including specialists caring for the enrollee, the Contractor shall ensure that there is a mechanism for members, their families and/or advocates and caregivers, or others chosen by the member, to be actively involved in the care plan development. Care plans shall be conducted jointly with other caseworkers for members who are accessing multiple services concurrently or consecutively. The Contractor shall provide an integrated care plan which avoids duplication and/or fragmentation of services.

#### 9.3.6.2 Care Plan Requirements

The care plan shall reflect cultural considerations of the member. In addition, the care plan development process shall be conducted in plain language, and be accessible to members who have disabilities and/or have limited English proficiency. The care plan shall be approved by the Contractor in a timely manner and in accordance with applicable quality measures and utilization review standards. For enrollees determined to meet a course of treatment or regular monitoring, the Contractor shall have direct access to a specialist as appropriate for the enrollee's condition and identified needs. The Contractor shall ensure that the care plan is provided to the member's PCP (if applicable) or other significant providers. The Contractor shall also provide the member the opportunity to review the care plan as requested.

### 9.3.7 Tracking and Reporting

The Contractor shall integrate information about members in order to facilitate positive member outcomes through care coordination. The system shall have the ability to track the results of the initial health risk screening, comprehensive health risk assessment, the care plan, and member outcomes and have the ability to share care coordination information with the member, his or her authorized representatives, and all relevant treatment providers, including, but not limited to: (i) behavioral health providers; (ii) primary care providers; and

(iii) specialists. The Contractor shall submit regular reporting regarding the selection criteria, strategies & outcomes of care coordination programs as prescribed in the Reporting Manual.

**9.3.8 Monitoring**
The Contractor shall develop a comprehensive program for monitoring, on an ongoing basis, the effectiveness of its care coordination program and processes. The Contractor shall promptly remediate all case specific findings identified through the monitoring process and track and trend findings to identify systemic issues of poor performance or non-compliance. The Contractor shall implement strategies to improve its care coordination program and processes and resolve areas of non-compliance.

**9.3.9 Reassessments**
The Contractor shall develop a process for reviewing and updating the care plans with members on an as-needed basis, but no less often than annually. In addition, members may move between stratified levels of care groups over time as their needs change; therefore, the Contractor shall develop a protocol for re-evaluating members periodically to determine if their present care levels are adequate. The Contractor shall also identify triggers which would immediately move the member to a more assistive level of service. Additionally, any member or provider can request a reassessment at any time.

**Revision 70:** Section 3.2.8.13.2 of the Contract's Scope of Work is amended to read as follows:

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

**Revision 71:** Section 3.2.8.13.3 of the Contract's Scope of Work is amended to read as follows:

**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.

**Revision 72:** Section 3.2.8.13.4 is hereby added to the Contract's Scope of Work, and the new clause reads as follows:

**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 73:** Subsection 10.1.1 of the Contract's Scope of Work is amended to read as follows:

10.1.1 *Program Objectives*

The Agency seeks to improve the quality of care and outcomes for Medicaid and CHIP enrollees across the healthcare delivery system through this Contract. The Contractor shall improve quality outcomes and develop a Quality Management/Quality Improvement (QM/QI) program that incorporates ongoing review of all major Contract areas. The QM/QI program shall have objectives that are measurable, realistic and supported by consensus among the Contractor's medical and quality improvement staff. Through the QM/QI program, the Contractor shall have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to members consistent with 42 C.F.R. § 438.330, as described below. The Contractor shall use the result of its QM/QI activities to improve the quality of physical health, behavioral health, and long-term care service delivery with appropriate input from provider and members.

(a) *General rules.* (1) Contractor shall establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its members that includes the elements identified in paragraph (b) of this section.

(2) Reserved.

(3) Reserved.

(b) *Basic elements of quality assessment and performance improvement programs.* The comprehensive quality assessment and performance improvement program described in paragraph (a) of this section must include at least the following elements:

(1) Performance improvement projects in accordance with paragraph (d) of this section.

(2) Collection and submission of performance measurement data in accordance with paragraph (c) of this section.

(3) Mechanisms to detect both underutilization and overutilization of services.

(4) Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs, as defined by the Agency in the quality strategy under 42 C.F.R. § 438.340.

(5) For Contractors providing long-term services and supports:

(i) Mechanisms to assess the quality and appropriateness of care furnished to members using long-term services and supports, including assessment of care between care settings and a

comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable; and

(ii) Participate in efforts by the Agency to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per 42 C.F.R. §§ 441.302 and 441.730(a)) that are based, at a minimum, on the requirements on the Agency for home and community-based waiver programs per 42 C.F.R. § 441.302(h).

(c) *Performance measurement.*

(1) Standard performance measures will include those performance measures that may be specified by CMS under 42 C.F.R. § 438.330(a)(2), relating to the performance of Contractor.

(2) Contractor shall, on an annual basis either:

(i) Measure and report to the Agency on its performance, using the standard measures required by the Agency;

(ii) Submit to the Agency data, specified by the Agency, which enables the Agency to calculate the Contractor's performance using the standard measures identified by the Agency; or

(iii) Perform a combination of the activities described in paragraphs (c)(2)(i) and (ii) of this section.

(d) *Performance improvement projects.* (1) Contractor shall conduct performance improvement projects, including any performance improvement projects required by CMS in accordance with 42 C.F.R. § 438.330(a)(2), that focus on both clinical and nonclinical areas.

(2) Each performance improvement project must be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and must include the following elements:

(i) Measurement of performance using objective quality indicators.

(ii) Implementation of interventions to achieve improvement in the access to and quality of care.

(iii) Evaluation of the effectiveness of the interventions based on the performance measures in paragraph (d)(2)(i) of this section.

(iv) Planning and initiation of activities for increasing or sustaining improvement.

(3) Contractor shall report the status and results of each project conducted per paragraph (d)(1) of this section to the Agency as requested, but not less than once per year.

(4) Reserved.

(e) *Program review by the Agency.* (1) The Agency will arrange for an annual, external independent review of the Contractor's quality of, timeliness of, and access to health care services

covered under the Contract, pursuant to Special Terms Appendix 1 – Scope of Work, Section 10.2.2.

(2) Reserved.

**Revision 74:** The first sentence of subsection 10.1.2 of the Contract's Scope of Work is amended to read as follows:

> The Contractor shall meet the requirements of 42 C.F.R. Part 438 subpart E and the standards of the credentialing body by which the Contractor is credentialed in development of its QM/QI program.

**Revision 75:** Subsection 10.1.2.4 of the Contract's Scope of Work is amended by deleting the text and marking the subsection "Reserved."

**Revision 76:** Subsection 10.1.3.3 of the Contract's Scope of Work is amended by deleting the text and marking the subsection "Reserved."

**Revision 77:** Subsection 10.2.1 of the Contract's Scope of Work is amended to read as follows:

10.2.1 *State Quality Review*

In accordance with 42 C.F.R. § 438.340, the Agency will establish a written strategy for assessing and improving the quality of services offered by program Contractors. The Agency will regularly monitor and evaluate the Contractor's compliance with the standards established in the Agency's quality strategy and the Contractor's QM/QI program.

**Revision 78:** The first sentence of subsection 10.2.2.1 of the Contract's Scope of Work is amended to read as follows:

> Pursuant to federal regulations at 42 C.F.R. § 438.350 through 438.370, the Agency will arrange for an annual, external independent review of the Contractor's quality of, timeliness of and access to health care services covered under the Contract.

**Revision 79:** Subsection 10.2.2.3 of the Contract's Scope of Work is amended to read as follows:

10.2.2.3 *Availability of Results*

The results of each external independent review shall be posted on the Agency's website required under 42 C.F.R. § 438.10(c)(3) and made available, upon request, to interested parties such as participating health care providers, members, and potential members of the Contractor, member advocacy groups, and members of the general public, except that the results may not be made available in a manner that discloses the identity of any individual patient.

**Revision 80:** Subsection 10.3.3.2 of the Contract's Scope of Work is amended to read as follows:

10.3.3.2 *Incentive Payment Restrictions*

If implementing the member incentive programs, the Contractor shall comply with all marketing provisions in 42 C.F.R. § 438.104 as delineated in Section 8.1, as well as federal and State regulations regarding inducements.

**Revision 81:** Subsection 11.1.4 of the Contract's Scope of Work is amended to read as follows:

11.1.4 *UM Subcontractors and Staff*

In accordance with 42 C.F.R. § 438.210(e), the Contractor shall assure that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member. If the Contractor delegates some or all of its UM activities, including prior authorization functions, to subcontractors, the Contractor shall conduct annual audits and ongoing monitoring to ensure the subcontractor's performance complies with the Contract, the Contractor's policies and procedures and State and Federal law.

**Revision 82:** Subsection 11.1.5 of the Contract's Scope of Work is amended to read as follows:

11.1.5 *Practice Guidelines*

(a) *Basic rule.* Contractor shall meet the requirements of this section in accordance with 42 C.F.R. § 438.236.

(b) *Adoption of practice guidelines.* Contractor shall adopt practice guidelines that meet the following requirements:

(1) Are based on valid and reliable clinical evidence or a consensus of providers in the particular field.

(2) Consider the needs of the Contractor's members.

(3) Are adopted in consultation with contracting health care professionals.

(4) Are reviewed and updated periodically as appropriate.

(c) *Dissemination of guidelines.* Contractor shall disseminate the guidelines to all affected providers and, upon request, to members and potential members.

(d) *Application of guidelines.* Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

**Revision 83:** Section 11.2 of the Contract's Scope of Work, as well as all subsections of Section 11.2, is amended to read as follows:

11.2 *Coverage and Authorization of Services*

11.2.1 *General*

(a) *Coverage.* In accordance with 42 C.F.R. §438.210, the Contractor shall provide covered services as outlined in Special Terms Appendix 1 – Scope of Work, Section 3.2, and no less than the amount, duration, and scope for the same services furnished to beneficiaries under

FFS Medicaid, as set forth in 42 C.F.R. § 440.230, and for members under the age of 21, as set forth in 42 C.F.R. subpart B of part 441.

(1) Reserved.

(2) Reserved.

(3) The Contractor—

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.

(4) The Contractor is permitted to place appropriate limits on a service—

(i) On the basis of criteria applied under the State plan, such as medical necessity; or

(ii) For the purpose of utilization control, provided that—

(A) The services furnished can reasonably achieve their purpose, as required in paragraph (a)(3)(i) of this section;

(B) The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member's ongoing need for such services and supports; and

(C) Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 C.F.R. § 441.20.

(5) The Contractor must furnish Medically Necessary Services as defined in Exhibit A and in a manner that—

(i) Is no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

(ii) Addresses:

(A) The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability.

(B) The ability for a member to achieve age-appropriate growth and development.

(C) The ability for a member to attain, maintain, or regain functional capacity.

(D) The opportunity for a member receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

(b) *Authorization of services.* For the processing of requests for initial and continuing authorizations of services, Contractor shall —

(1) Have in place, and follow, written policies and procedures.

(2)(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

(ii) Consult with the requesting provider for medical services when appropriate.

(iii) Authorize LTSS based on a member's current needs assessment and consistent with the person-centered service plan.

(3) Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's medical, behavioral health, or long-term services and supports needs.

(c) *Notice of adverse benefit determination.* Contractor shall notify the requesting provider, and give the member written notice of any decision by Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The member's notice must meet the requirements of 42 C.F.R. § 438.404.

(d) *Timeframe for decisions.*

(1) *Standard authorization decisions.* For standard authorization decisions, Contractor shall provide notice as expeditiously as the member's condition requires and within 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if—

(i) The member, or the provider, requests extension; or

(ii) The Contractor justifies (to the Agency upon request) a need for additional information and how the extension is in the member's interest.

(2) *Expedited authorization decisions.* (i) For cases in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service.

(ii) The Contractor may extend the 72 hour time period by up to 14 calendar days if the member requests an extension, or if the Contractor justifies (to the Agency upon request) a need for additional information and how the extension is in the member's interest.

(3) *Covered outpatient drug decisions.* For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Social Security Act.

(4) *Failure to respond.* If the Contractor fails to respond to a member's prior authorization request as outlined in paragraph (d)(1), the authorization is deemed granted unless otherwise prohibited by law.

(e) *Compensation for utilization management activities.* Consistent with 42 C.F.R. § 438.3(i), and 42 C.F.R. § 422.208, Contractor shall not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member. Contractor and subcontractor written policies and procedures for processing requests for initial and continuing authorizations of services are subject to Agency review and approval. The Contractor shall have in effect mechanisms to ensure consistent application of review criteria for prior authorization decisions. The Contractor shall have sufficient staff with clinical expertise and training to interpret and apply the UM criteria and practice guidelines to providers' requests for health care or service authorizations for the Contractor's members. Consultation with the requesting provider shall be ensured when appropriate.

11.2.1.1 *Reserved.*

11.2.2 *IDPH Prior Authorization*

Authorization shall not be required at any level of service for the IDPH population. Retrospective utilization monitoring shall be performed to ensure appropriate application of clinical criteria.

11.2.3 *Medical Necessity Determinations*

The Contractor shall use appropriate licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorization and decision making. The Contractor shall develop and implement written procedures, subject to the Agency and IDPH review and approval, documenting access to board certified consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested shall be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease, or in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services.

11.2.4 *Medical Necessity of Mental Health Services*

Psychosocial services are those mental health services, not including outpatient, inpatient and medication management services, designed to support an individual with a serious mental illness or child with an SED to successfully live and work in the community. The Contractor shall develop or adopt UM guidelines to interpret the psychosocial necessity of mental health services and supports. In the context of this requirement, psychosocial necessity is an expansion of the concept of medical necessity and shall mean clinical, rehabilitative or supportive mental health services which meet all the following conditions: (i) are appropriate and necessary to the symptoms, diagnoses or treatment of a mental health diagnosis; (ii) are provided for the diagnosis or direct care and treatment of a mental disorder; (iii) are within standards of good practice for mental health treatment; (iv) are required to meet the mental health needs of the member and not

primarily for the convenience of the member, the provider, or the Contractor; and (v) are the most appropriate type of service which would reasonably meet the need of the member in the least costly manner.

The determination of psychosocial necessity shall be made after consideration of: (i) the member's clinical history including the impact of previous treatment and service interventions; (ii) services being provided concurrently by other delivery systems; (iii) the potential for services/supports to avert the need for more intensive treatment; (iv) the potential for services/supports to allow the member to maintain functioning improvement attained through previous treatment; (v) unique circumstances which may impact the accessibility or appropriateness of particular services for an individual member (e.g., availability of transportation, lack of natural supports including a place to live); and (vi) the member's choice of provider or treatment location. The guidelines for interpreting psychosocial necessity shall also meet the requirements of all Contractor practice guidelines as set forth in Section 11.1.5.

11.2.5 *Prior Authorization Requests*

11.2.5.1 *Processing*

Prior authorization requests shall be processed in accordance with 42 C.F.R. § 438.210 and related rules and regulations which include, but are not limited to, provisions regarding decisions, notices, medical contraindications, and the failure of a Contractor to act timely upon a request. The Contractor shall have in place mechanisms to ensure that all prior authorization requests are processed within appropriate timeframes (as set forth in Section 11.2.1) for: (i) completing initial requests for prior authorization of services; (ii) completing initial determinations of medical necessity and psychosocial necessity; (iii) completing provider and member appeals and expedited appeals for prior authorization of service requests or determinations of medical necessity and psychosocial necessity, in accordance with law; (iv) notifying providers and members in writing of the Contractor's decisions on initial prior authorization requests and determinations of medical necessity and psychosocial necessity; and (v) notifying providers and members of the Contractor's decisions on appeals and expedited appeals of prior authorization requests and determinations of medical necessity and psychosocial necessity. Instances in which a member's health condition shall be deemed to require an expedited authorization decision by the Contractor shall include requests for home health services for members being discharged from a hospital or other inpatient setting when such home health services are needed to begin upon discharge.

11.2.5.2*Exceptions to Prior Authorization and/or Referrals*

As part of the UM function, the Contractor shall facilitate provider requests for authorization for primary and preventive care services and shall assist the provider in providing appropriate referrals for specialty services by locating resources for appropriate referral.

11.2.5.2.1.1 *Pharmacy Prior Authorization*

Pharmacy prior authorization requests shall be processed in accordance with 42 U.S.C. § 1396r-8(d)(5).

11.2.5.2.1.2 Reserved

11.2.5.2.1.3 Reserved

11.2.5.2.1.4 Reserved

11.2.5.2.1.5 *Newborn and Mothers Health Protection*

The Contractor shall meet the requirements of the Newborn and Mothers Health Protection Act (NMHPA) of 1996. The Contractor shall not limit benefits for postpartum hospital stays to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section, unless the attending provider, in consultation with the mother makes the decision to discharge the mother or the newborn child before that time. The Contractor shall not require a provider to obtain prior authorization for stays up to the forty-eight (48) or ninety-six (96) hour periods.

11.2.5.2.1.6 *Emergency and Post-Stabilization Care Services*

The Contractor shall provide emergency services without requiring prior authorization or PCP referral, regardless of whether these services are provided by a contract or non-contract provider. The Contractor shall provide post-stabilization care services in accordance with 42 C.F.R. § 438.114.

11.2.5.2.1.7 *EPSDT*

The Contractor shall not require prior authorization or PCP (if applicable) referral for the provision of EPSDT screening services.

11.2.5.2.1.8 *Behavioral Health Services*

The Contractor shall not require a PCP referral (if applicable) for members to access a behavioral health provider.

11.2.5.2.1.9 *Transition of New Members*

Pursuant to the requirements in Section 3.3 regarding transition of new members, the Contractor shall provide for the continuation of medically necessary covered services regardless of prior authorization or referral requirements.

11.2.6 *Tracking and Reporting*

11.2.6.1 *PA Tracking Requirements*

The Contractor shall track all prior authorization requests in its information system. All notes in the Contractor's prior authorization tracking system shall be signed by clinical staff and include the appropriate suffix (e.g., RN, MD, RPh, etc.). For prior authorization approvals, the Contractor shall provide a prior authorization number to the requesting provider and maintain a record of the following information, at a minimum, in the Contractor's information system: (i) name and title of caller or submitter, (ii) date and time of call, fax or online submission, (iii) prior authorization number, (iv) time to determination, from receipt and (v) approval/denial count.

11.2.6.2 *PA Denials*

For all denials of prior authorization requests, the Contractor shall maintain a record of the following information, at a minimum, in the Contractor's information system: (i) name and title of caller or submitter, (ii) date and time of call or submission, (iii) clinical synopsis inclusive of timeframe of illness or condition, diagnosis and treatment plan; and (iv) clinical guidelines or other rational supporting the denial (i.e. insufficient documentation).

11.2.7 Reserved

**Revision 84:** Section 12.1 of the Contract's Scope of Work, as well as all of its subparts, is amended to read as follows:

12.1 *General Expectations and Regulatory Compliance*

12.1.1 *General Expectations*

The Contractor shall:

(a) diligently safeguard against fraud and abuse in the implementation of the Contractor's Contract with the Agency;

(b) create and implement policies and procedures to diligently safeguard against fraud and abuse, as required by the provisions of this Article of the Contract; and

(c) cooperate and collaborate with the Agency and its representatives on program integrity issues, including, but not limited to cooperation with the program integrity contractor.

12.1.2 *Regulatory Compliance*

In accordance with 42 C.F.R. § 438.608, the following requirements shall apply:

(a) *Administrative and management arrangements or procedures to detect and prevent fraud, waste and abuse.* The Contractor, or subcontractor to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under the contract between the Agency and the Contractor, shall implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following:

(1) A compliance program that includes, at a minimum, all of the following elements:

(i) Written policies, procedures, and standards of conduct that articulate the Contractor or subcontractor's commitment to comply with all applicable requirements and standards under the Contract, and all applicable Federal and State requirements.

(ii) The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the board of directors.

(iii) The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the Contractor or subcontractor's compliance program and its compliance with the requirements under the Contract.

(iv) A system for training and education for the Compliance Officer, the Contractor or subcontractor's senior management, and the Contractor or subcontractor's employees for the Federal and State standards and requirements under the Contract.

(v) Effective lines of communication between the compliance officer and the Contractor or subcontractor's employees.

(vi) Enforcement of standards through well-publicized disciplinary guidelines.

(vii) Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract.

(2) Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the Agency.

(3) Provision for prompt notification to the Agency when it receives information about changes in a member's circumstances that may affect the member's eligibility including all of the following:

(i) Changes in the member's residence;

(ii) The death of a member.

(4) Provision for notification to the Agency when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor.

(5) Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members and the application of such verification processes on a regular basis.

(6) In the event that Contractor makes or receives annual payments under the Contract of at least $5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers.

(7) Provision for the prompt referral of any potential fraud, waste, or abuse that the Contractor identifies to the State Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit.

(8) Provision for the Contractor's suspension of payments to a network provider for which the Agency determines there is a credible allegation of fraud in accordance with 42 C.F.R. § 455.23.

(b) Reserved.

(c) *Disclosures.* Contractor and any subcontractors shall:

(1) Provide written disclosure of any prohibited affiliation under 42 C.F.R. § 438.610.

(2) Provide written disclosures of information on ownership and control required under 42 C.F.R. § 455.104.

(3) Report to the Agency within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the Contract.

(d) *Treatment of recoveries made by the Contractor of overpayments to providers.*

(1) Reporting and Retention of Overpayments:

(i) The Contractor will follow the retention policies (outlined in Section 12.8 of this Agreement) for the treatment of recoveries of all overpayments from the Contractor to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.

(ii) The Contractor will follow the process, timeframes, and documentation required (outlined in Section 12.3 of this Agreement) for reporting the recovery of all overpayments.

(iii) The Contractor will follow the process, timeframes, and documentation required for payment of recoveries of overpayments to the Agency (outlined in Section 12.3 of this Agreement) in situations where the Contractor is not permitted to retain some or all of the recoveries of overpayments.

(iv) This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

(2) Contractor shall require and have a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days after the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment.

(3) Contractor must report annually to the Agency on their recoveries of overpayments.

(4) The Agency will use the results of the information and documentation collected in paragraph (d)(1) of this section and the report in paragraph (d)(3) of this section for setting actuarially sound capitation rates for Contractor consistent with the requirements in 42 C.F.R. § 438.4.

**Revision 85:** Section 12.2 of the Contract's Scope of Work, as well as all of its subparts, is amended to read as follows:

12.2 *Compliance Plan*

The Contractor shall develop, implement, and adhere to a mandatory compliance plan (the "Compliance Plan") that describes in detail how it will comply with the compliance program required by 42 C.F.R. §438.608(a)(1) as well as any additional requirements of this Agreement. The Contractor shall include the Compliance Plan in any Work Plan required by Section 2.13 and follow the timelines set forth in Section 2.13.

The Compliance Plan shall include:

12.2.1 Identification of a data system, resources, and staff sufficient to perform compliance responsibilities, including, but not limited to, the ability of the system, resources and staff to adequately and sufficiently perform the following compliance responsibilities: run algorithms on claims, data analytics, predictive analytics, trending claims behavior, and provider and member profiling.

12.2.2 Designation of a Compliance Officer and a Compliance Committee who will be accountable to senior management. The Contractor shall require the Compliance Officer to meet with State audit and investigations representatives at the frequency required by the Agency.

12.2.3 Effective training and education for the Contractor's employees, including the Compliance Officer, that is adequate to train and educate the Contractor's employees in the detection of fraud, waste, and abuse. The Contractor shall identify the frequency of the training and shall ensure that Contractor's employees will be trained no less than annually. The Contractor shall identify the type of training that it will provide and the Contractor's training plan shall include training related to the False Claims Act, as directed by CMS and the Agency.

12.2.4 Identification of how information related to identifying and reporting fraud and abuse will be included in provider and member materials.

12.2.5 Program integrity related goals, objectives, and planned activities for the year following the establishment of the Compliance Plan or the year following the submission of an updated plan.

12.2.6 Reporting procedures in compliance with Section 12.3.

12.2.7 Designation of an SIU Manager. The Contractor shall employ an SIU Manager. The Contractor shall:

(a) ensure that the SIU Manager is dedicated full-time to the Contractor's Iowa Medicaid product lines;

(b) require the SIU Manager to be located in Iowa;

(c) require that the qualifications of the SIU Manager are equal to those of the Agency Program Integrity Director; and

(d) ensure that the SIU Manager responsibilities include:

(i) directing the activities of Special Investigation Unit staff;

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

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

(iv) reducing or eliminating wasteful, fraudulent, or abusive healthcare billings and services.

12.2.8 *SIU Staff.*

(a) In addition to employing the SIU Manager, the Contractor shall employ one full-time dedicated SIU staff member for each 100,000 members assigned to Contractor under this Contract.

(b) The Contractor shall require the SIU staff to review and investigate Contractor's providers and members to identify fraud, waste, and abuse.

(c) The Contractor shall ensure that, including the SIU Manager, a majority of SIU staff work in Iowa.

**Revision 86:** Section 12.3 of the Contract's Scope of Work, as well as all of its subparts, is amended to read as follows:

12.3 *Program Integrity Activity Reporting*
12.3.1 *Monthly Reporting*

In addition to any reporting required by the federal regulations, including 42 C.F.R. § 438.608(d)(3), the Contractor shall provide the Agency with a monthly Program Integrity Activity Report outlining the Contractor's program integrity activities for the previous calendar month. To the extent that the federal regulations require reporting less frequently than the provisions of this Contract, these reporting requirements of this Contract are in addition to the less frequent reporting requirements under the federal regulations.

In the monthly Program Integrity Activity Report, the Contractor shall provide the information requested by the Agency, in the format requested by the Agency, including, but not limited to:

(a) A list of the Contractor's program integrity related activities for the month.
(b) Identification of the Contractor's progress in meeting the program integrity goals and objectives of the Contractor's Plan.
(c) Identification of the recoupment totals for the reporting period.
(d) A summary of state fiscal year to date information of the Contractor.
(e) With respect to each provider reviewed:
1) The name and NPI of the provider.
2) The data source, referral, or other reason for the review.
3) Identification of any action taken by the Contractor, including, but not limited to, suspension, termination, recoupment, payment reduction, denial of enrollment or reenrollment, identification as excluded pursuant to 42 C.F.R. § 455.
4) Identification of the reason for the action and, if a payment or recoupment is involved, all of the relevant financial information related to the action.

12.3.2 *Quarterly Audit Report*

In addition to any reporting required by the federal regulations, including 42 C.F.R. § 438.608(d)(3), the Contractor shall provide the Agency with a quarterly audit report. To the extent that the federal regulations require reporting less frequently than the provisions of this Contract, these reporting requirements of this Contract are in addition to the less frequent reporting requirements under the federal regulations.

On a quarterly basis, and as otherwise directed by the Agency, the Contractor shall submit a detailed audit report to the Agency which outlines the Contractor's program integrity-related activities, as well as identifies the Contractor's progress in meeting program integrity-related goals and objectives. The audit report should also specify individual provider recoupment, repayment schedules, and actions taken for each audit or investigation. The Agency shall review and approve, approve with modifications, or reject the audit report and specify the grounds for rejection. Recoupment totals and summaries for each reporting period (quarterly unless otherwise specified by the Agency) must also be submitted in the audit report.

12.3.3 *Reporting of Suspected Fraud, Waste or Abuse*

The Contractor shall report possible fraud or abuse activity to the Agency. The Contractor shall initiate an immediate investigation to gather facts regarding the possible fraud or abuse. Documentation of the findings of the investigation shall be delivered to the Agency within two (2) days of the identification of suspected fraud or abuse activity. In addition, the Contractor shall provide reports of its investigative, corrective, and legal activities with respect to fraud and abuse to the Agency in accordance with contractual and regulatory requirements. The Contractor and its subcontractors shall cooperate fully in any Agency reviews or investigations and in any subsequent legal action. The Contractor shall implement corrective actions in instances of fraud and abuse detected by the State agency, or other authorized agencies or entities. The Contractor shall report to the Agency the following information in the timeframe and manner required by the Agency: (i) the number of complaints of fraud and abuse made to the Agency that warrant preliminary investigation; and (ii) for each complaint which warrants investigation: (a) the name and ID number; (b) source of complaint; (c) type of provider; (d) type of provider; (e) nature of complaint; (f) approximate dollars involved; (g) disposition of the case, (h) service type, and (i) any other relevant information requested by the Agency.

**Revision 87:** Section 12.4 of the Contract's Scope of Work, as well as all of its subparts, is amended to read as follows:

12.4 *Required Fraud, Waste and Abuse Activities*

12.4.1 The Contractor shall conduct regular review and audits of operations, including incorporation of Correct Coding Initiative editing in the Contractor's claims adjudication process.

12.4.2 The Contractor shall assess and strengthen internal controls to ensure claims are submitted and paid properly.

12.4.3 The Contractor shall educate employees, providers, and members about fraud and abuse and how to report it.

12.4.4 The Contractor shall ensure the accuracy, completeness, and truthfulness of claims and payment data as required by 42 C.F.R. Part 438 Subpart H and 42 C.F.R. § 457.950(a)(2).

12.4.5 The Contractor shall ensure sufficient organizational resources to effectively respond to complaints of fraud and abuse.

12.4.6 The Contractor shall effectively process fraud and abuse complaints.

12.4.7 The Contractor shall report information to the Agency in a format and timeframe designated by the Agency.

12.4.8 The Contractor shall monitor data and shall collect information related to utilization and service patterns of and potential overpayments made to providers, subcontractors, and members and compile that information including, but not limited to, the following compilations:

(a) A list of automated pre-payment claims edits.
(b) A list of automated post-payment claims edits.
(c) A list of desk audits on post—processing review of claims.
(d) A list of reports of provider profiling and credentialing created in conducting program and payment integrity reviews.

12.4.9 The Contractor shall also collect and compile the following information:

(a) A list of surveillance and utilization management protocols used to safeguard unnecessary or inappropriate use of Medicaid systems.
(b) A list of provisions in the subcontractor and provider agreements that ensure the integrity of provider credentials.
(c) A list of references in provider and member material regarding fraud and abuse referrals.
(d) Any claims algorithms, use of predictive modeling, or editing required by the Agency.

12.4.10 The Contractor shall develop data mining techniques and conduct on-site audits.

**Revision 88:** Section 12.5 of the Contract's Scope of Work, as well as all of its subparts, is amended to read as follows:

12.5 *Coordination of Program Integrity Efforts*
The Contractor shall coordinate any and all program integrity efforts with IME personnel, IDPH personnel, and Iowa's Medicaid Fraud Control Unit (MFCU), located within the Iowa Department of Inspections and Appeals. At minimum, the Contractor shall:

12.5.1 Meet no less than two times each month and as otherwise required with the Agency Program Integrity Unit, IDPH staff, and MFCU staff.

12.5.2 Provide any and all Documentation or information upon request to the Agency, the MFCU, HHS-OIG or the US Department of Justice related to any aspect of the Contract, including but not limited to policies, procedures, subcontracts, provider agreements, claims data, encounter data, provider records and report on recoupment actions and receivables.

12.5.3 Coordinate PI activities with other contractors as directed by the Agency

**Revision 89:** Section 12.6 of the Contract's Scope of Work is amended to read as follows:

12.6 *Verification of Services Provided*

The Contractor shall have in place a method and procedures to verify whether services reimbursed by the Contractor were actually furnished to members as billed by providers.

**Revision 90:** Section 12.7 of the Contract's Scope of Work, as well as all of its subparts, is amended to read as follows:

12.7 *Program Integrity Payment Related Issues*

12.7.1 *Credible Allegation of Fraud Temporary Suspensions*

The Contractor shall comply with 42 C.F.R. § 455.23 and § 438.608(a)(8) by suspending all payments to a provider after the Agency determines that there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the Agency or law enforcement (included but not limited to the MFCU) has identified in writing good cause for not suspending payments or to suspend payments only in part. The Contactor shall issue a notice of payment suspension that comports in all respects with the obligations set forth in 42 C.F.R. § 455.23(b) and maintain the suspension for the durational period set forth in 42 C.F.R. § 455.23(c). In addition, the notice of payment suspension shall state that payments are being withheld in accordance with 42 C.F.R. § 455.23. The Contractor shall not suspend payments until consulting first with the MFCU and second with the Agency. The Contractor shall maintain all materials related to payment suspensions for a minimum of five (5) years in compliance with the obligations set forth in 42 C.F.R. § 455.23(g). The Contractor shall afford a grievance process to providers for whom payments have been suspended by the Contractor under this section.

12.7.2 *Overpayments*

The Contractor shall maintain policies and procedures to ensure that providers comply with Iowa Code Chapter 249A Subchapter II – Program Integrity including but not limited to application of interest related to provider overpayments.

12.7.3 *Circumstances Whereby the Contractor May Not Recoup or Withhold Improperly Paid Funds*

The Contractor is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claim upon which the withhold or recoupment are based meet one or more of the following criteria:

12.7.3.1 The improperly paid funds have already been recovered by the State of Iowa directly or through resolution of a State or federal investigation, and/or lawsuit, including but not limited to false claims act cases; or

12.7.3.2 The funds have already been recovered by the Recovery Audit Contractor (RAC); or

12.7.3.3 When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Iowa, are the subject of pending federal or State litigation or investigation, or are being audited by the Iowa RAC.

This prohibition described above shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. The Contractor shall check with the IME Program Integrity Unit before initiating any recoupment or withhold of any program integrity related funds to ensure that the recoupment or withhold is permissible. In the event that the Contractor obtains funds in cases where recoupment or withhold is prohibited under this section, the Contractor shall return the funds to the provider.

**Revision 91:** Section 12.8 of the Contract's Scope of Work, as well as all of its subparts, is amended to read as follows:

12.8 *Recovery of Payments*

12.8.1 The Contractor shall recover improper payments and overpayments attributable to claims paid by the Contractor as identified by the Contractor or the Agency.

12.8.2 The Contractor may retain overpayments attributable to claims paid by the Contractor.

12.8.3 *Reserved.*

12.8.4 The State shall transmit recovery of an overpayment attributable to claims paid by Contractor on or before the 60th day following receipt of the overpayment.

12.8.5 The Contractor shall report improper payments and overpayments in accordance with Section 12.3.

12.8.6 The provisions above do not apply to any amount of recovery to be retained under the False Claims Act cases or through other investigations.

**Revision 92:** New Section 12.12 is added to the Contract's Scope of Work, and the new clause reads as follows:

12.12 *Referral for Sanction*

The Contractor and the Agency shall develop a process for referral of providers to the Agency for Sanction under 441 Iowa Administrative Code § 79.2. The Contractor shall vigorously pursue fraud, waste and abuse in the Medicaid Program and notify the Agency PI of any provider activity which would incur a sanction under 441 Iowa Administrative Code § 79.2(249A).

**Revision 93:** Section 12.9 of the Contract's Scope of Work is amended to read as follows:

12.9 *Contractor Reporting Obligations for Adverse Actions Taken on Provider Applications for Program Integrity Reasons 42 C.F.R. § 1002.3*

The Contractor shall not permit the provider into the provider network if the Agency or Contractor determines that any person who has ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or CHIP, or if the Agency or the Contractor determine that the provider did not fully and accurately make any disclosure required pursuant to 42 C.F.R. § 1001.1001(a)(1).

**Revision 94:** Reserved.

**Revision 95:** Section 13.1 of the Contract's Scope of Work is amended to read as follows. Note that this revision does not alter the subsections under Section 13.1:

13.1 *Information Services and System*

The Contractor shall maintain a fully integrated Information System (IS) sufficient to support program requirements, including but not limited to: (i) care coordination functions; (ii) utilization management; (iii) claims payment; (iv) service authorization; (v) provider network management; (vi) credentialing; (vii) grievance and appeals processing; (viii) quality management; (ix) utilization management; and (x) encounter data. The Contractor shall be prepared to submit all required data and reports in the format specified by the Agency. The Contractor shall maintain an IS with capabilities to perform the data receipt, transmission, integration, management, assessment and system analysis tasks described in this Contract. Further, the Contractor shall comply with the requirements of 42 C.F.R. § 438.242 as described below.

(a) *General rule.* Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of 42 C.F.R. part 438. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.

(b) *Basic elements of a health information system.* Contractor shall comply with the following:

(1) Section 6504(a) of the Affordable Care Act, which requires that State claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Social Security Act.

(2) Collect data on member and provider characteristics as specified by the Agency, and on all services furnished to members through an encounter data system or other methods as may be specified by the Agency.

(3) Ensure that data received from providers is accurate and complete by—

(i) Verifying the accuracy and timeliness of reported data, including data from network providers the Contractor is compensating on the basis of capitation payments.

(ii) Screening the data for completeness, logic, and consistency.

(iii) Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts.

(4) Make all collected data available to the Agency and upon request to CMS.

(c) *Member encounter data.* Contractor shall:

(1) Collect and maintain sufficient member encounter data to identify the provider who delivers any item(s) or service(s) to members.

(2) Submit member encounter data to the Agency at a frequency and level of detail to be specified by CMS and the Agency, based on program administration, oversight, and program integrity needs.

(3) Submit all member encounter data that the Agency as required to report to CMS under § 438.818.

(4) Specifications for submitting encounter data to the Agency in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate.

**Revision 96:** Subsection 13.1.1.20 of the Contract's Scope of Work is amended by deleting the text and marking the subsection "Reserved."

**Revision 97:** Reserved.

**Revision 98:** Subsection 13.1.3.2 of the Contract's Scope of Work is amended to read as follows:

13.1.3.2 *Data Accessibility*

The Contractor shall make data available to the Agency and, upon request, to CMS.

**Revision 99:** Subsection 13.1.12 of the Contract's Scope of Work is amended to read as follows:

13.1.12 *Electronic Visit Verification System*

In any Work Plan required by Section 2.13, if the use of an Electronic Visit Verification (EVV) System is proposed, the Contractor shall develop and describe the system that will be in place within a timeframe determined by the Agency. If an EVV System is not proposed, 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.

**Revision 100:** Subsection 13.3.1.2 of the Contract's Scope of Work is amended to read as follows. Note that this revision does not alter the subsections under subsection 13.3.1.2:

13.3.1.2 *Reconciliation Process*

The Contractor shall reconcile member eligibility data and 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 12.1.2. 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.

**Revision 101:** Subsection 13.4.6 and Section 13.4.7of the Contract's Scope of Work are amended 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 thirty (30) calendar days of receipt, ninety- five percent (95%) of all clean claims within forty-five (45) calendar days of receipt and ninety-nine percent (99%) of all claims within ninety (90) calendar days of receipt. 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.

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 upon a scheduled approved by the Agency. 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.

**Revision 102:** Subsection 13.5.2 of the Contract's Scope of Work is amended to read as follows:

13.5.2 *Reporting Format and Batch Submission Schedule*

The Contractor shall submit encounter claims in an electronic format that adheres to the data Specifications set forth by the Agency and in any State or federally mandated electronic claims submission standards. The Agency will have all of the remedies provided to it under the Contract, including liquidated damages, for failure to comply with these requirements. Drug encounter data shall be submitted by the Contractor once every other week for adjudicated claims in support of the IME's drug rebate invoicing process identified in section 3.2.6.11. Encounter data shall be submitted by the 20th of the month subsequent to the month for which data are reflected. All corrections to the monthly encounter data submission shall be finalized within forty-five (45) days from the date the initial error report for the month was sent to the Contractor or fifty-nine (59) days from the date the initial encounter data were due. The error rate for encounter data cannot exceed one percent (1%). The Agency will notify the Contractor of changes made to calculate encounter data timeliness, accuracy, and quality sixty (60) days prior to implementation.

**Revision 103:** Reserved.

**Revision 104:** Subsection 13.6.1.2 of the Contract's Scope of Work is amended to read as follows:

13.6.1.2 *TPL Data*

The Contractor shall share information regarding its members with these other payers as specified by the Agency and in accordance with 42 C.F.R. § 438.208(b). In the process of coordinating care, the Contractor shall protect each member's privacy in accordance with the confidentiality

requirements stated in 45 C.F.R. Parts 160 and 164, including confidentiality of family planning services. In addition, the Contractor must follow all applicable provisions under 42 C.F.R. §§ 59.2 and 59.11 relating specifically to confidentiality of family planning services. In particular, if an enrolled member requests confidentiality related to any family planning services sought and/or received, and also requests such confidentiality extend to any notification to a policy holder of any third-party coverage to which the enrolled member is also covered, the Contractor may not provide any notifications to the policy holder, related to such family planning services sought and/or received by the enrolled member. The Agency will provide information to the Contractor on member TPL that was collected at the time of Medicaid application and through ongoing TPL identification processes. The Contractor shall report weekly any new TPL to the Agency to retain in the TPL system. The information collected shall contain the following:

(a) First and last name of the policyholder
(b) Social security number of the policyholder
(c) Full insurance company name
(d) Group number, if available
(e) Name of policyholder's employer (if known)
(f) Insurance carrier ID
(g) Type of policy and coverage

Additionally, the Contractor shall implement Agency approved strategies and methodologies to ensure the collection and maintenance of current TPL data, for example, recoveries from direct billing, disallowance projects, and yield management activities.

**Revision 105:** Section 14.1 of the Contract's Scope of Work, including all of its subparts, is amended to read as follows:

14.1 *General*

Performance monitoring and data analysis are critical components in assessing how well the Contractor is maintaining and improving the quality of care delivered to members. The Agency will use various performance targets, industry standards, national benchmarks and program-specific standards in monitoring the Contractor's performance and outcomes. The Agency reserves the right to publish Contractor performance. Failure to meet performance targets shall subject the Contractor to the corrective actions as outlined in Exhibit E. Refer to Exhibit F for information on the pay-for-performance program.

The Contractor shall comply with the following data, information and documentation requirements in accordance with 42 C.F.R. § 438.604:

(a) *Specified data, information, and documentation.* Contractor shall submit to the Agency the following data:

(1) Encounter data in the form and manner described in 42 C.F.R. § 438.818.

(2) Data on the basis of which the Agency certifies the actuarial soundness of capitation rates to the Contractor under 42 C.F.R. § 438.4, including base data described in 42 C.F.R. § 438.5(c) that is generated by the Contractor.

(3) Data on the basis of which the Agency determines the compliance of the Contractor with the medical loss ratio requirement described in 42 C.F.R. § 438.8.

(4) Data on the basis of which the Agency determines that the Contractor has made adequate provision against the risk of insolvency as required under 42 C.F.R. § 438.116.

(5) Documentation described in 42 C.F.R. § 438.207(b) on which the Agency bases its certification that the Contractor has complied with the Agency's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 C.F.R. § 438.206.

(6) Information on ownership and control described in 42 C.F.R. § 455.104 from Contractor, and subcontractors as governed by 42 C.F.R. § 438.230.

(7) The annual report of overpayment recoveries as required in 42 C.F.R. § 438.608(d)(3).

(b) *Additional data, documentation, or information.* In addition to the data, documentation, or information specified in paragraph (a) of this section, Contractor must submit any other data, documentation, or information relating to the performance of the entity's obligations under 42 C.F.R. part 438 required by the Agency or the Secretary.

14.1.1 *Reporting Requirements*

The Contractor shall comply with all reporting requirements and shall submit the requested data completely and accurately within the requested timeframes and in the format identified by the Agency. The Agency reserves the right to require the Contractor to work with and submit data to third-party data warehouses or analytic vendors. The Contractor shall have policies, procedures and mechanisms in place to ensure that the financial and non-financial performance data submitted to the Agency is accurate. The Contractor shall comply with the following certification requirements in accordance with 42 C.F.R. §438.606:

(a) *Source of certification.* For the data, documentation, or information specified in 42 C.F.R. § 438.604, Contractor shall certify the data, documentation or information the Contractor submits to the Agency by either the Contractor's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.

(b) *Content of certification.* The certification provided by the individual in paragraph (a) of this section must attest that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 C.F.R. § 438.604 is accurate, complete, and truthful.

(c) Timing of certification. Contractor shall submit the certification concurrently with the submission of the data, documentation, or information required in 42 C.F.R. § 438.604(a) and (b).

14.1.2 *Audit Rights and Remedies*

The Agency reserves the right to audit the Contractor's self-reported data at any time. The Agency may require corrective action or other remedies as specified in Exhibit E for Contractor non-compliance with these and other subsequent reporting requirements and performance standards.

14.1.3 *Meeting with the Agency*

The Agency may schedule meetings or conference calls with the Contractor upon receiving the performance data. When the Agency identifies potential performance issues, the Contractor shall formally respond in writing to these issues within the timeframe required by the Agency. If the Contractor fails to provide a formal, written response to the feedback or fails to respond within the timeframe established by the Agency, the Agency may consider the Contractor noncompliant in its performance reporting and may implement corrective actions.

14.1.4 *Implementation Reporting*

The Agency reserves the right to require more frequent reporting at the beginning of the Contract to: (i) monitor program implementation; (ii) permit adequate oversight and correction of problems as necessary; and (iii) ensure satisfactory levels of member and provider services.

14.1.5 *Other Reporting and Changes*

The Agency will provide at least thirty (30) calendar days' notice to the Contractor before changing or adding any reporting requirements for reports that are anticipated as routine or are intended to be included in the reporting manual. The Agency will provide reasonable notice in advance but may request ad hoc reports at any time. The Reporting Manual, which shall be provided following the Contract award date, will detail reporting requirements and the full list of required reports.

**Revision 106:** Subsection 14.3.7 of the Contract's Scope of Work is amended to read as follows:

14.3.7 *Member Hearing and Appeals Report*

The Contractor shall resolve one hundred percent (100%) of appeals within thirty (30) calendar days of receipt, or within 72 hours of receipt for expedited appeals. Further, one hundred percent (100%) of appeals shall be acknowledged within three (3) business days. The Contractor shall maintain and report to the Agency a member appeal log, which shall include the current status of all appeals.

**Revision 107:** Subsection 14.8.2 of the Contract's Scope of Work is amended to read as follows:

14.8.2 *Prior Authorization Report*

Ninety-nine percent (99%) of standard authorization decisions shall be rendered within fourteen (14) calendar days of the request for service, or 72 hours for expedited authorization decisions. For pharmacy prior authorization one hundred percent (100%) of authorization decisions shall be rendered within twenty-four (24) hours of the request for service.

**Revision 108:** The definition of the term "Action" in Exhibit A to the Contract is deleted.

**Revision 109:** The following definition of the term "Adverse Benefit Determination" is added to Exhibit A of the Contract:

**Adverse Benefit Determination.** In the case of Contractor any of the following:

(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

(2) The reduction, suspension, or termination of a previously authorized service.

(3) The denial, in whole or in part, of payment for a service.

(4) The failure to provide services in a timely manner, as defined by the Agency.

(5) The failure of Contractor to act within the timeframes provided in 42 C.F.R. § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

(6) Reserved.

(7) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

**Revision 110:** The definition of the term "Appeal" in Exhibit A to the Contract is amended to read as follows:

**Appeal.** Review by Contractor of an adverse benefit determination.

**Revision 111:** The definition of the term "Grievance" in Exhibit A to the Contract is amended to read as follows:

**Grievance.** An expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by Contractor to make an authorization decision.

**Revision 112:** The following definition of the term "Grievance and Appeal System" is added to Exhibit A to the Contract:

**Grievance and appeal system.** The processes the Contractor implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

**Revision 113:** The following definition of the term "Gross Base LTSS Capitation" is added to Exhibit A to the Contract:

**Gross Base LTSS Capitation.** The column on the LTSS Gross Capitation rate chart that sets forth the total gross capitation rate applicable to a given capitation rate cell for LTSS services

before risk adjustment and before removal of any withhold permitted under Exhibit F. The illustrated capitation rate is applicable to all rate cells within a single LTSS blended rate group, which immediately precede the illustrated capitation rate.

**Revision 114:** The following definition of the term "Gross Base Risk Adjusted LTSS Capitation" is added to Exhibit A to the Contract:

> **Gross Base Risk Adjusted LTSS Capitation.** The column on the LTSS Gross Capitation rate chart that sets forth the total gross capitation rate applicable to a given capitation rate cell for LTSS services after risk adjustment but before removal of any withhold permitted under Exhibit F. The illustrated capitation rate is applicable to all rate cells within a single LTSS blended rate group, which immediately precede the illustrated capitation rate.

**Revision 115:** The following definition of the term "Gross Total State Plan plus 1915(b)(3)" is added to Exhibit A to the Contract:

> **Gross Total State Plan plus 1915(b)(3).** The total gross capitation rate applicable to a given capitation rate cell for medical services that is inclusive of all medical rate components included in the medical rate (i.e., risk adjustment, payment for 1915(b)(3) services, GME supplemental payments, UIHC supplemental payments, risk adjustment, and rebalancing). The values provided for the Gross Total State Plan plus 1915(b)(3) rates are provided before removal of any withhold permitted under Exhibit F.

**Revision 116:** The definition of the term "Indian Healthcare Provider" in Exhibit A to the Contract is deleted.

**Revision 117:** The definition of the term "Individuals with Limited English Proficiency (LEP)" in Exhibit A to the Contract is deleted.

**Revision 118:** The following definition of the term "LTSS Gross Capitation" is added to Exhibit A to the Contract:

> **LTSS Gross Capitation.** Contract attachment rate charts that provide capitation rate cells for LTSS services before removal of any withhold provided for in Exhibit F.

**Revision 119:** The following definition of the term "LTSS Net Capitation" is added to Exhibit A to the Contract:

> **LTSS Net Capitation.** Contract attachment rate charts that provide capitation rate cells for LTSS services after removal of any withhold provided for in Exhibit F.

**Revision 120:** The following definition of the term "Medical Gross Capitation" is added to Exhibit A to the Contract:

> **Medical Gross Capitation.** Contract attachment rate charts that provide capitation rate cells for medical services before removal of any withhold provided for in Exhibit F.

**Revision 121:** The following definition of the term "Medical Net Capitation" is added to Exhibit A to the Contract:

**Medical Net Capitation.** Contract attachment rate charts that provide capitation rate cells for medical services after removal of any withhold provided for in Exhibit F.

**Revision 122:** The definition of the term "Medical Loss Ratio (MLR)" in Exhibit A to the Contract is deleted.

**Revision 123:** The following definition of the term "State Fair Hearing" is added to Exhibit A to the Contract:

**State Fair Hearing.** The process set forth in 42 C.F.R. 431 subpart E.

**Revision 124:** The following definition of the term "Total Paid LTSS Rate" is added to Exhibit A to the Contract:

**Total Paid LTSS Rate.** The column on the LTSS net Capitation rate chart that sets forth the total net capitation rate applicable to a given capitation rate cell that is inclusive of all LTSS rate components included in the LTSS rate. The values provided for in the Total Paid LTSS Rate column represent capitation rates after removal of any withhold permitted under Exhibit F. The illustrated capitation rate is applicable to all rate cells within a single LTSS blended rate group, which immediately precede the illustrated capitation rate. The Agency will pay Contractor the monthly capitation rate provided for pursuant to Section 1.3.3 of the Contract's Special Terms based on the values represented in the Total Paid LTSS Rate as set forth in the applicable Contract attachment as compensation for all LTSS services provided to patients identified in the corresponding rate cells when the patient is identified as receiving LTSS services.

**Revision 125:** The following definition of the term "Total Paid Medical Rate" is added to Exhibit A to the Contract:

**Total Paid Medical Rate.** The column on the Medical Net Capitation rate chart that sets forth the total net capitation rate applicable to a given capitation rate cell that is inclusive of all medical rate components included in the medical rate including risk adjustment, payment for 1915(b)(3) services, GME supplemental payments, and UIHC supplemental payments. The values provided for in the Total Paid Medical Rate column represent capitation rates after removal of any withhold permitted under Exhibit F. The Agency will pay Contractor the monthly capitation rate provided for pursuant to Section 1.3.3 of the Contract's Special Terms based on the values represented in the Total Paid Medical Rate as set forth in the applicable Contract attachment as compensation for all medical goods and services provided to patients identified in the corresponding rate cells. When a patient receives both medical and LTSS services, the Total Paid Medical Rate is combined with the Total Paid LTSS Rate to arrive at a total amount to be paid the Contractor for that patient's managed care coverage for the month.

**Revision 126:** In the table set forth in Exhibit C to the Contract, the row entitled "Family Planning Waiver" is deleted in its entirety.

**Revision 127:** In Table D1 of Exhibit D to the Contract, the row entitled "1915(C) SERVICES" is amended to read as follows:

| | |
|---|---|
| 1915(C) SERVICES | The Contractor shall cover 1915(c) waiver services as authorized in |

| | |
|---|---|
| | accordance with the federal waiver. |

**Revision 128:** In Table D1 of Exhibit D to the Contract, the row entitled "1915(I) HABILITATION SERVICES" is amended to read as follows:

| | |
|---|---|
| 1915(I) HABILITATION SERVICES | The Contractor shall cover 1915(i) state plan services as authorized in accordance with the federal state plan amendment. |

**Revision 129:** Table D3 of Exhibit D to the Contract is deleted and marked "Reserved."

**Revision 130:** In Table E1 of Exhibit E to the Contract, the row entitled "Timely Prior Authorization Processing" is amended to read as follows:

| | | |
|---|---|---|
| Timely Prior Authorization Processing | The Contractor fails to process a prior authorization request within fourteen (14) calendar days of the request for service, or 72 hours for expedited authorization decisions or with twenty-four (24) hours for pharmacy prior authorizations. | $542 per occurrence |

**Revision 131:** In Table E1 of Exhibit E to the Contract, the row entitled "Grievance Resolution" is amended to read as follows:

| | | |
|---|---|---|
| Grievance Resolution | The Contractor fails to resolve one hundred percent (100%) of grievances within thirty (30) calendar days of receipt, or within 72 hours of receipt for expedited grievances. | $157 per occurrence |

**Revision 132:** In Table E1 of Exhibit E to the Contract, the row entitled "Appeals Resolution" is amended to read as follows:

| | | |
|---|---|---|
| Appeals Resolution | The Contractor fails to resolve one hundred percent (100%) of appeals within 30 calendar days of receipt, or within 72 hours of receipt for expedited appeals. | $157 per occurrence |

**Revision 133:** Exhibit F to the Contract is replaced with the document attached to this Amendment and labeled "Exhibit F."

**Revision 134:** The document attached hereto and labeled "Exhibit G" is hereby incorporated into the Contract as new Exhibit G.

**Revision 135:** Contract Scope of Work Section 2.13 and all of its subparts are hereby amended to read as follows:

**2.13 Written Policies and Procedures; Work Plan**

The Contractor shall develop and maintain written policies and procedures for each functional area in a global work plan (the "Work Plan"), including, but not limited to the strategies, policies, procedures, descriptions, mechanisms, and the like identified in the Contract to be included in the Work Plan. In drafting any Work Plan, the Contractor shall be guided by the Clarifications of

this Special Terms Appendix 1 – Scope of Work. Unless otherwise indicated, the Contractor shall submit a draft Work Plan to the Agency on or before the fifteenth day following execution of the Contract.

**Revision 136:** Contract Scope of Work Section 8.3.3 is hereby amended to read as follows:

8.3.3 Helpline Performance Metrics

99% of calls will be answered by an individual or an electronic device without receiving a busy signal. 80% of all calls will be answered in 30 seconds or less. The average speed for answering calls will be 30 seconds or less.

**Revision 137:** Contract Scope of Work Section 14.3.3 is hereby amended to read as follows:

Ninety-eight percent (98%) of members identified by the Contractor through the comprehensive health risk assessment as having a potential special healthcare care need shall have a care plan developed. Ninety-eight percent (98%) of care plans shall be updated, at minimum, annually.

**Revision 138:** Contract Scope of Work Section 14.3.4 is hereby amended to read as follows:

14.3.4 *Member Helpline Performance Report*

The Contractor shall demonstrate the following: maintain a service level of 99% of calls answered by an individual or an electronic device without receiving a busy signal, and 80% of all calls will be answered in 30 seconds or less. The average speed for answering calls will be 30 seconds or less.

**Revision 139:** Contract Scope of Work Section 6.1.3.3 is hereby amended to read as follows:

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) one hundred percent (100%) within forty-five (45) calendar days. The start time begins when the Contractor has received all necessary credentialing materials from the provider. 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 140:** Contract Scope of Work Section 14.4.3 is hereby amended to read as follows:

14.4.3 *Provider Credentialing Report*

The Provider Credentialing Report details the timeliness and effectiveness of the Contractor provider credentialing processes. Credentialing of all providers applying for network provider status shall be completed as follows: (i) ninety 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. Completion time ends when written communication is mailed or faxed to the provider notifying them of the Contractor's decision.

**Revision 141:** Contract Scope of Work Section 14.4.5 is hereby amended to read as follows:

14.4.5 *Provider Helpline Performance Report*

99% of calls will be answered by an individual or an electronic device without receiving a busy signal. 80% of all calls will be answered in 30 seconds or less. The average speed for answering calls will be 30 seconds or less.

**Revision 142:** Contract Scope of Work Section 14.6.5 is hereby amended to read as follows:

14.6.5 *Fall Risk Management*

The Fall Risk Management report shall document the percentage of members in long-term care who are at risk for falling who receive fall risk intervention.

**Revision 143:** Contract Scope of Work Section 14.6.8 is hereby amended to read as follows:

14.6.8 *Timeliness of Level of Care*

The Timeliness of Level of Care Report shall document the Contractor's timely completion of level of care reassessments. Ninety-five percent (95%) of reassessments shall be completed within twelve (12) months of the previous assessment. The Agency also reserves the right to audit the application of level of care criteria to ensure the accurate and appropriate application of criteria.

**Revision 144:** Contract Scope of Work Section 14.6.9 is hereby amended to read as follows:

14.6.9 *Timeliness of Needs Assessment and Reassessments*

The Timeliness of Needs Assessment and Reassessments report shall document the Contractor's timely completion of needs assessments and reassessments for 1915(c) HCBS waiver enrollees. Ninety-five percent (95%) of needs assessment shall be completed within the timeframe mutually agreed upon between the Contractor and the Agency in the course of Contract negotiations.

**Revision 145:** Contract Scope of Work Section 14.9.1 is hereby amended to read as follows:

14.9.1 *Adjudicated Claims Summary, Claims Aging Summary, and Claims Lag Report*

The Contractor shall pay or deny ninety percent (90%) of clean claims within thirty (30) calendar days of receipt, ninety- five percent (95%) of clean claims within forty-five (45) calendar days of receipt and ninety-nine percent (99%) of claims within ninety (90) calendar days of receipt.

**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.

| **Amerigroup Iowa, Inc.** |
|---|
| Signature of Authorized Representative: Cynthia M. MacDonald |
| Date: 9-8-17 |
| Printed Name: CYNTHIA M. MACDONALD |
| Title: PLAN PRESIDENT, AMERIGROUP IOWA |

| **Iowa Department of Human Services** |
|---|
| Signature of Authorized Representative: |
| Date: 9-11-17 |
| Printed Name: Jerry R. Foxhoven |
| Title: Director |

| **Iowa Department of Public Health** |
|---|
| Signature of Authorized Representative: Kathy Stone |
| Date: 9/14/17 |
| Printed Name: Kathy Stone |
| Title: Director, Division of Behavioral Services |

# Exhibit F

## PAY FOR PERFORMANCE

### PROGRAM ESTABLISHMENT AND ELIGIBILITY

The Agency has established a pay for performance program under which the Contractor may receive compensation if certain conditions are met. Eligibility for compensation under the pay for performance program is subject to the Contractor's complete and timely satisfaction of its obligations under the Contract.

The Agency may, at its option, reinstate the Contractor's eligibility for participation in the pay for performance program once the Contractor has properly cured all prior instances of non-compliance of its obligations under the Contract, and the Agency has satisfactory assurances of acceptable future performance.

IDPH reserves the right to establish a pay for performance program for IDPH-funded services. Such program shall be consistent with the Agency approach outlined in Exhibit F.

### INCENTIVE PAYMENT POTENTIAL

During each measurement year, the Agency will withhold a portion of the approved capitation payments from Contractor. In the first year of the Contract, the withheld amount shall be two percent (2%). The Agency reserves the right to change or increase the withhold amount in future years of the Contract term. Changes shall be made through the Contract amendment process. In the first year of the Contract, the Contractor may be eligible to receive some or all of the withheld funds based on the Contractor's performance in the areas outlined in Table F1 of this Exhibit.

### YEAR ONE OUTCOME MEASURES AND INCENTIVE PAYMENT STRUCTURE

The outcome measures, targets and incentive payment opportunities for the first Contract year are set forth in Table F1 below. Operational performance measures have been selected to measure the Contractor's performance during implementation and initial member transition. These performance standards require the Contractor to exceed the minimum performance standard required for Contract compliance and incentivize the Contractor to perform at a higher level in five (5) areas determined by the Agency to be critical for successful program implementation. Measures will be paid based on custom Specifications developed by the Agency and performance will be determined by the Agency or its designee. The Contractor shall submit information to the Agency, in the format and timeframe specified by the Agency, with respect to each performance measure set forth below. Incentive payments will be payable in the form of release of funds withheld.

TABLE F1: YEAR ONE OPERATIONAL PAY FOR PERFORMANCE MEASURES

| Performance Measure | Required Contractual Standard | Standard Required to Receive Incentive Payment | Amount of Performance Withhold at Risk |
|---|---|---|---|

| Performance Measure | Required Contractual Standard | Standard Required to Receive Incentive Payment | Amount of Performance Withhold at Risk |
|---|---|---|---|
| Timely Claims Processing | The Contractor shall pay or deny ninety percent (90%) of clean claims within fourteen (14) calendar days of receipt, ninety-nine point five percent (99.5%) of 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. | If the Contractor processes ninety-five percent (95%) of all clean claims within fourteen (14) calendar days of receipt, Contractor is eligible to receive an incentive payment equal to twenty-five percent (25%) of the amount of the Performance Withhold at risk.<br><br>If the Contractor processes ninety-seven percent (97%) of all clean claims within fourteen (14) calendar days of receipt, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk.<br><br>If the Contractor processes one hundred percent (100%) of all clean claims within fourteen (14) calendar days of receipt, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk. | 20% |
| Prior Authorization Processing | The Contractor shall process one hundred percent (100%) of prior authorization requests within seven (7) calendar days of the request for service, or three (3) business days for expedited authorization decisions, and one hundred percent (100%) of pharmacy prior authorization requests within twenty-four (24) hours of the request for service | If the Contractor processes ninety-five percent (95%) of prior authorization requests within four (4) calendar days of the request for services and two (2) business days for expedited authorizations and ninety-five percent (95%) of pharmacy prior authorization requests within twelve (12) hours of the request for service, Contractor is eligible to receive an incentive payment equal to twenty-five percent (25%) of the amount of the Performance Withhold at risk.<br><br>If the Contractor processes ninety-seven percent (97%) of prior authorization requests within four (4) calendar days of the request for services and two (2) business days for expedited authorizations and ninety-seven percent (97%) of pharmacy prior authorization requests within twelve (12) hours of the request for service, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk.<br><br>If the Contractor processes one hundred percent (100%) of prior authorization requests within four (4) calendar days of the request for services and two (2) business days for expedited authorizations and one hundred percent (100%) of pharmacy prior authorization requests within twelve (12) hours of the request for service, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk. | 20% |

| Performance Measure | Required Contractual Standard | Standard Required to Receive Incentive Payment | Amount of Performance Withhold at Risk |
|---|---|---|---|
| Completion of Initial Health Screening | Each quarter, at least seventy percent (70%) of the Contractor's new members, who have been assigned to the Contractor for a continuous period of at least ninety (90) days, shall complete an initial health risk screening within ninety (90) days. | If Contractor completion of initial health screening is at or above seventy-three percent (73%) screened and below seventy-six percent (76%) screened, Contractor is eligible to receive an incentive payment equal to twenty-five percent (25%) of the amount of the Performance Withhold at risk.<br><br>If Contractor completion of initial health screening is at or above seventy-six percent (76%) screened and below seventy-nine percent (79%) screened, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk.<br><br>If Contractor completion of the initial health screening is at or above seventy-nine percent (79%) screened, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk. | 20% |
| Provider Credentialing | Credentialing of all providers applying for network provider status shall be completed as follows: (i) ninety percent (90%) within thirty (30) calendar days; and (ii) one hundred percent (100%) within forty-five (45) calendar days. | Contractor completes: (i) eighty percent (80%) within twenty (20) calendar days; and (ii) ninety percent (90%) within thirty (30) calendar days, Contractor is eligible to receive an incentive payment equal to twenty-five percent (25%) of the amount of the Performance Withhold at risk.<br><br>Contractor completes: (i) eighty-five percent (85%) within twenty (20) calendar days; and (ii) ninety-five percent (95%) within thirty (30) calendar days, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk.<br><br>Contractor completes: (i) ninety percent (90%) within twenty (20) calendar days; and (ii) one hundred percent (100%) within thirty (30) calendar days, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk. | 20% |

| Performance Measure | Required Contractual Standard | Standard Required to Receive Incentive Payment | Amount of Performance Withhold at Risk |
|---|---|---|---|
| Provider Network | Contractor shall develop a provider network that meets the following distance requirements from the personal residence of members: (i) primary care physician within thirty (30) miles or thirty (30) minutes; and (ii) behavioral health provider within thirty (30) miles or thirty (30) minutes. Additionally, the Contractor shall contract with at least two (2) HCBS providers per county for each covered HCBS in the benefit package for each 1915(c) and 1915(i) HCBS waiver.<br><br>For areas of the State where provider availability is insufficient to meet any of these three (3) standards, the access standards shall meet the usual and customary standards for the community, which are documented and justified to the State. | Within (6) months of the Contract effective date, the Contractor develops a provider network that meets the following distance requirements from the personal residence of members: (i) primary care physicians within twenty (20) miles or twenty (20) minutes; (ii) behavioral health provider within twenty (20) miles or twenty (20) minutes. Additionally, the Contractor contracts with at least three (3) HCBS providers per county for each covered HCBS in the benefit package for each 1915(c) and 1915(i) HCBS waiver.<br><br>For areas of the State where provider availability is insufficient to meet any of these three (3) standards, the access standards shall meet the usual and customary standards for the community, which are documented and justified to the State. | 20% |

## YEAR TWO AND BEYOND OUTCOME MEASURES AND INCENTIVE PAYMENT STRUCTURE

The Agency has identified priority clinical performance measures for inclusion in the pay for performance program beginning in Contract year two (2) at which time sufficient clinical data is anticipated to be available to establish a baseline and target for each measure. The Agency reserves the right to change year two (2) measures based on information and data gathered during year one (1) or to better align with the Agency priorities and CMS initiatives. Performance measures and targets may change on a year-to-year basis as program priorities shift and as necessary to support continuous quality improvement. The performance measures and targets applicable during each Contract year shall be established annually by the Agency and reflected in an amendment to the Contract.

Except as otherwise set forth in Table F2, Contractor performance shall be calculated based on care delivered during the measurement year. For example, year two (2) performance measures are tied to performance in Contract year (2). Incentive payments for any measure will be conditioned upon the Contractor improving outcomes on that individual measure from the previous year.

The Contractor is required to collect performance data for all of the pay for performance measures listed in Table F2 in Contract year one (1) to serve as baseline data. The Agency expects to achieve continuous improvement in this program. The Agency reserves the right to tie performance improvement program requirements to pay for performance indicators where the Contractor has failed to meet the benchmark or improvement standard.

TABLE F2: YEAR TWO OPERATIONAL PAY FOR PERFORMANCE MEASURES

| Pay for Performance Tied to Medical Capitation Payments | | | |
|---|---|---|---|
| **Performance Measure** | **Required Contractual Standard** | **Standard Required to Receive Incentive Payment** | **Amount of 2.5% Medical Performance Withhold at Risk** |
| Value Based Purchasing | The Contractor must have at least 40% of the population defined by the Agency in a value based purchasing (VBP) arrangement (use of VIS and TCOC or MLR) with the healthcare delivery system by end of calendar year 2018. | If the Contractor is able to reach 25% of designated membership covered by value based purchasing contracts by June 30, 2018, inclusive of use of the VIS and TCOC or MLR, seventy-five percent (75%) of the amount of the Performance Withhold at risk.<br><br>If the Contractor is able to reach 30% of designated membership covered by value based purchasing contracts by June 30, 2018, inclusive of use of the VIS and TCOC or MLR, one hundred percent (100%) of the amount of the Performance Withhold at risk. | 20% |
| Children's Access to Care | No required contract standard. This NCQA measure assesses access to care and preventative health utilization. | Total (all sub-measures)<br>Rate — Percent of Performance Withhold at Risk<br>70 — 50%<br>80 — 75%<br>85 — 100% | 20% |
| Adult Access to Care | No required contract standard. This NCQA measure assesses access to care and preventative health utilization. | Total (all sub-measures)<br>Rate — Percent of Performance Withhold at Risk<br>65 — 50%<br>70 — 75%<br>85 — 100% | 20% |

| Pay for Performance Tied to Medical Capitation Payments | | | |
|---|---|---|---|
| **Performance Measure** | **Required Contractual Standard** | **Standard Required to Receive Incentive Payment** | **Amount of 2.5% Medical Performance Withhold at Risk** |
| Provider Network | Contractor shall develop a provider network that meets the following distance requirements from the personal residence of members (i) primary care physician within thirty (30) miles or thirty (30) minutes; and (ii) behavioral health provider within thirty (30) miles or thirty (30) minutes.<br><br>For areas of the State where provider availability is insufficient to meet standards, the access standards shall meet the usual and customary standards for the community, which are documented and justified to the State. | Contractor develops a provider network where providers accepting new patients (open panel) are within the following distance requirements of the personal residence of members: (i) primary care physicians within twenty (20) miles or twenty (20) minutes; (ii) behavioral health provider within twenty (20) miles or twenty (20) minutes.<br><br>For areas of the State where provider availability is insufficient to meet standards, the access standards shall meet the usual and customary standards for the community, which are documented and justified to the State.<br><br>Provider network gaps that have been approved by the Agency shall be excluded for purposes of determining whether the Contractor has met the standard required to receive an incentive payment. | 20% |
| Appeals | The Contractor shall make a decision on standard, non-expedited appeals within thirty (30) calendar days of receipt of the appeal.<br><br>The Contractor shall make a decision on an expedited appeal within seventy-two (72) hours of receipt of the expedited Appeal. | If the Contractor makes decisions on ninety percent (90%) of standard, non-expedited appeals within twenty-five (25) calendar days of receipt, the Contractor is eligible to receive an incentive payment equal to seventy-five percent (75%) of the amount of the Performance Withhold at risk in relation to Appeals.<br><br>If the Contractor makes decisions on ninety-five percent (95%) of standard non-expedited appeals within twenty-five (25) calendar days of receipt, the Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk in relation to Appeals.<br><br>Appeals with Agency approved extensions will be excluded from these calculations. | 20% |
| **Pay for Performance Tied to LTSS Capitation Payments** | | | |

| Performance Measure | Required Contractual Standard | Standard Required to Receive Incentive Payment | Amount of 0.5% LTSS Performance Withhold at Risk |
|---|---|---|---|
| Provider Network | The Contractor shall contract with at least two (2) HCBS providers per county for each covered HCBS in the benefit package for each 1915(c) and 1915 (i) HCBS waiver.<br><br>For areas of the State where provider availability is insufficient to meet standards, the access standards shall meet the usual and customary standards for the community, which are documented and justified to the State. | The Contractor contracts with at least three (3) HCBS providers per county for each covered HCBS in the benefit package for each 1915(c) and 1915(i) HCBS waiver.<br><br>For areas of the State where provider availability is insufficient to meet standards, the access standards shall meet the usual and customary standards for the community, which are documented and justified to the State.<br><br>Provider network gaps that have been approved by the Agency shall be excluded for purposes of determining whether the Contractor has met the standard required to receive an incentive payment. | 100% |

## Exhibit G

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

| NDC | Drug Name |
|---|---|
| 00944305302 | ADVATE |
| 00944305402 | ADVATE |
| 00944304510 | ADVATE |
| 00944305102 | ADVATE |
| 00944304610 | ADVATE |
| 00944304710 | ADVATE |
| 00944305202 | ADVATE |
| 00944425602 | ADYNOVATE |
| 00944462401 | ADYNOVATE |
| 00944462701 | ADYNOVATE |
| 00944425802 | ADYNOVATE |
| 00944462501 | ADYNOVATE |
| 00944425202 | ADYNOVATE |
| 00944462201 | ADYNOVATE |
| 00944462801 | ADYNOVATE |
| 00944425402 | ADYNOVATE |
| 00944462301 | ADYNOVATE |
| 00944462601 | ADYNOVATE |
| 69911047602 | AFSTYLA |
| 69911047702 | AFSTYLA |
| 69911047402 | AFSTYLA |
| 69911047802 | AFSTYLA |
| 69911047502 | AFSTYLA |
| 68516460101 | ALPHANATE/VON WILLEBRAND |
| 68516460501 | ALPHANATE/VON WILLEBRAND |
| 68516460201 | ALPHANATE/VON WILLEBRAND |
| 68516460601 | ALPHANATE/VON WILLEBRAND |
| 68516460302 | ALPHANATE/VON WILLEBRAND |
| 68516460702 | ALPHANATE/VON WILLEBRAND |
| 68516460402 | ALPHANATE/VON WILLEBRAND |
| 68516460802 | ALPHANATE/VON WILLEBRAND |
| 68516460902 | ALPHANATE/VON WILLEBRAND |
| 68516461002 | ALPHANATE/VON WILLEBRAND |
| 68516360202 | ALPHANINE SD |
| 68516360502 | ALPHANINE SD |
| 68516360302 | ALPHANINE SD |
| 68516360602 | ALPHANINE SD |
| 68516360102 | ALPHANINE SD |
| 68516360402 | ALPHANINE SD |
| 64406092201 | ALPROLIX |
| 64406093301 | ALPROLIX |
| 64406096601 | ALPROLIX |
| 64406094401 | ALPROLIX |
| 64406097701 | ALPROLIX |

| | |
|---|---|
| 64406091101 | ALPROLIX |
| 64193044502 | BEBULIN |
| 58394063503 | BENEFIX |
| 58394063603 | BENEFIX |
| 58394063303 | BENEFIX |
| 58394063703 | BENEFIX |
| 58394063403 | BENEFIX |
| 64406080401 | ELOCTATE |
| 64406080501 | ELOCTATE |
| 64406080601 | ELOCTATE |
| 64406080101 | ELOCTATE |
| 64406080701 | ELOCTATE |
| 64406080801 | ELOCTATE |
| 64406080901 | ELOCTATE |
| 64406080201 | ELOCTATE |
| 64406081001 | ELOCTATE |
| 64406080301 | ELOCTATE |
| 60923028410 | EXONDYS 51 |
| 60923036302 | EXONDYS 51 |
| 64193042302 | FEIBA |
| 64193042402 | FEIBA |
| 64193042502 | FEIBA |
| 00053813302 | HELIXATE FS |
| 00053813402 | HELIXATE FS |
| 00053813102 | HELIXATE FS |
| 00053813502 | HELIXATE FS |
| 00053813202 | HELIXATE FS |
| 00944394402 | HEMOFIL M |
| 00944394602 | HEMOFIL M |
| 00944394002 | HEMOFIL M |
| 00944394202 | HEMOFIL M |
| 63833061702 | HUMATE-P |
| 63833061502 | HUMATE-P |
| 63833061602 | HUMATE-P |
| 69911086602 | IDELVION |
| 69911086702 | IDELVION |
| 69911086402 | IDELVION |
| 69911086502 | IDELVION |
| 53270027105 | IXINITY |
| 53270027106 | IXINITY |
| 53270027205 | IXINITY |
| 53270027206 | IXINITY |
| 53270027005 | IXINITY |
| 76125067650 | KOATE |
| 76125025620 | KOATE |
| 76125066830 | KOATE |
| 76125066750 | KOATE-DVI |
| 76125067250 | KOATE-DVI |
| 76125067351 | KOATE-DVI |

| | |
|---|---|
| 76125025020 | KOATE-DVI |
| 76125050030 | KOATE-DVI |
| 76125066730 | KOATE-DVI |
| 00026379550 | KOGENATE FS BIO-SET |
| 00026378550 | KOGENATE FS |
| 00026378555 | KOGENATE FS |
| 00026379660 | KOGENATE FS BIO-SET |
| 00026378660 | KOGENATE FS |
| 00026378665 | KOGENATE FS |
| 00026379220 | KOGENATE FS BIO-SET |
| 00026378220 | KOGENATE FS |
| 00026378225 | KOGENATE FS |
| 00026379770 | KOGENATE FS BIO-SET |
| 00026378770 | KOGENATE FS |
| 00026378775 | KOGENATE FS |
| 00026379330 | KOGENATE FS BIO-SET |
| 00026378330 | KOGENATE FS |
| 00026378335 | KOGENATE FS |
| 00026382425 | KOVALTRY |
| 00026382650 | KOVALTRY |
| 00026382125 | KOVALTRY |
| 00026382850 | KOVALTRY |
| 00026382225 | KOVALTRY |
| 00053763302 | MONOCLATE-P |
| 00053763402 | MONOCLATE-P |
| 00053623302 | MONONINE |
| 00169781001 | NOVOEIGHT |
| 00169781501 | NOVOEIGHT |
| 00169782001 | NOVOEIGHT |
| 00169782501 | NOVOEIGHT |
| 00169783001 | NOVOEIGHT |
| 00169785001 | NOVOEIGHT |
| 00169720101 | NOVOSEVEN RT |
| 00169720201 | NOVOSEVEN RT |
| 00169720501 | NOVOSEVEN RT |
| 00169720801 | NOVOSEVEN RT |
| 68982014401 | NUWIQ |
| 68982014601 | NUWIQ |
| 68982014001 | NUWIQ |
| 68982014201 | NUWIQ |
| 68982014301 | NUWIQ |
| 68982014501 | NUWIQ |
| 68982013901 | NUWIQ |
| 68982014101 | NUWIQ |
| 00944500101 | OBIZUR |
| 00944500105 | OBIZUR |
| 00944500110 | OBIZUR |
| 68516320202 | PROFILNINE |
| 68516320502 | PROFILNINE SD |

| | |
|---|---|
| 68516320302 | PROFILNINE |
| 68516320602 | PROFILNINE SD |
| 68516320101 | PROFILNINE |
| 68516320401 | PROFILNINE SD |
| 00944284410 | RECOMBINATE |
| 00944284510 | RECOMBINATE |
| 00944284110 | RECOMBINATE |
| 00944284210 | RECOMBINATE |
| 00944284310 | RECOMBINATE |
| 00944303002 | RIXUBIS |
| 00944303202 | RIXUBIS |
| 00944302602 | RIXUBIS |
| 00944303402 | RIXUBIS |
| 00944302802 | RIXUBIS |
| 64406005801 | SPINRAZA |
| 00944755302 | VONVENDI |
| 00944755102 | VONVENDI |
| 67467018201 | WILATE |
| 67467018202 | WILATE |
| 68982018201 | WILATE |
| 68982018202 | WILATE |
| 58394001401 | XYNTHA |
| 58394001501 | XYNTHA |
| 58394001201 | XYNTHA |
| 58394001301 | XYNTHA |
| 58394002403 | XYNTHA SOLOFUSE |
| 58394002503 | XYNTHA SOLOFUSE |
| 58394001603 | XYNTHA SOLOFUSE |
| 58394002303 | XYNTHA SOLOFUSE |
| 58394002203 | XYNTHA SOLOFUSE |
| 00944292102 | ADVATE |
| 00944294210 | ADVATE |
| 00944294310 | ADVATE |
| 00944294810 | ADVATE |
| 00944296410 | ADVATE |
| 00944296510 | ADVATE |