**Second Amendment to the Iowa Department of Human Services**

**Iowa Health Link Request for Proposal**

This Amendment to RFP Number MED-23-005 is effective as of March 25, 2022. The RFP is amended as follows:

**Revision 1.** The following language from Duration of Contract is hereby amended to read as follows:

The Agency anticipates executing a contract that will have an initial four (4) year contract term with the ability to extend the contract for two (2) additional two (2) year terms. The Agency will have the sole discretion to extend the contract.

**Revision 2.** The following language from RFP Section 3, Subsection 3.1, Number of Hard Copies row in the table, is hereby amended to read as follows:

Submit one (1) original hard copy of the Proposal. The original hard copy must contain original (pen and ink) and/or certified digital signatures.

**Revision 3.**  The following language from RFP Section 3, Subsection 3.2.4.2.1 is hereby amended to read as follows:

* 1. Identify in table format all of your publicly-funded managed care contracts for Medicaid, CHIP, and other low-income populations within the last five (5) years. The Bidder should submit information relevant to the Bidder as well as any holding company, parent company, subsidiary, or intermediary company of the Bidder. For each prior experience identified, provide a brief description of the following (including if the experience identified is direct experience or from a parent company):
	2. Name of your plan and the State in which you provided services;
	3. Scope of work and covered benefits (state whether physical health, behavioral health, and long-term services and supports (LTSS) were in or out of scope);
	4. Duration of the contract;
	5. Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s);
	6. Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s);
	7. Contact name, phone number, and email address;
	8. Number of members served by population type;
	9. Annual contract payments and description if payment was capitated;
	10. Any improvements made in utilization trends and quality indicators;
	11. Overall NCQA rating;
	12. Accreditation information;
	13. How the contract emphasizes member choice, access, safety, independence, and responsibility; and
	14. The role of subcontractors, if any.

**Revision 4.** The following language from RFP Section 3, Subsection 3.2.6 is hereby amended to read as follows:

3.2.6 Information to Include Behind Tab 6: RFP Forms.

The forms listed below are attachments to this RFP. Fully complete and return these forms behind Tab 6 (reference to Vendor Security Questionnaire was removed):

* Release of Information Form
* Primary Bidder Detail & Certification Form
* Subcontractor Disclosure Form (one (1) for each proposed subcontractor)
* Certification and Disclosure Regarding Lobbying

**Revision 5.** The following language from Attachment B, Section 1, Subsection 1.4 is hereby amended to read as follows:

1.4 *Reserved*;

**Revision 6.** The following language from Attachment F – Section 1, Subsection 1.5.2 is hereby amended to read as follows:

**1.5.2 Vendor Security Questionnaire.** The Contractor shall provide a fully completed copy of the Agency’s Vendor Security Questionnaire (VSQ) available in the Bidder’s Library.

**Revision 7.** The following language from Attachment F, Section 4, Subsection A.07.e.17 is hereby amended to read as follows:

17) *LTSS Manager:* Shall ensure oversight of the Contractor’s implementation of the State’s community based and facility programs. The LTSS Manager shall, at minimum, have at least five (5) years of experience in LTSS policy and have a comprehensive understanding of CMS rules and regulations. The LTSS Manager shall oversee long-term care Provider reviews, Utilization Reviews, Enrolled Member satisfaction surveys, and Enrolled Member health and welfare.

**Revision 8.** The following language from Attachment F, Section 4, Subsection D.4.07 is hereby amended to read as follows (bullet c was split out from bullet b and a typo of (iii) was removed):

D.4.07. *Activities that improve health care quality*. Activities that improve health care quality are limited to two percent (2%) of capitation payments and must be in one of the following categories:

1. A Contractor activity that meets the requirements of 45 C.F.R. § 158.150(b) and is not excluded under 45 C.F.R. § 158.150(c).
2. A Contractor activity related to any EQR-related activity as described in 42 C.F.R. § 438.358(b) and (c).
3. Any Contractor expenditure that is related to Health Information Technology and meaningful use, meets the requirements placed on issuers found in 45 C.F.R. § 158.151, and is not considered incurred claims.

**Revision 9.** The following language from Attachment F, Section 4, Subsection D.4.23 is hereby amended to read as follows:

D.4.23. *Revenue.* The revenue used in the Medical Loss Ratio calculation will consist of both Capitation and Risk Corridor revenue. Capitation revenue will be the Capitation payments made by the Agency to each Contractor adjusted to exclude any supplemental payments not at risk to the MCOs, taxes, and regulatory fees due from and or received from the Agency for services provided during the Coverage Year. Any unearned withhold amounts and any reconciled supplemental/directed payments will not be included in the capitation revenue for the purposes of the medical loss ratio calculation. Any risk corridor payments from the Agency to the Contractor or from the Contractor to the Agency will be considered as premium revenue in the calculation of the contractually required eighty-eight percent (88%) minimum loss ratio.

**Revision 10.** The following language from Attachment F, Section 4, Subsection D.4.24.e is hereby amended to read as follows:

e) Supplemental Payments. Any reconciled supplemental/directed payments shall be excluded from the Benefit Expense.

**Revision 11.** The following language from Attachment F, Section 4, Subsection E.8.03 is hereby amended to read as follows:

E.8.03. *Value-Based Purchasing Arrangements.* 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 the first year of any managed care contract. By the end of the second year, the Contractor shall have 50% VBP enrollment. Thereafter, the Contractor shall maintain or exceed 50% VBP enrollment. The VBP arrangement shall recognize population health outcome improvement as measured through Agency-approved metrics combined with a total cost of care measure for the population in the VBP arrangement. Driving population health through delivery system reform under VBP means that Providers need a clear understanding of the specific lives for which they are accountable. As such, any Enrolled Members that are part of a VBP must be assigned by the Contractor to a designated PCP. This PCP information shall be immediately reported by the Contractor for use in system wide coordination enhancements as specified by the Agency. The Contractor shall also require that all contracted hospitals report admission and discharge information to support this exchange and coordination. Contractor shall use an Agency-approved tool, to provide a consistent, real-time notification platform for hospitals to uniformly report inpatient and ED events for Enrolled Members to the Contractor and care teams participating in VBP agreements. The Contractor shall notify the Agency of any risk sharing agreements it has arranged with a Provider and require in the Provider agreement for any Providers who are paid on a capitated basis the submission of encounter data within ninety (90) Days of the date of service. As applicable, the Provider agreements shall comply with the requirements set forth in this Contract for subcontracts 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.

**Revision 12.** The following language fromAttachment F, Section 4, Subsection G.2.04 is hereby amended to read as follows:

G.2.04 *Reserved.*

**Revision 13.** The following language from Attachment F, Section 4, Subsection G.2.24is hereby amended to read as follows:

G.2.24. *Care Plan Requirements*. The care plan shall reflect cultural considerations of the Enrolled Member. In addition, the care plan development process shall be conducted in plain language and be accessible to Enrolled Members who have disabilities and/or have LEP. The care plan shall be approved by the Contractor in accordance with applicable Quality measures and Utilization Review standards. For Enrolled Members determined to need a course of treatment or regular monitoring, the Contractor shall have direct Access to a specialist as appropriate for the Enrolled Member’s condition and identified needs. The Contractor shall ensure that the care plan is provided to the Enrolled Member’s PCP (if applicable) or other significant Providers. The Contractor shall also provide the Enrolled Member the opportunity to review the care plan as requested.

**Revision 14.** The following language from Attachment F, Section 4, Subsection G.2.37is hereby amended to read as follows:

G.2.37 *Transition Period-Out of Network Care.*  During the first 90 Days following Contractor’s entry into the IA Health Link marketplace, with the exception of LTSS, residential services and certain services rendered to dual diagnosis populations, which are addressed in Section F.13.28, the Contractor shall allow an Enrolled Member who is receiving covered Benefits from a non-Network Provider at the time of Contractor enrollment to continue accessing that Provider, even if the network has been closed due to the Contractor meeting the network Access requirements.  The Contractor is permitted to establish single case agreements with Providers enrolled with Iowa Medicaid or otherwise authorize non-network care past the initial 90 Days of the Contract to provide continuity of care for Enrolled Members receiving out-of-network services.  The Contractor shall make commercially reasonable attempts to contract with Providers from whom an Enrolled Member is receiving ongoing care. Out-of-Network Providers will be reimbursed a percentage of the network rate unless otherwise agreed upon through a single case agreement.

**Revision 15.** The following language from Attachment F, Section 4, Subsection H.10.04 is hereby amended to read as follows:

H.10.04. *Timeline for Resolutions.* Contractor shall resolve each Grievance and provide Notice, as expeditiously as the Enrolled Member’s health condition requires, within thirty (30) Days from the day the Contractor receives the Grievance. See: 42 C.F.R. § 438.408(a); 42 C.F.R. § 438.408(b)(1); 42 C.F.R. § 457.1260. {From CMSC H.10.04}.

**Revision 16.** The following language from Attachment F,Section 4, Subsection I.1.02 is hereby amended to read as follows:

I.1.02. *Exclusion Checks.* Contractor shall check employees and Subcontractors every month against the OIG’s List of Excluded Individuals/Entities (LEIE), the GSA Excluded Parties List System (EPLS), the Social Security Administration Death Master File (SSDMF), the National Plan and Provider Enumeration System (NPPES), and the Iowa Medicaid exclusion list to ensure that no employee or Subcontractor has been excluded.

**Revision 17.** The following language from Attachment F, Section 4, Subsection I.2.16 is hereby amended to read as follows (reference to 42 CFR 455.436 has been removed):

I.2.16. *Excluded Providers.* The Contractor is prohibited from subcontracting with Providers who have been excluded by the Agency from participating in the Iowa Medicaid program for Fraud or Abuse. The Contractor shall ensure that a reimbursed Consumer Choice Option Provider is not an excluded entity.  The Contractor shall be responsible for checking the lists of Providers currently excluded by the State and the federal government every 30 Days. In addition, the Contractor shall check the SSA’s Death Master File, the NPPES, the SAM, the Medicare Exclusion Database (the MED) and any such other databases as the Secretary of DHHS may prescribe. Upon request by the Agency, the Contractor shall terminate its relationship with any Provider identified as in continued violation of law by the Agency. See: 42 C.F.R. § 438.610(d)(2); 42 C.F.R. § 438.610(a); Exec. Order No. 12549; 42 C.F.R. § 457.1285.]

**Revision 18.** The following language from Attachment F, Section 4, Subsection K.41.a is hereby amended to read as follows:

1. *Claims Processing Capability*. The Contractor shall process and pay Provider Claims for services rendered to the Contractor’s Enrolled Members. The Contractor shall have a Claims processing system for both in- and Out-of-Network Providers capable of processing all Claims types. The Contractor shall accept Claims submitted via standard EDI transactions directly from Providers, or through their intermediary, and must have the capacity to process paper Claims. The Contractor shall submit to Iowa Medicaid a daily file of pre-adjudicated Claims received on the previous day. The Contractor shall electronically accept and adjudicate Claims and accurately support payment of Claims for Enrolled Members’ periods of eligibility. The Contractor shall also provide electronic remittance advice and to transfer Claims payment electronically. The Contractor shall process as many Claims as possible electronically. The Contractor shall track electronic versus paper Claim submissions over time to measure success in increasing electronic submissions. The Contractor shall accurately price specific procedures or encounters (according to the agreement between the Provider(s) and the Contractor) and to maintain detailed records of remittances to Providers. The Contractor shall update Provider reimbursement rates in its Claims processing system and adjudicate Claims using the new rates no later than thirty (30) Days from notification by the Agency, or as otherwise directed by the Agency. Except as otherwise specified in law, or as otherwise directed by the Agency, rate updates shall be implemented prospectively. The Contractor shall develop, implement, and adhere to policies and procedures, subject to Agency review and approval, to monitor Claims adjudication accuracy and shall submit its policies and procedures to the Agency for review and approval within fifteen (15) Days of Contract execution. The Out-of-Network Provider filing limit for submission of Claims to the Contractor is twelve (12) months from the date of service. This conforms with the filing limit under the Medicaid State Plan (42 C.F.R. § 447.45(d)(4)). The in-Network Provider filing limit is established in the Contractor’s Provider agreements as described in Section E.1 and shall be no more than one hundred eighty (180) Days from the date of service.

**Revision 19.** The following language from Attachment F, Section 4, Subsection K.45.a is hereby amended to read as follows:

a) *Accuracy of Encounter Claims.* The Contractor shall implement policies and procedures to ensure that encounter Claims submissions are accurate. The Agency reserves the right to monitor encounter Claims for accuracy against Contractor internal criteria as well as State and Federal requirements. The Agency will regularly monitor the Contractor’s accuracy by reviewing the Contractor’s compliance with its internal policies and procedures for accurate encounter Claims submissions and by random sample audits of Claims. The Agency will implement a quarterly Encounter Utilization Monitoring report and review process to be implemented in the first quarter following the Contract effective date. The Contractor shall submit timely and accurate reports in the format and timeframe designated by the Agency. The Contractor shall investigate root cause of report inaccuracies and submit a revised report in the timeframe designated by the Agency. The Contractor shall fully comply with requirements of these audits and provide all requested documentation, including, but not limited to, applicable Medical Records and Prior Authorizations. The Agency will require the Contractor to submit a Corrective Action Plan and will require non-compliance remedies for Contractor failure to comply with accuracy of these reporting requirements.

**Revision 20.** The following language from Attachment F, Section 5, Exhibit B, Definition of CMSC, is hereby amended to read as follows:

CMSC: The CMS State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval (also known as the CMS Checklist), available at: <https://www.medicaid.gov/medicaid/downloads/mce-checklist-state-user-guide.pdf>

**Revision 21.** The following definition is hereby added to Attachment F, Section 5, Exhibit B:

*Single case agreement:* A single case agreement (SCA) is defined as a contract between an out-of-network health care provider and the Contractor to ensure that members have access to covered Medicaid services.  A single case agreement may be used to provide members’ medically necessary services when the Contractor's provider network cannot provide access to necessary services to maintain a member’s health and/or the member’s health would be endangered if required to travel or wait for care from an in-network provider.

Only under very limited circumstances may a provider or organization bill and receive payment for services without being enrolled as an Iowa Medicaid provider. Specifically, the Contractor may pay a claim to a furnishing provider that is not enrolled in Iowa Medicaid to the extent that the claim is otherwise payable and meets the following criteria:

* The treatment rendered to the member is considered emergent and would place the member in serious jeopardy if treatment was not provided or the treatment rendered to the member is considered a post-stabilization service
* Clinical documentation supports the need for emergency care and is submitted with the claim, including an emergency indicator in Box 45 of the ADA claim form
* The health care provider is screened in accordance with 42 CFR part 455, subpart E standards

All health care providers are encouraged to enroll in Iowa Medicaid to receive payment and may be denied payment if the required above criteria are not met. All non-enrolled Medicaid provider payments must be reviewed and approved by Iowa Medicaid prior to payment to assure program quality and integrity.

**Revision 22.** The following language from Attachment J,Section A, Subsection A.04-A.13 is hereby amended to read as follows:

A.04 Staffing Requirements – A.13 Staff Training and Qualifications

1. Describe in detail your staffing plan and the staffing levels you commit to maintaining.
2. Confirm that a final staffing plan, including a resume for each Key Personnel member, will be delivered on or before the tenth day following execution of the Contract
3. Describe your back up personnel plan, including a discussion of the staffing contingency plan for:
	1. The process for replacement of personnel in the event of a loss of Key Personnel or others.
	2. Allocation of additional resources in the event of an inability to meet a performance standard.
	3. The method of bringing replacement or additions up to date regarding the Contract.

d) Describe which staff will be located in Iowa, and where other staff will be located.

1. Describe how out-of-state staff will be supervised to ensure compliance with Contract requirements and maintain a full understanding of Iowa operations and requirements.
2. Indicate the proposed location of the Iowa office from which key staff members will perform their duties and responsibilities.

e) Describe how you will ensure that all staff are knowledgeable in Iowa-specific policies and operations.

f) Describe your staff training plans (including subcontractors’ staff) and ongoing policies and procedures for training all staff.

**Revision 23.** The following language from Attachment J, Section F, Subsection F.11is hereby amended to read as follows:

F.11 Outpatient Prescription Drugs

a) Describe how you will ensure that the State preferred drug list (PDL), prior authorization (PA), utilization edits, and reimbursement will be applied appropriately.