

BOARD OF SUPERVISORSDistrict 1 | **Kirsten Running-Marquardt**District 2 | **Ben Rogers**District 3 | **Louis J. Zumbach****JEAN OXLEY LINN COUNTY PUBLIC SERVICE CENTER**

935 2ND ST. SW

CEDAR RAPIDS, IA 52404

PH: 319-892-5000

LinnCountyIowa.gov

**LINN COUNTY BOARD OF SUPERVISORS
MEETING AGENDA**

Wednesday, April 5, 2023

10 a.m.

Formal Board Room—Jean Oxley Public Service Center
935 2nd St. SW, Cedar Rapids, IA**Call to Order****Pledge of Allegiance****Public Comment: Five Minute Limit per Speaker**

This comment period is for the public to address topics on today's agenda.

Consent Agenda

Items listed on the consent agenda are routine and will be considered by one motion without individual discussion unless the Board removes an item for separate consideration.

Reports**Resolutions**

Resolution authorizing the number of Deputy Auditor positions

Resolution approving Rural Land Use Map Amendment case JA23-0002, request of Daniel & Carolyn Thies Trusts, owner, to change the map designation for approximately 9.34 acres located at 505 Dows Rd from 6414 Old River Rd SE from Metro Urban Services Area (MUSA) to Rural Residential 2-Acre Area (RRD2).

Contract and Agreements

Approve and authorize Chair to sign an Agreement between Grant Wood Area Education Agency and Linn County Board of Supervisors to ensure appropriate educational programming for youth residing at the Juvenile Detention Center effective July 1, 2023 through June 20th, 2024.

Authorize Chair to sign a Memorandum of Understanding (MOU) between the Mental Health/Disability Services of the East Central Region of Iowa and Options of Linn County for \$30,000 for funding of mental health and disability services per guidelines for the period of July 1, 2022 through June 30, 2023.

Licenses & Permits**Regular Agenda****Discuss and Decide on Consent Agenda****Minutes**

Discuss and decide on meeting minutes.

Claims

Discuss and decide on claims.

Second consideration for rezoning case JR23-0003, request to rezone property located at 505 Dows Rd, from the Agricultural (Ag) zoning district to the Rural Residential 2-Acre (RR2) zoning district, approximately 9.34 acres, Daniel & Carolyn Thies Trusts, owner.

Second Consideration on an ordinance amending the Code of Ordinances, Linn County, Iowa by amending provisions in Chapter 107, Unified Development Code, relating to accessory dwelling units and updating the use table to include softball fields and other similar uses.

Discuss and decide signing of Letter of Trespass between Linn County and City of Cedar Rapids Police Department

Discuss and decide Home the Community Based Provider Services agreement between Options of inn County and Molina Healthcare of Iowa, Inc. for Medicaid services provided at Options of Linn County for the term July 1, 2023 through June 30, 2024.

Public Comment: Five Minute Limit per Speaker

This is an opportunity for the public to address the board on any subject pertaining to board business.

Payroll Authorizations

Discuss and decide on Employment Change Roster (payroll authorizations).

Legislative Update

Discuss and decide on action related to proposed legislation

Correspondence

Appointments

Adjournment

For questions about meeting accessibility or to request accommodations to attend or to participate in a meeting due to a disability, please contact the Board of Supervisors office at 319-892-5000 or at bd-supervisors@linncountyiowa.gov.

RESOLUTION

**Authorizing the Number of
Deputy Auditor Positions**

WHEREAS, the Board of Supervisors, Linn County, Iowa, is empowered pursuant to Section 331.903, Code of Iowa, to determine the number of deputies, assistants, and clerks for the offices of Auditor, Treasurer, Recorder, Sheriff, and County Attorney, and

WHEREAS, the Board of Supervisors, Linn County, Iowa authorized four (4) Deputy Linn County Auditor positions, and

WHEREAS, the Board of Supervisors approved the position of Accounting Manager for the Auditor's Office on March 13, 2023, and

WHEREAS, the Linn County Auditor, Joel D. Miller, is requesting that the Board of Supervisors authorize the reduction of one (1) Deputy Auditor position in the Linn County Auditor's Office, and

NOW, THEREFORE, BE IT AND IT IS HEREBY RESOLVED by the Board of Supervisors, Linn County, Iowa, this date met in lawful session, that the reduction of one (1) Deputy Linn County Auditor position is hereby approved, decreasing the number of authorized Deputy Linn County Auditor positions from four (4) to three (3), for the stated purpose of adding an Accounting Manager position for the Linn County Auditor's Office.

Dated at Cedar Rapids, Linn County, Iowa this 5th day of April, 2023.

LINN COUNTY BOARD OF SUPERVISORS

AYE:

NAY:

ABSTAIN:

ABSENT:

ATTEST:

**JOEL D. MILLER, Linn County Auditor &
Clerk to the Board of Supervisors**

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Resolution # _____

STATE OF IOWA }
 }
COUNTY OF LINN }

I, JOEL D. MILLER, County Auditor of Linn County, Iowa, and Clerk to the Board of Supervisors, Linn County, Iowa, hereby certify that at a regular meeting of the said Board, the foregoing was duly adopted by a vote of _____aye, _____nay, _____absent and _____abstained from voting.

JOEL D. MILLER

Subscribed and sworn to before me by the aforesaid on this _____day of April, 2023.

NOTARY PUBLIC – State of Iowa

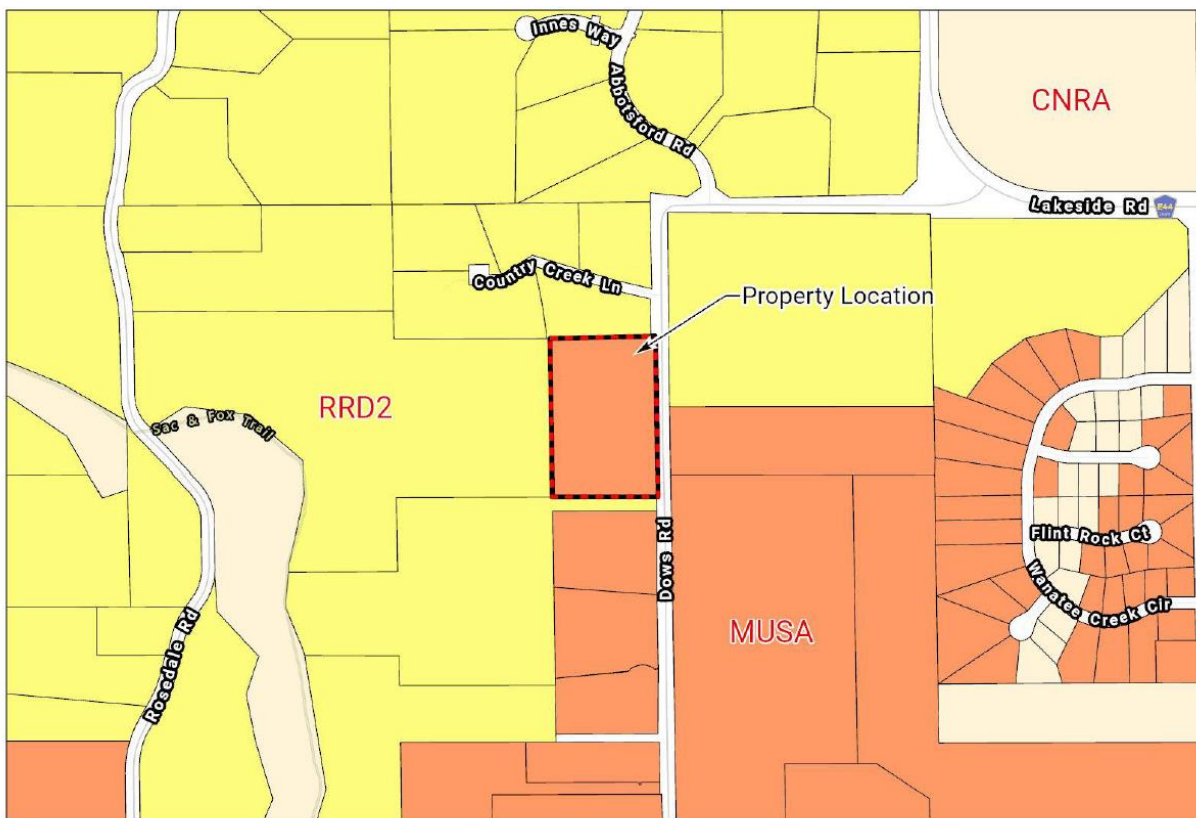
Prepared by Jessie Black
Linn County Planning & Development
935 2nd Street S.W., Cedar Rapids, Iowa 52404-2100
(319) 892-5130
Return to Becky Shoop, Auditor's Office

LINN COUNTY RESOLUTION # _____

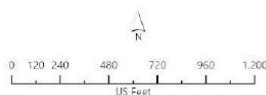
**AN AMENDMENT TO THE LINN COUNTY
2013 RURAL LAND USE MAP**

BE IT RESOLVED by the Board of Supervisors, Linn County, Iowa, that the following amendment, Case JA23-0002, be made to the Rural Land Use Map of the Linn County Comprehensive Plan, dated July 19, 2013:

Amend the Rural Land Use Map designation from Metro Urban Service Area (MUSA) to Rural Residential Development 2-Acre Area (RRD2) on the Linn County Rural Land Use Plan Map as shown below.



LINN COUNTY PLANNING & DEVELOPMENT
JEAN OXLEY LINN COUNTY PUBLIC SERVICE CENTER
935 2ND ST. SW
CEDAR RAPIDS, IA 52404
Ph: 319-892-5141 | Fax: 319-892-5155



Land Use
JA23-0002

Passed and approved this 5th day of April 2023

Linn County Board of Supervisors

Louis Zumbach, Chairperson

Ben Rogers, Vice-Chairperson

Kirsten Running-Marquardt, Supervisor

Aye:

Nay:

Abstain:

Absent:

Attest:

Joel Miller, Linn County Auditor

State of Iowa)
) SS
County of Linn)

I, Joel Miller, County Auditor of Linn County, Iowa, hereby certify that at a regular meeting of the said Board of Supervisors, the foregoing resolution was duly adopted by a vote of:

___ Aye ___ Nay ___ Abstain ___ Absent

Joel Miller

Linn County Board of Supervisors
Resolution # _____
April 5, 2023
JA23-0002
Page 3 of 3

Subscribed and sworn to before me by the aforesaid Joel Miller, _____,

on this _____ day of _____, 2023.

Notary Public State of Iowa

2023-2024 Agreement
For the operation of the Juvenile Detention Center
Linn County Juvenile Detention & Diversion Services

This agreement, between the Linn County Board of Supervisors and Grant Wood Area Education Agency, is entered into at the request of the Linn County Board of Supervisors in accordance with Section 281-63.1(282) of the Code of Iowa.

The period of this agreement is from July 1, 2023 through June 20, 2024.

PURPOSE

The purpose of this agreement is to ensure an appropriate educational program for youth residing at the Juvenile Detention Center through a coordinated effort between Linn County Board of Supervisors and Grant Wood Area Education Agency, hereinafter known as (“GWAEA”).

The Linn County Board of Supervisors agrees to:

1. Provide adequate facilities for the educational components of the Juvenile Detention Center to include the operation and maintenance costs.
2. Provide the financial support for the non-school programs to include salaries and all other related costs.
3. Approve expenditures and encumbrances for non-school related costs.

GWAEA agrees to:

1. Provide the administration and supervision of the educational programs under the direction of the Associate Chief Administrator. The Associate Chief Administrator will assign coordination and supervisory roles to qualified personnel employed by GWAEA.
2. Develop and evaluate the curriculum and program content of the educational programs operating in the Juvenile Detention Center. The educator assigned to this site will be involved in the planning process.
3. Financially support those programs which are allowable under the Rules and Regulations established by the State Department of Education, and in keeping with the Code of Iowa, and which have been authorized by the GWAEA Board of Directors.
4. Be responsible for the recruitment, employment, evaluation and dismissal of the education program staff. Educational program staff members are covered by a negotiated agreement (Master contract) and are subject to all rights, privileges and limitations specified therein. A calendar reflecting such things as non-work days, holidays and staff development days will be developed with the staff member’s immediate supervisor. The number of teachers and associates hired will comply with the number mandated by the Rules and Regulation of the State Department of Education.
5. Educational program staff may initiate requisitions for instructional materials and supplies following procedures established by the GWAEA and the Associate Chief Administrator. These requisitions will be reviewed by supervisory personnel and may culminate with the approval of the requested expenditure by the Associate Chief Administrator or designed.
6. Provide a minimum of 1,080 hours of educational instruction with appropriately certified teaching staff.



GRANT WOOD
AREA EDUCATION AGENCY

We, the undersigned, hereby certify that we are the properly authorized officers of the Agencies to be bound by the approval of this Agreement and that we hereby accept the terms and conditions provided herein. This agreement will be reviewed and considered for renewal on an annual basis.

Chairperson
Linn County Board of Supervisors

Board President
Grant Wood Area Education Agency

Date

Date

This Memorandum of Understanding (hereinafter “MOU”) is entered into between Options of Linn County and Mental Health/Disability Services of the East Central Region (ECR).

- I. **Funding of Mental Health and Disability Services.** This MOU establishes an agreement between and ECR for the funding of expenditures for mental health and disability services within the guidelines provided.

In consideration, the following responsibilities are assumed by the participating agencies:

Agency Responsibilities. Options of Linn County, hereinafter referred to as Contractor, agrees to:

- a. Return the signed MOU to Chelle Klootwyk at mklootwyk@ecriowa.us.
- b. Submit an invoice, copy of this MOU, and receipts/supporting documentation no later than **July 31, 2023. If invoices are not received by this date, the funds will be forfeited. Invoices, MOU, and receipts are to be sent either**
 - i. By mail to: MH/DS of the ECR 210 5th Ave. NE, Independence, IA 50644 or
 - ii. By email to claims@ecriowa.us
- c. Spend all approved funds between **July 1, 2022 and June 30th, 2023**. No purchases outside of this timeframe will be reimbursed. Trainings must occur prior to June 30th, 2023. Cost for memberships, contracts, service agreements, etc. may not exceed one year.
- d. Return any unauthorized funds should it be determined through the course of an audit that it was found to be an unauthorized use of such funds.
- e. Use any items purchased under this grant as efficiently and effectively as possible and make every reasonable effort to ensure the commitment of public funds obtains the most value for the money spent.
- f. Ensure that all items purchased are located in an office within one of the ECR counties. The recipient further agrees that all workforce funds are utilized for staff who serve individuals living in one of the ECR counties.
- g. Certify that this funding is not duplicative of other funding received.

ECR Responsibilities. ECR agrees to:

- a. Pay requested funds when invoiced with receipts and a copy of the MOU after the application and MOU are approved and funds are expended.
- b. Follow the ECR Management Plan Policies and Procedures for payment of services: J. Service Provider Payment Provisions (p. 27).

- II. **Termination.** This MOU will end June 30th, 2023 unless terminated earlier in writing by any party for its convenience upon sixty (60) days prior written notice to the other party. The agreement is subject to revision due to legislation, updated federal or state guidance, change in operating practices and policies of the involved parties, or other factors, as agreed to by the involved parties. It may be amended by mutual written agreement of the parties.

- III. **Indemnification.** Each party agrees to hold harmless all other parties (including its officers, agents and employees) from and against any and all claims, demands, liabilities and costs incurred by the indemnified party, including reasonable attorney’s fees, directly or indirectly arising out of or in connection with the

indemnifying party's performance, or any service, or any other act or omission by or under the direction of the indemnifying party, or its officers, agents or employees.

IV. Approved Expenditures.

OPERATIONAL/TECHNOLOGY ENHANCEMENTS, WORKFORCE ASSISTANCE, or SPECIAL PROJECT APPROVED

Category	Amount Approved	Brief description of item including length of service agreement/subscription/membership (if applicable)
Operations/Technology	\$22,958.00	IACP membership, copy lease, software costs, office & programs supplies and uniforms
Workforce	\$7,042.00	CPR, med. man. training, Direct Course membership, 3 staff registrations for IACP conference
Total	\$30,000.00	

OTHER TERMS: Any technology device purchased under this grant will be the property of the grantee and may be checked out for individual use. For accountability purposes, grantee shall send a copy of receipt to the East Central Region upon payment of goods. The device(s) will be property of and retained by the grantee. All devices are considered fixed assets and may not be sold for cash value or used for purposes other than stated in the grantee's application. Retention and depreciation of the fixed asset will be in accordance with the agency's fixed asset policy and procedures or in the absence of a policy, the OMB guidance 200.439.

V. Items Denied: None

This agreement has been executed by the parties hereto, through their duly authorized officials, and the effective date of this agreement is the 23rd day of March 2023.

MHDS of the ECR:

By: Dewey L. Hildebrandt

Print Name: Dewey Hildebrandt

Print Title: MHDS of the ECR Governing Board Chair

Date: March 23, 2023

Provider:

By: _____

Print Name: _____

Print Title: _____

Date: _____

Submit invoices with a copy of all receipts and a copy of this MOU to claims@ecriowa.us OR by mail to 210 5th Avenue NE, Independence, Iowa 50644 no later than July 31st, 2023.



CEDAR RAPIDS POLICE DEPARTMENT



LETTER OF TRESPASS

(Date)

This letter authorizes the Cedar Rapids Police Department to take whatever action necessary, up to and including arrest, of those people not authorized to be on our property.

Business/Property: _____

Address or Location: _____

Business hours: _____

Names and phone numbers of people to contact about the property after business hours (please print or type)

_____ Name	_____ Cell Phone/Home Phone
_____ Name	_____ Cell Phone/Home Phone
_____ Name	_____ Cell Phone/Home Phone
_____ Name	_____ Cell Phone/Home Phone

(Signature)

(Printed Name)

(Street Address or P.O. Box)

(City, State & Zip Code)

(email address for future correspondence)

NOTE: This trespass form must be filed yearly or your letter on file will be deleted.

PLEASE RETURN TO:

Administrative Operations
Letter of Trespass
Cedar Rapids Police Department
505 First Street SW
Cedar Rapids, IA 52404.

CRPD Form #783 (Rev 3/2016)

MOLINA HEALTHCARE OF IOWA, INC.
HOME AND COMMUNITY BASED PROVIDER SERVICES AGREEMENT

SIGNATURE PAGE

In consideration of the promises and representations stated, the Parties agree as set forth in this Agreement. The Authorized Representative acknowledges, warrants, and represents that the Authorized Representative has the authority and authorization to act on behalf of its Party. The Authorized Representative further acknowledges and represents that he/she received and reviewed this Agreement in its entirety.

The Authorized Representative of Provider acknowledges the Provider Manual was available for review prior to entering into this Agreement and agrees that Provider will comply with the provisions set forth under the Provider Manual section and other applicable provisions related to the Provider Manual in the Agreement.

The Authorized Representative for each Party executes this Agreement with the intent to bind the Parties in accordance with this Agreement.

Provider Signature and Information.

Provider's Legal Name ("Provider") – Matching the applicable tax form (i.e., W-9, Line 1):	
Authorized Representative's Signature:	Authorized Representative's Name – Printed:
Authorized Representative's Title:	Authorized Representative's Signature Date:
Telephone Number:	Fax Number – Official Correspondence:
Mailing Address – Official Correspondence:	Payment Address – If different than Mailing Address:
IRS 1099 Address – If different than Mailing Address:	Tax ID Number – As listed on corresponding tax form:
NPI – That corresponds to the above Tax ID Number:	Email Address – Official Correspondence:

Health Plan Signature and Information.

Molina Healthcare of Iowa, Inc., an Iowa Corporation ("Health Plan")	
Authorized Representative's Signature:	Authorized Representative's Name – Printed:
Authorized Representative's Title:	Authorized Representative's Countersignature Date:
Mailing Address – Official Correspondence:	Email Address – Official Correspondence:
Effective Date of the Agreement ("Effective Date"):	

HOME AND COMMUNITY BASED PROVIDER SERVICES AGREEMENT

Provider and Health Plan enter into this Agreement as of the Effective Date set forth on the Signature Page of this Agreement. The Provider and Health Plan each are referred to as a “Party” and collectively as the “Parties.”

RECITALS

- A. WHEREAS Health Plan is a corporation licensed and approved by required governmental agencies to operate a health care service plan, including without limitation, to issue benefit agreements covering the provision of health care and related services, including home and community-based services, and supplies in accordance with the law;
- B. WHEREAS Provider is approved by required governmental agencies to provide home and community-based services and supports and desires to provide such services and supports to eligible recipients in accordance with the law; and
- C. WHEREAS the Parties intend by entering into this Agreement that they will make home and community-based services and supports available to eligible recipients enrolled in various Products covered under this Agreement.

NOW, THEREFORE, in consideration of the promises and representations stated, the Parties agree as follows:

ARTICLE ONE – DEFINITIONS

- 1.1 Capitalized words or phrases in this Agreement have the meaning set forth below.
 - a. **Affiliate** means an entity owned or controlled by Health Plan or Molina Healthcare, Inc.
 - b. **Agreement** means this Home and Community Based Provider Services Agreement between Provider and Health Plan and all attachments, exhibits, addenda, amendments, and incorporated documents or materials.
 - c. **Appeals and Grievance Programs** mean the policies and procedures established by Health Plan to timely identify, process, and resolve Member and Provider appeals, grievances, complaints, disputes, or inquiries.
 - d. **Centers for Medicare and Medicaid Services** (“CMS”) means the agency responsible for Medicare and certain parts of Medicaid, CHIP, Medicare-Medicaid Program, and the Health Insurance Marketplace.
 - e. **Claim** means a bill for Covered Services provided by Provider.
 - f. **Clean Claim** means a Claim for Covered Services submitted on an appropriate industry standard form, which has no defect, impropriety, lack of required substantiating documentation necessary to adjudicate the Claim, or particular circumstance requiring special treatment that prevents timely adjudication of the Claim.
 - g. **Covered Services** mean those home and community-based services and supports and long-term services and supports that are provided to a Member that are benefits of a Member’s Product and are provided in accordance with the Member’s Plan of Care and, when applicable, are Medically Necessary.
 - h. **Cultural Competency Plan** means a plan that ensures Members receive Covered Services utilizing methods to promote access and delivery of Covered Services in a culturally competent manner including, but not limited to, those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. These methods must ensure that Member have access to Covered Services that are delivered in a manner that meets each Member’s unique needs.
 - i. **Date of Service** means the date on which Provider provides or completes a Covered Service as determined by Health Plan.
 - j. **Downstream Entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage, Medicaid, CHIP, or MMP Products below the level of the arrangement between Health Plan (or applicant) and Provider. These written arrangements continue down to the level of the ultimate provider for health and administrative services.
 - k. **Emergency Medical Condition** means a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the

woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

- l. **Emergency Services** mean covered inpatient and outpatient services furnished by a provider who is qualified to furnish the services and the services are needed to evaluate or stabilize an Emergency Medical Condition.
- m. **Encounter Data** means the information that is captured in a Clean Claim and the additional information required for compliance with Laws and Government Program Requirements.
- n. **Government Contract** means the contract between Health Plan and a governmental agency for a Product.
- o. **Government Program Requirements** mean the requirements of governmental agencies for a Product, which includes, but are not limited to, the requirements set forth in the Government Contract.
- p. **Health Insurance Marketplace** means those health insurance products/programs required by Title I of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), referred to collectively as the Affordable Care Act, including all implementing statutes and regulations.
- q. **Health Plan** means Molina Healthcare of Iowa, Inc., an Iowa Corporation.
- r. **Iowa Department of Human Services** ("DHS") means the agency within the State of Iowa that is responsible for the oversight and administration of the Medicaid and CHIP programs.
- s. **Law** means, without limitation, federal, state/commonwealth, tribal, or local statutes, codes, orders, ordinances, and regulations applicable to this Agreement.
- t. **Medicaid** means the joint federal-state or federal-commonwealth program provided for under Title XIX of the Social Security Act, as amended.
- u. **Medically Necessary or Medical Necessity** means health care and related services and supplies provided to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care provider; and (iv) not more costly than an alternative service, or site of services, and at least as likely to produce equivalent results.
- v. **Medicare Advantage** ("MA") means a program in which private health plans provide health care and related services and supplies through a Government Contract with CMS, which is authorized under Title XVIII of the Social Security Act, as amended (otherwise known as "Medicare"). Medicare Advantage also includes Medicare Advantage Special Needs Plans ("MA-SNP").
- w. **Medicare-Medicaid Program** ("MMP") means a program in which private health plans provide health care and related services and supplies to beneficiaries eligible for both Medicaid and Medicare through a Government Contract with CMS and the state/commonwealth.
- x. **Member** means a person enrolled in a Product and who is eligible to receive Covered Services.
- y. **Molina Marketplace** means the products offered and sold by Health Plan under the requirements of the Health Insurance Marketplace.
- z. **Overpayment** means a payment Provider receives, which after applicable reconciliation, Provider is not entitled to receive or retain pursuant to Laws, Government Program Requirements, or this Agreement.
- aa. **Participating Provider** means an individual or entity that is contracted with Health Plan to provide health care and related services and supplies to Members and, as applicable, is credentialed by Health Plan or Health Plan's designee.
- bb. **Plan of Care** means the person-centered plan developed for each Member that is comprehensive and integrated and establishes the amount, duration, and scope of medical services, support services, and behavioral health services.
- cc. **Products** mean the health insurance programs, identified on Attachment A, Products, in which Provider agrees to participate and which will include any successors to the health insurance programs.

- dd. **Provider** means the entity or person identified on the Signature Page of this Agreement and includes any persons or entities performing Covered Services on behalf of the entity or person identified on the Signature Page of this Agreement. Provider will ensure all persons and entities performing Covered Services comply with the applicable terms of the Agreement. Each person or entity will be considered an “Individual Provider.”
- ee. **Provider Manual** means Health Plan’s provider manuals, policies, procedures, documents, educational materials, including, but not limited to, Health Plan’s Drug Formulary/Prescription Drug List and prescription requirements and rules, and, as applicable, Supplemental Materials, setting forth Health Plan’s requirements and rules that Provider is required to follow.
- ff. **Quality Improvement Program** (“QI Program”) means the policies and procedures, interventions, and systems, developed by Health Plan for monitoring, assessing, and improving the accessibility, quality, and continuity of care provided to Members.
- gg. **Responsible Entity** means an entity, including, but not limited to, a capitated independent practice association or any entities that are capitated by Health Plan, which are financially responsible for certain Covered Services.
- hh. **State Children’s Health Insurance Program** (“SCHIP” or “CHIP”) means the program established pursuant to Title XXI of the Social Security Act, as amended.
- ii. **Subcontractor** means an individual or organization, including, but not limited to, a Downstream Entity, with which Provider contracts for the provision of Covered Services or administrative functions related to the performance of this Agreement. For the avoidance of doubt, a Subcontractor does not include Individual Providers.
- jj. **Utilization Review and Management Program** (“UM Program”) means the policies, procedures, and systems developed by Health Plan for evaluating and monitoring the Medical Necessity appropriateness, efficacy, or efficiency of core health care benefits and services, including, but not limited to, procedures or settings and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective reviews, including, but not limited to, under-utilization and over-utilization.

ARTICLE TWO – PROVIDER OBLIGATIONS

2.1 Provider Standards.

- a. **Standard of Care.** Provider agrees to provide Covered Services within the scope of Provider’s business. Provider will ensure all services and interactions with Members are at a level of care and competence that equals or exceeds generally accepted and professionally recognized standards of practice, rules, and standards of professional conduct, and Laws and Government Program Requirements. Provider agrees to perform Covered Services in compliance with the terms of this Agreement, which includes, but is not limited to, the attached Statement of Work.
- b. **Facilities, Equipment, and Personnel.** Provider’s facilities, equipment, personnel, technology (hardware and software), and administrative services will be at a level and quality necessary to perform Provider’s duties under this Agreement and to comply with Laws and Government Program Requirements, including, but not limited to, the ability to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Members with physical or mental disabilities. Provider will further ensure that its personnel comply with the applicable terms of this Agreement.
- c. **Prior Authorization.** Provider will communicate with Health Plan’s staff to identify those services that are Covered Services for each Member. For a service that needs added to a Plan of Care or for a Covered Service that requires a prior authorization, Provider is required to obtain prior authorization from Health Plan for such Covered Service. Health Plan will have the right to deny payment for a service that was not prior authorized by Health Plan. Provider will not have to obtain prior authorizations before providing Emergency Services.
- d. **Use of Participating Providers.** Provider will not refer Members to another individual or entity without Health Plan’s prior authorization.
- e. **Provider-Member Communication.** Health Plan encourages open Provider-Member communication regarding Medical Necessity, appropriate treatment, and care. Provider is free to communicate all treatment options to Members regardless of limitations on Covered Services.

- f. **Member Eligibility Verification.** Provider will verify a Member's eligibility before providing a Covered Service and will confirm eligibility in a manner that is consistent with Law and Government Program Requirements on redeterminations of eligibility.
- 2.2 **Rights of Members.** Provider will observe, protect, and promote the rights of Members.
- 2.3 **Use of Name.** Neither Provider nor Health Plan will use the other's name, including, but not limited to, trademarks, service marks, domain names, or logos ("Marks") without the prior written approval of the other Party. This Agreement does not grant either Party a license or sublicense to the other Party's Marks. However, Provider may refer to Health Plan in its listings of participating health plans. Additionally, Health Plan may use Provider's name and related information: (i) in Health Plan's filings and publications to identify Provider as a Participating Provider; (ii) in communications to identify Provider to Members; and (iii) as may be required to comply with the Laws and Government Program Requirements. Provider agrees that marketing materials related to this Agreement require Health Plan's review and prior written approval unless otherwise noted in the Agreement.
- 2.4 **Non-Discrimination.** Provider will not differentiate or discriminate against individuals based on their status as protected veterans or because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, physical, sensory or mental handicap, disability, socioeconomic status, or participation in publicly financed programs of health care services or any other basis prohibited by Law. Provider will provide Covered Services in the same location, in the same manner, in accordance with the same standards, and within the same time or availability, regardless of payer.
- 2.5 **Recordkeeping.**
- a. **Maintaining Records.** Provider will maintain complete and correct books and records relating to services provided under this Agreement for tax, accounting, and operation purposes. Provider will maintain service and billing records ("Records") for each Member to whom Provider provides services. The Member's Records will contain all information required by Laws, generally accepted and prevailing professional practices/industry standards, applicable Government Program Requirements, and Health Plan's policies and procedures. Provider will retain such Records for as long as required by Laws and Government Program Requirements. This section will survive any termination.
 - b. **Confidentiality of Member Record.** Provider will comply with all Laws, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act, Health Plan's policies and procedures, and Government Program Requirements regarding privacy and confidentiality. Provider will not disclose or use a Member's name, address, social security number, identity, other personal information, treatment modality, or Record without obtaining appropriate authorization. This section does not affect or limit Provider's obligation to make available the Record, Encounter Data, and information concerning a Member's care to Health Plan, a governmental agency, or another provider of health care. This section will survive any termination.
 - c. **Delivery of Member Information.** Provider will promptly deliver to Health Plan, upon request or as may be required by Laws, Health Plan's policies and procedures, Government Program Requirements, or third-party payers, any information, statistical data, Encounter Data, or Record pertaining to a Member to the extent permitted by Law. Provider is responsible for the costs associated with producing the above items. Provider will further give direct access to the items as requested by Health Plan or as required by a governmental agency. This section will survive any termination.
 - d. **Member Access to Member Record.** Provider will give each Member access to the Member's Record and other applicable information in accordance with Laws, Government Program Requirements, and Health Plan's policies and procedures. This section will survive any termination.
- 2.6 **Program Participation.**
- a. **Participation in Appeals and Grievance Programs.** Provider will ~~participate in and~~ comply with Health Plan's Appeals and Grievance Programs. Provider's failure to exhaust Health Plan's Appeals and Grievance Program will bar Provider from obtaining other remedies available under this Agreement.

- b. **Participation in Quality Improvement Program.** Provider will ~~participate in and~~ comply with Health Plan's QI Program. Provider will cooperate in conducting peer reviews and audits of care and services provided by Provider.
 - c. **Participation in Utilization Review and Management Program.** Provider will ~~participate in and~~ comply with Health Plan's UM Program. Provider will cooperate with Health Plan in audits to identify, confirm, and assess utilization levels of Covered Services.
 - d. **Participation in Certification Verification.** Provider will ~~participate in and~~ comply with Health Plan's certification and, as applicable, credentialing and re-credentialing program. Provider must be certified or credentialed by Health Plan or Health Plan's designee before providing Covered Services and must remain certified/credentialed throughout the term of the Agreement to continue to provide Covered Services. Provider will promptly notify Health Plan of any change in the information submitted or relied upon by Provider to achieve or maintain its certification or credentialed status.
 - e. **Health Education/Training.** Provider will participate in and comply with Health Plan's provider education and training program, which includes the Cultural Competency Plan and such standards, policies, and procedures as may be necessary for Health Plan to comply with Laws and Government Program Requirements.
- 2.7 **Provider Manual.** Provider will comply with the Provider Manual, which is incorporated by reference into this Agreement, as may be unilaterally updated by Health Plan. Provider acknowledges the Provider Manual is available to Provider at Health Plan's website. A physical copy of the Provider Manual is available upon request.
- 2.8 **Supplemental Materials.** Health Plan may issue bulletins or other written materials to supplement the Provider Manual or to give additional instruction, guidance, or information ("Supplemental Materials"). Health Plan may issue Supplemental Materials in an electronic format, which includes, but is not limited to, posting on Health Plan's web-portal; physical copies are available upon request. Supplemental Materials become binding as of the effective date indicated on the Supplemental Materials or, if applicable, the effective date will be determined in accordance with this Agreement.
- 2.9 **Health Plan's Electronic Processes and Initiatives.** Provider will participate in and comply with Health Plan's electronic processes and initiatives, including, but not limited to, electronic submission of prior authorization, access to electronic medical records, electronic claims filing, electronic data interchange, electronic remittance advice, electronic fund transfers, and registration and use of Health Plan's web-portal.
- 2.10 **Information Reporting and Changes.** Provider will deliver to Health Plan a complete and accurate list of its business/practice/facility locations and, as applicable, a list of each person and entity performing Covered Services, together with the specific information required for administration of this Agreement. The information includes, but is not limited to, the information required by Health Plan to produce provider directories and any subsequent changes to that information. Provider will be required to deliver any changes as to the persons and entities who are covered under this Agreement within five (5) days. Each person or entity will only be part of this Agreement after Provider has received written approval from Health Plan, which includes, but is not limited to, confirmation that credentialing is complete, if required. Notwithstanding the above, if a Law or Government Program Requirement requires the delivery of information described in this section in another manner or different timeframe, Provider will notify Health Plan in accordance with the Law or Government Program Requirement. Health Plan also reserves the right to request such information at any time.
- 2.11 **Standing.**
- a. **Requirements.** Provider represents it has the appropriate approvals, including, but not limited to, applicable licenses, certifications, registrations, and permits to provide Covered Services in accordance with Laws and Government Program Requirements. Provider will deliver evidence of any approvals to Health Plan upon request. Provider will maintain such approvals in good standing, free of disciplinary action, and in unrestricted status. Provider will promptly notify Health Plan of changes in its status, including, but not limited to, disciplinary action taken or proposed by any agency responsible for oversight of Provider.
 - b. **Unrestricted Status.** Provider represents to its best knowledge, information, and belief, neither it, nor any of its employees, temporary employees, volunteers, consultants, members of its board of directors, officers, or contractors or any persons or entities with an ownership or control interest in Provider as defined and set forth

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Participation is not well defined

Commented [BD2R1]: Agree to change.

in 42 CFR 455.101 and 455.104 (collectively, “Personnel”) have been excluded from participation in the Medicare Program, any state, commonwealth, or the District of Columbia’s Medicaid Program, or any other federal health care program (collectively “Federal Health Care Program”). Provider agrees that it must check the Department of Health and Human Services Office of Inspector General List of Excluded Individuals and Entities, the System for Award Management, any other list maintained by a state, commonwealth, or federal government, and every state, commonwealth, and the District of Columbia’s Medicaid exclusion lists (including criminal background and registry checks) to determine whether Provider or any of its Personnel have been excluded from participation in any Federal Health Care Program. These databases must be checked for any new Personnel and thereafter not less than monthly. Provider will notify Health Plan immediately in writing if Provider determines that Provider or any of its Personnel are suspended or excluded from any Federal Health Care Program. Provider agrees that it is subject to 2 CFR Part 376 and will require its Personnel to agree that they are subject to 2 CFR Part 376. If a governmental agency imposes a penalty, sanction, or other monetary adjustment or withhold due to Provider’s non-compliance with this provision or any payments were made to Provider while under non-compliance with this provision, Health Plan will issue a letter requesting payment of the amount imposed. If the Provider does not timely pay the amount, Health Plan may collect the amount by offsetting or recouping from any amounts due. If required, such offset or recoupment will be done in a manner that is compliant with Laws and Government Program Requirements. This section will survive any termination.

- c. **Legal Actions.** Provider will give prompt written notice to Health Plan when related to services provided under this Agreement of: (i) a legal claim asserted by a Member and information about its resolution; (ii) a criminal investigation or charge, information, or indictment filed and information about its resolution; and (iii) a legal claim that may jeopardize financial soundness and information about its resolution. This section will survive any termination.

- d. **Liability Insurance.** Provider will maintain general liability insurance, professional liability insurance, and additional insurance coverage consistent with industry standards and as required by Laws and Government Program Requirements in coverage amounts appropriate for the size and nature of Provider’s facilities and health care activities, be it purchased or a self-funded plan, and in compliance with Laws and Government Program Requirements. If the purchased coverage is claims made or reporting, Provider agrees to purchase “tail” coverage upon termination of the Provider’s present or subsequent policy unless such policy covers prior acts. Provider will deliver copies of such insurance policy to Health Plan within five (5) business days of a written request by Health Plan. Provider will deliver advance written notice fifteen (15) business days before any change, reduction, cancellation, or termination or material change of its insurance coverage. If the coverage is through a self-funded plan, Provider will maintain a separate reserve for its self-funded plan. Prior to the Effective Date, upon Health Plan’s request, Provider will provide a statement, verified by an independent auditor or actuary, that its reserve funding levels and process of funding appears adequate to meet the requirements of this section and fairly represents the financial condition of the fund. Provider will provide a similar statement during the term of this Agreement upon Health Plan’s request, which will be made no more frequently than annually. Provider’s self-funded plan will comply with applicable Laws. This section will survive any termination. ~~Provider will maintain general liability insurance and additional insurance coverage consistent with industry standards and as required by Laws and Government Program Requirements. If the coverage is claims made or reporting, Provider agrees to purchase “tail” coverage upon termination of the Provider’s present or subsequent policy unless such policy covers prior acts. Provider will deliver copies of such insurance policy to Health Plan within five (5) business days of a written request by Health Plan. Provider will deliver advance written notice fifteen (15) business days before any change, reduction, cancellation, or termination of its insurance coverage. This section will survive any termination.~~

Commented [BD3]: Linn County to Deb Burnham
Request that this section be limited to services provided under this agreement

Commented [BD4R3]: Agree to change.

Commented [BD5]: Linn County to Deb Burnham
Options is administered by Linn County government; Linn County government is self-insured.

Commented [BD6R5]: Agree to change

2.12 **Non-Solicitation of Members.** Provider will not solicit or encourage Members to select another health plan. Nothing in this provision is intended to limit the information available to Members related to Medical Necessity, appropriate treatment, or alternative care.

2.13 Laws and Government Program Requirements.

- a. **Compliance with Laws and Government Program Requirements.** Provider will comply with the Laws that are applicable to this Agreement. Provider acknowledges Health Plan has entered into Government Contracts and Provider agrees it will comply with the applicable Government Program Requirements for each Product.

Upon written request from Provider, Health Plan will give Provider a copy of each Government Contract under which Provider is participating, redacted to remove financial and other private and trade secret information.

- b. **Fraud and Abuse Reporting.** Provider will comply with Laws and Government Program Requirements relating to fraud, waste, and abuse. Provider will establish and maintain policies and procedures for identifying and investigating fraud, waste, and abuse. In the event Provider discovers an occurrence of fraud, waste, or abuse, Provider will promptly notify Health Plan. Provider will participate in and comply with investigations conducted by Health Plan or by a governmental agency. This section will survive any termination.
 - c. **Advance Directive.** Provider will comply with Laws and Government Program Requirements related to Advance Directives.
 - d. **Ownership Disclosure Information.** If applicable, Provider must disclose to Health Plan the name and address of each person, entity, or business with an ownership or control interest in the disclosing entity before the Effective Date and throughout the term of this Agreement. Provider or disclosing entity must also disclose to Health Plan whether any person, entity, or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling before the Effective Date and throughout the term of this Agreement. Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the Provider or disclosing entity also has an ownership or control interest.
- 2.14 **Reciprocity Agreements.** Provider will cooperate with Affiliates and agrees to ensure reciprocity of health care services and related services and supplies to Affiliates' enrollees. For Affiliates' enrollees, Provider will be compensated for Clean Claims that are determined to be payable at the rate set forth in this Agreement unless otherwise required by a Law or Government Program Requirement. Provider will follow the hold harmless provisions of this Agreement for Affiliates' enrollees.
- 2.15 **Abuse, Neglect, and Exploitation.** Provider will comply with the Laws and Government Program Requirements relating to the reporting of abuse, neglect, and exploitation.
- 2.16 **Condition Change.** Provider will promptly notify Health Plan's Care Management Team upon becoming aware of a significant change in a Member's health or functional status or death except when otherwise required by a Law or Government Program Requirement.

ARTICLE THREE – HEALTH PLAN'S OBLIGATIONS

- 3.1 **Health Plan Compliance.** Health Plan will comply with all Laws and Government Program Requirements that are applicable to this Agreement.
- 3.2 **Member Eligibility Determination.** Health Plan will maintain data on Member eligibility and enrollment. Health Plan will promptly verify Member eligibility at the request of Provider.
- 3.3 **Prior Authorization Review.** Health Plan will respond with a determination on a prior authorization request in accordance with the time frames required by Laws and Government Program Requirements after receiving all necessary information from Provider.
- 3.4 **Medical Necessity Determination.** Health Plan's determination regarding Medical Necessity will govern.
- 3.5 **Member Services.** Health Plan will provide services to Members, including, but not limited to, assisting Members in selecting a primary care physician, processing Member complaints and grievances, informing Members of Health Plan's policies and procedures, providing Members with membership cards, providing Members with information about Health Plan, and providing Members with access to Health Plan's Provider Directory.
- 3.6 **Provider Services.** Health Plan will make available a Provider Services Department that, among other Health Plan duties, is available to assist Provider with questions about this Agreement.
- 3.7 **Corrective Action.** Health Plan and governmental agencies routinely monitor the level, manner, and quality of Covered Services provided as well as Provider's compliance with this Agreement. If a deficiency is identified, the parties will meet and confer on Health Plan or an agency, in its sole discretion, may choose to issue a corrective action plan to address the deficiency. Provider is required to accept and implement such corrective action plan. Provider is not entitled to a corrective action plan prior to any termination.

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Request change to this section to discuss before corrective action plan is implemented.

Commented [BD8R7]: Agree to change

- 3.8 **Plan of Care.** As applicable to the Member, Health Plan will maintain a person-centered comprehensive care plan developed using specific health assessments to determine interventions that support the achievement of both short and long-term goals while minimizing barriers to care. Health Plan will develop the comprehensive care plan with the Member or, when applicable, the Member's representative based on the Member's specific needs, goals, and preferences. Additionally, Health Plan will maintain a Plan of Care that is person centric and reflects the services and supports that are important for the Member to meet their needs, goals, and preferences that are identified through an assessment of functional need. The Plan of Care will identify what is important with regard to the delivery of the services and supports.

ARTICLE FOUR – CLAIMS PAYMENT

- 4.1 **Claims.** Provider will promptly submit to Health Plan Claims for Covered Services in a standard form that is acceptable to Health Plan. Provider is not eligible for payment on Claims submitted after one hundred and eighty (180) days from the Date of Service unless Health Plan is required to follow a different timeframe pursuant to a Law or Government Program Requirement. When Health Plan is the secondary payer, Provider is not eligible for payment for Claims submitted after one hundred and eighty (180) days from the date the primary payer adjudicated the Claim unless Health Plan is required to follow a different timeframe pursuant to a Law or Government Program Requirement. Provider will include all medical records pertaining to the Claim if requested by Health Plan and as may be required by Health Plan's policies and procedures.
- 4.2 **Compensation.** Health Plan will pay Provider for Clean Claims for Covered Services, that are determined to be payable, in accordance with Laws, Government Program Requirements, and this Agreement. Health Plan will make payment within sixty (60) days, unless otherwise required by Laws or Government Program Requirements. Provider agrees to accept such payments, Member cost-sharing, coordination of benefits, and amounts due from third-parties as payment in full for Covered Services. Provider's failure to comply with the terms of this Agreement may result in non-payment to Provider.
- 4.3 **Member Cost-Sharing.** Provider is responsible for the collection of co-payments, co-insurances, and deductibles, if any, from Members. Provider agrees to bill Members and collect such cost-sharing amounts from Members.
- 4.4 **Member Hold Harmless.** Provider agrees in no event, including, but not limited to, non-payment, insolvency, or breach of this Agreement by Health Plan, will Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member or person acting on a Member's behalf for Covered Services provided pursuant to this Agreement. This does not prohibit Provider from collecting co-payments, co-insurances, or deductibles as specifically provided in the Member's evidence of coverage or fees for non-Covered Services in accordance with Laws and Government Program Requirements. For the purposes of this section, non-Covered Services do not include services that have been determined to be not Medically Necessary by Health Plan. This section will survive any termination, regardless of the reason for the termination, including insolvency of Health Plan.
- 4.5 **Coordination of Benefits.** Health Plan is a secondary payer where another entity is the primary payer. Provider will inquire of each Member to learn if the Member has health insurance or health benefits other than from Health Plan or is entitled to payment from: (i) another insurer or plan of any type; or (ii) a third-party under any other form of compensation, including, but not limited to, personal injury settlements. Provider will file and make reasonable efforts to collect such potential entitlements and Provider will promptly notify Health Plan of such potential entitlement. Unless otherwise required by a Law or Government Program Requirement, Provider will be compensated in an amount equal to the allowable Clean Claim less the amount due from other insurers, plans, or third-parties not to exceed the amount specified in the Compensation Schedule of this Agreement.
- 4.6 **Offset.** In the event of an Overpayment, Health Plan will issue an Overpayment letter requesting repayment of the funds. If the Provider does not timely repay the Overpayment, Health Plan may collect the amount by offsetting or recouping from any amounts due after issuing the Overpayment letter to Provider. If required, the offset or recoupment will be done in a manner that is compliant with Laws and Government Program Requirements. As applicable to the Product, Provider will comply with the Laws and Government Program Requirements regarding the identification and return of Overpayments. Provider will notify Health Plan and applicable governmental agencies of any Overpayments identified by Provider. The offset and recoupment rights set forth in this Agreement will be deemed to be and to constitute rights of offset and recoupment authorized under Law or in equity to the maximum extent legally permissible. Notwithstanding any other provision of this Agreement, the offset and

recoupment rights for an Overpayment may be exercised to the time period permitted by Law. Such rights will not be subject to any requirement of prior or other approval from a court or other governmental agency that may now or hereafter have jurisdiction over Health Plan or Provider unless otherwise required for compliance with a Law or Government Program Requirement. This section will survive any termination.

- 4.7 **Claim Review.** Claims will be reviewed and paid in accordance with Health Plan's policies and procedures which are based on Health Plan's experience and industry standard billing and payment rules, including, but not limited to, the Uniform Billing ("UB") manual and editor, Current Procedural Terminology ("CPT") and Healthcare Common Procedure Coding System ("HCPCS"), federal and state/commonwealth billing and payment rules, and National Correct Coding Initiatives ("NCCI") Edits. Furthermore, Provider acknowledges Health Plan's right to conduct Medical Necessity reviews and apply clinical practice standards to determine appropriate payment when applicable. Payment may exclude certain items not billed in accordance with Health Plan's policies and procedures or, when applicable, that do not meet Medical Necessity criteria. This section will survive any termination.
- 4.8 **Claim Auditing.** Provider acknowledges Health Plan's right to conduct post-payment billing audits. Provider will cooperate with Health Plan's audits of claims and payments by providing access at reasonable times to requested claims information, all supporting records, Provider's charging policies, and other related data. Health Plan will use established industry claims adjudication, and clinical practices, federal and state/commonwealth guidelines, and Health Plan's policies and data to determine the appropriateness of the billing, coding, and payment. This section will survive any termination.
- 4.9 **Financially Responsible Entity Payments.** If Provider provides Covered Services that are the responsibility of a Responsible Entity, Provider will look solely to the Responsible Entity for payment for the Covered Services.
- 4.10 **Timely Submission of Encounter Data.** Provider understands Health Plan may have certain contractual reporting obligations that require timely submission of Encounter Data. If a Clean Claim does not contain the necessary Encounter Data, Provider will submit Encounter Data to Health Plan. This section will survive any termination.

ARTICLE FIVE – TERM AND TERMINATION

- 5.1 **Term.** This Agreement will commence on the Effective Date indicated by Health Plan and will continue in effect for one (1) year and will renew for successive one (1) year terms unless terminated by either Party in accordance with this Agreement.
- 5.2 **Termination without Cause.** This Agreement, an individual Product, or an Individual Provider under this Agreement may be terminated without cause at any time by either Party by giving at least ninety (90) days prior written notice to the other Party.
- 5.3 **Termination with Cause.** In the event of a breach of a material provision of this Agreement, the Party claiming the breach will give the other Party written notice of termination setting forth the facts underlying its claim that the other Party breached this Agreement. The Party receiving the notice of termination will have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other Party. During this thirty (30) day period, the Parties agree to meet as reasonably necessary and to confer to resolve the claimed breach. If the Party receiving the notice of termination has not remedied or cured the breach within such thirty (30) day period, the Party who delivered the notice of termination has the right to immediately terminate this Agreement, or an individual Product or an Individual Provider under this Agreement, upon expiration of the thirty (30) day period. Notwithstanding the forgoing, either Party may immediately terminate this Agreement, an individual Product, or an Individual Provider under this Agreement, without providing the other Party the opportunity to cure a material breach should the terminating Party reasonably believe the material breach of this Agreement to be non-curable.
- 5.4 **Immediate Termination.** Notwithstanding any other provision of this Agreement, this Agreement, an individual Product, or an Individual Provider under this Agreement, may immediately be terminated upon written notice to the other Party in the event any of the following occurs:
- Provider's license or any other approval needed to provide Covered Services is limited, suspended, or revoked, a disciplinary proceeding is commenced against Provider by a governmental or accrediting agency, or an indictment is issued against Provider;
 - Either Party fails to maintain adequate levels of self-insurance;

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Linn County is self-insured

Commented [BD10R9]: Deb Burnham to Linn County
Agree to change.

- c. Provider has not or is unable to comply with Health Plan's certification/credentialing requirements, including, but not limited to, having or maintaining its certification/credentialing status;
 - d. Either Party becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Provider or Health Plan is appointed by appropriate authority;
 - e. Health Plan reasonably determines that Provider's facility, equipment, or Personnel are insufficient to provide Covered Services;
 - f. Either Party is excluded/precluded from participation in a state, commonwealth, or federal health care program;
 - g. Provider is terminated as a provider by a state, commonwealth, or federal health care program;
 - h. Either Party engages in fraud, waste, or abuse or permits fraud, waste, or abuse by another in connection with the Party's obligations under this Agreement;
 - i. Health Plan reasonably determines that Covered Services are not being properly provided or arranged for by Provider and such failure poses a threat to Members' health and safety;
 - j. Provider violates any Law;
 - k. Provider fails to satisfy the terms of a corrective action plan; or
 - l. Termination is required by a governmental agency.
- 5.5 **Notice to Members.** In the event of any termination, Health Plan will give reasonable notice to Members who are currently receiving services and the Parties will ensure the continuity of services in accordance with and to the extent required by Laws and Government Program Requirements.

ARTICLE SIX – GENERAL PROVISIONS

- 6.1 **Indemnification.** ~~Only to the extent permitted by -Within the limits of- the Iowa Constitution and the laws of the State of Iowa, except where preempted by federal law, each Party will indemnify and hold harmless the other~~ Each Party will indemnify and hold harmless the other Party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from a breach of the duties and obligations of the indemnifying Party or its officers, directors, shareholders, employees, agents, and representatives under this Agreement. Each Party agrees to give the other Party prompt written notice of any claim made against the other Party. This section will survive the termination of this Agreement. ~~Nothing in this section shall constitute a waiver of the defenses available to Provider under Chapter 670 of the Code of Iowa.~~
- 6.2 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor will it be construed to create, any relationship between the Parties other than that of independent parties contracting with each other solely for effectuating this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the Parties. Nothing herein contained will prevent the Parties from entering into similar arrangements with other parties. Each Party will maintain separate and independent management and will be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor will it be construed to create, any right in any third-party to enforce this Agreement.
- 6.3 **Governing Law.** The laws of the State of Iowa will govern this Agreement to the extent such laws are not preempted by federal laws.
- 6.4 **Entire Agreement.** This Agreement, including attachments, addenda, amendments, Provider Manual, Supplemental Materials, and incorporated documents or materials, contains the entire agreement between the Parties relating to the rights granted and obligations imposed by this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, between the Parties and relating to the subject matter of this Agreement, are of no force or effect.
- 6.5 **Severability.** If a term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction or any governmental agency with oversight authority for this Agreement to be invalid, void, or unenforceable, the remaining provisions will remain in full force and effect and will in no way be affected, impaired, or invalidated because of such decision.

Commented [BD11]: Linn County to Deb Burnham
As a County government agency, Linn County has different requirements.

Commented [BD12R11]: Agree to change.

- 6.6 **Headings and Construction.** The headings in this Agreement are for reference purposes only and are not considered a part of this Agreement in construing or interpreting its provisions. It is the Parties' desire that if a provision of this Agreement is determined to be ambiguous, then the rule of construction that such provision is construed against its drafter will not apply to the interpretation of the ambiguous provision. The following rules of construction apply to this Agreement: (i) the word "day" means calendar day unless otherwise specified; (ii) the term "business day" means Monday through Friday, except federal holidays; (iii) all words used in this Agreement will be construed to be of such gender or number as circumstances require; (iv) references to specific statutes, regulations, rules or forms, such as CMS-1500, include subsequent amendments or successors to them; and (v) references to any government department or agency include any successor departments or agencies.
- 6.7 **Non-exclusivity.** This Agreement will not be construed to be an exclusive Agreement between the Parties. Nor will it be deemed to be an Agreement requiring Health Plan to refer Members to Provider.
- 6.8 **Amendments.**
- a. **Regulatory Amendments.** Health Plan may immediately amend this Agreement to maintain consistency or compliance with applicable policy, directive, Law, or Government Program Requirement at any time and without Provider's consent. Such regulatory amendment will be binding upon Provider.
 - b. **Non-Regulatory Amendments.** Notwithstanding the Regulatory Amendments section, Health Plan may otherwise amend this Agreement upon thirty (30) days prior written notice to Provider. If Provider does not deliver a written disapproval to such amendment within the thirty (30) day period, the amendment will be deemed accepted by and binding upon Provider. If Health Plan receives a written disapproval within the thirty (30) day period, the Parties agree to meet and confer in good faith to determine if a revised amendment can be accepted by and binding upon the Parties.
- 6.9 **Delegation or Subcontract.** Provider will submit to Health Plan a list identifying Provider's Subcontractors with a description of the services each Subcontractor provides. Provider will promptly submit updates to the list to Health Plan. Provider will ensure each Subcontractor complies with the applicable terms of this Agreement. Provider's contract with a Subcontractor will be in writing and will bind the Subcontractor to the applicable terms required for compliance with this Agreement. Health Plan has the right to request Provider limit the use of a Subcontractor that does not meet the applicable terms of the Agreement and Provider will take reasonable action to comply with the request.
- 6.10 **Assignment.** Provider may not assign or transfer, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of Health Plan. Subject to the foregoing, this Agreement is binding upon, and inures to the benefit of the Parties and respective successors in interest and assignees. Neither the acquisition of Health Plan nor a change of its legal name shall be deemed an assignment.
- 6.11 **Arbitration.**
- a. **Arbitration Requirements.** Any dispute, claim, or controversy arising out of or relating to this Agreement or the breach, termination, enforcement, interpretation, or validity thereof, including the determination of the scope or applicability of this agreement to arbitrate (hereafter "Dispute"), ~~shall~~ may be determined by arbitration, subject to the terms of this section. The arbitration ~~shall~~ may take place in Polk County, Iowa before one (1) arbitrator. The arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in health care. The arbitration ~~shall~~ may be administered by JAMS pursuant to its Comprehensive Arbitration Rules and Procedures. Judgment on the award may be entered in any court having jurisdiction. This section ~~shall~~ may not preclude the Parties from seeking provisional remedies in aid of arbitration from a court of appropriate jurisdiction. Matters that primarily involve Provider's professional competence or conduct (i.e., malpractice, professional negligence, or wrongful death) are not eligible for arbitration.
 - b. **Meet and Confer.** Prior to the initiation of arbitration, the Parties shall attempt to resolve any Dispute arising out of or relating to this Agreement via a good faith "Meet and Confer." To initiate a Meet and Confer, a Party shall deliver to the other Party a written notice of the Dispute that includes a demand to Meet and Confer. The notice shall include: (i) a statement of the Party's position and a summary of arguments supporting that position; and (ii) the name and contact information of the executive who will participate in the Meet and Confer. The Meet and Confer shall be held within forty-five (45) days of the delivery of the notice, at a

Commented [BD13]: Linn County to Deb Burnham
County requests "shall" be replaced with "may"

Commented [BD14R13]: Agree to change

mutually acceptable time and place, between appropriate representatives of the Parties, including a person authorized to settle the Dispute (the “First Meeting”). The Parties may agree to further discussions after the First Meeting. At no time prior to the First Meeting shall either Party initiate an arbitration or litigation related to this Agreement, except to pursue a provisional remedy that is authorized by law or by JAMS Rules or by agreement of the Parties. This limitation is inapplicable to a Party if the other party refuses to comply with the requirements of this subsection.

- c. **Rules for Arbitration.** The arbitrator will have no authority to give a remedy or award damages that would not be available to such prevailing Party in a court of law, nor will the arbitrator have the authority to award punitive, exemplary, or treble damages. The arbitrator will deliver a written reasoned decision within thirty (30) days of the close of arbitration, unless an alternate agreement is made during the arbitration. The Parties adopt and agree to implement the JAMS Optional Arbitration Appeal Procedure that is in place at the time of the arbitration with respect to any final award in an arbitration arising out of or related to this Agreement.

The Parties agree to accept any decision by the arbitrator, which is grounded in applicable law, as a final determination of the matter in dispute. The award may be vacated, modified, or corrected pursuant to the Federal Arbitration Act, 9 USC §§ 9-11. Grounds for vacating an award include: (i) where the award was procured by corruption, fraud, or undue means; (ii) where the arbitrators were guilty of misconduct or exceeded their powers; (iii) evident material miscalculation; (iv) evident material mistake in the description of any person, thing, or property referred to in the award; and (v) imperfections in a matter of form not affecting the merits.

Each Party shall bear its own costs and expenses of arbitration, including its own attorneys’ fees, and shall bear an equal share of the arbitrator and administrative fees of arbitration.

Arbitration must be initiated within one (1) year of the earlier of the date the Dispute arose, was discovered, or should have been discovered with reasonable diligence; otherwise, the Dispute will be deemed waived, and the complaining Party shall be barred from initiating arbitration or other proceedings. The Parties expressly agree that the deadline to file arbitration shall not be subject to waiver, tolling, alteration, or modification of any kind or for any reason other than fraud.

6.12 **Notice.**

- a. **Delivery.** All notices required or permitted by this Agreement, except for Supplemental Materials, will be in writing and delivered: (i) in person; (ii) by U.S. Postal Service (“USPS”) registered, certified, or express mail with postage prepaid; (iii) by overnight courier that guarantees next day delivery; (iv) by facsimile transmission; or (v) by email. Notice is deemed given: (i) on the date of personal delivery; (ii) on the second day after the postmark date for USPS registered, certified, or express mail with postage prepaid; (iii) on the date of delivery shown by overnight courier; or (iv) on the date of transmission for facsimile or email.
- b. **Addresses.** The mailing address, email address, and facsimile number set forth under the Signature Page will be the Party’s information for delivery of notice. Each Party may change its information through written notice in compliance with this section without amending this Agreement. Notice will be sent to the attention of the Authorized Representative.

- 6.13 **Waiver.** A failure or delay of a Party to exercise or enforce any provision of this Agreement will not be deemed a waiver of any right of that Party. Any waiver must be specific, in writing, and executed by the Parties.

- 6.14 **Execution in Counterparts and Duplicates.** This Agreement may be executed in counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument. The Parties agree facsimile signatures, pdf signatures, photocopied signatures, electronic signatures, or signatures scanned and sent via email will have the same effect as original signatures.

- 6.15 **Force Majeure.** Neither Party will be liable or deemed to be in default for any delay or failure to perform any duty under this Agreement resulting directly or indirectly, from acts of God, civil or military authority, acts of a public enemy, war, accident, fire, explosion, earthquake, flood, strikes by either Party’s employees, or any other similar cause beyond the reasonable control of such Party if it is determined that: (i) the Party used the efforts a reasonable person would during the force majeure event to perform its duties under this Agreement; and (ii) the Party’s inability to perform its duties during the force majeure event is not due to its failure to take measures to protect itself against the force majeure event.

- 6.16 **Confidentiality.** Any information disclosed by either Party in fulfillment of its duties under this Agreement, including, but not limited to, health care information, compensation rates, and the terms of the Agreement, will be kept confidential. Information provided to Provider, including, but not limited to, Member lists, QI Program, certification/credentialing criteria, compensation rates, and any other administrative protocols or procedures of Health Plan, is the proprietary property of Health Plan and will be kept confidential. Provider will not disclose or release information to a third-party without the written consent of Health Plan. However, each Party may share information with its subsidiaries and affiliates and its respective Personnel and designees as necessary to fulfill the terms of this Agreement. Nothing in the Agreement will preclude either Party from disclosing information as required for compliance with a Law or Government Program Requirement or as required to comply with a governmental authority request provided that the information is only disclosed in a manner and to the extent required for compliance and in accordance with applicable Law. Provider will either return confidential information or destroy confidential information and provide confirmation of the destruction to Health Plan upon request if the Agreement terminates. This section will survive any termination.
- 6.17 **Adjustments.** If a governmental agency imposes a penalty, sanction, or other monetary adjustment or withhold due to Provider's non-compliance with this Agreement, Health Plan will be able to collect the amount imposed on or withheld from Health Plan. Health Plan will issue a letter requesting payment of the amount imposed or withheld. If Provider does not timely pay the amount, Health Plan may collect the amount by offsetting or recouping from any amounts due. If required, such offset or recoupment will be done in a manner that is compliant with Laws and Government Program Requirements. This section will survive any termination.
- 6.18 **Expenses.** Unless otherwise specifically stated in the Agreement, all costs and expenses incurred in connection with this Agreement will be paid by the Party incurring the cost or expense.
- 6.19 **Offshore Resources.** Neither Provider nor its Subcontractors will perform any work related to the administration of the Agreement outside the United States of America without the prior written consent of Health Plan.
- 6.20 **Business Associate.** Provider will obtain and maintain a National Provider Identification ("NPI") Number through the CMS National Plan and Provider Enumeration System. If Provider is unable to obtain an NPI Number or if otherwise required for compliance with a Law, Provider agrees to execute a Business Associate Agreement ("BAA") with Health Plan and further agrees that this Agreement will be subject to the requirements of the BAA executed separately from this Agreement. Notwithstanding any other term of the Agreement, Health Plan may immediately terminate this Agreement upon written notice to Provider if the Parties are unable to execute BAA.

ATTACHMENT A

Products

Provider's participation in the Medicaid Product listed below is contingent upon Health Plan executing a Government Contract with the appropriate governmental agency. Provider agrees to participate in the Medicaid Product on the date it becomes operational for Health Plan under its Government Contract and Provider shall be bound to the terms of this Agreement. For all other Products, Provider's participation in each Product listed below is contingent upon the Product being offered by the appropriate governmental agency and upon Health Plan executing a Government Contract with the appropriate governmental agency. Subject to applicable Laws and Government Program Requirements, Provider agrees to participate in each Product on the date it becomes operational for Health Plan under its Government Contract and Provider shall be bound to the terms of this Agreement.

- 1.1 **Medicaid and CHIP** – including, but not limited to, IA Health Link and Hawki programs and any other Medicaid programs Health Plan offers in the future.
- 2.1 **Medicare Advantage.**
- 3.1 **Medicare-Medicaid Program.**

ATTACHMENT B
Compensation Schedule

- 1.1 **Compensation for Medicaid and CHIP.** Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided under the Medicaid and CHIP Products that are determined by Health Plan to be payable pursuant to Laws, Government Program Requirements, and this Agreement and that are submitted on a Clean Claim, less any applicable amounts paid or to be paid by other liable third-parties and the Member for cost-sharing, including, but not limited to, co-payments, deductibles, or co-insurances, if any, at the lesser of the following amounts in effect for the Date of Service: (i) Provider's billed charges; or (ii) an amount equivalent to the Medicaid Fee-for-Service Program allowable payment rate as set forth by the State of Iowa ("Medicaid Rate") or, for those Covered Services where there is no Medicaid Rate, at an amount equivalent to the Medicare Fee-for-Service Program allowable payment rate, geographically adjusted ("Medicare Rate").

Notwithstanding any other term of the Agreement, compensation will be thirty percent (30%) of Provider's billed charges, not to exceed seventy-five dollars (\$75.00), for those Covered Services where there is no Medicaid Rate or Medicare Rate.

Except when otherwise set forth by a Law or Government Program Requirement, Provider agrees that Health Plan will implement updates or revisions to the Medicaid or Medicare Fee-for-Service Program fee schedules on a prospective basis within sixty (60) days of the update or revision from the agency. The update or revision will be applied to all Claims received after the implementation and Health Plan will not be required to retrospectively adjust any Claims.

- 2.1 **Compensation for Medicare Advantage.** Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided under the Medicare Advantage Product that are determined by Health Plan to be payable pursuant to Laws, Government Program Requirements, and this Agreement and that are submitted on a Clean Claim, less any applicable amounts paid or to be paid by other liable third-parties and the Member for cost-sharing, including, but not limited to, co-payments, deductibles, or co-insurances, if any, at the lesser of the following amounts in effect for the Date of Service: (i) Provider's billed charges; or (ii) an amount equivalent to the Medicare Fee-for-Service Program allowable payment rate, geographically adjusted ("Medicare Rate"). Notwithstanding any other term of the Agreement, compensation will be thirty percent (30%) of Provider's billed charges, not to exceed seventy-five dollars (\$75.00), for those Covered Services where there is no Medicare Rate.

Except when otherwise set forth by a Law or Government Program Requirement, Provider agrees that Health Plan will implement updates or revisions to the Medicare Fee-for-Service Program fee schedules on a prospective basis within sixty (60) days of the update or revision from the agency. The update or revision will be applied to all Claims received after the implementation and Health Plan will not be required to retrospectively adjust any Claims.

- 3.1 **Compensation for Medicare-Medicaid Program.** Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided under the Medicare-Medicaid Program Product that are determined by Health Plan to be payable pursuant to Laws, Government Program Requirements, and this Agreement and that are submitted on a Clean Claim, less any applicable amounts paid or to be paid by other liable third-parties and the Member for cost-sharing, including, but not limited to, co-payments, deductibles, or co-insurances, if any, at the lesser of Provider's billed charges or the following amounts in effect for the Date of Service.

For Covered Services which are covered by or are primary to Medicare, an amount equivalent to the Medicare Fee-for-Service Program allowable payment rate, geographically adjusted, ("Medicare Rate") and any portion, if any, that the Medicaid agency or Health Plan would have been responsible for paying if the Member was enrolled in the Medicare Fee-for-Service Program. The Medicare Fee-for-Service Program allowable payment rate deducts any cost-sharing amounts, including, but not limited to, co-payments, deductibles, co-insurances, or amounts paid or to be paid by other liable third-parties that would have been deducted if the Member were enrolled in the Medicare Fee-for-Service Program.

For Covered Services which are covered by or are primary to Medicaid, an amount equivalent to the Medicaid Fee-for-Service Program allowable payment rate as set forth by the State of Iowa ("Medicaid Rate").

Notwithstanding any other term of the Agreement, compensation will be thirty percent (30%) of Provider's billed charges, not to exceed seventy-five dollars (\$75.00), for those Covered Services where there is no Medicaid Rate or Medicare Rate.

Except when otherwise set forth by a Law or Government Program Requirement, Provider agrees that Health Plan will implement updates or revisions to the Medicaid and Medicare Fee-for-Service Program fee schedules on a prospective basis within sixty (60) days of the update or revision from the agency. The update or revision will be applied to all Claims received after the implementation and Health Plan will not be required to retrospectively adjust any Claims.

ATTACHMENT B-1

Statement of Work

This attachment sets forth additional terms and conditions that are applicable to this Agreement. All provisions of the Agreement not specifically modified by this Statement of Work (“SOW”) attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise defined in this attachment.

ARTICLE ONE – WAIVERS

- 1.1 **Eligible Members.** Provider will only provide Covered Services to those qualifying Members identified as eligible by Health Plan.
- 1.2 **Waiver Types.** Provider agrees to provide services and supports under the waiver service as indicated by the check mark next to the waiver service below. Provider recognizes that failure to mark the applicable box may result in payment delay and that all services and supports are subject to Member benefit limits. Please mark each box next to the applicable waiver service.
- | | |
|--|--|
| ☐ AIDS/HIV Waiver | ☐ Intellectual Disability (“ID”) Waiver |
| ☐ Brain Injury (“BI”) Waiver | ☐ Physical Disability (“PD”) Waiver |
| ☐ Children’s Mental Health (“CMH”) Waiver | ☐ State Plan HCBS Habilitation Services Program (1915i) |
| ☐ Elderly Waiver | ☐ Other: |
| ☐ Health and Disability (“HD”) Waiver | |

ARTICLE TWO - RESPONSIBILITIES

- 2.1 **Responsibilities of Provider.**
- Provider will communicate with Health Plan’s care management staff.
 - Provider will give Health Plan the name of an individual who may act as a point of contact between Health Plan and Provider.
 - As requested by Health Plan or required for compliance with Laws and Government Program Requirements, Provider will assist Health Plan with creating documented policies and operating procedures to support this Agreement. Provider will further assist in implementing such operating procedures.
 - As requested by Health Plan or required for compliance with Laws and Government Program Requirements, Provider will coordinate quarterly joint operations meetings or calls with Health Plan to include Provider’s authorized representatives.

ARTICLE THREE - INVOICE COMPENSATION

- 3.1 **Invoice Compensation.**
- For Covered Services not reimbursed on fee-for-service basis and which are reimbursed on an invoice, Provider will promptly submit to Health Plan invoices for Covered Services in a standard form that is acceptable to Health Plan. Invoices will include all information required by Health Plan, which will include, but not be limited to Provider’s legal name (including its “doing business as name” when applicable), Provider’s Tax ID that corresponds to Provider’s legal name, the name of the Member who received the Covered Service, and the Covered Service provided and the date on which the Covered Service was completed. Provider is not eligible for payment on an invoice submitted after thirty (30) days from the date the Covered Service were completed, unless Health Plan is required to follow a different timeframe pursuant to a Law or Government Program Requirement. For Provider to be eligible to receive payment for a Covered Service provided, Health Plan must receive supporting documentation, including Encounter Data when applicable, for each Member listed on the Invoice submitted.

- b. Health Plan agrees to compensate Provider for Covered Services provided that are submitted on an invoice, which have no defect, impropriety, lack of required substantiating documentation, or particular circumstance requiring special treatment that prevents timely processing of the invoice, that are determined to be payable in accordance with Laws, Government Program Requirements, and this Agreement. Provider agrees to accept such payments less any applicable amounts paid or to be paid by other liable third-parties and the Member for cost-sharing, including, but not limited to, co-payments, deductibles, or co-insurances, if any, as payment in full for Covered Services provided.
- c. Provider agrees it is responsible for all fees and costs necessary for Provider to complete Covered Services reimbursed on an invoice, this includes, but is not limited to, materials, labor, subcontractors, permits, and inspections.

ATTACHMENT C

State of Iowa Required Provisions

State Laws

This attachment sets forth applicable State Laws or other provisions necessary to reflect compliance with State Laws. This attachment will be automatically modified to conform to subsequent changes to Law. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with Law will not be effective and will be interpreted in a manner that is consistent with the applicable Law. For the avoidance of doubt, this attachment does not apply to the Medicare Advantage Product or the Medicare-Medicaid Product to the extent such Products are preempted by Federal Law.

- 1.1 **Hold Harmless Provisions.** Provider, or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to nonpayment by the Health Plan, Health Plan insolvency or breach of this agreement, shall Provider, or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against subscriber/enrollee or persons other than the Health Plan acting on their behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or co-payments on Health Plan's behalf made in accordance with terms of the applicable agreement between Health Plan and Member.

Provider, or its assignee or subcontractor, further agrees this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Member and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Member or persons acting on their behalf.

ATTACHMENT D

Medicaid and CHIP

Laws and Government Program Requirements

This attachment sets forth applicable Laws and Government Program Requirements, or other provisions necessary to reflect compliance for the Medicaid and CHIP Products. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control for the Medicaid and CHIP Products. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to Medicaid and CHIP Products.

- 1.1 **Health Plan's State Contract.** Provider, and its assignee or subcontractor, agree that all applicable terms and conditions set out in the contract and any amendments between the Health Plan and the State of Iowa and all applicable State and Federal laws, as amended, govern the duties and responsibilities of the Provider with regard to the provision of Covered Services to Members.
- 1.2 **Continuation of Benefits.** Provider will ensure the continuation of benefits in accordance with Laws and Government Program Requirements and this Agreement.
- 1.3 **BAA.** The Parties will execute a signed Business Associate Agreement ("BAA") when required due to the services provided under this Agreement.
- 1.4 **TPL.** Provider will make every reasonable effort to determine third-party liability and collect third-party liability in accordance with Law and Government Program Requirements and this Agreement.
- 1.5 **Provider Enrollment.** Provider agrees to enroll with the Iowa Department of Human Services ("Agency"), Iowa Medicaid Enterprise, as a condition of participation in the Health Plan's network.
- 1.6 **Records.** Provider will, within the timeframe designated by the Agency or other authorized entity, permit Health Plan, representatives of the Agency, and other authorized entities to review Members' records for the purposes of monitoring the Provider's compliance with the record standards, capturing information for clinical studies, monitoring quality, or any other reason.
- 1.7 **Payment to Providers.** The Health Plan shall pay Providers for Covered Services rendered to the Members in accordance with Law. The Health Plan 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.
- 1.8 **Medicaid Ownership Form.** Provider agrees to fully complete the Iowa Department of Human Services Medicaid Ownership and Control Disclosure, Form 470-5186.
- 1.9 **Nursing Facility Provider.** If Provider is a nursing facility, the following requirements apply.
 - a. Provider will promptly notify Health Plan of a Member's admission or request for admission to the nursing facility as soon as the facility has knowledge of such admission or request for admission;
 - b. Provider will notify Health Plan immediately if the nursing facility is considering discharging a Member and will consult with the Member's care coordinator;
 - c. Provider will notify Member and the Member's representative (if applicable) in writing prior to discharge in accordance with State and Federal requirements;
 - d. Provider will be responsible for the collection of client participation (formerly known as "patient liability") pursuant to Laws and Government Program Requirements and this Agreement;
 - e. Provider will notify Health Plan of any change in a Member's medical or functional condition that could impact the Member's level of care eligibility for the currently authorized level of nursing facility services;

- f. Provider will comply with federal pre-admission screening and resident review requirements to provide or arrange to provide specialized services and all applicable Iowa Law governing admission, transfer, and discharge policies; and
 - g. If Provider is involuntarily decertified by the State or CMS, the Agreement shall automatically be terminated in accordance with Federal requirements.
- 1.10 **HCBS Provider.** If Provider is a home and community-based services (“HCBS”) provider, the following requirements apply.
- a. Provider will provide at least thirty (30) days advance notice to Health Plan when the Provider is no longer willing or able to provide services to a Member and cooperate with the Member’s care coordinator to facilitate a seamless transition to alternate Providers; and
 - b. If a provider change is initiated for a Member, regardless of any other provision in the Agreement, Provider will continue to provide services to the Member in accordance with the Member’s plan of care until the Member has been transitioned to a new provider, as determined by Health Plan , or as otherwise directed by Health Plan, which may exceed thirty (30) days from the date of notice of the provider change to the Health Plan.
- 1.11 **LTSS Community-Based Care.** If Provider offers long-term support services (“LTSS”), Provider will offer LTSS community-based care to Members and shall not involuntarily discharge a resident without providing a minimum of thirty (30) days’ notice and an acceptable transition plan to avoid placement in an inappropriate or more restrictive setting.
- 1.12 **Right to Audit.** The Iowa Department of Human Services, the Centers for Medicare & Medicaid Services, the Office of the Inspector General, the Comptroller General or their designees may, at any time, inspect and audit any records or documents of Health Plan and Provider 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 exists for ten (10) years from the final date of the Health Plan’s State Contract or from the date of completion of any audit, whichever is later.
- 1.13 **Encounter Data.** Provider will ensure there is no duplicate submissions of Encounter Data for claims made to Health Plan. Health Plan reserves the right to seek recovery from Provider for any penalties incurred by the Health Plan related to or arising from duplicate encounter data submissions as set forth in Health Plan’s State Contract.

ATTACHMENT E

Medicare Advantage

Laws and Government Program Requirements

This attachment sets forth applicable Laws and Government Program Requirements, or other provisions necessary to reflect compliance for the Medicare Advantage Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control for the Medicare Advantage Product. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to the Medicare Advantage Product.

1.1 Definitions.

- a. **Completion of Audit** means a completion of audit by The U.S. Department of Health and Human Services (“HHS”), the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or Related Entity.
- b. **Downstream Entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between a Medicare Advantage Organization (or applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider for health and administrative services.
- c. **Final Contract Period** means the final term of the contract between CMS and the Medicare Advantage Organization.
- d. **First Tier Entity** means any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the Medicare Advantage program.
- e. **Medicare Advantage Organization** means a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the Medicare Advantage contract requirements.
- f. **Related Entity** means any entity that is related to the Medicare Advantage Organization by common ownership or control and: (i) performs some of the Medicare Advantage Organization's management functions under contract or delegation; (ii) furnishes services to Medicare enrollees under an oral or written agreement; or (iii) leases real property or sells materials to the Medicare Advantage Organization at a cost of more than \$2,500 during a contract period.

- 1.2 **Right to Audit.** HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the First Tier Entity, Downstream Entity, and Related Entity, through ten (10) years from the final date of the Final Contract Period of the contract entered into between CMS and the Medicare Advantage Organization or from the date of completion of any audit, whichever is later.

- 1.3 **Right to Audit Directly from FDR.** HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under Section 1.2, of this attachment, directly from any First Tier Entity, Downstream Entity, and Related Entity. For records subject to review under Section 1.2, except in exceptional circumstances, CMS will provide notification to the Medicare Advantage Organization that a direct request for information has been initiated.

- 1.4 **Confidentiality.** Provider will comply with the confidentiality and Member record accuracy requirements, including: (i) abiding by all Laws regarding confidentiality and disclosure of medical records, or other health and enrollment information; (ii) ensuring that medical information is released only in accordance with applicable Law,

or pursuant to court orders or subpoenas; (iii) maintaining the records and information in an accurate and timely manner; and (iv) ensuring timely access by Members to the records and information that pertain to them.

- 1.5 **Hold Harmless.** Members will not be held liable for payment of any fees that are the legal obligation of the Medicare Advantage Organization.
- 1.6 **Cost-Sharing.** For all Members eligible for both Medicare and Medicaid, Members will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Provider will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Provider will: (i) accept the Health Plan payment as payment in full; or (ii) bill the appropriate State source.
- 1.7 **Delegation.** Any services or other activity performed in accordance with a contract or written agreement by Provider or a Downstream Entity of Provider must be consistent and comply with the Medicare Advantage Organization's contractual obligations.
- 1.8 **Prompt Payment.** Health Plan will pay Provider for Clean Claims for Covered Services, that are determined to be payable, in accordance with Laws, Government Program Requirements, and this Agreement. Health Plan will make such payment within sixty (60) days.
- 1.9 **Compliance with Medicare Laws.** Provider will comply with all applicable Medicare Laws, regulations, and CMS instructions.
- 1.10 **Benefit Continuation.** Provider agrees to provide for continuation of Member health care benefits: (i) for all Members, for the duration of the period for which CMS has made payments to Health Plan for Medicare services; and (ii) for Members who are hospitalized on the date Health Plan's contract with CMS terminates, or, in the event of insolvency, through discharge.
- 1.11 **Accountability.** Health Plan may only delegate activities or functions to a First Tier Entity or Downstream Entity in a manner that is consistent with the requirements set forth in Health Plan's contractual obligations.
- 1.12 **Reporting.** Provider agrees to provide relevant data to support Health Plan in complying with the requirements set forth in 42 CFR 422.516 and 42 CFR 422.310.

ATTACHMENT F

Medicare-Medicaid Program

Laws and Government Program Requirements

This attachment sets forth applicable Laws and Government Program Requirements, or other provisions necessary to reflect compliance for the MMP Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control for the MMP Product. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to MMP Product.

1.1 Placeholder - Not currently an active Product.

ATTACHMENT G

Coronavirus Disease Requirements

This attachment sets forth applicable Coronavirus Disease (“COVID”) requirements which are required to be included by Law as stated below. This attachment will be automatically modified to conform to subsequent changes to Law. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with Law will not be effective and will be interpreted in a manner that is consistent with the applicable Law. For the avoidance of doubt, this attachment applies to the Medicare Advantage Product and the Medicare-Medicaid Product.

- 1.1 **Executive Order 14042.** Ensuring Adequate COVID-19 Safety Protocols for Federal Contractors for Subcontractors Over the Simplified Acquisition Threshold of Two Hundred and Fifty Thousand Dollars (\$250,000).
- a. **Definition.** As used in this section, “United States or its outlying areas” means:
 - i. The fifty States;
 - ii. The District of Columbia;
 - iii. The commonwealths of Puerto Rico and the Northern Mariana Islands;
 - iv. The territories of American Samoa, Guam, and the United States Virgin Islands; and
 - v. The minor outlying islands of Baker Island, Howland Island, Jarvis Island, Johnston Atoll, Kingman Reef, Midway Islands, Navassa Island, Palmyra Atoll, and Wake Atoll.
 - b. **Authority.** This clause implements Executive Order 14042, Ensuring Adequate COVID Safety Protocols for Federal Contractors, dated September 9, 2021 (published in the Federal Register on September 14, 2021, 86 FR 50985).
 - c. **Compliance.** Provider, a subcontractor, shall comply with all guidance, including guidance conveyed through Frequently Asked Questions, as amended during the performance of this Agreement, for contractor or subcontractor workplace locations published by the Safer Federal Workforce Task Force (“Task Force Guidance”) at <https://www.saferfederalworkforce.gov/contractors/>.
 - d. **Subcontracts.** Provider shall include the substance of this clause, including this paragraph (d), in subcontracts at any tier that exceed the simplified acquisition threshold, as defined in Federal Acquisition Regulation 2.101 on the date of subcontract award, and are for services, including construction, performed in whole or in part within the United States or its outlying areas.