Third Amendment to the Iowa Health Link Contract

This Amendment to Contract Number MED-24-005 is effective as of July 1, 2023, between the Iowa Department of Health and Human Services (Agency) and Molina Healthcare of Iowa, Inc. (Contractor).

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

Revision 1. Section B.4.01 Auto-Reenrollment, is amended as follows:
Pursuant to Iowa Medicaid's 1915(b) waiver, the Agency automatically reenrolls in the same MCO any recipient who is disenrolled solely because the Enrolled Member loses Medicaid or CHIP eligibility for a period of 12 months or less. See: 42 C.F.R. § 438.56(g); 42 C.F.R. § 457.1201(m); 42 C.F.R. 457.1212. {From CMSC B.4.01}.

Revision 2. Section C.11.02 Applicability, is amended as follows:
Contractor shall submit any proposed Value-Added Services to the Agency for evaluation, review and approval at least 30 days prior to implementation. Agency approval does not confirm the legality of any value-added service.

Revision 3. Section D.4.06 Incurred claims, amounts that must be deducted from incurred claims, subheading a), is hereby amended as follows:
a) Cost sharing and overpayment recoveries received from network providers.

Revision 4. Section D.4.33 Timelines, paragraph 2, is hereby amended as follows:
Prior to twelve (12) months following contract period, Agency shall provide the Contractor with a final settlement under the risk share program for the contract period. Any balance due between Agency and the Contractor, as the case may be, will be paid within sixty (60) days of receiving the final reconciliation from Agency.

Revision 5. Section F.4.10 Single Case Agreements, is hereby added as follows:
Single Case Agreements. A single case agreement may be used to provide members' medically necessary services when the Contractor's provider network is unable to provide access to necessary services to maintain a member's health and/or the member's health would be endangered if required to travel or wait for care from an in-network provider. Only under very limited circumstances may a provider or organization bill and receive payment for services without being enrolled as an Iowa Medicaid provider to ensure that members have access to covered Medicaid services. The health care provider shall be screened in accordance with 42 CFR part 455, subpart E standards. SCA standards / requirements:

- Complete an SCA for each enrolled member.
- Review SCA's every six (6) months to ensure continued medically necessity and continued lack of available services within the Enrolled Provider Network.

When the provider is out of state, the SCA is required to include an attestation to the following before the Managed Care Plan signs the SCA:

- The provider is actively enrolled with Medicaid or Medicare in the state in which they provide services.
- The individual or organization is in good standing and has not been excluded from receiving payment from state or federal programs.

Revision 6. Section F.11.13. 340B Drug Pricing Program, 340B Covered Entities, is hereby amended as follows:
Contractor shall ensure that all 340B Covered Entities that use 340B Program drugs and serve Iowa Medicaid managed care Enrollees adhere to all Agency 340B Program policies and procedures including appropriate Claim level identifiers. This requirement applies to outpatient pharmacy Claims, Physician/Provider administered drugs, vaccines, diabetic supplies and exclusion of 340B contract pharmacies. See: IL 2243-MC (July 13, 2021).

a) The Contractor shall be required to meet the same timeframes for reimbursement, prior approval responses and clean claims for 340B claims as for non-340B claims.

b) The Contractor shall not apply a different timeframe for timely filing to 340B claims than non-340B claims, unless otherwise permitted by federal law.

c) The Contractor shall not apply restrictions to 340B claims or covered entities if not applied to non-340B claims or providers such as fees, chargebacks, claw backs, adjustments, or other assessments not already required or permitted by Iowa law or Administrative Code.

d) The Contractor shall not require any additional prior approvals, fraud checks, forms, or data reporting for 340B covered entities or 340B prescription drugs that is not required of non-340B providers or non-340B prescription drugs, unless otherwise required by federal law or approved by Iowa Medicaid as an amendment to this agreement.

Revision 7. Section I.2.01, Encounter Data Submission Obligation, is hereby amended as follows:
The word “Data” replaces “Date” in the heading.

Revision 8. Section, J.2.03 Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), is hereby added as follow:
In the event that the Agency determines a need to share confidential client information from the Iowa WIC program, the Contractor agrees to not use, further disclose, or permit others to use or disclose the Iowa WIC Data received through this Contract except as directed by the Agency. The Contractor shall allow only those members of its workforce who have a legitimate business need for the Data to access the Data.

Records and data regarding participants, applicants, and vendor information for the Iowa WIC program are confidential (Iowa Code Section 22.7(2), 641 IAC 73.25(135), 7 CFR 246). Iowa HHS may disclose WIC program data to the Contractor as persons directly connected with the administration of the WIC Program determined by the State agency to have a need to know the information for WIC Program purposes (7 CFR 246.26 (d)(1)(ii)).
The Contractor shall maintain the confidentiality of and protect from unauthorized access, use, and disclosure all Iowa WIC Data shared through this Contract. Except as authorized through this Contract or as required by law, the User shall not disclose, release, sell, loan, or otherwise grant access to the Iowa WIC Data shared through this Contract, either during the period of this Agreement or hereafter.

Revision 9. Section K.44 Reporting Format and Batch Submission Schedule, is hereby amended as follows:
The Contractor shall submit encounter Claims in an electronic format that adheres to the data Specifications set forth by the Agency and in any State or federally mandated electronic Claims submission standards. The Agency will have all of the remedies provided to it under the

Contract, including liquidated damages, for failure to comply with these requirements. Drug encounter data shall be submitted by the Contractor once a week for adjudicated Claims in support of the Iowa Medicaid's Drug Rebate invoicing process identified in Section F.11. All encounter data including the drug encounter data shall be submitted by the twentieth (20th) of the following month (i.e., subsequent to the month for which data are reflected). All corrections to the monthly encounter data submission shall be finalized within forty-five (45) Days from the date the initial error report for the month was sent to the Contractor or fifty-nine (59) Days from the date the initial encounter data were due. The error rate for encounter data shall not exceed one percent (1%). The Agency will notify the Contractor of changes made to calculate encounter data timeliness, accuracy, and Quality sixty (60) Days prior to implementation.

Revision 10. Section K.45 Encounter Claims Policies, a) Accuracy of Encounter Claims, is hereby amended as follows:
The Contractor shall implement policies and procedures to ensure that encounter Claims submissions are accurate. The Agency reserves the right to monitor encounter Claims for accuracy against Contractor internal criteria as well as State and Federal requirements. The Agency will regularly monitor the Contractor's accuracy by reviewing the Contractor's compliance with its internal policies and procedures for accurate encounter Claims submissions and by random sample audits of Claims. The Agency will establish a quarterly Encounter Utilization Monitoring report and review process during the second contract year. The Contractor shall submit timely and accurate reports in the format and timeframe designated by the Agency. The Contractor shall investigate root cause of report inaccuracies and submit a revised report in the timeframe designated by the Agency. The Contractor shall fully comply with requirements of these audits and provide all requested documentation, including, but not limited to, applicable Medical Records and Prior Authorizations. The Agency will require the Contractor to submit a Corrective Action Plan and will require non-compliance remedies for Contractor failure to comply with accuracy of these reporting requirements.

Revision 11. Exhibit B: Glossary of Terms/Definitions, the following definitions have been updated as follows:
Hospitalization: Medically necessary care determined to require a hospital stay.
Single Case Agreement: A single case agreement (SCA) is defined as a contract between an out-of-network (not enrolled with Iowa Medicaid) health care provider and the Managed Care Plan (MCP).
Skilled Nursing Care: Medicare Benefit Manual Policy 30.3 Direct Skilled Nursing Services to Patients. Skilled nursing services are services provided when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse are required.

Revision 12. Exhibit H: State Directed Payments, H.1 UIHC Physician ACR Payments - Description of Arrangement, has been amended as follows:
The methodology used to calculate the initial estimate for this arrangement is described below and is consistent with the information submitted by the State in the 438.6(c) pre-print approved by CMS for SFY24

Historically, this payment arrangement has been based on actual utilization within the contract period and was structured such that the MCOs paid the customary Medicaid rate when adjudicating claims. For the SFY24 contract period the Hospital ACR directed payment will be reimbursed outside of the Health Link capitation rates via a separate payment term structure. Effective March 2020, the MCOs began paying the enhanced ACR amount when adjudicating

claims. The CY19 data reflects the Medicaid reimbursement for all claims under this arrangement. Consistent with prior cycles, the basis for the supplemental payment is the difference between the customary Medicaid rate and the average commercial rate (minimum fee schedule) for specific physician service procedure codes. The MCOs are responsible for paying the calculated differential payments to qualifying practices based on actual utilization within the contract period.

Revision 13. Exhibit H: State Directed Payments, H.2 UIHC Hospital ACR Payments - Description of Arrangement, has been amended as follows:
For the SFY24 contract period the Hospital ACR directed payment will be reimbursed outside of the Health Link capitation rates via a separate payment term structure. The Actuarial contractor is required to develop estimates for the separate payment term and include a description of the arrangement when certifying the Health Link capitation rates. The methodology used to estimate the payments associated with the hospital directed payment is similar to the physician arrangement described previously. The basis for the supplemental payment is the difference between the provider's negotiated Medicaid managed care reimbursement and the average commercial rate (minimum alternative fee schedule) calculated using an ACR payment-to-charge ratio for inpatient and outpatient (both acute and behavioral health) hospital services. The MCOs are responsible for paying the calculated differential payments to qualifying providers based on actual utilization on a per claim basis within the contract period.

Once actual utilization for SFY24 is available, the Actuarial contractor and the Agency will calculate revised PMPMs using the actual claims incurred for each rate cell under the arrangement and actual membership for the contract period. Any differences between the original Hospital ACR estimate (calculated as the rate cell specific PMPMs x SFY24 membership) and actual claims incurred under the arrangement will be paid out as a lump sum payment/recoupment from the Agency to the MCOs. After the rating period is complete and the State makes any necessary reconciliation payment/recoupment, the Actuarial vendor will submit a rate certification addendum outlining the distribution methodology and revised PMPMs that reflect the final payments made under this arrangement for SFY24.

Revision 14. Exhibit H: State Directed Payments, H.3 Ground Emergency Transportation (GEMT) Payment Program - Description of Arrangement, has been amended as follows:
Effective July 1, 2019, the State has implemented the Ground Emergency Medical Transportation (GEMT) Payment Program in accordance with 42 CFR 438.6(c). The GEMT Payment Program is made to qualifying Emergency Medical Service (EMS) providers within Iowa for Emergency Medical Transportation services. The Agency provided the Actuarial contractor with the list of applicable providers and procedure codes that will be receiving the prospective provider-specific payment rates during the SFY24 contract period. The provider-specific rates reflect an approved minimum fee schedule and are based on CMS- approved GEMT cost reports submitted by the EMS providers. The EMS additional payments will provide support for contracting and maintain access for Medicaid beneficiaries to receive GEMT services. Under this arrangement, in accordance with 42 CFR 438.6(c)(2)(i)(B), the supplemental payment for covered emergency transportation services will be billed under procedure code A0999 for the services provided by an approved EMS provider participating in the GEMT Payment Program. The A0999 procedure codes associated with the GEMT directed payment arrangement were excluded from the CY19 base data underlying rate development to avoid duplication with this supplemental payment calculation.

The payment arrangement for the SFY24 contract period will be based on actual emergency transportation service utilization within the contract period and is structured such that the MCOs pay both the customary Medicaid rate and the supplemental provider-specific prospective rate when adjudicating claims. The provider-specific prospective payment rate, billed under procedure code A0999, represents the additional uncompensated actual costs necessary to perform EMS transports based on submitted cost reports. Base reimbursement for the eligible emergency transportation services is Iowa Medicaid reimbursement. The supplemental (directed) payment brings the final reimbursement to approximately 10 times the standard Medicaid reimbursement.

Revision 15. Exhibit H: State Directed Payments, H.4 Nursing Facility COVID-19 Relief Rate (NF CRR) Directed Payment - Description of Arrangement, has been deleted.

Revision 16. Exhibit H: State Directed Payments, H.5 ARPA Section 9817 Home and Community Based Services (HCBS) - Description of Arrangement, has been deleted.

Revision 17. Special Contract Amendment is hereby replaced as follows:
Updated Special Contract Amendment below.

Revision 18. Federal Funds. The following federal funds information is provided

Contract Payments include Federal Funds? Yes **UEI #:** S419DSARU593 **The Name of the Pass-Through Entity:** Iowa Department of Health and Human Services	
CFDA #: 93.778 **Grant Name:** Title XIX: The Medical Assistance Program	**Federal Awarding Agency Name:** Centers for Medicare and Medicaid Services (CMS)
CFDA #: 93.767 **Grant Name:** Children's Health Insurance Program	**Federal Awarding Agency Name:** Centers for Medicare and Medicaid Services (CMS)

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

Section 3: Execution
IN WITNESS WHEREOF, in consideration of the mutual covenants set forth above and for other good and valuable consideration, the receipt, adequacy and legal sufficiency of which are hereby acknowledged, the parties have entered into the above Amendment and have caused their duly authorized representatives to execute this Amendment.

Contractor, Molina Healthcare of Iowa, Inc.		**Agency, Iowa Department of Health and Human Services**	
Signature of Authorized Representative:	Date: 10/20/2023	Signature of Authorized Representative: Kelly Garcia	Date: Nov 7, 2023
Printed Name: Jennifer Vermeer		Printed Name: Kelly Garcia	
Title: Iowa Plan President		Title: Director	

Special Contract Amendment

	Molina Healthcare Rates, Net Withhold						
Rate Cell	SFY22 Statewide MMs	Rates - Net Additional Payments	Withhold PMPM	Rates - Net Withhold, Net Additional Payments	GME PMPM	GEMT PMPM	Rates - Net Withhold, Gross Additional Payments
Children 0-59 days M&F	51,954	$ 2,546.85	$ 50.94	$ 2,495.91	$ 4.45	$ 3.01	$ 2,503.37
Children 60-364 days M&F	188,355	$ 334.67	$ 6.69	$ 327.97	$ 4.45	$ 1.61	$ 334.03
Children 1-4 M&F	827,054	$ 173.03	$ 3.46	$ 169.57	$ 4.45	$ 0.96	$ 174.98
Children 5-14 M&F	1,706,648	$ 173.84	$ 3.48	$ 170.36	$ 4.45	$ 0.62	$ 175.43
Children 15-20 F	350,013	$ 285.93	$ 5.72	$ 280.21	$ 4.45	$ 2.68	$ 287.34
Children 15-20 M	336,259	$ 210.86	$ 4.22	$ 206.65	$ 4.45	$ 1.78	$ 212.88
CHIP - Hawk-i	647,114	$ 167.81	$ 3.36	$ 164.45	$ -	$ 0.52	$ 164.97
Non-Expansion Adults 21-34 F	393,502	$ 437.02	$ 8.74	$ 428.28	$ 4.45	$ 4.54	$ 437.27
Non-Expansion Adults 21-34 M	93,296	$ 271.95	$ 5.44	$ 266.51	$ 4.45	$ 3.30	$ 274.26
Non-Expansion Adults 35-49 F	258,815	$ 640.23	$ 12.80	$ 627.43	$ 4.45	$ 4.68	$ 636.55
Non-Expansion Adults 35-49 M	107,659	$ 449.16	$ 8.98	$ 440.18	$ 4.45	$ 4.18	$ 448.81
Non-Expansion Adults 50+ M&F	53,075	$ 774.11	$ 15.48	$ 758.63	$ 4.45	$ 4.75	$ 767.83
Pregnant Women	138,854	$ 272.55	$ 5.45	$ 267.10	$ 4.45	$ 1.95	$ 273.50
WP 19-24 F (Medically Exempt)	11,421	$ 1,159.03	$ 23.18	$ 1,135.85	$ -	$ 15.63	$ 1,151.48
WP 19-24 M (Medically Exempt)	9,036	$ 1,289.54	$ 25.79	$ 1,263.75	$ -	$ 12.25	$ 1,275.99
WP 25-34 F (Medically Exempt)	41,983	$ 1,176.02	$ 23.52	$ 1,152.50	$ -	$ 14.38	$ 1,166.88
WP 25-34 M (Medically Exempt)	39,700	$ 1,156.26	$ 23.13	$ 1,133.14	$ -	$ 20.87	$ 1,154.01
WP 35-49 F (Medically Exempt)	62,802	$ 1,422.58	$ 28.45	$ 1,394.13	$ -	$ 16.91	$ 1,411.04
WP 35-49 M (Medically Exempt)	57,448	$ 1,283.43	$ 25.67	$ 1,257.76	$ -	$ 25.11	$ 1,282.87
WP 50+ M&F (Medically Exempt)	90,090	$ 1,774.31	$ 35.49	$ 1,738.83	$ -	$ 27.08	$ 1,765.91
WP 19-24 F (Non-Medically Exempt)	290,185	$ 280.46	$ 5.61	$ 274.86	$ -	$ 2.51	$ 277.36
WP 19-24 M (Non-Medically Exempt)	257,827	$ 165.24	$ 3.30	$ 161.94	$ -	$ 2.38	$ 164.31
WP 25-34 F (Non-Medically Exempt)	334,869	$ 351.72	$ 7.03	$ 344.68	$ -	$ 2.40	$ 347.08
WP 25-34 M (Non-Medically Exempt)	309,115	$ 303.98	$ 6.08	$ 297.90	$ -	$ 3.89	$ 301.79
WP 35-49 F (Non-Medically Exempt)	338,344	$ 573.85	$ 11.48	$ 562.37	$ -	$ 3.84	$ 566.21
WP 35-49 M (Non-Medically Exempt)	325,219	$ 471.83	$ 9.44	$ 462.40	$ -	$ 5.44	$ 467.84
WP 50+ M&F (Non-Medically Exempt)	520,871	$ 854.90	$ 17.10	$ 837.81	$ -	$ 6.35	$ 844.16
ABD Non-Dual <21 M&F	126,038	$ 1,056.93	$ 21.14	$ 1,035.79	$ 4.45	$ 4.75	$ 1,045.00
ABD Non-Dual 21+ M&F	243,679	$ 1,945.41	$ 38.91	$ 1,906.50	$ 4.45	$ 27.23	$ 1,938.18
Residential Care Facility	4,291	$ 6,380.72	$ 127.61	$ 6,253.10	$ 4.45	$ 15.74	$ 6,273.30
Breast and Cervical Cancer	1,633	$ 2,873.38	$ 57.47	$ 2,815.92	$ -	$ 2.95	$ 2,818.87
Dual Eligible 0-64 M&F	365,294	$ 638.88	$ 12.78	$ 626.10	$ -	$ 1.86	$ 627.96
Dual Eligible 65+ M&F	150,272	$ 263.96	$ 5.28	$ 258.68	$ -	$ 1.42	$ 260.10
Custodial Care Nursing Facility <65	21,268	$ 5,432.60	$ 108.65	$ 5,323.95	$ 4.45	$ 20.72	$ 5,349.12
Custodial Care Nursing Facility 65+	109,797	$ 4,513.33	$ 90.27	$ 4,423.07	$ -	$ 2.66	$ 4,425.73
Elderly HCBS Waiver	90,926	$ 4,513.33	$ 90.27	$ 4,423.07	$ -	$ 3.43	$ 4,426.49
Non-Dual Skilled Nursing Facility	1,811	$ 5,432.60	$ 108.65	$ 5,323.95	$ 4.45	$ 21.94	$ 5,350.33
Dual HCBS Waivers: PD; H&D	16,517	$ 5,432.60	$ 108.65	$ 5,323.95	$ -	$ 1.77	$ 5,325.72
Non-Dual HCBS Waivers: PD; H&D; AIDS	18,927	$ 5,432.60	$ 108.65	$ 5,323.95	$ 4.45	$ 17.20	$ 5,345.60
Brain Injury HCBS Waiver	15,724	$ 5,432.60	$ 108.65	$ 5,323.95	$ 4.45	$ 10.04	$ 5,338.44
ICF/ID	14,742	$ 7,833.60	$ 156.67	$ 7,676.93	$ 4.45	$ 6.75	$ 7,688.13
State Resource Center	3,342	$ 7,833.60	$ 156.67	$ 7,676.93	$ 4.45	$ 2.57	$ 7,683.95
Intellectual Disability HCBS Waiver	137,201	$ 7,833.60	$ 156.67	$ 7,676.93	$ 4.45	$ 4.14	$ 7,685.52
PMIC	3,429	$ 3,418.20	$ 68.36	$ 3,349.84	$ 4.45	$ 20.71	$ 3,375.00
Children's Mental Health HCBS Waiver	12,852	$ 3,418.20	$ 68.36	$ 3,349.84	$ 4.45	$ 5.81	$ 3,360.09
CHIP - Children 0-59 days M&F	875	$ 2,546.85	$ 50.94	$ 2,495.91	$ -	$ 3.01	$ 2,498.92
CHIP - Children 60-364 days M&F	2,931	$ 334.67	$ 6.69	$ 327.97	$ -	$ 1.61	$ 329.58
CHIP - Children 1-4 M&F	832	$ 173.03	$ 3.46	$ 169.57	$ -	$ 0.96	$ 170.53
CHIP - Children 5-14 M&F	138,786	$ 173.84	$ 3.48	$ 170.36	$ -	$ 0.62	$ 170.98
CHIP - Children 15-20 F	27,236	$ 285.93	$ 5.72	$ 280.21	$ -	$ 2.68	$ 282.89
CHIP - Children 15-20 M	27,214	$ 210.86	$ 4.22	$ 206.65	$ -	$ 1.78	$ 208.43
TANF Maternity Case Rate	7,655	$ 6,888.71	$ 137.77	$ 6,750.94	$ -	$ -	$ 6,750.94
Pregnant Women Maternity Case Rate	4,851	$ 6,174.82	$ 123.50	$ 6,051.33	$ -	$ -	$ 6,051.33
Total	**9,377,125**	**$ 703.23**	**$ 14.06**	**$ 689.16**	**$ 2.42**	**$ 3.81**	**$ 695.39**