Second Amendment to the Iowa Health Link Contract

This Amendment to Contract Number MED-24-006 is effective as of July 1, 2023, between the Iowa Department of Human Services (Agency) and Amerigroup, Iowa (Contractor).

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

Revision 1. Section A.17 Coordination with Other State Agencies and Program Contractors, subheading b), is deleted and replaced as follows:

Family Well Being and Protection. This department has oversight of: Child Care; Child Protection and Services; and Early Intervention and Support.

Revision 2. Section A.17 Coordination with Other State Agencies and Program Contractors, subheading d), is deleted and replaced as follows:

Behavioral Health and Disability Services. This department has oversight of: Community-Based Prevention, Services, and Integration for People with Disabilities; Performance, Innovation and Mental Health.

Revision 3. Section A.17 Coordination with Other State Agencies and Program Contractors, subheading e), is deleted and replaced as follows:

Community Access. This department has oversight of: Child Support Services; Eligibility; Wellness and Preventive Health.

Revision 4. Section C.2.02. Obligation to Provide Handbook, is hereby amended as follows:

Contractor shall provide each Enrolled Member and their authorized representative an Enrollee handbook, which serves as a summary of Benefits and coverage, within seven (7) days after receiving notice of the beneficiary's enrollment. See: 42 C.F.R. § 438.10(g)(1); 45 C.F.R. § 147.200(a); 42 C.F.R. § 457.1207. {From CMSC C.2.02}.

Revision 5. Section C.8.07 Definition of terms, is hereby amended as follows:

Habilitation services and devices is replaced with habilitation services. Rehabilitation services and devices has been removed.

Revision 6. Section C.8.08. Additional Definitions, is hereby amended as follows:

Preauthorization is replaced with prior authorization.

Revision 7. Section D.4.01 Medical Loss Ratio (MLR) Applicability, is hereby amended as follows:

The Contractor shall submit the MLR in accordance with MLR standards and the Agency instructions outlined in the reporting manual. The following MLR standards apply to both Title XIX and Title XXI capitation payments. Contractor shall report separate MLRs for the Title XIX and Title XXI populations and aggregate across both populations for minimum MLR application.

Revision 8. Section D.4.06 Incurred claims, Amounts that must be deducted from incurred claims, is hereby amended as follows:

a) Premiums and overpayment recoveries received from network providers.
b) Prescription drug rebates received and accrued.

Revision 9. Section D.4.07 Activities that improve health care quality, is hereby amended as follows:

Activities that improve health care quality must be in one of the following categories. See: 42 C.F.R. § 438.8(e)(3):

Revision 10. Section D.4.15.f Credibility Adjustment, is hereby amended as follows:

CMS may adjust the number of member months necessary for a MCO's, PIHP's, or PAHP's experience to be non-credible, partially credible, or fully credible so that the standards are rounded for the purposes of administrative simplification. The number of member months will be rounded to one hundred (100) or a different degree of rounding as appropriate to ensure that the credibility thresholds are consistent with the objectives outlined herein.

Revision 11. Section D.4.18 Reporting Requirements, is hereby amended as follows:

Contractor shall submit a report in accordance with MLR standards and Agency instructions outlined in the reporting manual that includes at least the following information for each MLR reporting year:

Revision 12. D.4.32. Risk Corridor Percentage.

The Risk Corridor Percentage is calculated as the total adjusted medical expenditures divided by the total capitation revenue for all populations.

The Risk Sharing Corridor is defined as follows:

Risk Corridor Minimum Percentage	Risk Corridor Maximum Percentage	Contractor Share	State / Federal Share
0.0%	88.1%	0.0%	100.0%
88.1%	91.1%*	100.0%	0.0%
91.1%*	94.1%	100.0%	0.0%
94.1%	94.1%+	0.0%	100.0%

**Risk corridor bands reflected in the risk corridor table are +/- 3.0%. The target MLR of 91.1% is based on the weighted average of total non-medical load amounts built into capitated rates for July 1, 2023 to June 30, 2024, based on SFY22 statewide enrollment distribution.*

In the circumstance that during the contract period the Agency implements programmatic changes that results in a change, (increase or decrease), to the total capitation rate but does not impact the non-medical load the risk corridor target may change to reflect the non-medical load reflected in the adjusted rates; however, the risk corridor bands will remain +/- 3.0% from the revised target.

The actual target MLR used for the risk corridor reconciliation may vary slightly based on the actual population distribution for the Contractor during the twelve-month contract period. To the extent the actual target MLR varies from 91.1% using the actual enrollment mix and revised capitation rates during the contract period, the risk corridor bands will still be +/- 3.0% from the revised target.

Revision 13. Section E.1.04. Provider Website, the following sentence is hereby added as follows:

The Contractor shall update the Provider Relations regional maps at least quarterly, or more frequently as staffing changes occur.

Revision 14. Section E.1.30. Provider Recredentialing Performance Metric, is hereby amended as follows:

Contractor shall complete recredentialing of all contracted Providers no less than every three (3) years. The agency will conduct an annual audit to ensure compliance with recredentialing requirements. For contracts new to Iowa health Link program the audit will occur on the third year of the contract. Failure to comply with the audit or recredentialing requirements may result in corrective actions in accordance with contract section J.8.08.

Revision 15. Section E.3.03. Credentialing Policies and Procedures, is hereby deleted and replaced as follows:

Contractor shall develop, implement, and adhere to written policies and procedures, subject to Agency review and approval, related to Provider Credentialing and re-Credentialing, which shall include standards of conduct that articulate Contractor's understanding of the requirements and that direct and guide Contractor's and Subcontractors' compliance with all applicable federal and State standards and performance metrics related to Provider Credentialing, including those required in 42 C.F.R. Parts 438 and 455, Subpart E, which shall include the following: (i) a training plan designed to educate staff in the Credentialing and re-Credentialing requirements; (ii) provisions for monitoring and auditing compliance with Credentialing standards; (iii) provisions for prompt response and corrective action when non-compliance with Credentialing standards is detected; (iv) a description of the types of Providers that are credentialed; (v) methods of verifying Credentialing assertions, including any evidence of prior Provider sanctions; and (vi) prohibition against employment or contracting with Providers excluded from participation in federal health care programs. The Contractor shall ensure that the Credentialing process provides for mandatory re-Credentialing at a minimum of every three (3) years. Contractor shall document its Credentialing Policies and Procedures in the PPM.

Revision 16. Section F.1.10 Post-Stabilization Care Coverage, b) is hereby amended as follows:

Preauthorization is replaced with prior authorization.

Revision 17. Section F.6.14 Deemed Granting of Prior Authorization Requests, is hereby deleted.

Revision 18. The subsequent sections have been renumbered as follows:
F.6.14. Covered Services
F.6.15. Benefit Package
F.6.16. Hawki Enrollees
F.6.17. Iowa Health and Wellness Plan Benefits.

F.6.18. Medically Exempt.
F.6.19. Identification of Medically Exempt Members.
F.6.20. Benefits for Medically Exempt Members.
F.6.21. Changes in Covered Services.
F.6.22. Integrated Care.
F.6.23. QTL & NQTL.
F.6.24. EPSDT Services:
F.6.25. Prior Authorization - EPSDT.
F.6.26. Newborn and Mothers Health Protection.
F.6.27. Sufficiency of Services.
F.6.28. Age-Appropriate Growth and Development.
F.6.29. Functional Capacity.
F.6.30. Living Setting of Enrollee's Choice.
F.6.31. Mental Health Parity.
F.6.32. Contractor may cover services or settings for Enrolled Members that are in lieu of those covered under the State Plan if:

Revision 19. Section F.11.02 Pharmacy Network is hereby amended as follows:

The Contractor shall provide a pharmacy network that complies with Special Contract Exhibit C requirements and at a minimum includes pharmacies licensed with the Iowa Board of Pharmacy.

Revision 20 Section F.11.13 – is hereby amended to add the following at the end of this section

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

Revision 21. Section F.11.18. Drug Encounter Claims Submission, second sentence, is hereby replaced as follows:

Drug Encounter Claims Submission. Contractor shall submit pharmacy encounter data in compliance with the Iowa Medicaid Encounter Companion Guide, inclusive of all fields listed in the guide. The Contractor shall submit a Claim-level detail file weekly of drug encounters to the Agency or its Designee,

unless otherwise approved. The Contractor shall provide this reporting to the Agency in the manner and timeframe prescribed by the Agency, including, but not limited to, the submission of complete and accurate drug encounter data rebate file and required Attestation Form to the Agency or its Designee. The detail must provide the basis for comparing the actual amount paid to pharmacies to the amount that the PBM charged the Contractor for the transaction. The Contractor shall comply with spread pricing and if pass through pricing is used for PBM contracting, any administrative fee the PBM charges the Contractor cannot be sent as part of the encounter claim pricing. The Contractor shall comply with all file layout requirements including, but not limited to, format and naming conventions and submission of Provider paid amount. A complete listing of Claim fields required will be determined by the Agency. The Contractor shall ensure that its pharmacy Claims process recognizes Claims from 340B pharmacies for products purchased through the 340B Program at the Claim level utilizing the NCPDP field designed for this purpose. The Contractor shall ensure that the Physician/Provider administered drug Claims process recognizes Claims from 340B Providers at the Claim level. See: CMS CIB 050519 and 42 C.F.R. § 438.8(e)(2)(v)(A) and 42 CFR 438.8(k)(3)

Revision 22. Section F.11.20. Disputed Drug Encounter Submissions, is hereby deleted and replaced as follows:

The Contractor shall assist the Agency or the Agency's Designee in resolving Drug Rebate disputes with a manufacturer in a timely manner and at the Contractor's expense. The process must be followed as indicated in the Drug Rebate Dispute Information/Communication Process including any subsequent revisions. On a monthly basis, the Agency will review the Contractor's drug encounter Claims and provide a file to the Contractor of disputed encounters that were identified through the Drug Rebate invoicing process. Within sixty (60) Days of receipt of the disputed encounter file from the Agency, the Contractor must resolve any disputed encounters and send a response file to the Agency indicating the specific resolution action taken and date of completion. In addition to the administrative sanctions of this Contract, failure of the Contractor to submit, once every 1 week, drug encounter Claims files and/or a response file to the disputed encounters file within sixty (60) Days as detailed above for each disputed encounter shall result in a quarterly offset to the Capitation Payment equal to the value of the Provider reimbursement amount on the disputed encounters.

Revision 23. Section F.13.16. Individual Service Coordination and Treatment Planning Requirements, is hereby amended to add the following language:

a) The Contractor shall ensure the provision of care for Enrolled Members, which includes coordinating with inpatient mental health and substance use disorder treatment facilities including but not limited to PMICS, MHIs, subacute mental health facilities, psychiatric hospitals, and substance use disorder treatment facilities. The Contractor shall initiate and lead transitional care coordination to Enrolled Members residing in a facility to ensure transition into the community where appropriate. Transitional care activities include but are not limited to the

Contractor's development and implementation of a transitional care plan and securing placement and services with community providers that are able to meet the Enrolled Member's needs. The Contractor shall implement strategies, as approved by the Agency, to monitor transition and ensure that services and supports are made available to ensure transition success.

b) Monitoring of Community Transition Activities. The Contractor shall monitor all aspects of the transition process and take immediate action to address any issues that arise. The Contractor shall monitor hospitalizations and MH/SUD facility readmissions for Enrolled Members who transition to the community to identify issues and implement strategies to improve Outcomes. The Contractor shall conduct face-to-face visits with the Enrolled Member, at minimum: (i) within two (2) Days of the transition to the community; (ii) every two (2) weeks for the first two (2) months from discharge; and (iii) once per month for the first year after transition. More frequent contact shall occur based on an individualized assessment of the Enrolled Member's needs and risk factors.

c) MH/SUD Facilities; Case Management Requirements. Contractor shall obtain Agency approval of strategies for monitoring services for Enrolled Members in MH/SUD facilities. Community Based Case management must meet the requirements contained in Section F.12C of this Contract.

d) Discharge Planning. Contractor shall develop, implement, and adhere to policies and procedures to ensure that community-based case managers are actively involved in Discharge Planning when an Enrolled Member is hospitalized, receiving inpatient mental health or substance use disorder treatment or otherwise served outside of the home. The Contractor shall define circumstances that require that hospitalized/ inpatient Enrolled Members receive an in-person visit to complete a needs reassessment and an update to the Enrolled Member's plan of care. Contractor shall document its policies and procedures in its PPM.

Revision 24. Section I.5.03, is hereby deleted and replaced as follows:

I.5.03. Annual and Quarterly Reports and Report Templates. Annually, on the date identified by the Agency, the Contractor shall submit the following reports on the identified reporting templates, including all of the information required by those templates:

a) an annual report of Overpayment recoveries.

Revision 25. Section I.5.04 Quarterly Reports, is hereby amended by adding the following:

d) Single Case Agreements.

Revision 26. Exhibit B: Glossary of Terms/Definitions, the following have been added to the Exhibit:

Day Habilitation: Day habilitation services are services that assist or support the consumer in developing or maintaining life skills and community integration.

Durable Medical Equipment: Durable medical equipment. DME is equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services that a member receives in an emergency room.

Excluded Services: Services that are not covered on the members identified plan.

Functional Family Therapy (FFT): An evidenced based family therapy that provides clinical assessment and treatment for the youth and their family to improve communication, problem solving, and conflict management in order to reduce problematic behavior of the youth.

Habilitation Services: Habilitation Services means the 1915(i) State Plan Home and Community Based Services. Habilitation services are provided to maintain persons with functional deficits typically associated with chronic mental illness in their own homes and communities.

Home Based Habilitation: Habilitation Services means the 1915(i) State Plan Home and Community Based Services. Habilitation services are provided to maintain persons with functional deficits typically associated with chronic mental illness in their own homes and communities.

Home Health Care: Home health care is a wide range of health care services that can be given in a member's home for an illness or an injury.

Hospice: Services to provide comfort and support for members in the last stages of a terminal illness, and their families.

Hospitalization: Inpatient care based on diagnosis-related groups.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

Multi-Systemic Therapy (MST): An evidenced based intensive treatment process that focuses on diagnosed behavioral health disorders and on environmental systems (family, school, peer groups, culture, neighborhood, and community) that contribute to, or influences a youth's involvement, or potential involvement in the juvenile justice system.

Non-participating provider: A provider that is enrolled with Iowa Medicaid, is credentialed, but not contracted, with a managed care plan. Participating Provider: A provider that is enrolled with Iowa Medicaid and is credentialed and contracted with a managed care plan.

Physician Services: Health care services a licensed medical physician provides or coordinates.

Plan: An individual or group plan that provides, or pays the cost of, medical care.

Premium: A health insurance premium is the amount that policyholders pay for health coverage.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prevocational Services: Prevocational services means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

Supported Employment: Supported employment means the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state's minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals. Supported employment services can be provided

through many different service models.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.

Revision 27. Exhibit A: Capitation Rate Information, MLR, Pay for Performance, Liquidated Damages, and Excluded Pharmaceuticals - Section 3: SFY 2024 Payment for Performance Chart is amended to read as follows:

Performance Standard 1	**Amount of Performance Withhold at Risk**
Timely Claims Reprocessing	20%
Required Contractual Standard	
The Contractor shall also reprocess all claims processed in error within thirty (30) calendar days of identification of the error or upon a schedule approved by the Agency. Except in cases in which system configuration is necessary, the start time begins when the Contractor identifies, or is made aware of the error, and has received all necessary information to validate the error; identification of the error could be brought forward by a provider, the Agency, or internal Contractor staff. In the event the Contractor requests clarification from the Agency regarding a claim reprocessing project, the time for reprocessing will begin to run on the day the Contractor receives all information necessary to accurately reprocess the claims. In cases in which a system configuration is necessary, the Contractor shall make corrections to the system and reprocess claims within sixty (60) calendar days unless an extension is approved by the Agency.	
Standard Required to Receive Incentive Payment	
The Contractor will achieve a measure of ninety percent (90%) of all reprocessed claims within fifteen (15) business days of discovery of an error not related to a system configuration and ninety-five percent (95%) of all claims reprocessed within thirty (30) business days when a system configuration change is required.	
Performance Standard 2	**Amount of Performance Withhold at Risk**
Follow-up After Hospitalization for Mental Illness (Child)	20%
Standard Description	

<table>
<tr><td colspan="2">The percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: the percentage of discharges for which beneficiary received follow-up within 30 days of discharge, and the percentage of discharges for which beneficiary received follow-up within 7 days of discharge.</td></tr>
<tr><td colspan="2">Standard Required to Receive Incentive Payment</td></tr>
<tr><td colspan="2">The Contractor must calculate this HEDIS measure based on the timeframe of SFY2023 (7/1/22-6/30/23), and the contractor must obtain validation of the SFY2023 results through an authorized NCQA representative.
For hospitalizations for mental illness for children ages 6 to 17 who are discharged and have a follow-up within 7 days after discharge, the Contractor must increase from their CY2021 results by the percentage identified in the chart below to accrue the corresponding withhold payment.
For hospitalizations for mental illness for children ages 6-17 who are discharged and have a follow-up within 30 days after discharge, the Contractor must increase from their CY2021 results by the percentage identified in the chart below to accrue the corresponding withhold payment.

The Contractor must achieve the same level of increase on both the 7 day and 30 day measures to earn the corresponding withhold. If the Contractor achieves differing levels of increase on the two measures, the Contractor will receive the lower percentage of withhold achieved.

Increase by 2% or more – 100% of withhold earned
Increase by 1.1-1.99% – 75% of withhold earned
Increase by 0.75-1.09% – 50% of withhold earned
Increase by 0.74% or less – 0% of withhold earned</td></tr>
<tr><td>Performance Standard 3</td><td>Amount of Performance Withhold at Risk</td></tr>
<tr><td>Follow-up After Hospitalization for Mental Illness (Adult)</td><td>20%</td></tr>
<tr><td colspan="2">Standard Description</td></tr>
<tr><td colspan="2">The percentage of discharges for patients 18 to 64 years of age who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: the percentage of discharges for which the patient received follow-up within 30 days of discharge; and the percentage of discharges for which the patient received follow-up within 7 days of discharge.</td></tr>
<tr><td colspan="2">Standard Required to Receive Incentive Payment</td></tr>
</table>

The Contractor must calculate this HEDIS measure based on the timeframe of SFY2023 (7/1/22-6/30/23), and the contractor must obtain validation of the SFY2023 results through an authorized NCQA representative. For hospitalizations for mental illness for adults ages 18 to 64 who are discharged and have a follow-up within 7 days after discharge, the Contractor must increase from their CY2021 results by the percentage identified in the chart below to accrue the corresponding withhold payment. For hospitalizations for mental illness for adults ages 18 to 64 who are discharged and have a follow-up within 30 days after discharge, the Contractor must increase from their CY2021 results by the percentage identified in the chart below to accrue the corresponding withhold payment. The Contractor must achieve the same level of increase on both the 7 day and 30 day measures to earn the corresponding withhold. If the Contractor achieves differing levels of increase on the two measures, the Contractor will receive the lower percentage of withhold achieved. Increase by 2% or more – 100% of withhold earned Increase by 1.1-1.99% – 75% of withhold earned Increase by 0.75-1.09% – 50% of withhold earned Increase by 0.74% or less – 0% of withhold earned	
Performance Standard 4	**Amount of Performance Withhold at Risk**
Prenatal and Postpartum Care: Timeliness of Prenatal Care	20%
Standard Description	
Percentage of deliveries of live births within the period under review that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in Medicaid or CHIP.	
Standard Required to Receive Incentive Payment	
The Contractor must calculate this HEDIS measure based on the timeframe of SFY2024 (7/1/23-6/30/24), and the contractor must obtain validation of the SFY2024 results through an authorized NCQA representative. For deliveries of live births within the period under review that received a prenatal care visit in the first trimester, on or before the enrollment start date or within forty-two (42) days of enrollment in Medicaid or CHIP, the Contractor must increase from their CY2022 results by the percentage identified in the chart below to accrue the corresponding withhold payment. Increase by 2% or more – 100% of withhold earned Increase by 1.1-1.99% – 75% of withhold earned Increase by 0.75-1.09% – 50% of withhold earned Increase by 0.74% or less – 0% of withhold earned	
Performance Standard 5	**Amount of Performance Withhold**

	at Risk
Service Level for the MCO NEMT Helpline	10%
Standard Description	
MCO will consistently reach a service level for the NEMT helpline of eighty-two percent (82%).	
Standard Required to Receive Incentive Payment	
MCO shall maintain an eighty-two percent (82%) or greater service level. The amount of withhold earned by the Contractor will be determined by the total number of months within SFY2023 that the Contractor achieves this service level threshold: 0 months – 0% of withhold earned 1-3 months – 25% of withhold earned 4-6 months – 50% of withhold earned 7-9 months – 75% of withhold earned 10-12 months – 100% of withhold earned	
Performance Standard 6	**Amount of Performance Withhold at Risk**
Wait Time for NEMT Members	10%
Standard Description	
Contractor will reduce the percentage of members waiting fifteen (15) minutes or more for an NEMT trip.	
Standard Required to Receive Incentive Payment	
The percentage of members waiting for fifteen (15) minutes or more is reduced at least five (5) percent annually for SFY2024 from the baseline of the same percentage for SFY2023. <u>Percentage calculation:</u> Numerator: Measure Order #7 on current NEMT reporting template Denominator: Measure Order #4 on current NEMT reporting template To earn 100% of the withhold for this measure, the percentage calculated for all combined 12 months of SFY2024 must be reduced at least 5% from the percentage calculated for all combined 12 months of SFY2023.	

Revision 28. Exhibit C: General Access Standards, B. Specialty Care Standards a), has been deleted and replaced as follows:

Specialty Network: The Contractor shall contract with a sufficient number of specialists with the applicable range of expertise to ensure that the needs of Enrolled Members are met within the Contractor's Provider Network. The Contractor shall also have a system to refer Enrolled Members to, and pay for, non-Network Providers when medically necessary. The Contractor shall also pay for non-Network Providers when an Enrolled Member has medical needs that would be adversely affected by a change in service Providers. All non-Network Providers referred to and reimbursed shall have the necessary qualifications or certifications to provide the medically necessary service. At minimum, the Contractor shall have Provider agreements with Providers practicing the following specialties: (i) allergy; (ii) cardiology; (iii) dermatology; (iv) endocrinology; (v) gastroenterology; (vi) general surgery; (vii) hematology (viii) neonatology; (ix) nephrology; (x) neurology; (xi) neurosurgery; (xii) obstetrics and gynecology; (xiii) occupational therapy; (xiv) oncology; (xv) ophthalmology; (xvi) orthopedics; (xvii) otolaryngology; (xviii) pathology; (xix) physical therapy; (xx) pulmonology; (xxi) psychiatry; (xxii) radiology; (xxiii) reconstructive surgery; (xxiv) rheumatology; (xxv) speech therapy; (xxvi) urology; and (xxvii) pediatric specialties. The Contractor shall analyze the clinical needs of the Enrolled Membership to identify additional specialty Provider types to enroll.

Revision 29. Exhibit E: Covered Benefits, Table E.02: Iowa Wellness Plan Benefits Coverage List, 1. ambulatory services, the following was added:

TMJ

Revision 30. Exhibit E: Covered Benefits, Table E.02: Iowa Wellness Plan Benefits Coverage List, 10. Pediatric Services including oral & vision, the following was added:

EPSDT - Multi-Systemic Therapy Covered up to age 20
EPSDT - Family Functional Therapy Covered up to age 20

Revision 31. Exhibit E: Covered Benefits, Table E.02: Iowa Wellness Plan Benefits Coverage List, 9. Preventive Wellness ChronicDisease Management, removed excluded coding from Nutritional Counseling.

Revision 32. Exhibit E: Covered Benefits, Table E.02: Iowa Wellness Plan Benefits Coverage List, 10. Pediatric Services including oral & vision, the following was added:

EPSDT - Multi-Systemic Therapy Covered up to age 20
EPSDT - Family Functional Therapy Covered up to age 20

Revision 33. Exhibit E: Covered Benefits, Table E.02: Iowa Wellness Plan Benefits Coverage List, 10. Pediatric Services including oral & vision, the following was deleted:

TMJ

Revision 34. Exhibit E: B, Table E.02: the following was removed from the Benefits Not Provided:

TMJ

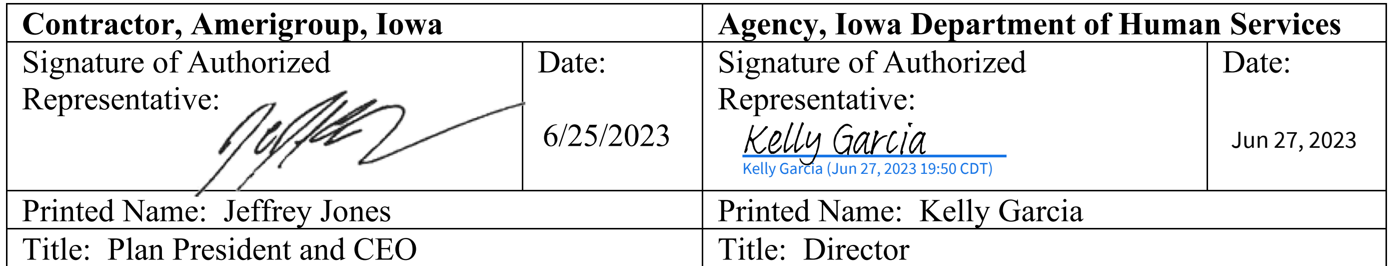
Revision 35. Federal Funds. The following federal funds information is provided

<table>
<tr><td colspan="2">Contract Payments include Federal Funds? Yes
DUNS #: 080218547
The Name of the Pass-Through Entity: Iowa Department of Human Services</td></tr>
<tr><td>CFDA #: 93.778
Title XIX: The Medical Assistance Program</td><td>Federal Awarding Agency Name:
Centers for Medicare and Medicaid Services (CMS)</td></tr>
<tr><td>CDFA #: 93.767
Children’s Health Insurance Program</td><td>Federal Awarding Agency Name:
Centers for Medicare and Medicaid Services (CMS)</td></tr>
</table>

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, Amerigroup, Iowa		**Agency, Iowa Department of Human Services**	
Signature of Authorized Representative:	Date: 6/25/2023	Signature of Authorized Representative: Kelly Garcia Kelly Garcia (Jun 27, 2023 19:50 CDT)	Date: Jun 27, 2023
Printed Name: Jeffrey Jones		Printed Name: Kelly Garcia	
Title: Plan President and CEO		Title: Director	

Special Contract Amendment

Rate Cell	Amerigroup Rates, Net Withhold						
	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	$2,546.81	$ 50.94	$2,495.88	$4.45	$ 3.01	$2,503.34
Children 60-364 days M&F	188,355	$ 334.64	$ 6.69	$ 327.95	$4.45	$ 1.61	$ 334.01
Children 1-4 M&F	827,054	$ 172.65	$ 3.45	$ 169.19	$4.45	$ 0.96	$ 174.60
Children 5-14 M&F	1,706,648	$ 170.03	$ 3.40	$ 166.63	$4.45	$ 0.62	$ 171.69
Children 15-20 F	350,013	$ 280.59	$ 5.61	$ 274.98	$4.45	$ 2.68	$ 282.11
Children 15-20 M	336,259	$ 207.15	$ 4.14	$ 203.01	$4.45	$ 1.78	$ 209.24
CHIP - Hawki	647,114	$ 165.29	$ 3.31	$ 161.98	$ -	$ 0.52	$ 162.50
Non-Expansion Adults 21-34 F	393,502	$ 428.09	$ 8.56	$ 419.53	$4.45	$ 4.54	$ 428.52
Non-Expansion Adults 21-34 M	93,296	$ 267.59	$ 5.35	$ 262.24	$4.45	$ 3.30	$ 269.99
Non-Expansion Adults 35-49 F	258,815	$ 631.36	$ 12.63	$ 618.73	$4.45	$ 4.68	$ 627.86
Non-Expansion Adults 35-49 M	107,659	$ 443.86	$ 8.88	$ 434.98	$4.45	$ 4.18	$ 443.61
Non-Expansion Adults 50+ M&F	53,075	$ 770.34	$ 15.41	$ 754.93	$4.45	$ 4.75	$ 764.14
Pregnant Women	138,854	$ 269.95	$ 5.40	$ 264.55	$4.45	$ 1.95	$ 270.95
WP 19-24 F (Medically Exempt)	11,421	$1,118.15	$ 22.36	$1,095.79	$ -	$ 15.63	$1,111.42
WP 19-24 M (Medically Exempt)	9,036	$1,242.72	$ 24.85	$1,217.86	$ -	$ 12.25	$1,230.11
WP 25-34 F (Medically Exempt)	41,983	$1,123.62	$ 22.47	$1,101.15	$ -	$ 14.38	$1,115.53
WP 25-34 M (Medically Exempt)	39,700	$1,100.07	$ 22.00	$1,078.07	$ -	$ 20.87	$1,098.93
WP 35-49 F (Medically Exempt)	62,802	$1,385.13	$ 27.70	$1,357.42	$ -	$ 16.91	$1,374.34
WP 35-49 M (Medically Exempt)	57,448	$1,234.28	$ 24.69	$1,209.59	$ -	$ 25.11	$1,234.70
WP 50+ M&F (Medically Exempt)	90,090	$1,752.98	$ 35.06	$1,717.92	$ -	$ 27.08	$1,745.00
WP 19-24 F (Non-Medically Exempt)	290,185	$ 276.84	$ 5.54	$ 271.30	$ -	$ 2.51	$ 273.81
WP 19-24 M (Non-Medically Exempt)	257,827	$ 163.70	$ 3.27	$ 160.42	$ -	$ 2.38	$ 162.80
WP 25-34 F (Non-Medically Exempt)	334,869	$ 347.51	$ 6.95	$ 340.56	$ -	$ 2.40	$ 342.96
WP 25-34 M (Non-Medically Exempt)	309,115	$ 301.26	$ 6.03	$ 295.23	$ -	$ 3.89	$ 299.12
WP 35-49 F (Non-Medically Exempt)	338,344	$ 570.56	$ 11.41	$ 559.15	$ -	$ 3.84	$ 562.99
WP 35-49 M (Non-Medically Exempt)	325,219	$ 469.33	$ 9.39	$ 459.95	$ -	$ 5.44	$ 465.39
WP 50+ M&F (Non-Medically Exempt)	520,871	$ 853.17	$ 17.06	$ 836.11	$ -	$ 6.35	$ 842.46
ABD Non-Dual <21 M&F	126,038	$1,047.09	$ 20.94	$1,026.15	$4.45	$ 4.75	$1,035.35
ABD Non-Dual 21+ M&F	243,679	$1,939.01	$ 38.78	$1,900.23	$4.45	$ 27.23	$1,931.91
Residential Care Facility	4,291	$6,362.46	$ 127.25	$6,235.21	$4.45	$ 15.74	$6,255.41
Breast and Cervical Cancer	1,633	$2,869.82	$ 57.40	$2,812.42	$ -	$ 2.95	$2,815.37
Dual Eligible 0-64 M&F	365,294	$ 634.85	$ 12.70	$ 622.15	$ -	$ 1.86	$ 624.01

Dual Eligible 65+ M&F	150,272	$ 261.01	$ 5.22	$ 255.79	$ -	$ 1.42	$ 257.21
Custodial Care Nursing Facility <65	21,268	$5,301.28	$ 106.03	$5,195.26	$4.45	$ 20.72	$5,220.43
Custodial Care Nursing Facility 65+	109,797	$4,346.79	$ 86.94	$4,259.85	$ -	$ 2.66	$4,262.52
Elderly HCBS Waiver	90,926	$4,346.79	$ 86.94	$4,259.85	$ -	$ 3.43	$4,263.28
Non-Dual Skilled Nursing Facility	1,811	$5,301.28	$ 106.03	$5,195.26	$4.45	$ 21.94	$5,221.64
Dual HCBS Waivers: PD; H&D	16,517	$5,301.28	$ 106.03	$5,195.26	$ -	$ 1.77	$5,197.03
Non-Dual HCBS Waivers: PD; H&D; AIDS	18,927	$5,301.28	$ 106.03	$5,195.26	$4.45	$ 17.20	$5,216.91
Brain Injury HCBS Waiver	15,724	$5,301.28	$ 106.03	$5,195.26	$4.45	$ 10.04	$5,209.75
ICF/ID	14,742	$7,829.69	$ 156.59	$7,673.10	$4.45	$ 6.75	$7,684.30
State Resource Center	3,342	$7,829.69	$ 156.59	$7,673.10	$4.45	$ 2.57	$7,680.11
Intellectual Disability HCBS Waiver	137,201	$7,829.69	$ 156.59	$7,673.10	$4.45	$ 4.14	$7,681.69
PMIC	3,429	$2,905.70	$ 58.11	$2,847.58	$4.45	$ 20.71	$2,872.74
Children's Mental Health HCBS Waiver	12,852	$2,905.70	$ 58.11	$2,847.58	$4.45	$ 5.81	$2,857.84
CHIP - Children 0-59 days M&F	875	$2,546.81	$ 50.94	$2,495.88	$ -	$ 3.01	$2,498.89
CHIP - Children 60-364 days M&F	2,931	$ 334.64	$6.69	$ 327.95	$ -	$ 1.61	$ 329.56
CHIP - Children 1-4 M&F	832	$ 172.65	$3.45	$ 169.19	$ -	$ 0.96	$ 170.15
CHIP - Children 5-14 M&F	138,786	$ 170.03	$3.40	$ 166.63	$ -	$ 0.62	$ 167.24
CHIP - Children 15-20 F	27,236	$ 280.59	$5.61	$ 274.98	$ -	$ 2.68	$ 277.66
CHIP - Children 15-20 M	27,214	$ 207.15	$4.14	$ 203.01	$ -	$ 1.78	$ 204.79
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	$ 693.03	$ 13.86	$ 679.17	$2.42	$ 3.81	$ 685.40