Fourth 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 D.6.01 Timely Payment Obligation, is hereby amended as follows:
Contractor shall meet the requirements of FFS timely payment (see also D.6.04), including the paying of 90% of all Clean Claims from practitioners (i.e. those who are in individual or group practice or who practice in shared health facilities) within thirty (30) Days of the date of receipt; paying 95% of all Clean Claims within forty-five (45) Days of the date of receipt; and paying 99% of all Claims from practitioners (who are in individual or group practice or who practice in shared health facilities) within ninety (90) Days of the date of receipt. The obligation for timely payment shall be met at both an aggregate and provider type level (e.g., hospital, home health, waiver, nursing facility, etc.). Final provider type levels will be determined by the Agency. See: 42 C.F.R. §447.45(d)(2) - (3); 42 C.F.R. § 447.46; sections 1902(a)(37)(A) and 1932(f) of the Social Security Act). {From CMSC D.6.01}.

Revision 2. Section D.6.02 Claims Reprocessing and Adjustments, is amended as follows:
The Contractor shall accurately adjudicate 90% of all clean identified adjustments including Reprocessed Claims within thirty (30) business days of receipt and 99% of all Claims identified adjustments including Reprocessed Claims within ninety (90) business days of receipt (see also D.6.04). The Contractor shall also reprocess all claims processed in error within thirty (30) business days of identification of the error or upon a scheduled approved by the Agency. 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. The Contractor shall reprocess mass adjustments of Claims upon a schedule approved by the Agency and the Contractor. See: Sections 1902(a)(37)(A) and 1932(f) of the Social Security Act; 42 C.F.R. § 447.45(d)(2) - (3); 42 C.F.R. § 447.46.

Revision 3. Section F.4.04 Out of Network Providers, is hereby amended as follows:
The Contractor shall negotiate and execute written single case agreements or arrangements with non-Network Providers, when medically necessary, to ensure Access to covered services.

Revision 4. Section F.11.07 Pharmacy Benefit Manager (PBM), is hereby amended as follows:
The Contractor shall use a PBM to process prescription Claims online through a real-time, rules-based POS Claims processing system. The Contractor shall ensure that the PBM is directly available to the Agency staff. The Contractor must utilize a pass-through pricing model which means there is no difference in the PBM to pharmacy net payment amounts and MCO to PBM reported payment amounts. No additional direct or indirect remuneration fees, membership fees or similar fees from pharmacies or other contracted entities acting on behalf of pharmacies as a condition of claims payment or network inclusion. No additional retrospective remuneration models including fees related to brand effective rates (BERs) or generic effective rates (GERs) shall be permitted. The Contractor shall prohibit clawback business arrangements whereby the PBM reimburse network pharmacies an initial drug reimbursement amount and dispensing fee, and subsequently the PBM receives remuneration for a portion of that fee that is unreported to the Department and its actuary. However, nothing shall preclude the reprocessing of

Claims due to Claims adjudication errors of the Contractor or its agent.

Revision 5. Section F.12A.05 LOCs for SNF, NF & ICF/ID Residents, is hereby replaced as follows:
The Agency will perform initial level of care assessments for SNF, NF or ICF/ID enrollment for individuals who are enrolled with the Contractor and are applying for initial Medicaid LTSS eligibility, as follows:

a). Skilled Nursing Facilities:

1. A prior authorization is required prior to admission for a skilled nursing facility stay and the prior authorization must be uploaded to the Agency identified database within five (5) days upon the prior authorization approval.
2. Prior authorization reassessments are to be performed by the Contractor. The Contractor shall submit the prior authorization reassessment to the Agency approved database within five (5) days of the completed assessment.

b). Nursing Facilities

1. The Agency will perform initial level of care assessments for NF enrollment for individuals who are enrolled with the Contractor and are applying for initial Medicaid LTSS eligibility.
2. Annual reassessments are to be performed by the Contractor. The Contractor shall submit the level of care/support needs assessment to the Agency approved database within five (5) days of the completed assessment.

c). ICF/ID

1. The Agency will perform initial level of care assessments for ICF/ID enrollment for individuals who are enrolled with the Contractor and are applying for initial Medicaid LTSS eligibility.
2. Annual reassessments are to be performed by the Contractor.

The Agency will retain all authority for determining Medicaid categorical, financial, and level of care eligibility and enrolling Members into a Medicaid eligibility category. The Agency will notify the Contractor when an Enrolled Member has been enrolled in SNF, NF or ICF/ID eligibility category and any applicable Client Participation amounts.

Revision 6. Section F.12B.03 Waiting List, is hereby added as follows:
In the event there is a waiting list for a 1915(c) Waiver, at the time of application, the Contractor shall advise the Enrolled Member there is a waiting list and that they may choose to receive other non-waiver support services because 1915(c) Waiver enrollment is not immediately available. The Contractor shall provide regular outreach to ensure that Enrolled Members are receiving all necessary services and supports to address all health and safety needs while on the wait list.

Enrolled Members are awarded waiver slots by the Agency. When an Enrolled Member is in a facility and qualifies for a reserved capacity slot, the Agency will work with the Contractor for slot release. Contractor shall ensure that each Enrolled Member has obtained supporting documentation necessary to support eligibility for the particular waiver.

The Contractor shall ensure that the number of Enrolled Members assigned to LTSS is managed in such a way that ensures maximum Access, especially for HCBS community integrated services, while controlling overall LTSS costs. Achieving these goals requires that the Agency and the Contractor jointly manage Access to LTSS. To that end, the Contractor shall provide the Agency with LTSS utilization information at regularly specified intervals in a specified form. The Agency will convene regular joint LTSS Access meetings with all Contractors. The purpose of the meetings will be to collaboratively and effectively manage access to LTSS. Except as specified below, the Contractor shall not add Enrolled Members to LTSS without the Agency authorization resulting from joint LTSS Access meetings.

a) In Lieu of Services for members on waiting lists. The Contractor may provide the following in lieu of services to individuals on a 1915(c) HCBS waiver waiting list:

1. Housing supports services:
    i. Pre-tenancy and tenancy sustaining services, including tenant rights education and eviction prevention.
    ii. Housing transition navigation services.
    iii. Medically necessary air conditioners, humidifiers, air filtration devices and asthma remediation, and refrigeration units as needed for medical treatment.
    iv. Medically necessary home modifications and remediation services such as accessibility ramps, handrails, grab bars, repairing or improving ventilation systems, and mold/pest remediation.
2. Case management:
    i. Outreach and education including linkage and referral to community resources and non-Medicaid supports, physical health, behavioral health, and transportation coordination.
3. Respite care services:
    i. Up to 120 hours of respite care per year.
4. Personal care services:
    i. Up to 52 hours per year for eating, bathing, dressing and personal hygiene.
    ii. Medication reminders
5. Medically Tailored Meals (MTM):
    i. Covered population: Any currently enrolled 1915(c) waiver member that have been discharged from an inpatient hospital, skilled nursing facility, or rehab facility and have mobility needs, no family support to assist with food access and/or be at risk for readmission due to nutritional issues (no age requirement).
        1. Use information collected in the assessment for needs. 2.Service frequency:
            i. Up to 2 meals a day delivered in the home, or private residence, for up to 6 months.
            ii. Medically tailored or nutritionally appropriate food prescriptions delivered in various forms such as nutrition vouchers and food boxes, for up to 6 months
6. Home and Vehicle Modification:
    i. Annual limit of $4,000 for Home Modification and $5,000 for vehicle modifications.
7. Intermittent Supported Community Living Services (SCL)
    i. Monthly limit of $1,202/mo. (30 hrs/mo @ $10.02/15 min. unit).
8. Supported Employment Services (SE)
    i. Monthly limit of $2,200/mo. (45 hrs/mo) to maintain employment.
    ii. SE is allowed if the member is on a wait list for IVRS or have exhausted IVRS funding.
9. Support services necessary to aid member to participate in community activities.
10. Transportation including to conduct personal business essential to the health and welfare of the member.
11. Personal emergency response system (PERS)
12. Specialized medical equipment shall include medically necessary items intended for personal use by a member, supporting the member's health and safety, up to $3,000 per year. These items may include:
    i. Electronic aids and organizers
    ii. Medicine dispensing devices
    iii. Communication devices

iv. Bath aids
v. Environmental control units
vi. Repair and maintenance of items purchased through the waiver specialized medical equipment can be covered when it is:

- Identified in the member's approved service plan documented in IoWANS.
- Not ordinarily covered by Medicaid.
- Not funded by educational or vocational rehabilitation programs.
- Not provided by voluntary means.
- Necessary for the member's health and safety, as documented by a health care professional.

Revision 7. Section F.12B.09 Submission of Level of Care, is hereby amended as follows:
Once the assessment is completed, the Contractor shall submit the level of care or needs-based eligibility assessment to the Agency. This level of care or needs based assessment shall be uploaded to the Agency database within five (5) days of the date the assessment was completed. The Agency will retain all authority for determining Medicaid categorical, financial, and level of care eligibility and enrolling Members into a Medicaid eligibility category. The Agency will notify the Contractor when an Enrolled Member has been enrolled in a 1915(c) HCBS Waiver eligibility category or 1915(i) HCBS program and any applicable Client Participation amounts.

Revision 8. Section F.12B.15 Frequency for Service Planning, is hereby amended as follows:
The Contractor shall ensure service plans are completed within 30 days of notification by the Agency of level of care or needs-based eligibility approval, and that the service plan is approved prior to the provision of HCBS services. The Contractor shall ensure completed service plans are uploaded to the Agency designated database and distributed to the member and other people responsible for implementation of the plan within fifteen (15) days of the date the IDT meeting was held. The Contractor shall ensure service plans are reviewed and revised: (i) at least every 365 days; or (ii) when there is significant change in the Enrolled Member's circumstance or needs; or (iii) at the request of the Enrolled Member.

Revision 9. Section I.8.01. Compliance with Retention Policies, is hereby amended as follows:
The Contractor shall comply with the retention policies in this section and in Sections I.7 and I.9 for the treatment of all Overpayments from the Contractor to a Provider, including specifically the retention policies for the treatment of recoveries of Overpayments due to Fraud, waste, or Abuse. See: 42 C.F.R. § 438.608(d)(1)(i). {From CMSC I.6.01}.

Revision 10. Section I.8.02. Recovery of Improper Payments, is hereby amended as follows:
Except as otherwise provided in this Section and Sections I.7 and I.9, the Contractor shall recover improper payments and Overpayments attributable to Claims paid by the Contractor, whether identified by the Contractor or the Agency, for five (5) years following the date the Claim was paid.

Revision 11. Section I.8.03. Retention of Recouped Overpayments, is hereby amended as follows:
Except as otherwise provided in this Section and Sections I.7 and I.9, the Contractor may recoup and retain Overpayments attributable to Claims paid by the Contractor.

Revision 12. Exhibit B: Glossary of Terms/Definitions, the following has been added:
Premium Tax: In accordance with Iowa Code §432.1B and 42 CFR § 433.68, an amount equal to a percentage of the premiums received and taxable under Iowa Code subsection 514B.31 and shall be

paid as taxes to the director of the department of revenue for deposit in the Medicaid managed care organization premiums fund created in Iowa Code section 249A.13.

Revision 13. Exhibit G: Pandemic-Related Contract Provision language, Provider Directed Payments for 1915(c) HCBS Waiver and 1915(i) State Plan HCBS habilitation services A-C has been deleted.

Revision 14. Exhibit H: State Directed Payments, H.1 UIHC Physician ACR Payments - Description of Arrangement, the first paragraph has been amended as follows:
University of Iowa Physician Average Commercial Rate (ACR) payments were the pass-through payments incorporated into the historical capitation rates. After the originally developed SFY19 rates were certified, the State worked with CMS to develop an approvable alternative minimum fee schedule for physician and professional services at qualifying Iowa State-Owned or Operated Professional Services Practices, in accordance with 42 CFR 438.6(c). Beginning with the SFY22 capitation rate period the state directed payments were not included in the monthly capitation rates. State directed payments were paid through a separate payment term on a quarterly basis.

Revision 15. Exhibit H: State Directed Payments, H.4 Directed Payment Program for Hospital Inpatient and Hospital Outpatient Services, has been added as follows:
Effective July 1, 2023, the Agency implements a Medicaid state directed payment program for hospital inpatient and hospital outpatient services in accordance with 42 C.F.R. § 438 and guidance provided by the U.S. Centers for Medicare & Medicaid Services ("CMS"). The purpose of this directed payment is to increase Medicaid reimbursement for hospital inpatient and hospital outpatient services provided by qualifying Iowa hospitals to Medicaid recipients in such a manner that does not require a dedicated state appropriation and increases such reimbursement amounts to the maximum allowable under federal law.

The methodology used is consistent with 42 CFR §438.6(c)(2)(ii)(A). This proposal will direct Iowa Medicaid Managed Care Organizations to make directed payments to eligible Iowa hospitals for inpatient and outpatient hospital services provided to the Managed Care Organizations' enrollees. Each hospital will receive an interim quarterly payment based on inpatient and outpatient service utilization from a previous rating period. The Managed Care Organizations will be directed to pay uniform percentage add-on payments for every adjudicated claim for all eligible hospitals.

Due to the number of hospital stakeholders in Iowa, the Agency is entering into a Memorandum of Understanding (MOU) with the Iowa Hospital Association (IHA), as set forth in the Special Contract Exhibit I, to serve as a coordinating intermediary between the Agency and the qualifying hospitals participating in this program. The Managed Care Organizations are required to comply with all the requirements as set forth in the MOU – Exhibit I.

If an eligible Iowa hospital disagrees with the directed payment received from the Medicaid Managed Care Organization, the eligible Iowa hospital will resolve the difference with the Agency, and the Managed Care Organization will not be held responsible.

Revision 16. Exhibit I: Memorandum of Understanding of State Directed Payments Between the Agency and the Iowa Hospital Association has been added below.

Revision 17. Exhibit J: Managed Care Premium Tax, has been added as follows:
Managed Care Organization Premium Tax. The Premium Tax is applicable to, but not limited to:

1. Capitation Payments.

2. Maternity Case Rate Payments, which include but are not limited to: TANF Maternity Case Rate and Pregnant Women Case Rate.
3. Directed payments authorized under 42 CFR § 438.6(c), include but not limited to: GEMT, GME, UIHC directed payments (physician and hospital) and all Hospital directed payments.
4. Payments for Medicaid Covered Services paid outside the capitation rates, which include but are not limited to specialty pharmaceuticals.
5. Pay for Performance withhold payments.

Revision 18. Effective July 1, 2023, the state is updating the rates for SFY24. Updated Special Contract Amendment below.

Revision 19. 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 #: 93.778 **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: 03/07/2024	Signature of Authorized Representative:	Date: Mar 18, 2024
Printed Name: Jennifer H. Vermeer		Printed Name: Kelly Garcia	
Title: Iowa Plan President		Title: Director	

Special Contract Amendment- SFY2024 Rates

SFY24 July- December Rating Withhold Summary

	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
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	$ 168.72	$ 3.37	$ 165.35	$ 4.45	$ 0.96	$ 170.76
Children 5-14 M&F	1,706,648	$ 162.38	$ 3.25	$ 159.13	$ 4.45	$ 0.62	$ 164.20
Children 15-20 F	350,013	$ 268.22	$ 5.36	$ 262.86	$ 4.45	$ 2.68	$ 269.98
Children 15-20 M	336,259	$ 200.57	$ 4.01	$ 196.56	$ 4.45	$ 1.78	$ 202.79
CHIP - Hawk-i	647,114	$ 153.29	$ 3.07	$ 150.23	$ -	$ 0.52	$ 150.75
Non-Expansion Adults 21-34 F	393,502	$ 445.54	$ 8.91	$ 436.63	$ 4.45	$ 4.54	$ 445.62
Non-Expansion Adults 21-34 M	93,296	$ 266.30	$ 5.33	$ 260.98	$ 4.45	$ 3.30	$ 268.73
Non-Expansion Adults 35-49 F	258,815	$ 625.90	$ 12.52	$ 613.38	$ 4.45	$ 4.68	$ 622.51
Non-Expansion Adults 35-49 M	107,659	$ 416.95	$ 8.34	$ 408.61	$ 4.45	$ 4.18	$ 417.24
Non-Expansion Adults 50+ M&F	53,075	$ 763.42	$ 15.27	$ 748.15	$ 4.45	$ 4.75	$ 757.35
Pregnant Women	138,854	$ 360.67	$ 7.21	$ 353.46	$ 4.45	$ 1.95	$ 359.86
WP 19-24 F (Medically Exempt)	11,421	$ 1,157.41	$ 23.15	$ 1,134.26	$ -	$ 15.63	$ 1,149.89
WP 19-24 M (Medically Exempt)	9,036	$ 1,116.04	$ 22.32	$ 1,093.72	$ -	$ 12.25	$ 1,105.97
WP 25-34 F (Medically Exempt)	41,983	$ 1,112.43	$ 22.25	$ 1,090.18	$ -	$ 14.38	$ 1,104.56
WP 25-34 M (Medically Exempt)	39,700	$ 1,193.22	$ 23.86	$ 1,169.36	$ -	$ 20.87	$ 1,190.23
WP 35-49 F (Medically Exempt)	62,802	$ 1,338.72	$ 26.77	$ 1,311.95	$ -	$ 16.91	$ 1,328.86
WP 35-49 M (Medically Exempt)	57,448	$ 1,256.49	$ 25.13	$ 1,231.36	$ -	$ 25.11	$ 1,256.47
WP 50+ M&F (Medically Exempt)	90,090	$ 1,686.85	$ 33.74	$ 1,653.12	$ -	$ 27.08	$ 1,680.20
WP 19-24 F (Non-Medically Exempt)	290,185	$ 275.51	$ 5.51	$ 270.00	$ -	$ 2.51	$ 272.50
WP 19-24 M (Non-Medically Exempt)	257,827	$ 160.10	$ 3.20	$ 156.90	$ -	$ 2.38	$ 159.27
WP 25-34 F (Non-Medically Exempt)	334,869	$ 343.05	$ 6.86	$ 336.19	$ -	$ 2.40	$ 338.59
WP 25-34 M (Non-Medically Exempt)	309,115	$ 327.59	$ 6.55	$ 321.04	$ -	$ 3.89	$ 324.93
WP 35-49 F (Non-Medically Exempt)	338,344	$ 547.07	$ 10.94	$ 536.13	$ -	$ 3.84	$ 539.97
WP 35-49 M (Non-Medically Exempt)	325,219	$ 467.52	$ 9.35	$ 458.17	$ -	$ 5.44	$ 463.62
WP 50+ M&F (Non-Medically Exempt	520,871	$ 821.29	$ 16.43	$ 804.87	$ -	$ 6.35	$ 811.22
ABD Non-Dual <21 M&F	126,038	$ 859.65	$ 17.19	$ 842.46	$ 4.45	$ 4.75	$ 851.66
ABD Non-Dual 21+ M&F	243,679	$ 1,677.14	$ 33.54	$ 1,643.60	$ 4.45	$ 27.23	$ 1,675.28
Residential Care Facility	4,291	$ 4,786.99	$ 95.74	$ 4,691.25	$ 4.45	$ 15.74	$ 4,711.44
Breast and Cervical Cancer	1,633	$ 3,214.81	$ 64.30	$ 3,150.51	$ -	$ 2.95	$ 3,153.46
Dual Eligible 0-64 M&F	365,294	$ 503.44	$ 10.07	$ 493.37	$ -	$ 1.86	$ 495.23
Dual Eligible 65+ M&F	150,272	$ 253.28	$ 5.07	$ 248.21	$ -	$ 1.42	$ 249.63
Custodial Care Nursing Facility <65	21,268	$ 6,973.76	$ 139.48	$ 6,834.29	$ 4.45	$ 20.72	$ 6,859.45
Custodial Care Nursing Facility 65+	109,797	$ 5,705.56	$ 114.11	$ 5,591.44	$ -	$ 2.66	$ 5,594.11
Elderly HCBS Waiver	90,926	$ 5,705.56	$ 114.11	$ 5,591.44	$ -	$ 3.43	$ 5,594.87
Non-Dual Skilled Nursing Facility	1,811	$ 6,973.76	$ 139.48	$ 6,834.29	$ 4.45	$ 21.94	$ 6,860.67
Dual HCBS Waivers: PD; H&D	16,517	$ 6,973.76	$ 139.48	$ 6,834.29	$ -	$ 1.77	$ 6,836.06
Non-Dual HCBS Waivers: PD; H&D; AI	18,927	$ 6,973.76	$ 139.48	$ 6,834.29	$ 4.45	$ 17.20	$ 6,855.94
Brain Injury HCBS Waiver	15,724	$ 6,973.76	$ 139.48	$ 6,834.29	$ 4.45	$ 10.04	$ 6,848.78
ICF/ID	14,742	$ 9,722.80	$ 194.46	$ 9,528.35	$ 4.45	$ 6.75	$ 9,539.55
State Resource Center	3,342	$ 9,722.80	$ 194.46	$ 9,528.35	$ 4.45	$ 2.57	$ 9,535.37
Intellectual Disability HCBS Waiver	137,201	$ 9,722.80	$ 194.46	$ 9,528.35	$ 4.45	$ 4.14	$ 9,536.94
PMIC	3,429	$ 3,279.99	$ 65.60	$ 3,214.39	$ 4.45	$ 20.71	$ 3,239.55
Children's Mental Health HCBS Waive	12,852	$ 3,279.99	$ 65.60	$ 3,214.39	$ 4.45	$ 5.81	$ 3,224.65
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	$ 168.72	$ 3.37	$ 165.35	$ -	$ 0.96	$ 166.31
CHIP - Children 5-14 M&F	138,786	$ 162.38	$ 3.25	$ 159.13	$ -	$ 0.62	$ 159.75
CHIP - Children 15-20 F	27,236	$ 268.22	$ 5.36	$ 262.86	$ -	$ 2.68	$ 265.53
CHIP - Children 15-20 M	27,214	$ 200.57	$ 4.01	$ 196.56	$ -	$ 1.78	$ 198.34
TANF Maternity Case Rate	7,655	$ 6,888.71	$ 137.77	$ 6,750.94	$ -	$ -	$ 6,750.94
Pregnant Women Maternity Case Rat	4,851	$ 6,174.82	$ 123.50	$ 6,051.33	$ -	$ -	$ 6,051.33
Total	**9,377,125**	**$ 747.61**	**$ 14.95**	**$ 732.66**	**$ 2.42**	**$ 3.81**	**$ 738.89**

January - June 2024 Rating Withhold Summary

		Molina Healthcare Rates, Net Withhold							Premium Tax	
Cap Group	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	Loaded Rates - Net Withhold, Gross Additional Payments	Loaded Rates - Gross Withhold, Gross Additional Payments
H	Children 0-59 days M&F	51,954	$ 2,546.85	$ 50.94	$ 2,495.91	$ 4.45	$ 3.01	$ 2,503.37	$ 2,528.02	$ 2,579.46
H	Children 60-364 days M&F	188,355	$ 334.67	$ 6.69	$ 327.97	$ 4.45	$ 1.61	$ 334.03	$ 337.32	$ 344.08
H	Children 1-4 M&F	827,054	$ 168.72	$ 3.37	$ 165.35	$ 4.45	$ 0.96	$ 170.76	$ 172.44	$ 175.84
H	Children 5-14 M&F	1,706,648	$ 162.38	$ 3.25	$ 159.13	$ 4.45	$ 0.62	$ 164.20	$ 165.81	$ 169.09
H	Children 15-20 F	350,013	$ 268.22	$ 5.36	$ 262.86	$ 4.45	$ 2.68	$ 269.98	$ 272.64	$ 278.06
H	Children 15-20 M	336,259	$ 200.57	$ 4.01	$ 196.56	$ 4.45	$ 1.78	$ 202.79	$ 204.79	$ 208.84
1	CHIP - Hawki	647,114	$ 153.29	$ 3.07	$ 150.23	$ -	$ 0.52	$ 150.75	$ 152.23	$ 155.33
H	Non-Expansion Adults 21-34 F	393,502	$ 445.54	$ 8.91	$ 436.63	$ 4.45	$ 4.54	$ 445.62	$ 450.01	$ 459.01
H	Non-Expansion Adults 21-34 M	93,296	$ 266.30	$ 5.33	$ 260.98	$ 4.45	$ 3.30	$ 268.73	$ 271.38	$ 276.76
H	Non-Expansion Adults 35-49 F	258,815	$ 625.90	$ 12.52	$ 613.38	$ 4.45	$ 4.68	$ 622.51	$ 628.63	$ 641.28
H	Non-Expansion Adults 35-49 M	107,659	$ 416.95	$ 8.34	$ 408.61	$ 4.45	$ 4.18	$ 417.24	$ 421.35	$ 429.77
H	Non-Expansion Adults 50+ M&F	53,075	$ 763.42	$ 15.27	$ 748.15	$ 4.45	$ 4.75	$ 757.35	$ 764.81	$ 780.23
I	Pregnant Women	138,854	$ 360.67	$ 7.21	$ 353.46	$ 4.45	$ 1.95	$ 359.86	$ 363.40	$ 370.68
J	WP 19-24 F (Medically Exempt)	11,421	$ 1,157.41	$ 23.15	$ 1,134.26	$ -	$ 15.63	$ 1,149.89	$ 1,161.21	$ 1,184.59
J	WP 19-24 M (Medically Exempt)	9,036	$ 1,116.04	$ 22.32	$ 1,093.72	$ -	$ 12.25	$ 1,105.97	$ 1,116.86	$ 1,139.40
J	WP 25-34 F (Medically Exempt)	41,983	$ 1,112.43	$ 22.25	$ 1,090.18	$ -	$ 14.38	$ 1,104.56	$ 1,115.44	$ 1,137.90
J	WP 25-34 M (Medically Exempt)	39,700	$ 1,193.22	$ 23.86	$ 1,169.36	$ -	$ 20.87	$ 1,190.23	$ 1,201.95	$ 1,226.04
J	WP 35-49 F (Medically Exempt)	62,802	$ 1,338.72	$ 26.77	$ 1,311.95	$ -	$ 16.91	$ 1,328.86	$ 1,341.94	$ 1,368.98
J	WP 35-49 M (Medically Exempt)	57,448	$ 1,256.49	$ 25.13	$ 1,231.36	$ -	$ 25.11	$ 1,256.47	$ 1,268.84	$ 1,294.22
J	WP 50+ M&F (Medically Exempt)	90,090	$ 1,686.85	$ 33.74	$ 1,653.12	$ -	$ 27.08	$ 1,680.20	$ 1,696.75	$ 1,730.81
K	WP 19-24 F (Non-Medically Exempt)	290,185	$ 275.51	$ 5.51	$ 270.00	$ -	$ 2.51	$ 272.50	$ 275.19	$ 280.75
K	WP 19-24 M (Non-Medically Exempt)	257,827	$ 160.10	$ 3.20	$ 156.90	$ -	$ 2.38	$ 159.27	$ 160.84	$ 164.07
K	WP 25-34 F (Non-Medically Exempt)	334,869	$ 343.05	$ 6.86	$ 336.19	$ -	$ 2.40	$ 338.59	$ 341.92	$ 348.85
K	WP 25-34 M (Non-Medically Exempt)	309,115	$ 327.59	$ 6.55	$ 321.04	$ -	$ 3.89	$ 324.93	$ 328.13	$ 334.74
K	WP 35-49 F (Non-Medically Exempt)	338,344	$ 547.07	$ 10.94	$ 536.13	$ -	$ 3.84	$ 539.97	$ 545.29	$ 556.34
K	WP 35-49 M (Non-Medically Exempt)	325,219	$ 467.52	$ 9.35	$ 458.17	$ -	$ 5.44	$ 463.62	$ 468.18	$ 477.62
K	WP 50+ M&F (Non-Medically Exempt)	520,871	$ 821.29	$ 16.43	$ 804.87	$ -	$ 6.35	$ 811.22	$ 819.21	$ 835.80
M	ABD Non-Dual <21 M&F	126,038	$ 859.65	$ 17.19	$ 842.46	$ 4.45	$ 4.75	$ 851.66	$ 860.05	$ 877.41
M	ABD Non-Dual 21+ M&F	243,679	$ 1,677.14	$ 33.54	$ 1,643.60	$ 4.45	$ 27.23	$ 1,675.28	$ 1,691.77	$ 1,725.64
N	Residential Care Facility	4,291	$ 4,786.99	$ 95.74	$ 4,691.25	$ 4.45	$ 15.74	$ 4,711.44	$ 4,757.83	$ 4,854.51
O	Breast and Cervical Cancer	1,633	$ 3,214.81	$ 64.30	$ 3,150.51	$ -	$ 2.95	$ 3,153.46	$ 3,184.51	$ 3,249.44
P	Dual Eligible 0-64 M&F	365,294	$ 503.44	$ 10.07	$ 493.37	$ -	$ 1.86	$ 495.23	$ 500.10	$ 510.27
P	Dual Eligible 65+ M&F	150,272	$ 253.28	$ 5.07	$ 248.21	$ -	$ 1.42	$ 249.63	$ 252.09	$ 257.20
Q	Custodial Care Nursing Facility <65	21,268	$ 6,973.76	$ 139.48	$ 6,834.29	$ 4.45	$ 20.72	$ 6,859.45	$ 6,926.99	$ 7,067.84
Q	Custodial Care Nursing Facility 65+	109,797	$ 5,705.56	$ 114.11	$ 5,591.44	$ -	$ 2.66	$ 5,594.11	$ 5,649.19	$ 5,764.42
R	Elderly HCBS Waiver	90,926	$ 5,705.56	$ 114.11	$ 5,591.44	$ -	$ 3.43	$ 5,594.87	$ 5,649.96	$ 5,765.19
S	Non-Dual Skilled Nursing Facility	1,811	$ 6,973.76	$ 139.48	$ 6,834.29	$ 4.45	$ 21.94	$ 6,860.67	$ 6,928.22	$ 7,069.07
T	Dual HCBS Waivers: PD; H&D	16,517	$ 6,973.76	$ 139.48	$ 6,834.29	$ -	$ 1.77	$ 6,836.06	$ 6,903.36	$ 7,044.21
U	Non-Dual HCBS Waivers: PD; H&D; AIDS	18,927	$ 6,973.76	$ 139.48	$ 6,834.29	$ 4.45	$ 17.20	$ 6,855.94	$ 6,923.44	$ 7,064.29
V	Brain Injury HCBS Waiver	15,724	$ 6,973.76	$ 139.48	$ 6,834.29	$ 4.45	$ 10.04	$ 6,848.78	$ 6,916.21	$ 7,057.06
W	ICF/ID	14,742	$ 9,722.80	$ 194.46	$ 9,528.35	$ 4.45	$ 6.75	$ 9,539.55	$ 9,633.47	$ 9,829.85
X	State Resource Center	3,342	$ 9,722.80	$ 194.46	$ 9,528.35	$ 4.45	$ 2.57	$ 9,535.37	$ 9,629.25	$ 9,825.62
Y	Intellectual Disability HCBS Waiver	137,201	$ 9,722.80	$ 194.46	$ 9,528.35	$ 4.45	$ 4.14	$ 9,536.94	$ 9,630.84	$ 9,827.21
Z	PMIC	3,429	$ 3,279.99	$ 65.60	$ 3,214.39	$ 4.45	$ 20.71	$ 3,239.55	$ 3,271.45	$ 3,337.69
0	Children's Mental Health HCBS Waiver	12,852	$ 3,279.99	$ 65.60	$ 3,214.39	$ 4.45	$ 5.81	$ 3,224.65	$ 3,256.40	$ 3,322.64
D	CHIP - Children 0-59 days M&F	875	$ 2,546.85	$ 50.94	$ 2,495.91	$ -	$ 3.01	$ 2,498.92	$ 2,523.53	$ 2,574.97
D	CHIP - Children 60-364 days M&F	2,931	$ 334.67	$ 6.69	$ 327.97	$ -	$ 1.61	$ 329.58	$ 332.83	$ 339.59
D	CHIP - Children 1-4 M&F	832	$ 168.72	$ 3.37	$ 165.35	$ -	$ 0.96	$ 166.31	$ 167.94	$ 171.35
D	CHIP - Children 5-14 M&F	138,786	$ 162.38	$ 3.25	$ 159.13	$ -	$ 0.62	$ 159.75	$ 161.32	$ 164.60
D	CHIP - Children 15-20 F	27,236	$ 268.22	$ 5.36	$ 262.86	$ -	$ 2.68	$ 265.53	$ 268.15	$ 273.57
D	CHIP - Children 15-20 M	27,214	$ 200.57	$ 4.01	$ 196.56	$ -	$ 1.78	$ 198.34	$ 200.29	$ 204.34
	TANF Maternity Case Rate	7,655	$ 6,888.71	$ 137.77	$ 6,750.94	$ -	$ -	$ 6,750.94	$ 6,817.41	$ 6,956.54
	Pregnant Women Maternity Case Rate	4,851	$ 6,174.82	$ 123.50	$ 6,051.33	$ -	$ -	$ 6,051.33	$ 6,110.91	$ 6,235.62
Total	**Total**	**9,377,125**	**$ 747.61**	**$ 14.95**	**$ 732.66**	**$ 2.42**	**$ 3.81**	**$ 738.89**	**$ 746.16**	**$ 761.26**

Memorandum of Understanding

This Memorandum of Understanding ("MOU") is entered into by Iowa Medicaid, a division of the Iowa Department for Health and Human Services, an instrumentality of the State of Iowa ("Iowa Medicaid"), and the Iowa Hospital Association ("IHA"), (collectively, "Parties") on the effective date listed below.

Recitals

WHEREAS, Iowa Medicaid intends to implement a Medicaid state directed payment program ("Program") for hospital inpatient and hospital outpatient services in accordance with the 42 C.F.R. § 438 and guidance promulgated by the U.S. Centers for Medicare & Medicaid Services ("CMS");

WHEREAS, the purpose of Program is to increase Medicaid reimbursement for hospital inpatient and hospital outpatient services provided by qualifying Iowa hospitals to Medicaid recipients in such a manner that does not require a dedicated state appropriation and increases such reimbursement amounts to the maximum allowable under federal law;

WHEREAS, Iowa Medicaid seeks to implement the Program to progress toward a number of goals of the Medicaid program including, preserving and expanding access to health care, strengthening population health initiatives in rural communities, offsetting economic head-winds caused by workforce market changes and inflation because there is a direct correlation between increasing reimbursement rates and myriad economic and social benefits that derive from a healthy Iowa citizenry;

WHEREAS, due to the number of hospital stakeholders in Iowa, Iowa Medicaid recognizes the challenge of implementing the Program, and engages the assistance of IHA to serve as a coordinating intermediary between Iowa Medicaid and qualifying hospitals participating in Program to facilitate communications and operations for implementing Program in an efficient and compliant manner;

WHEREAS, IHA agrees to serve as intermediary between Iowa Medicaid and qualifying hospitals participating in Program in a manner consistent with this MOU and in full compliance with federal and state law;

THEREFORE, the Parties agree to the following terms and conditions:

Section 1. Definitions.

(A) "Inpatient Managed Care Gap" means an annual amount calculated as the maximum actuarially sound amount, determined at no less than ninety percent (90%) of average commercial rates, eligible for inclusion in managed care rates for hospital inpatient services provided by Qualifying Hospitals less the amount of total payments by all Managed

Care Organizations to Qualifying Hospitals for hospital inpatient services.

(B) "Outpatient Managed Care Gap" means an annual amount calculated as the maximum actuarially sound amount, determined at no less than ninety percent (90%) of average commercial rates, eligible for inclusion in managed care rates for hospital outpatient services provided by Qualifying Hospitals less the amount of total payments by all Managed Care Organizations to Qualifying Hospitals for hospital outpatient services.

(C) "Managed care organization" means an entity contracted with Iowa Medicaid to provide Medicaid benefits pursuant to 42 C.F.R. § 438.

(D) "Program Year" means the state fiscal year in which the Program is authorized by CMS.

(E) "Qualifying Hospital" means a Medicaid-participating, in-state hospital licensed by the State of Iowa, including acute care hospitals, long-term acute hospitals, and free-standing psychiatric hospitals, but excluding hospitals wholly owned by the state.

Section 2. Directed Payments

(A) To the extent allowable under federal law and in accordance with the implementation provisions outlined in this Section (2), Iowa Medicaid shall develop the following programs to increase Medicaid reimbursement for hospital services provided by Qualifying Hospitals to Medicaid recipients:

i. A program to increase hospital inpatient reimbursement to Qualifying Hospitals within the Medicaid managed care program in an aggregate amount equivalent to the Managed Care Gap for hospital inpatient services; and

ii. A program to increase hospital outpatient reimbursement to Qualifying Hospitals within the Medicaid managed care program in an aggregate amount equivalent to the Managed Care Gap for outpatient services

(B) Iowa Medicaid shall calculate the following values for the purpose of making the directed payments consistent with this MOU:

(i) Inpatient Directed Payments

(1) With time frames subject to CMS approval of the Program, on an annual basis the following values shall be calculated sixty (60) days prior to the start of a Program Year:

(a) A maximum annual Inpatient Managed Care Gap.

(b) An "Inpatient Quarterly Gap Amount" calculated by dividing the annual Inpatient Managed Care Gap by four (4).

(c) At least ninety (90) days prior to the start of a Program Year, Iowa Medicaid shall provide IHA the base data utilized for the calculations in this subparagraph (1).

(d) Data shared with IHA shall not contain any personal health information or other patient identifying information.

(2) On a quarterly basis the following values shall be calculated on or around thirty (30) days prior to the start of a quarter:

(a) A uniform inpatient adjustment percentage for each Qualifying Hospital calculated as the Inpatient Quarterly Gap Amount divided by the total managed care inpatient paid claims for all Qualifying Hospitals.

(b) A directed payment to be made to each Qualifying Hospital by each Managed Care Organization calculated by multiplying the uniform inpatient adjustment percentage with the Qualifying Hospital's total managed care inpatient paid claims for the applicable quarter.

(c) The managed care inpatient paid claims data used in the calculations in this subparagraph shall be the data from two (2) quarters prior to the quarter for which the directed payment is made.

(d) At least thirty (30) days prior to the beginning of a quarter in which directed payments will be made, Iowa Medicaid shall provide IHA the base data utilized for all calculations that are made in this subparagraph.

(e) Data shared with IHA shall not contain any personal health information or other patient identifying information

(ii) Outpatient Directed Payments

(1) With time frames subject to CMS approval of the Program, on an annual basis the following values shall be calculated sixty (60) days and prior to the start of a Program Year:

(a) A maximum annual Outpatient Managed Care Gap.

(b) An "Outpatient Quarterly Gap Amount" calculated by dividing the annual Outpatient Managed Care Gap by four (4).

(c) At least ninety (90) days prior to the start of a Program Year, Iowa Medicaid shall provide IHA the base data utilized for the calculations in this subparagraph.

(d) Data shared with IHA shall not contain any personal health information or other patient identifying information.

(2) On a quarterly basis the following values shall be calculated on or around thirty (30) days prior to the start of a quarter:

(a) A uniform outpatient adjustment percentage for each Qualifying Hospital calculated as the Outpatient Quarterly Gap Amount divided by the total managed care outpatient paid claims for all Qualifying Hospitals.

(b) A directed payment to be made to each Qualifying Hospital by each Managed Care Organization calculated by multiplying the uniform outpatient adjustment percentage with the Qualifying Hospital's total managed care outpatient paid claims for the applicable quarter.

(c) The managed care outpatient paid claims data used in the calculations in this subparagraph shall be the data from two (2) quarters prior to the quarter for which the directed payment is made.

(d) At least thirty (30) days prior to the beginning of a quarter in which directed payments will be made, Iowa Medicaid shall provider IHA the base data utilized for all calculations that are made in this subparagraph.

(e) Data shared with IHA shall not contain any personal health information or other patient identifying information.

(iii) The Parties shall independently calculate the values expressed in this Section to validate the accuracy of the directed payments to be made to Qualifying Hospitals. Prior to the start of a Program Year or a quarter, as appropriate, the Parties shall communicate with each other promptly regarding the base data upon which values are calculated. The Parties agree to discuss promptly any discrepancies that may be discovered regarding base data or calculated values to assure that directed payments are accurate and made on a timely basis consistent with this MOU. Iowa Medicaid shall have the final determination of the amount of payments to be allocated to each Qualifying Hospital.

(iv) At least ten (10) days prior to the start of the quarter, Iowa Medicaid shall provide each Managed Care Organization with a listing of the payments calculated under this subsection (B) that is to be transferred to each Managed Care Organization for payment to each Qualifying Hospital for both inpatient and outpatient services.

(v) Iowa Medicaid shall have the flexibility and discretion to allocate the total directed payments to Qualifying Hospitals among the Managed Care Organizations so as to assure that each Qualifying Hospital receives the total amount of its directed payment as calculated in accordance with this subsection (B). In the event a new Managed Care Organization enters a contract with Iowa Medicaid, the Parties shall convene to determine the best manner for estimating paid claims data to be used in calculating the inpatient and outpatient directed payments to assure that Qualifying Hospitals receive to the total amount of funds eligible for directed payments.

(C) On the first day of the quarter, Iowa Medicaid shall provide each Managed Care Organization with a supplemental capitation payment to

cover all quarterly directed payments to be made by the Managed Care Organizations to Qualifying Hospitals.

(D) Iowa Medicaid shall require each Managed Care Organization to pay the directed payments to each Qualifying Hospital within ten (10) business days of the Managed Care Organization receiving the supplemental capitation payment from Iowa Medicaid. Iowa Medicaid will amend its state contracts with Managed Care Organizations to provide that a Managed Care Organization that fails to make a directed payment in accordance with the terms of this MOU shall be subject to such remedies as exist within the Managed Care Organization's contract with the State. Consistent with the intent and purpose of this MOU Iowa Medicaid shall direct each Managed Care Organization to cooperate fully with IHA to fulfill the MOU in all material respects, including the timely execution of documents and the provision of reports intended to implement the Program.

(E) The process outlined in subsections (A) through (D) shall result in each Qualifying Hospital receiving four (4) quarterly directed payments within a Program Year in amounts determined by the calculations in subsection (B).

(F) *Reconciliation Adjustments*. Approximately nine (9) months after the conclusion of a Program Year Iowa Medicaid shall review and reconcile the directed payments made to each Qualifying Hospital in the Program Year. Because the directed payments are made based upon historical paid claims data, Iowa Medicaid will recalculate the values in subsection (B) using the actual paid claims data of the applicable quarter in which a directed payment was made. If the reconciliation re-calculations result in either a net overpayment or net underpayment in total for the Program Year, then Iowa Medicaid shall make any necessary adjustment to the Qualifying Hospital's next quarterly directed payment. In the event that the directed payment program is materially changed or terminated such that a payment adjustment cannot be made through directed payments, then an adjustment shall not be made.

(G) *Request for Department Reconsideration*. A Qualifying Hospital shall have the ability to request reconsideration of any material error alleged regarding a directed payment or reconciliation adjustment by notifying Iowa Medicaid of the allegation of material error and providing documentation supporting the allegation within thirty (30) days of the Qualifying Hospital receiving notice receipt of a quarterly supplemental payment from a Managed Care Organization. A "material error" is one

in which the alleged error may affect at least five percent (5%) of the value of the Qualifying Hospital's quarterly directed payment attributable to either inpatient services or outpatient services. If Iowa Medicaid agrees that a material error occurred in a Qualifying Hospital's quarterly directed payment, Iowa Medicaid shall reconcile the payment error through an adjustment to the Qualifying Hospital's next quarterly directed payment. Iowa Medicaid's decision on the request for reconsideration shall be considered final agency action.

Section 3. Assessment

(A) Prior to the start of a Program Year, Iowa Medicaid shall estimate the total non-federal share funds necessary to obtain the federal matching funds to make both the inpatient directed payments and outpatient directed payments calculated in Section 2.

(B) The non-federal share funds for inpatient directed payments ("Non-federal Share Inpatient Funds") and the non-federal share funds for outpatient directed payments ("Non-federal Share Outpatient Funds") shall be the target for calculating a quarterly inpatient assessment and a quarterly outpatient assessment that Qualifying Hospitals will pay consistent with the terms outlined in this Section 3. The total assessment collected shall not exceed the total non-federal share funds necessary to make the directed payments. In any given quarter, Iowa Medicaid shall collect assessments from a Qualifying Hospital only after the Qualifying Hospital has first received the inpatient directed payment and the outpatient directed payment for the quarter.

(C) On a quarterly basis Qualifying Hospitals will pay a hospital-specific quarterly inpatient assessment amount which, when paid by all Qualifying Hospitals in the aggregate, will equal the total quarterly inpatient assessment referenced in Subsection (B). Qualifying Hospitals licensed by Iowa as long-term acute care hospitals and free-standing psychiatric hospitals shall be excluded from the quarterly inpatient assessment and assessment calculations shall not include values from those excluded hospitals. The hospital-specific quarterly inpatient assessment amount shall be calculated consistent with the following terms.

(i) Qualifying Hospitals shall be subject to a quarterly inpatient assessment percentage rate, ("Inpatient Rate"), except that Qualifying Hospitals that identify as rural either because it is designated by CMS as a critical access hospital or it is located outside a metropolitan statistical area as of January 1, 2023, shall

be subject to a quarterly inpatient assessment percentage rate equal to eighty percent (80%) of the Inpatient Rate, ("Rural Inpatient Rate"). The Inpatient Rate and Rural Inpatient Rate shall be determined so that, in the aggregate, the total quarterly inpatient assessment collected equals the non-federal share funds necessary to make the inpatient directed payments.

(ii) The Inpatient Rate and Rural Inpatient Rate shall be determined by calculating:

(1) The total net inpatient revenues less Medicare inpatient revenues of Qualifying Hospitals subject to the Inpatient Rate taken from Medicare cost reports for fiscal year 2021 on file by October 1, 2022 and as confirmed by IHA.

(2) The total net inpatient revenues less Medicare inpatient revenues of Qualifying Hospitals subject to the Rural Inpatient Rate, which shall be multiplied by eighty percent (80%) and taken from Medicare cost reports for fiscal year 2021 on file by October 1, 2022 and as confirmed by IHA.

(3) Adding the values in subparagraphs (1) and (2) of this subsection (C), into a sum ("Adjusted Inpatient Assessment Base").

(4) The Non-federal Share Inpatient Funds shall be divided by the Adjusted Inpatient Assessment Base to determine the Inpatient Rate.

(5) The Inpatient Rate shall be multiplied by eighty percent (80%) to determine the Rural Inpatient Rate.

(6) A Qualifying Hospital's hospital-specific net inpatient revenue less Medicare inpatient revenue, as taken from Medicare cost reports for fiscal year 2021 on file by October 1, 2022 and as confirmed by IHA, shall be multiplied by either the Inpatient Rate or Rural Inpatient Rate, as appropriate, to determine the Qualifying Hospital's hospital-specific quarterly inpatient assessment amount.

(D) On a quarterly basis Qualifying Hospitals will pay a hospital-specific quarterly outpatient assessment amount which, when paid by all Qualifying Hospitals in the aggregate, will equal the total quarterly outpatient assessment referenced in Subsection (B). Qualifying Hospitals licensed by Iowa as long-term acute care hospitals and free-

standing psychiatric hospitals shall be excluded from the quarterly outpatient assessment and assessment calculations shall not include values from those excluded hospitals. The hospital-specific quarterly outpatient assessment amount shall be calculated consistent with the following terms.

(i) Qualifying Hospitals shall be subject to a quarterly outpatient assessment percentage rate, ("Outpatient Rate"), except that Qualifying Hospitals that identify as rural either because it is designated by CMS as a critical access hospital or it is located outside a metropolitan statistical area as of January 1, 2023, shall be subject to a quarterly outpatient assessment percentage rate equal to eighty percent (80%) of the Outpatient Rate, ("Rural Outpatient Rate"). The Outpatient Rate and Rural Outpatient Rate shall be determined so that, in the aggregate, the total quarterly outpatient assessment collected equals the non-federal share funds necessary to make the outpatient directed payments.

(ii) The Outpatient Rate and Rural Outpatient Rate shall be determined by calculating:

(1) The total net outpatient revenues less Medicare outpatient revenues of Qualifying Hospitals subject to the Outpatient Rate taken from Medicare cost reports for fiscal year 2021 on file by October 1, 2022 and as confirmed by IHA.

(2) The total net outpatient revenues less Medicare inpatient revenues of Qualifying Hospitals subject to the Rural Outpatient Rate, which shall be multiplied by eighty percent (80%) and taken from Medicare cost reports for fiscal year 2021 on file by October 1, 2022 and as confirmed by IHA.

(3) Adding the values in subparagraphs (1) and (2) of this subsection (D), into a sum ("Adjusted Outpatient Assessment Base").

(4) Dividing the Non-federal Share Outpatient Funds by the Adjusted Outpatient Assessment Base to determine the Outpatient Rate.

(5) The Rural Outpatient Rate shall be determined by multiplying the Outpatient Rate by eighty percent (80%).

(6) A Qualifying Hospital's hospital-specific net outpatient revenue less Medicare outpatient revenue, as taken from Medicare cost reports for fiscal year 2021 on file by October 1, 2022 and as confirmed by IHA, shall be multiplied by either the Outpatient Rate or Rural Outpatient Rate, as appropriate, to determine the Qualifying Hospital's hospital-specific quarterly outpatient assessment amount.

(E) Iowa Medicaid shall submit a Notice of Assessment to each Qualifying Hospital, with a copy to IHA, no earlier than ten (10) days after the start of the quarter. The Notice of Assessment shall provide a Qualifying Hospital's hospital-specific inpatient assessment and outpatient assessment for the quarter. The Notice shall contain all variables and values used in calculating the assessment so that each Qualifying Hospital is capable of validating the inpatient assessment and the outpatient assessment.

(F) The Notice of Assessment shall list a Qualifying Hospital's inpatient assessment separate from the outpatient assessment, and each shall be considered a distinct assessment. However, a Qualifying Hospital may submit one (1) payment in satisfaction of both the inpatient assessment and outpatient assessment listed in the Notice.

(G) Iowa Medicaid may charge an administrative fee to each Qualifying Hospital of no more than two percent (2%) of the Qualifying Hospital's total quarterly inpatient and outpatient assessments. An administrative fee shall be a line item on the Notice of Assessment.

(H) A Qualifying Hospital shall have no obligation to pay its quarterly assessment until the Qualifying Hospital has received its directed payments; however, once a Qualifying Hospital has received its directed payments, a Qualifying Hospital shall pay its quarterly assessment within thirty (30) days of receipt of its directed payments.

(I) Consistent with state law, a Qualifying Hospital shall not knowingly pass on the cost of any assessment to non-Medicaid payors, including as a fee or rate increase. A Qualifying Hospital that violates state law in this regard shall not receive directed payments for the remainder of the rate year as approved by CMS from the date the violation is discovered. Instead, the Qualifying Hospital shall be reimbursed only in accordance with its Medicaid managed care provider agreements for health care services as provided under the Iowa medical assistance program. IHA shall include such prohibition in any agreements it enters into with

Qualifying Hospitals in its role as the intermediary for the Qualifying Hospitals in the Program.

(J) The assessments authorized under this MOU shall be used by Iowa Medicaid only for collecting the non-federal share of funds necessary for implementing the directed payments referenced in this MOU.

(K) A Qualifying Hospital shall have the right to request reconsideration regarding the calculation of any assessment by notifying Iowa Medicaid of the allegation of error and providing documentation supporting the allegation within thirty (30) days of the date of a Notice of Assessment. If the department agrees that an error occurred in a Qualifying Hospital's quarterly Notice of Assessment, Iowa Medicaid shall submit a corrected Notice of Assessment to the Qualifying Hospital for consideration of payment consistent with the terms of this MOU.

(L) The assessments authorized under this MOU shall not be implemented if federal financial participation is not available or, if required, a provider tax waiver is not approved by CMS. Conversely, a Qualifying Hospital shall have no obligation to pay an assessment to Iowa Medicaid if any federal agency determines that federal financial participation is not available for any assessment.

(M) Any assessments received by Iowa Medicaid that cannot be matched with federal funds shall be returned *pro rata* to each Qualified Hospital according to the assessment it paid.

(N) In the event that a Qualifying Hospital obtains approval from CMS to convert its provider designation to a rural emergency hospital ("REH"), Iowa Medicaid shall adjust that Qualifying Hospital's assessment so that the Qualifying Hospital shall not be required to pay an assessment for inpatient services that the Qualifying Hospital will no longer be providing. Any adjustment shall be prospective only, not retrospective, and shall apply on the date CMS approved the Qualifying Hospital's conversion to a REH.

Section 4. Quality Metrics

IHA will engage Qualifying Hospitals to aggregate and report data relative to the goals and objectives of the quality strategy ("Quality Strategy") identified in the preprint approved by CMS. IHA and Iowa Medicaid shall establish a schedule to periodically report aggregated, statewide data relative to the Quality Strategy for the Program Year. The Parties may meet and confer regarding the method and content of the report submitted by IHA. Reports shall include only statewide, aggregate data, and shall not include data

regarding any individual Qualifying Hospital. Consistent with the preprint approved by CMS, such data as IHA may report to Iowa Medicaid shall be for benchmark purposes only and shall not be a basis for withholding any directed payments in the event any quality and performance improvement targets are not achieved. Consistent with the Parties' prior discussions, IHA and Iowa Medicaid will collaborate on the development of policy protocols for non-birthing Qualifying Hospitals to address precipitous deliveries and an attestation process for Qualifying Hospitals to attest that they are following the protocols that are developed.

Section 5. IHA as an Intermediary for Qualifying Hospitals

(A) The Parties recognize that the data collection and payment responsibilities, and associated communications, between Iowa Medicaid, Managed Care Organizations, and Qualifying Hospitals requires extensive coordination to ensure integrity in the Program. To promote integrity, consistency, efficiency and accountability in the Program, Iowa Medicaid invites IHA to facilitate data collection, payment and communication activities by and between Iowa Medicaid, Managed Care Organizations, and Qualifying Hospitals. Accordingly, Qualifying Hospitals have engaged IHA to serve as a third-party administrator to perform various tasks to advance integrity, consistency, efficiency and accountability within the Program to ensure:

(i) accurate and timely data collection of inpatient and outpatient paid claims data by Qualifying Hospitals to Iowa Medicaid for determining quarterly values and calculating the directed payments in accordance with the methodology within this MOU;

(ii) accurate and timely data collection by Qualifying Hospitals to Iowa Medicaid to comply with quality metrics integrated with the Program;

(iii) accurate and timely payments of assessments by Qualifying Hospitals to Iowa Medicaid; and

(iv) accurate and timely processing of directed payments by Iowa Medicaid and Managed Care Organizations to Qualifying Hospitals.

(B) IHA's role and responsibilities shall be that of an intermediary by and for the benefit of Qualifying Hospitals participating in the Program. IHA agrees that its actions and responsibilities as an intermediary shall promote and facilitate compliance with federal and state laws governing federal financial participation in Medicaid, including 42 U.S.C. §

1396b(w) and 42 C.F.R. § 438.6. IHA agrees to cooperate with requests by Iowa Medicaid to validate compliance with federal and state laws.

(C) In the event a Qualifying Hospital does not provide IHA authority to act as its intermediary in the implementation of the Program, IHA shall promptly identify the Qualifying Hospital and its designated representative to Iowa Medicaid and Managed Care Organizations so data collection, payments, and communications can be made directly with the Qualifying Hospital.

Section 6. Term of MOU

(A) The term of this MOU shall be for the time period in which CMS initially approves the Program ("Initial Term").

(B) The MOU shall automatically renew for any subsequent periods in which CMS may approve the Program ("Renewal Terms"), provided that the Parties shall revisit the terms and conditions of this MOU to consider whether amendment to the MOU is necessary as a result of any material change to the Program each time it is proposed to, or approved by, CMS.

Section 7. Miscellaneous

(A) No Cross-Subsidization. Iowa Medicaid shall prohibit Medicaid managed care organizations from setting, establishing or negotiating reimbursement rates with any Qualifying Hospital in any manner that takes into account, directly or indirectly, the directed payments that a Qualifying Hospital receives from the Program.

(B) Governing Law. This MOU shall be construed and enforced in accordance with, and governed by, the laws of the State of Iowa, without regard to its provisions concerning conflicts of laws.

(C) No Rights to Third-Parties. This MOU shall be enforceable only by the Parties. In all other respects this MOU is not intended and cannot be construed to create any rights to third-parties.

(D) Construction. Any ambiguities within this MOU shall be construed in a manner that achieves the objectives of the Program as approved by CMS and in accord with the If any language is stricken or deleted from this MOU, such language shall be deemed never to have appeared herein and no other connotation shall be drawn there from. The paragraph headings used herein are for convenience only and shall not be used in the construction or interpretation of this MOU.

(E) Notice. The Parties agree that timely and proactive communication is essential to the integrity and efficiency of the Program. Each Party shall provide prompt notice to the other Party regarding issues material to the Program. Notice shall be delivered through each Party's designated contact person(s) as set forth below.

To Iowa Medicaid	**To IHA**
Attn: Director	Attn: Legal Department
Hoover Building	100 East Grand Avenue
1305 E. Walnut St.	Des Moines, Iowa 50309
Des Moines, IA 50319	legal@ihaonline.org
ematney@dhs.state.ia.us or email of Iowa Medicaid Director at the time of notice.	

(F) Entire Agreement. This MOU, including any attachments, constitutes the sole and entire arrangement between Iowa Medicaid and IHA and may be modified only by a written amendment executed by both Parties. Any prior agreement, promises, negotiations or representations, either oral or written, relating to the subject matter of this MOU not expressly set forth in this MOU are of no force or effect.

(G) No Waiver. No waiver of any of the terms of this MOU shall be valid unless it is in writing and signed by all Parties to this MOU.

(H) Amendments. This MOU cannot be changed, modified or discharged orally, but only by the mutual written agreement of the Parties.

(I) Wind-down of the Program. In the event the Program is not renewed and this MOU expires or lapses, both Parties acknowledge that various performance obligations may exist following expiration or lapse of this MOU and the Parties agree to work in good faith to identify an orderly means of winding-down the Program in a manner that minimizes the burden and fiscal hardship on the Qualifying Hospitals.

(J) Severability. If a court of competent jurisdiction determines that any section or language within this MOU is invalid, illegal, or unenforceable for any reason, then the offending section or language shall be severed from the MOU and the remainder of the MOU shall remain in full force

and effect as if the offending section or phrase was never part of the MOU.

(K) Signing Authority. Each person signing this MOU hereby represents that he or she is authorized to enter into this MOU on behalf of the Party for which he or she is signing.

Effective Date. This MOU is effective as of 13th day of November 2023.

On behalf of Iowa Department of Health and Human Services	On behalf of IHA
DocuSigned by: Elizabeth Matney	DocuSigned by:
Signature	Signature
Elizabeth Matney	Chris Mitchell
Printed Name	Printed Name
Director of Medicaid	President and CEO
Title	Title
11/16/2023	11/14/2023
Date	Date

Medicaid - MED-24-005 Molina AMD 4 DSO 1

Final Audit Report 2024-03-18

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