Fifth Amendment to the Iowa Health Link Contract

This Amendment to Contract Number MED-24-005 is effective as of July 1, 2024, 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 1.3.3.1 Pricing, is hereby replaced as follows:
In accordance with the payment terms outlined in this section and the Contractor's completion of the Scope of Work as set forth in this Contract, the Agency will make capitation payments to the Contractor on a monthly basis (as outlined in Section 1.3.3.2 below) or upon occurrence of a qualifying maternity delivery. The capitation payments include both per member per month capitation rates and maternity case rate payments, as further defined in this section. The capitation payments and any Case rate shall be payment in full for goods and services provided pursuant to this Contract. Retroactive adjustments to the capitation rates/payments to reflect the actual cost of goods and services provided pursuant to the Contract are prohibited. For more information on retroactive adjustments please see Sections 1.3.3.4, 1.3.3.6, and Special Contract Exhibits, Exhibits A and G.

The parties anticipate Contractor to begin providing managed care services to its assigned Medicaid population on July 1, 2023. However, if the implementation date is delayed for any reason, Contractor shall not be entitled to payments pursuant to this Contract until Contractor begins providing managed care services for its patient population consistent with the Scope of Work as set forth in this Contract. The Agency has sole discretion to determine the implementation date.

For each capitated rate period as defined on the rate sheet, the parties will agree on a rate sheet specifying the payment for each enrollee by the categories determined by the Agency to be appropriate. These categories will be determined by the Agency. Nothing in this Contract shall limit the ability of the Agency to require the determination of a state-wide average even if the Contractor is not providing services for members in all counties in the State. The rate-setting methodology will be in compliance with federal requirements.

The Agency's actuarial contractor will analyze data to determine actuarially sound rates to be offered to Contractor. The Agency and Contractor may discuss proposed capitation rates, but the Agency's actuarial contractor will ultimately be responsible for establishing the actuarially-sound rates to be offered and attesting to the capitation rates to be presented to CMS. After the first rate period, subsequent capitated rates will be added to the Contract in sequentially numbered Special Contract Exhibits (i.e., Exhibit A-01, Exhibit A-02, etc.). Contractor and the Agency must mutually agree to the capitation rates and signify this agreement by executing the Contract amendment. Capitation rates within any rate period are subject to amendment, which shall only occur through formal Contract amendment. The parties agree to work diligently and in good faith to establish and agree to capitation rates before the expiration of any rate period. If the parties are unable to establish new annual capitation rates for a subsequent rate period due to delays or disagreements, the Agency or Contractor may terminate the Contract upon ninety (90) days written notice. Effective date of the termination shall be no sooner than ninety (90) days from expiration of the current rate period and contract amendment term or, if notice is given after the expiration of the current rate period, ninety (90) days written notice from the date of the notice.

Examples:

Example 1: Current agreed rates expire June 30, 2024. The MCO determines that it does not want to agree to continue with the managed care contract and provides notice of termination on January 1, 2024. Because the parties are currently performing under agreed rates that run through June 30, 2024, the first day of the ninety (90) day notice period is July 1, 2024 – the first day of the new rate period. The effective date of contract termination is September 30, 2024 – the last day of the month that is ninety (90) days from the first day of the notice period.

Example 2: Rates expired on June 30, 2025. The Agency and MCO are unable thereafter to come to terms on new rates after expiration of the current rates. The MCO provides notice of termination on August 1, 2025. The first day of the ninety (90) day notice period is August 1, 2025. The last day of the notice period is October 31, 2025 – the last day of the month that is ninety (90) days from the beginning of the notice period.

Upon agreement to the capitation rates, the Agency will perform a reconciliation between the capitation rates paid and the newly agreed upon rates for the rate period. Any discrepancy will be reconciled through the capitation rate payment process.

By agreeing to the rates offered to Contractor through the Contract amendment process, Contractor irrevocably and unconditionally releases, acquits, and forever discharges the State of Iowa, the Agency, and all of the Agency's officers, directors, employees, agents, and attorneys, from any and all liability whatsoever from any and all claims, demands and causes of action of every nature whatsoever that Contractor may have or may ever claim to have now existing or hereafter arising that relate to or arise out of any assertion regarding the actuarial soundness of the agreed rates.

The Agency will make capitation payments to the Contractor based on the Contractor's Medicaid-member enrollment as reflected on the monthly HIPAA 834 file (full positive file). Contractor shall reconcile Contractor's HIPAA 820 capitation file with the monthly HIPAA 834 file (full positive file) on a monthly basis. Any discrepancies found between these two (2) files shall be reported to the Agency within ninety (90) Days from the date the Contractor receives the HIPAA 820 capitation file. No adjustments to the capitation payment may be claimed by Contractor for any discrepancies reported after the ninety (90) Day period. The capitation payments will be subject to retroactive changes to the Medicaid-member eligibility criteria. This may include, but is not limited to, Medicaid-members moving from Medicaid-only eligibility to Medicare and Medicaid eligibility. The Agency will adjust payments to Contractor to reflect the Member enrollment changes.

In addition to the monthly capitation payment made to Contractor, the Agency will also make a payment to Contractor when a Medicaid member assigned to the Contractor gives birth and the member is in the population designated in the Contract's then current rate sheet as subject to a payment for giving birth. The amount of this payment, commonly referred to as a "maternity case rate payment," shall be in an amount established as part of the capitation rate-setting process and included in the rate sheet applicable to the given Contract period. To receive payment the Contractor must:

1) Supply documentation of the birth in a form and format determined by the Agency in accordance with the specifications described in the MCO Interface Guide.
2) Attest that the Contractor paid the provider for the entire delivery. If the delivery was covered entirely by a third-party insurer the Agency will not reimburse the Contractor for the 'maternity case rate payment'.
3) Ensure that the delivery and payment to the provider are recorded in accepted encounter data.

4) Ensure that 'maternity case rate payment' is submitted in accordance with Section G.2.05 of the Contract.
    a. When an enrolled member disenrolls to another contractor during an inpatient stay, the contractor of record maintains financial responsibility. For example, delivery and newborn expenses that occur prior to July 1 will be the responsibility of the contractor of record on June 30.

Upon verification by the Agency of the birth, the Agency shall cause the maternity case rate payment to be made separately and apart from the usual capitation payment for contracted services. Contractor shall diligently monitor births in its assigned Medicaid population and claim a maternity case rate payment for each birth in the assigned Medicaid population for which a maternity case rate payment is available no later than sixty (60) Days following the date on which the Contractor was made aware of the birth. The Agency shall have no obligation to pay a maternity case rate payment for a birth that occurred more than two hundred ten (210) Days prior to Contractor's claim for a maternity case rate payment.

The Agency shall periodically evaluate accepted encounter data for Health Link enrolled beneficiaries where the Agency paid the Contractor a 'maternity case rate payment'. If the evaluation identifies instances where the encounter data does not support the payment for the delivery event, the Agency may recoup the "maternity case rate payment".

The Agency will exclude from the capitation rates the select prescription drugs and treatments as set forth in Special Contract Exhibits, Exhibit A. Contractor shall continue to provide coverage for these pharmaceuticals and treatments, and the Agency will reimburse the Contractor based on Contractor's invoice to the Agency for Special Contract Exhibits, Exhibit A pharmaceuticals or treatments paid. Contractor may only invoice for the lower of (1) actual cost to the Contractor, (2) actual cost to Contractor's PBM, or (3) the actual cost paid for the drug. All such invoices must be submitted by Contractor within 12 months of the date of service, with the exception of coordination of benefits situations, in which Contractor shall invoice for these pharmaceuticals or treatments within six (6) months from the Contractor's receipt date of the claim and explanation of benefits from a primary carrier. The Agency will pay Contractor the lesser of the amount that would be paid under the fee-for-service system for the pharmaceutical or treatment, or the amount the Contractor actually paid for the pharmaceutical or treatment. Contractor must include with the invoice details as required by the Agency to document that the claim was appropriately paid, as well as verification regarding oversight to ensure appropriate utilization of these drugs. At minimum, Contractor's invoice must include claim level detail sufficient to support the invoices. The selected prescription drugs and treatments included in Special Contract Exhibits, Exhibit A are intended to be those which are new, emerging, high cost, and/or not accounted for in capitation rate development. Special Contract Exhibits, Exhibit A is subject to change upon Agency approval, and Agency may remove any previously included prescription drug or treatment from Special Contract Exhibits, Exhibit A when its financial impact has been quantified and incorporated into the capitation rates.

The Agency will exclude from the capitation rates the costs associated with COVID 19 vaccine administration services. Contractor shall continue to provide coverage for COVID 19 vaccine administration services. The Agency will reimburse the Contractor on a retrospective basis for such claims using the Medicare payment methodology and rates for the same services and consistent with CMS guidance and Agency policy as published in any and all provider informational letters (ILs).

However, payments to Contractor under this provision shall be limited to the lower of (1) what Medicare would have paid for the same services for a Medicare eligible individual and consistent with all published ILs, or (2) the Contractor's actual out-of-pocket payments for such services. All invoices for reimbursement under this paragraph must be submitted no later than twelve (12) months from the date of service. All adjustments made to invoices shall be submitted to the Agency within ninety (90) days from the date of the invoice being adjusted and must be backed by claim level detail sufficient to support the invoice.

Revision 2. Section B.1.03. Other Discrimination Prohibited, is hereby replaced as follows:
Contractor shall not discriminate against individuals to enroll on the basis of race, color, national origin, disability or sex which includes discrimination on the basis of sex characteristics, including intersex traits, pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes. See: 42 C.F.R. § 438.3(d)(4); 42 C.F.R. § 457.1201(d).

Revision 3. Section B.1.04. Non-Discriminatory Policies, is hereby replaced as follows:
Contractor shall not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, disability or sex which includes discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes. See: 42 C.F.R. § 438.3(d)(4); 42 C.F.R. § 457.1201(d).

Revision 4. Section C.2.02. Obligation to Provide Handbook, is hereby replaced as follows:
Contractor shall provide each Enrolled Member and their authorized representative an Enrollee handbook, which serves as a summary of Benefits and coverage, and Member Identification (ID) card 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 replaced as follows:
Contractor shall use the State-developed definition for the following terms: Appeal; durable medical equipment; Emergency Medical Condition; emergency medical transportation; emergency room care; Emergency Services; Grievance; habilitation services and devices; home health care; hospice services; hospitalization; hospital outpatient care; physician services; prescription drug coverage; prescription drugs; Primary Care physician; PCP; rehabilitation services and devices; skilled nursing care; and specialist. See: 42 C.F.R. § 438.10(c)(4)(i); 42 C.F.R. § 457.1207. {From CMSC C.8.10 - C.8.29}.

Revision 6. Section C.10.01. Agency Approval of Enrollee Communications, is hereby replaced as follows:
The Contractor shall obtain Agency prior approval of all Contractor developed Enrolled Member communications. All materials shall be submitted at least thirty (30) Days or within the timeframe requested by the Agency, prior to expected use and distribution. All substantive changes to previously approved communications shall also be submitted to the Agency for review and approval at least thirty (30) Days or within the timeframe requested by the Agency, prior to use. In cases of Emergency Communication to ensure the health and safety of members, and when obtaining Agency approval would introduce unnecessary delay in issuing the communication, the Contractor may issue information to Enrolled Members without prior Agency approval in alignment with Agency guidance. The Contractor shall comply with any the Agency processes implemented to facilitate submission and approval of materials. For example, the Agency may opt to mandate use of an inventory control number on all submissions or the use of specific cover sheets with document submission. Information that includes the State's name and correspondence that may be sent to participants on behalf of the Agency shall also be

submitted by the Contractor for the Agency review and approval. Any approval given for the Agency or other State agency name or logo is specific to the use requested and shall not be interpreted as blanket approval. The Contractor shall include the State Program logo(s) in their Marketing or other Enrolled Member communication materials upon the Agency request. The Agency reserves the right to mandate that specific language be included in Enrolled Member communication materials. MCO must provide/produce the number of brochures determined by the Agency to be placed in the enrollment packets. Brochures must be full color, tri-fold, eight-and-a-half by eleven inches (8.5x11), front-back.

Revision 7. Section D.3.02.b) General, is hereby amended as follows:
b) The withhold amount shall be two percent (2%) of capitation payments. The withhold amount is based on the capitation rates less premium tax. Payment from the Agency to the Contractor will be adjusted for Premium tax.

Revision 8. Section D.4.28. Risk Corridor, is hereby replaced as follows:
Agency shall include a risk corridor for the rate period beginning July 1, 2024, running through June 30,2025. The Agency reserves the right to prospectively modify the terms of the risk corridor described though a contract amendment.

Revision 9. Section D.4.32 Risk Corridor Percentage, is hereby replaced as follows:
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%	87.7%	0.0%	100.0%
87.7%	90.7%*	100.0%	0.0%
90.7%*	93.7%	100.0%	0.0%
93.7%	93.7%+	0.0%	100.0%

** The target MLR of 90.7% is based on the weighted average of total non-medical load amounts built into the SFY25 rates using the SFY23 enrollment distribution.*

The actual target used for the final reconciliation will vary slightly based on the actual population distribution for the MCO during the SFY25 contract period. To the extent the target MLR varies from 90.7% using the actual MCO enrollment mix during the contract period, the risk corridor bands will still be +/- 3.0% from the revised target MLR.

Revision 10. Section D.4.33. Timelines, first paragraph is hereby replaced as follows:
Within two hundred forty five (245) days following the end of the contract period, the Contractor shall provide Agency with a complete and accurate report of actual medical expenditures for enrollees, by category of service, based on claims incurred for the contract period including six (6) months of claims run-out, and its best estimate of any claims incurred but not reported (IBNR) for claims run-out beyond six (6) months, and any applicable IBNR completion factors.

Revision 11. Section E.1.02. Communication Review and Approval, first paragraph is hereby replaced as follows:

All Contractor-developed Provider communications shall be pre-approved by the Agency. Unless otherwise requested by the Agency, all materials shall be submitted at least thirty (30) Days prior to expected use and distribution. All substantive changes to previously approved communications shall also be submitted to the Agency for review and approval at least thirty (30) Days prior to use. In cases of Emergency Communication to ensure the health and safety of members, and when obtaining Agency approval would introduce unnecessary delay in issuing the communication, the Contractor may issue information to Providers without prior Agency approval in alignment with Agency guidance. The Contractor shall comply with any the Agency processes implemented to facilitate submission and approval of materials. For example, the Agency may opt to mandate use of an inventory control number on all submissions or the use of specific cover sheets with document submission. The Agency may waive the right to review and approve Provider communications.

Revision 12. Section E.1.06. Provider Agreements, is hereby amended as follows:
The repeat word "contract" was removed from the third sentence.

Revision 13. Section F.6.32.f), is hereby added as follows:

f) The approved in lieu of services meet the requirements outlined in SMDL 23-001, including the in lieu of services cost percentage limits (e.g., 1.5% of the total capitation or no more than 5.0% with enhanced qualifications).

Revision 14. Section F.11.04. Coverage of Outpatient Drugs, is hereby renamed as follows:
Coverage of Outpatient Prescription Drugs.

Revision 15. Section F.11.04 is hereby replaced as follows:
Contractor shall provide coverage of outpatient prescription drugs as defined in section 1927(k)(2) of the Social Security Act, in alignment with standards for such coverage imposed by section 1927 of the Social Security Act. See: 42 C.F.R. § 438.3(s)(1). {From CMSC F.11.01}.

Revision 16. Section F.11.05. Coverage of All Classes of Drugs, is hereby replaced as follows:
The Contractor shall provide coverage for all classes of drugs including over the counter, to the extent and manner they are covered by the Medicaid Fee For Service (FFS) pharmacy benefit. The Medicaid FFS pharmacy benefit includes outpatient drugs self-administered by the Enrolled Member or those administered in the home. Medicaid is required to cover all medications that are rebated by the pharmaceutical manufacturer, in accordance with Section 1927 of the Social Security Act, with the exception of drugs subject to restriction as outlined in Section 1927 (d)(2) of the Act.

Revision 17. Section F.11.07. Pharmacy Benefit Manager, is hereby replaced 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 may be imposed 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 18. Section F.11.16. Federal Drug Rebates, is hereby replaced as follows:
The Contractor shall ensure compliance with the rebate requirements under Section 1927 of the Social Security Act. Contractor shall provide information on drugs administered/dispensed to individuals enrolled in the MCO. Specifically, Section 1927(b) of the Social Security Act, as amended by Section 2501(c) of PPACA, requires the Agency to provide utilization information for Contractor covered drugs in the quarterly rebate invoices to drug manufacturers and in quarterly utilization reports to the CMS. The Contractor shall submit all outpatient prescription drug encounters and Physician/Provider administered drug encounters, with the exception of inpatient hospital drug encounters to the Agency or its Designee pursuant to the requirements of this Contract. The Agency or its Designee will submit these encounters for federal Drug Rebates from manufacturers.

Revision 19. Section F.11.20. Disputed Drug Encounter Submissions, is hereby renamed as follows:
Drug Rebate Dispute Resolution.

Revision 20. Section F.11.20. Disputed Drug Encounter Submissions, is hereby replaced as follows:
Participating drug manufacturers in the Medicaid Drug Rebate Program (MDRP) are invoiced quarterly for utilization of their drug products per CMS regulations and guidelines.
When a labeler remits payment to the state, they may dispute certain claims if they have identified an error that needs corrected. The contractor is responsible for resolving all pharmacy and medical drug disputes submitted by drug manufacturers for the contractor's claims.
The process indicated in the 'Drug Dispute Workflow' document must be followed including any subsequent revisions. Excluding months when there are no drug disputes, the Contractor will receive a monthly file of disputes that must be worked in a timely manner.
Upon initial receipt, the contractor has a maximum of sixty (60) days to accurately resolve all drug rebate disputes and submit a completed file to the secure system specified by the state. The Contractor must also submit the corrected pharmacy claims on a weekly encounter data file and the corrected medical drug claims on a monthly encounter data file.

In addition to the administrative sanctions of this contract, failure of the Contractor to submit corrected claims on the encounter data files and/or upload a completed monthly file within the required timelines provided shall result in a monthly offset to the capitation payment equal to the value of the provider reimbursement amount on the disputed claims.

Revision 21. Section F.11.23. DUR Program, is hereby renamed as follows:
Drug Utilization Review Program (DUR) Program.

Revision 22. Section F.11.23. DUR Program, is hereby replaced as follows:
Contractor shall operate a DUR program that includes prospective drug review, retrospective drug review, and an educational program as required at 42 C.F.R. part 456, subpart K. See: 42 C.F.R. § 438.3(s)(4). {From CMSC F.11.05}.

Revision 23. Section F.11.36. Preferred Drug List, is hereby replaced as follows:
Iowa law permits the Agency to restrict access to prescription drugs through the use of a PDL with PA. Iowa Admin. Code 441-78.2(4)(a). The Contractor will follow and enforce the PDL under the Medicaid FFS Pharmacy benefit with PA criteria, including all utilization edits. Pursuant to Iowa Code §

249A.20A, drugs prescribed for the treatment of human immunodeficiency virus or acquired immune deficiency syndrome, transplantation and cancer are excluded from inclusion on the PDL. The Agency developed the RDL for these drug categories. The Contractor shall utilize the RDL, which is a voluntary list of drugs recommended to the Agency by the Iowa Medicaid P&T Committee to inform prescribers of the most cost-effective drugs in those categories. Contractor shall enforce any Medicaid FFS PA criteria, including all utilization edits on the RDL drugs or categories.

Revision 24. Section F12A.05 LOCs for SNF, NF & ICF/ID Residents, b).2 is hereby amended as follows:

2. Continued stay reviews must be completed annually and 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.

Revision 25. Section F12A.05.b).2 LOCs for SNF, NF & ICF/ID Residents, c). 2 is hereby amended as follows:

2. For all members enrolled with a Managed Care Organization, the MCO shall review the Member's need for continued care in an ICF/ID at least annually.

Revision 26. Section F.12B.03. Waiting List, is hereby replaced 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 (ILOS) for members on waiting lists the Contractor may offer the following ILOS to individuals on a 1915(c) HCBS waiting list whose name has been placed on a waiting list and who are at risk of hospitalization or imminent institutionalization or in need of ILOS to return to a community living environment where no other resources are available. The determination of ILOS shall be based on the Agency approved standardized assessment tool conducted by the Contractor to assess Medical Necessity for the following services:

1. Pre-tenancy and tenancy sustaining services: these are services that include tenant rights, education, and eviction prevention.

a. Exclusions and limitations: may NOT include room and board, rental assistance, deposits.

2. Housing transition navigation services: these services encompass tenant rights, eviction prevention, and education. They are designed to support members experiencing homelessness or at risk of homelessness in securing housing.

a. Exclusions and limitations: may NOT include room and board, rental assistance, deposits.

3. Case management: these services include outreach and education including linkage and referral to community resources and non-Medicaid supports, physical health, behavioral health, and transportation coordination.

a. Exclusions and limitations: none.

4. Respite care services: these are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.
    a. Exclusions and limitations: up to 120 hours of respite care per year. Must have a primary live-in caregiver who has primary responsibility for caregiving activities.
5. Personal care services: these services are a range of human assistance provided to persons with disabilities and chronic conditions of all ages to enable them to accomplish tasks that they would normally do for themselves if they did not have a disability. Such assistance most often relates to performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs), which includes assistance with daily activities such as eating, bathing, dressing, toileting, transferring, personal hygiene, light housework, medication management, etc.
    a. Exclusions and limitations:
        i. Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/ID or IMD, part of the individualized plan of treatment. Only available when no Home Health Agency (HHA) agency or In Home Health Related Care (IHHRC) is available and cannot be combined with HHA services or IHHRC. Documentation of denial of HHA services or IHHRC is required. Must have a need for physical assistance with eating, bathing, personal hygiene, and medication administration.
        ii. These services include up to 52 hours per year for eating, bathing dressing and personal hygiene. Assistance may take the form of hands-on assistance or as cueing so that the person performs the task by him/herself.
6. Medically Tailored Meals (MTM): these services include up to 2 meals a day delivered in the home or private residence for up to six months. Medically tailored or nutritionally appropriate food prescriptions delivered in various forms such as nutrition vouchers and food boxes, for up to 6 months. The covered population includes 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).
    a. Exclusions and limitations:
        i. Medically Tailored Meals Home delivered including prep; per meal (2 meals/day delivered to home).
        ii. Standard home delivered meals will not exceed 2 meals per day for seven days or 60 meals per month.

iii. Monthly documentation of member's receipt of meals is to be submitted by vendor and is to be on file with the Managed Care Organization. State may request this documentation from the MCO at any time during the State ILOS review process.
iv. Medically tailored or nutritionally appropriate food prescriptions delivered in various forms such as nutrition vouchers and food boxes, for up to 6 months.

7. Assistive Services/Devices: these services mean practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. Assistive devices include but are not limited to: long-reach brush, extra-long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup, sipper lid.
    a. Exclusions and limitations:
        i. Must require physician letter specifically stating member's dx and why their health would require them to be in a NF without the assistive device and how this helps the member to remain in their home. Item must be least costly to meet member's need.
        ii. Assistive Devices shall include medically necessary items for personal use by a member, supporting the member's health and safety, up to $124.81 per item, not to exceed $500 per year.
8. Home modifications: these services are physical modifications to the member's home that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home. Medically necessary home modifications and remediation services may include accessibility ramps, handrails, grab bars, repairing or improving ventilation systems, and mold/pest remediation.
    a. Exclusions and limitations:
        i. Must require physician letter specifically stating member's dx and why their health would require them to be in a NF without the modification and how this helps the member to remain in their home. Item must be least costly to meet member's need.
        ii. Must also have a PT/OT evaluation for physical modification.
        iii. Member must own their own home or have written approval from landlord if renting home.
        iv. Can also not duplicate or substitute any DME through State Plan Medicaid or any other funding source.
        v. Annual limit of $4,000 for Home Modification.
        vi. Three (3) bids, physician order, follow protocols like HVM and specialized medical equipment (SME).
9. Vehicle Modifications: these services may include ramps, lifts, wheelchair securement systems or other modifications that increase the waiver applicant's ability to be transported safely and securely and remain in their own home.
    a. Exclusions and limitations:
        i. Must require physician letter specifically stating member's dx and why their health would require them to be in a NF without the modification and how this helps the member to remain in their home.
        ii. Service must be least costly to meet member's need.
        iii. Member must own their own vehicle or have written approval from vehicle owner.

iv. Annual limit of $5,000 for vehicle modifications.
v. 3 bids, physician order, follow protocols like HVM and SME.

10. Intermittent Supported Community Living Services (SCL): these services include supported community living services are provided within the member's home and community, according to the individualized member need. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.
    a. Exclusions and limitations:
        i. Activities do not include those associated with vocational services, academics, day care, or medical services.
        ii. Monthly limit of $1,202/mo. (30 hrs./mo. @ $10.02/15 min. unit).
11. Supported Employment Services: 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 goals of the member. Includes Individual Supported Employment and Long-Term Job Coaching
    a. Exclusions and limitations:
        i. Monthly limit of $2,200/mo. (45 hrs./mo.) to obtain and maintain employment.
12. Personal emergency response system (PERS): the personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.
    a. Exclusions and limitations:
        i. Cannot duplicate or substitute any other funding mechanism such as Medicare benefits, Veteran's benefits, etc.
        ii. Must have fall risk or wandering concerns. Cannot be for caregiver convenience and cannot be for members who are not left alone.

13. Specialized medical equipment: specialized medical equipment and supplies include: devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; such other durable and non-durable medical equipment not available under the state plan that is necessary to address participant functional limitations; and, necessary medical supplies not available under the state plan.
    a. Exclusions and limitations:
        i. Specialized medical equipment shall include medically necessary items for personal use by a member, supporting the member's health and safety, up to $3,000 per year. These items may include:
            1. Electronic aids and organizers
            2. Medicine dispensing devices
            3. Communication devices
            4. Bath aids
            5. Environmental control units

6. Repair and maintenance of items purchased through the waiver specialized medical equipment can be covered when it is:
    a. Not available under the state plan.
    b. Not funded by educational or vocational rehabilitation programs.
    c. Not provided by voluntary means.
    d. Necessary for the member's health and safety, as documented by a health care professional.

14. Adult Day Care: these services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. Components of the service include health-related care, social services, and other related support services.
    a. Exclusions and limitations:
        i. Max 23 days per month if no other services are being utilized.
        ii. Only allowable when a member has a need to be supervised 24/7 and primary caregiver is required to work.
        iii. Transportation is allowed to and from the Adult Day Care center as a component of the service.
15. Non-medical Transportation: these services include assisting the member to conduct personal business essential to the health and welfare of the member. Non-Medical Transportation are services offered to member on a waitlist to enable those members on the waitlist to gain access to community services, activities, and resources.
    a. Exclusions and limitations:
        i. Whenever possible, natural supports (family, neighbors, or friends) or community agencies which can provide this service without charge are utilized.
        ii. This service does not include transportation to medical services.

Revision 27. Section F.12B.03. Waiting List, b) has been added as follows:
b) The ILOS notated in this section are limited to less than 1.5% of the total capitation (including directed payments and pass-through payments).

Revision 28. Section F.12B.15. Frequency for Service Planning, is hereby replaced 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 thirty (30) 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 29. Section F.12C.01. Community-Based Case Management Requirements, is hereby replaced as follows:
The Contractor shall provide for the delivery of Community-Based Case Management (CBCM) to all community-based LTSS Enrolled Members, including all of the activities described in this section, the approved 1915(c) waiver applications, 1915(i) SPA, the case management manual and the Iowa

Administrative Code for Enrolled Members who are receiving services under the 1915(c) and 1915(i) HCBS programs. Members enrolled in 1915(i) Habilitation and 1915(c) CMH Waiver may choose to receive Care Coordination via the IHH with the Contractor acting as the lead entity.

Unless enrolled in an IHH, the Contractor shall assign to each Enrolled Member receiving home and community-based LTSS a community-based case manager who is the Enrolled Member's main point of contact with the Contractor and their service delivery system. The Contractor shall establish mechanisms to ensure ease of Access and a reasonable level of responsiveness for each Enrolled Member to their community-based case manager during regular business hours. The Contractor shall provide for after-hours contact for Enrolled Members receiving CBCM. Community-based case manager staff shall have knowledge of community alternatives for the LTSS population, and the full range of LTSS resources as well as specialized knowledge of the conditions and functional limitations of the target populations served by the Contractor, and of the individual Enrolled Members to whom they are assigned. The Contractor shall also ensure that additional requirements are met including Section F.12B applicable to Enrolled Members receiving 1915(c) and 1915(i) HCBS programs.

The Contractor shall ensure CBCM is provided in a conflict free manner that administratively separates the final approval of 1915(c) and 1915(i) HCBS program plans of care from the approval of funding amount determined by the Contractor. CBCM efforts made by the Contractor, or its designee, shall avoid duplication of other coordination efforts provided within the Enrolled Members' systems of care.

Revision 30. Section F.12C.02. Community-Based Case Manager Qualifications, is hereby replaced as follows:

Contractor shall submit the required qualifications, experience and training of community-based case managers to the Agency for approval. Community-based case managers serving Enrolled Members that have chosen self-direction through the Consumer Choices Option shall have specific experience with self-direction and additional training regarding self-direction. The Agency reserves the right to require the Contractor to hire additional community-based case managers if it is determined, at the sole discretion of the Agency, the Contractor has insufficient CBCM staff to perform its obligations under the Contract. The Agency reserves the right to establish CBCM to Enrolled Member ratios.

The Contractor shall ensure that all case managers serving LTSS populations that are hired on or after July 1, 2024, complete the Agency-identified initial training curriculum on the Agency's Learning Management System (LMS) platform within six (6) months of hire. The Contractor shall also ensure that all case managers serving LTSS populations complete the Agency-identified refresher curriculum by December 31, 2024, as well as on an annual basis within 365 calendar days since the most recent completion date of the initial or refresher curriculum. The Contractor shall be responsible for ensuring that training is also provided on designated topics within the Agency-identified curriculum that are not provided by the Agency. The Contractor shall submit all training content to the agency for prior approval. The Contractor must maintain documentation of staff names and completion dates of all Agency-identified training for LTSS case managers that will be available to the Agency upon request.

Revision 31. Section F.12C.08. Frequency of Community-Based Case Manager and Care Coordination Contact, is hereby replaced as follows:

The Contractor shall ensure that case management contacts occur as frequently as necessary and that contacts are conducted and documented consistent with the following:

a. Community-based case managers must have at least one (1) face-to-face contact per month with Enrolled Members for the first three (3) months when Enrolled Members first become

eligible for the Habilitation or HCBS waiver program and the Contractor's CBCM case management. This requirement applies when a case management-eligible member newly enrolls with the Contractor or when an existing member first becomes eligible for the Contractor's case management services.

b. After the first three (3) months of case management services with the Contractor, the community-based case manager shall consult the Enrolled Member, their authorized representative, and their care team to identify the appropriate frequency of community-based case manager and member communication.

Following the first three (3) months of case management services, community-based case managers shall have:

a. At least one, in-home, face-to-face contact every other month with Enrolled Members who have a diagnosis of intellectual and/or developmental disability and every three (3) months for all other community-based LTSS members.
b. At least one contact per month with the member or the member's authorized representative. This contact may be face-to-face or by telephone. Written communication does not constitute a contact unless there are extenuating circumstances outlined in the Enrolled Member's person-centered service plan.

Revision 32. F.12C.10. Community-Based Case Management Monitoring, is hereby replaced as follows:

The Contractor shall develop a comprehensive program for monitoring, on an ongoing basis, the effectiveness of its CBCM processes. The Contractor shall include a description of that program, along with its policies and procedures, in its PPM. The Contractor shall: (i) immediately remediate all individual findings identified through its monitoring process; (ii) track and trend such findings and remediation to identify systemic issues of marginal performance and/or non-compliance; (iii) implement strategies to improve CBCM processes and resolve areas of non-compliance or Enrolled Member dissatisfaction; and (iv) measure the success of such strategies in addressing identified issues. At a minimum, the Contractor shall monitor the following:

a) CBCM tools and protocols are consistently and objectively applied, and Outcomes are continuously measured to determine effectiveness and appropriateness of processes;
b) Level of care and reassessments occur at least every three-hundred and sixty-five (365) days;
c) Comprehensive needs-based assessments and reassessments, as applicable, occur at least every three-hundred and sixty-five (365) days and in compliance with the Contract;
d) Care plans are developed in accordance with 42 C.F.R. § 438.208(c)(3)(i)-(v), 42 CFR 441.300-441.310, and 42 CFR 441.700 – 441.745 for HCBS Waivers and State Plan HCBS by a person trained in person-centered planning using a person-centered process and plan.
e) Care plans are to occur at least every three-hundred and sixty-five (365) days and are led by the Enrolled Member with provider consultation in compliance with the Contract.
f) Care plans reflect needs identified in the comprehensive needs assessment and reassessment process;
g) Care plans address all of the Enrolled Member's needs;
h) Services are delivered as described in the care plan and authorized by the Contractor;
i) Services and providers are appropriate to address the Enrolled Member's needs, and in accordance with 42 C.F.R. § 438.208(c)(4), Contractor allows Enrolled Members with special health care needs determined through an assessment in accordance with 42 C.F.R. § 438.208(c)(2) to need a course of treatment or regular care monitoring to directly Access a specialist as appropriate for the Enrollee's condition and identified needs;

j) Services are delivered in a timely manner;
k) Service utilization is appropriate;
l) Service gaps are identified and addressed;
m) Minimum community-based case manager contacts are conducted;
n) Case management training and reporting requirements are facilitated in accordance with the Reporting Manual and other Agency guidance.
o) Community-Based Case Manager-to-Member ratios do not exceed a statewide average of 45 members to a single CBCM. No single CBCM may exceed 50 members. If there are extenuating circumstances which lead to a CBCM exceeding 45 members, Contractor must alert the agency in writing. The Contractor must provide a plan to reduce the amount of members assigned for each CBCM exceeding 45 members. These ratios shall be met by January 1, 2025.
p) Service limits are monitored, and appropriate action is taken if an Enrolled Member is nearing or exceeds needs-based service limits outlined in the service plan. Appropriate action includes assessment of whether the service plan requires revision to allocate additional units of waiver services or if other non-waiver resources are available to meet the Enrolled Member's needs in the community.
q) A critical incident or involuntary discharge must result in an audit of case management activities and development of a remediation plan to include CBCM training where appropriate.

Revision 33. G.2.45. Dual Eligible Special Needs Plan Coordination, is hereby replaced as follows:
Contractor shall coordinate with all Dual Eligible Special Needs Plans with which the Agency has contracted by coordinating the delivery of all benefits covered by both Medicare and the Iowa Medicaid Program consistent with the coordination obligations set forth in the D-SNP agreements entered into between the Agency and the individual D-SNP Health Plans.

The Contractor shall take all required steps to obtain Centers for Medicare & Medicaid Services (CMS) approval to operate a statewide Dual Eligible Special Needs Plan (D-SNP) that will start January 1, 2027.

The Contractor is responsible for monitoring State and CMS information regarding dates of submission for D-SNP related documentation. The State and CMS continue to develop the timeline regarding D-SNP submission applications and associated documents, therefore, the deadlines for such documents are subject to change. The State and/or CMS may provide specific due dates to the Contractor.

Revision 34. Section G.3.19. PA Performance Metric, is hereby replaced as follows:
99% of standard authorization decisions shall be rendered within fourteen (14) Days of the request for service, or seventy-two (72) hours for expedited authorization decisions. For outpatient prescription drug PA, 100% of authorization decisions shall be rendered within twenty-four (24) hours of the request. Requests for extensions approved in accordance with previous sections of the Contract shall be removed from this timeliness measure.

Revision 35. Section G.6.01. Cultural Competence Obligation, is hereby replaced as follows:
Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all Enrolled Members, including those with LEP and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex which includes sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity and sex stereotypes. See: 42 C.F.R. § 438.206(c)(2); 42 C.F.R. § 457.1230(a).

Revision 36. Section I.9.04. Payment Disputes, is hereby replaced as follows:
If the Contractor disputes the Overpayment, the Program Integrity Director or other Agency representative will consider the Contractor's dispute and shall notify the Contractor of its final decision on or before the thirtieth (30th) day following the date the written dispute is received. The Agency has the sole discretion to uphold, overturn, or amend an identified Overpayment. If the Contractor disputes the Overpayment and the Agency's final decision identifies an Overpayment, the Contractor shall pay the Agency the identified Overpayment on or before the tenth (10th) business day following the final decision.

Revision 37. Section I.11.05. Notification of Provider Disenrollment, is hereby replaced as follows:
Contractor shall notify the Agency of Provider decredentialing for program integrity reasons. The Agency will report to the Office of Inspector General in compliance with 42 C.F.R. Part 1001.

Revision 38. Special Contract Exhibits, Exhibit A, Section 3. SFY 2024 Payment for Performance Chart, is hereby renamed as follows:
SFY 2025 Payment for Performance Chart

Revision 39. Special Contract Exhibits, Exhibit A, Section 3. SFY 2025 Payment for Performance Chart, third paragraph is hereby replaced as follows:
During each measurement year, the Agency will withhold a portion of the approved Capitation Payments from Contractor. The amount withheld in this current rate period is two percent (2%) of the Capitation Payments made. Contractor may be eligible to receive some or all the withheld funds based on the Contractor's performance in the areas outlined in the tables immediately below. The withhold amount is based on the capitation rates less premium tax. Payment from the Agency to the Contractor will be adjusted for Premium tax.

Revision 40. Special Contract Exhibits, Exhibit A, Table A, is hereby replaced as follows:
Table A: SFY 2025 PAY FOR PERFORMANCE MEASURES – INCUMBENT IOWA HEALTH LINK PROGRAM CONTRACTORS

The Agency will provide a document with the full description of the guidelines and data definitions for the SFY 2025 Pay for Performance Measures.

Performance Standard 1	**Amount of Performance Withhold at Risk**
Timeliness of Prior Authorization Decisions	20%
Required Contractual Standard	
The finalized CMS Interoperability and Prior Authorization Final Rule requires States to send prior authorization decisions within 72 hours for expedited (i.e., urgent) requests and seven calendar days for standard (i.e., non-urgent) requests for medical items and services. The rule is effective January 2026.	
Standard Required to Receive Incentive Payment	
The Contractor will achieve a measure of ninety-seven percent (97%) of standard Prior authorization decisions sent within seven (7) calendar days of receiving the request for service. The percentage will be calculated for the second, third and fourth quarters of SFY2025, with the available withhold for this measure will be earned for each quarter that the 97% threshold is achieved (without rounding). The available withhold to be earned for each quarter is as follows:	

Q2 SFY2025 – 4%
Q3 SFY2025 – 6%
Q4 SFY2025 – 10%

Performance Standard 2	Amount of Performance Withhold at Risk
Timely Claims Reprocessing	20%

Standard Description

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.

Both percentages will be calculated for each quarter of SFY2025, and one quarter of the available withhold for this measure (5%) will be earned for each quarter that both the 90% and 95% thresholds are achieved (without rounding).

Performance Standard 3	Amount of Performance Withhold at Risk
Encounter Data Reconciliation	20%

Standard Description

Encounter data shall be submitted by the 20th of the month subsequent to the month for which data are reflected. All corrections to the monthly encounter data submission shall be finalized within 45 days from the date the initial error report for the month was sent to the Contractor or 59 days from the date the initial encounter data were due. The error rate for encounter data cannot exceed 1%. For every service provided, providers must submit corresponding claim or encounter data with claim detail identical to that required for fee-for-service claims submissions.

Standard Required to Receive Incentive Payment

Within 90 days of the end of each quarter the Contractor's accepted encounter data shall match the contractor's submitted financial information within plus or minus 2% using reporting criteria set forth in the F1 reporting template.

Performance Standard 4	Amount of Performance Withhold at Risk
Community Based Behavioral Health (B3) Service Project Plan	20%

Standard Description

Strengthening the network of and increasing access to community-based behavioral health (B3) services and supports using a quality management framework.

Standard Required to Receive Incentive Payment

The contractor will submit a plan to strengthen 1915(b)(3) services through a Quality Framework and include the following elements:

1) The Improvement Plan must cover a two-year timeframe (July 1, 2025, through June 30, 2027)
2) Submit current organizational policies and procedures that clearly communicate contracting requirements, service descriptions, utilization management expectations, and the existing internal guidance on B3 services.
3) Define Strategic goals which must include a background and context narrative that will explain the selection of goals under each priority area. Background information should include a complete description including identified issues or barriers around areas of improvement including:
    a. Network adequacy.
        i. Address plan for statewide coverage.
            1. Identify providers currently contracted to deliver each service.
            2. Increase the number of providers contracted to deliver each service.
    b. Access to care.
        i. Address causes for low utilization of services.
            1. Identify and engage target population.
            2. Increase the utilization of each service.
4) Identify key system elements necessary to achieve the strategic goals, to include at a minimum:
    a. An education plan for each of the following: providers, members, case managers, and stakeholders.
5) Identify qualitative and quantitative data streams that will be used to identify issues and barriers.
6) Identify clear measures of success with goals being clear and measurable.
7) Define measures and metrics to be used to track progress toward the strategic goals.
    a. Network adequacy.
    b. Access to care.
8) Define who will be monitoring progress.
9) Identify how the plan will be revisited and updated based on progress.
10) Contractor must include a description of the resources (internal and external) needed to achieve that goal.

Standard Required to Receive Incentive Payment

- September 30, 2024: A draft plan must be submitted to HHS. Timely submission of a complete draft plan with all elements listed above is worth 10% of the performance withhold.
- October 30, 2024: Once the plan has been reviewed by HHS, HHS will schedule a meeting with the contractor. The contractor must come to this meeting prepared to identify all 10 required elements within their draft plan and engage HHS staff to answer questions and discuss.
- December 31, 2024: Submit a final plan that includes all of the feedback from HHS.
- January 31, 2025: Final plan will be reviewed by HHS and if determined that all the requirements are met, the remaining 10% withhold will be provided.
- June 30, 2025: All aspects of the plan will be implemented.

Performance Standard 5	**Amount of Performance Withhold at Risk**
Long Term Services and Supports (LTSS) Project Plan	20%

Standard Description
Access to Care through network adequacy and connecting to LTSS services, to ensure members are receiving needed services using a quality management framework.
Standard Required to Receive Incentive Payment
The contractor will submit a plan to address Improvement Plan through a Quality Framework and include the following elements: 1) The Improvement Plan must cover a two-year timeframe (July 1, 2025, through June 30, 2027) 2) Submit current organizational policies and procedures that demonstrate meeting Access to Care through network adequacy and connecting to services to ensure members are receiving needed services. 3) Define Strategic goals which must include a background and context narrative that will explain the selection of goals under each priority area. Background information should include a complete description including identified issues or barriers around areas of improvement including: a. Network adequacy. i. Address causes for member is not getting needed services. b. Timeliness to needed services. i. Address causes for members not getting services timely. 4) Identify key system elements necessary to achieve the strategic goals, to include at a minimum: a. An education plan for the community for each strategic goal. 5) Identify qualitative and quantitative data streams that will be uses to identify issues and barriers. 6) Identify clear measures of success with goals being clear and measurable. 7) Define measures and metrics to be used to track progress toward the strategic goals. a. Network adequacy. b. Timeliness to needed services. i. Assessments timely 100% without exception. ii. Plans timely 100% without exception. 8) Define who will be monitoring progress. 9) Identify how the plan will be revisited and updated based on progress. 10) Contractor must include a description of the resources (internal and external) needed to achieve that goal. Standard Required to Receive Incentive Payment • September 30, 2024: A draft plan must be submitted to HHS. Timely submission of a complete draft plan with all elements listed above is worth 10% of the performance withhold. • October 30, 2024: Once the plan has been reviewed by HHS, HHS will schedule a meeting with the contractor. The contractor must come to this meeting prepared to identify all 10 required elements within their draft plan and engage HHS staff to answer questions and discuss. • December 31, 2024: Submit a final plan that includes all of the feedback from HHS. • January 31, 2025: Final plan will be reviewed by HHS and if determined that all the requirements are met, the remaining 10% withhold will be provided. • June 30, 2025: All aspects of the plan will be implemented.

Revision 41. Special Contract Exhibits, Exhibit A, Section 4. Liquidated Damages the eighth requirement, is hereby replaced as follows:
The Contractor shall render a decision on ninety-nine percent (99%) of prior authorization requests within fourteen (14) Days of the request for service, within seventy-two (72) hours for expedited authorization decisions, and within twenty-four (24) hours for outpatient prescription drug prior authorizations.

Measured monthly. Requests for extensions approved in accordance with the Contract shall be removed from this timeliness measure.

Revision 42. Special Contract Exhibits, Exhibit A, Section 5. Excluded Pharmaceuticals, is hereby replaced as follows:

The Agency will exclude from the capitation rates the select prescription drugs and treatments as set forth herein. Prescription drugs or gene therapies that cost more than $1.5 million per individual dose or treatment will be excluded from capitation rates. All drugs and gene therapies must be approved by the U.S. Food and Drug Administration AND the manufacturer must have entered into, and have in effect, a National Drug Rebate Agreement with the Secretary of the Department of Health and Human Services. Contractor shall continue to provide coverage for these pharmaceuticals and treatments, and the Agency will reimburse the Contractor based on Contractor's invoice to the Agency for pharmaceuticals or treatments paid. Contractor may only invoice for the lower of (1) actual cost to the Contractor, (2) actual cost to Contractor's PBM, or (3) the actual cost paid for the drug. The list of pharmaceuticals and treatments excluded from the capitation payments will be posted on the HHS website here Medicaid Contracts and Rates | Health & Human Services (iowa.gov). This list will be reviewed and updated, if necessary, at least once every 6 months.

Revision 43. Special Contract Exhibits, Exhibit B. Glossary of Terms/Definitions, these definitions have been added as follows:

Emergency Communication: An urgent or emergent situation that requires immediate communication by the Managed Care Plan to Providers and Enrolled Members to ensure their health and safety. These situations include but may not be limited to extreme weather events, natural disasters, violence, terrorism, or other mass casualty events.

Expedited Grievances: If an Enrolled Member requests to switch plans to stay with their established provider, because their provider is leaving the Contractor's network for any reason than the MCP must "Expedite" the grievance. This is the only scenario where using the expedited grievance is required.

Habilitation Services and Devices: Per 441 IAC 78.27(249A) Habilitation services are to assist members who have functional deficits typically seen in persons with a chronic mental illness. These home and community-based services assist in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.

Managed Care Plan (MCP): a term used when the contract section applies to both the Managed Care Organization and the Pre-Paid Ambulatory Health Plan.

MCO Interface Guide: The MCO Interface Guide is a resource that outlines all file transfers between MMIS and the MCOs. The document describes File Transfer Protocols and File Naming Conventions. Corresponding File Layouts for supplemental files, disenrollment files, and Companion Guides for 834, 820, and 837 files are available for MCO reference. These documents can be found in the MCO Resource Library on IMPA.

Rehabilitation Services and Devices: All services determined to be medically necessary and reasonable for a member to improve health status. All services must meet a significant need of the member that cannot be met by a significant other, a friend, or medical staff; must meet accepted standards of medical practice by prior authorization. All services must be specific and effective treatment for a member's medical or disabling condition. A licensed skilled therapist must complete a plan of treatment every 30 days and indicate the type of service provided.

Revision 44. Special Contract Exhibits, Exhibit E. Table E.01 Full Medicaid Covered Benefits & Limitations, B3 Services limitations is hereby replaced as follows:

Contractor to develop and implement UM guidelines for Intensive Psychiatric Rehabilitation, Community Support Services, Peer Support, Integrated Services and Supports, and Respite. Contractor shall use the American Society of Addiction Medicine (ASAM) Criteria as UM guidelines for substance use disorder residential treatment.

Revision 45. Special Contract Exhibits, Exhibit H. State Directed Payments, is hereby replaced as follows:

Exhibit H: State Directed Payments

H.1 UIHC Physician ACR Payments - Description of Arrangement

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. 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.

The methodology used to calculate the initial estimate for this arrangement is described below and is consistent with the information submitted by the State in the 42 CFR 438.6 pre-print approved by CMS for SFY25.

The additional payment made to these qualifying physicians under the minimum fee schedule provide support for contracting and maintain access for Medicaid beneficiaries to the applicable physicians and the MCOs. Under this arrangement, in accordance with 42 CFR 438.6, a supplemental payment for covered physician services will be made for the services provided by a faculty or staff member of a qualifying Iowa State-Owned or Operated Professional Services Practice to reflect the reimbursement of the approved minimum fee schedule. Currently, only physicians affiliated with the University of Iowa meet this definition. Base reimbursement for these services is Iowa Medicaid reimbursement, which based on the historical mix of services for the applicable providers, is approximately 84.09% of Medicare. The supplemental (directed) payment brings the final reimbursement to an Average Commercial Rate level, which is approximately 371.77 % of Medicaid, or around 315.23% of Medicare.

Historically, this payment arrangement has been based on actual utilization within the contract period and was structured such that the MCOs paid the customary Medicaid rate when adjudicating claims. For the SFY25 contract period the Hospital ACR directed payment will be reimbursed outside of the Health Link capitation rates via a separate payment term structure. Effective March 2020, the MCOs began paying the enhanced ACR amount when adjudicating claims. Consistent with prior cycles, the basis for the supplemental payment is the difference between the customary Medicaid rate and the average commercial rate (minimum fee schedule) for specific physician service procedure codes. The MCOs are responsible for paying the calculated differential payments to qualifying practices based on actual utilization within the contract period.

H.2 UIHC Hospital ACR Payments – Description of Arrangement

The University of Iowa Hospital Average Commercial Rate (ACR) payments is a new state-directed alternative minimum fee schedule payment for inpatient and outpatient hospital services at qualifying Iowa State-Owned teaching hospitals with more than 500 beds and either or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education. The directed payment is effective July 1, 2021, and is structured in accordance with 42 CFR 438.6. Currently, only the University of Iowa Hospitals and Clinics (UIHC) meets the eligibility criteria for this directed payment arrangement.

For the SFY25 contract period the Hospital ACR directed payment will be reimbursed outside of the Health Link capitation rates via a separate payment term structure. The Actuarial contractor is required to develop estimates for the separate payment term and include a description of the arrangement when certifying the Health Link capitation rates. The methodology used to estimate the payments associated with the hospital directed payment is similar to the physician arrangement described previously. The basis for the supplemental payment is the difference between the provider's negotiated Medicaid managed care reimbursement and the average commercial rate (minimum alternative fee schedule)

calculated using an ACR payment-to-charge ratio for inpatient and outpatient (both acute and behavioral health) hospital services. The MCOs are responsible for paying the calculated differential payments to qualifying providers based on actual utilization on a per claim basis within the contract period.

Once actual utilization for SFY25 is available, the Actuarial contractor and the Agency will calculate revised PMPMs using the actual claims incurred for each rate cell under the arrangement and actual membership for the contract period. Any differences between the original Hospital ACR estimate (calculated as the rate cell specific PMPMs x SFY22 membership) and actual claims incurred under the arrangement will be paid out as a lump sum payment/recoupment from the Agency to the MCOs. After the rating period is complete and the State makes any necessary reconciliation payment/recoupment, the Actuarial vendor will submit a rate certification addendum outlining the distribution methodology and revised PMPMs that reflect the final payments made under this arrangement for SFY25.

The methodology used to calculate the initial estimate for this arrangement is described below and is consistent with the information submitted by the State in the 42 CFR 438 pre-print that was approved on August 12, 2021.

The additional payment made to these qualifying hospitals under the minimum fee schedule provide support for contracting and maintain/expand access to services essential for Medicaid beneficiaries. Under this arrangement, in accordance with 42 CFR 438.6, a supplemental payment for qualifying Inpatient and Outpatient hospital services will be made to reflect the reimbursement of the approved minimum fee schedule. Base reimbursement for these services is Iowa Medicaid reimbursement, which based on the historical mix of services for the applicable providers, is approximately 73.33 % of Medicare for Inpatient services and 82.94 % of Medicare for Outpatient services. The supplemental (directed) payment brings the final reimbursement to an Average Commercial Rate level, which is approximately 260.58 % of Medicare for Inpatient services and 277.31 % for Outpatient services.

H.3 Ground Emergency Transportation (GEMT) Payment Program - Description of Arrangement

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

The payment arrangement for the SFY25 contract period will be based on actual emergency transportation service utilization within the contract period and is structured such that the MCOs

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

H.4 Directed Payment Program for Hospital Inpatient and Hospital Outpatient Services, has been added as follows:
Effective July 1, 2023, the Agency implemented 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"). For purposes of this section, "qualifying" or "eligible" Iowa hospital means an Iowa hospital that is enrolled in the Iowa State Directed Payment Program. 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. 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 Iowa 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 Iowa 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 46. Effective July 1, 2024, the state is updating the rates for SFY25. Updated Special Contract Amendment below.

Revision 47. Federal Funds. The following federal funds information is provided

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

Section 2: Ratification & Authorization

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

Section 3: Execution

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

Contractor, Molina Healthcare of Iowa, Inc.		**Agency, Iowa Department of Health and Human Services**	
Signature of Authorized Representative:	Date: 06/26/2024	Signature of Authorized Representative: Kelly Garcia	Date: Jun 27, 2024
Printed Name: Jennifer H. Vermeer		Printed Name: Kelly Garcia	
Title: Iowa Plan President		Title: Director	

Special Contract Amendment – SFY2025 Rates

SFY25 Rating Withhold Summary

Paid to MCOs

		Molina Healthcare Rates							Premium Tax	
Cap Group	**Rate Cell**	**SFY23 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**
Reference			**(A)**	**(B)** = (A) * 2%	**(C)** = (A) - (B)	**(D)**	**(E)**	**(F)** = (C) + (D) + (E)	**(G)** = (F) / (1 - 0.975%)	**(H)** = [(A) + (D) + (E)] /
H	Children 0-59 days M&F	52,245	$ 2,541.53	$ 50.83	$ 2,490.70	$ 5.04	$ 3.88	$ 2,499.62	$ 2,524.23	$ 2,575.56
H	Children 60-364 days M&F	189,808	$ 355.40	$ 7.11	$ 348.29	$ 5.04	$ 2.46	$ 355.79	$ 359.29	$ 366.47
H	Children 1-4 M&F	871,813	$ 191.08	$ 3.82	$ 187.26	$ 5.04	$ 1.29	$ 193.59	$ 195.50	$ 199.35
H	Children 5-14 M&F	1,797,787	$ 185.89	$ 3.72	$ 182.17	$ 5.04	$ 0.77	$ 187.98	$ 189.83	$ 193.59
H	Children 15-20 F	398,378	$ 324.70	$ 6.49	$ 318.21	$ 5.04	$ 3.16	$ 326.41	$ 329.62	$ 336.18
H	Children 15-20 M	390,930	$ 216.51	$ 4.33	$ 212.18	$ 5.04	$ 2.50	$ 219.72	$ 221.88	$ 226.26
1	CHIP - Hawki	566,560	$ 182.78	$ 3.66	$ 179.12	$ -	$ 0.67	$ 179.79	$ 181.56	$ 185.26
H	Non-Expansion Adults 21-34 F	413,050	$ 467.96	$ 9.36	$ 458.60	$ 5.04	$ 5.48	$ 469.12	$ 473.74	$ 483.19
H	Non-Expansion Adults 21-34 M	104,281	$ 289.65	$ 5.79	$ 283.86	$ 5.04	$ 4.10	$ 293.00	$ 295.88	$ 301.73
H	Non-Expansion Adults 35-49 F	286,743	$ 648.72	$ 12.97	$ 635.75	$ 5.04	$ 5.92	$ 646.71	$ 653.08	$ 666.18
H	Non-Expansion Adults 35-49 M	118,351	$ 464.67	$ 9.29	$ 455.38	$ 5.04	$ 4.54	$ 464.96	$ 469.54	$ 478.92
H	Non-Expansion Adults 50+ M&F	60,547	$ 828.50	$ 16.57	$ 811.93	$ 5.04	$ 5.93	$ 822.90	$ 831.00	$ 847.74
I	Pregnant Women	163,050	$ 403.95	$ 8.08	$ 395.87	$ 5.04	$ 2.07	$ 402.98	$ 406.95	$ 415.11
J	WP 19-24 F (Medically Exempt)	11,911	$ 1,143.15	$ 22.86	$ 1,120.29	$ -	$ 20.88	$ 1,141.17	$ 1,152.41	$ 1,175.49
J	WP 19-24 M (Medically Exempt)	9,322	$ 1,651.49	$ 33.03	$ 1,618.46	$ -	$ 22.21	$ 1,640.67	$ 1,656.82	$ 1,690.18
J	WP 25-34 F (Medically Exempt)	42,930	$ 1,208.44	$ 24.17	$ 1,184.27	$ -	$ 17.52	$ 1,201.79	$ 1,213.62	$ 1,238.03
J	WP 25-34 M (Medically Exempt)	42,458	$ 1,306.00	$ 26.12	$ 1,279.88	$ -	$ 24.15	$ 1,304.03	$ 1,316.87	$ 1,343.25
J	WP 35-49 F (Medically Exempt)	68,081	$ 1,460.46	$ 29.21	$ 1,431.25	$ -	$ 19.44	$ 1,450.69	$ 1,464.97	$ 1,494.47
J	WP 35-49 M (Medically Exempt)	64,548	$ 1,306.04	$ 26.12	$ 1,279.92	$ -	$ 34.49	$ 1,314.41	$ 1,327.35	$ 1,353.73
J	WP 50+ M&F (Medically Exempt)	94,484	$ 1,763.68	$ 35.27	$ 1,728.41	$ -	$ 33.19	$ 1,761.60	$ 1,778.94	$ 1,814.56
K	WP 19-24 F (Non-Medically Exempt)	295,239	$ 317.22	$ 6.34	$ 310.88	$ -	$ 3.09	$ 313.97	$ 317.06	$ 323.46
K	WP 19-24 M (Non-Medically Exempt)	270,284	$ 208.49	$ 4.17	$ 204.32	$ -	$ 2.83	$ 207.15	$ 209.19	$ 213.40
K	WP 25-34 F (Non-Medically Exempt)	361,260	$ 385.17	$ 7.70	$ 377.47	$ -	$ 3.14	$ 380.61	$ 384.36	$ 392.13
K	WP 25-34 M (Non-Medically Exempt)	342,617	$ 313.37	$ 6.27	$ 307.10	$ -	$ 4.72	$ 311.82	$ 314.89	$ 321.22
K	WP 35-49 F (Non-Medically Exempt)	365,685	$ 594.18	$ 11.88	$ 582.30	$ -	$ 4.31	$ 586.61	$ 592.39	$ 604.38
K	WP 35-49 M (Non-Medically Exempt)	355,312	$ 495.59	$ 9.91	$ 485.68	$ -	$ 6.78	$ 492.46	$ 497.31	$ 507.32
K	WP 50+ M&F (Non-Medically Exempt)	552,381	$ 858.30	$ 17.17	$ 841.13	$ -	$ 7.71	$ 848.84	$ 857.20	$ 874.54
M	ABD Non-Dual <21 M&F	127,506	$ 931.25	$ 18.63	$ 912.63	$ 5.04	$ 6.14	$ 923.81	$ 932.90	$ 951.71
M	ABD Non-Dual 21+ M&F	239,598	$ 1,782.88	$ 35.66	$ 1,747.22	$ 5.04	$ 33.97	$ 1,786.23	$ 1,803.82	$ 1,839.83
N	Residential Care Facility	3,876	$ 6,045.09	$ 120.90	$ 5,924.19	$ 5.04	$ 16.01	$ 5,945.24	$ 6,003.78	$ 6,125.87
O	Breast and Cervical Cancer	1,415	$ 3,335.73	$ 66.71	$ 3,269.02	$ -	$ 3.79	$ 3,272.81	$ 3,305.03	$ 3,372.40
P	Dual Eligible 0-64 M&F	372,008	$ 549.91	$ 11.00	$ 538.91	$ -	$ 1.82	$ 540.73	$ 546.05	$ 557.16
P	Dual Eligible 65+ M&F	179,652	$ 246.37	$ 4.93	$ 241.44	$ -	$ 1.08	$ 242.52	$ 244.91	$ 249.89
Q	Custodial Care Nursing Facility <65	21,757	$ 7,247.85	$ 144.96	$ 7,102.89	$ 5.04	$ 29.83	$ 7,137.76	$ 7,208.04	$ 7,354.43
Q	Custodial Care Nursing Facility 65+	107,945	$ 5,697.58	$ 113.95	$ 5,583.63	$ -	$ 3.50	$ 5,587.13	$ 5,642.14	$ 5,757.21
R	Elderly HCBS Waiver	89,540	$ 5,697.58	$ 113.95	$ 5,583.63	$ -	$ 3.98	$ 5,587.61	$ 5,642.63	$ 5,757.70
S	Non-Dual Skilled Nursing Facility	1,994	$ 7,247.85	$ 144.96	$ 7,102.89	$ 5.04	$ 62.01	$ 7,169.94	$ 7,240.54	$ 7,386.92
T	Dual HCBS Waivers: PD; H&D	16,046	$ 7,247.85	$ 144.96	$ 7,102.89	$ -	$ 2.24	$ 7,105.13	$ 7,175.09	$ 7,321.47
U	Non-Dual HCBS Waivers: PD; H&D; AIDS	18,974	$ 7,247.85	$ 144.96	$ 7,102.89	$ 5.04	$ 20.58	$ 7,128.51	$ 7,198.70	$ 7,345.08
V	Brain Injury HCBS Waiver	15,397	$ 7,247.85	$ 144.96	$ 7,102.89	$ 5.04	$ 9.39	$ 7,117.32	$ 7,187.40	$ 7,333.78
W	ICF/ID	11,855	$ 8,951.96	$ 179.04	$ 8,772.92	$ 5.04	$ 7.00	$ 8,784.96	$ 8,871.46	$ 9,052.26
X	State Resource Center	2,829	$ 8,951.96	$ 179.04	$ 8,772.92	$ 5.04	$ 9.23	$ 8,787.19	$ 8,873.71	$ 9,054.51
Y	Intellectual Disability HCBS Waiver	136,740	$ 8,951.96	$ 179.04	$ 8,772.92	$ 5.04	$ 3.94	$ 8,781.90	$ 8,868.37	$ 9,049.17
Z	PMIC	3,443	$ 3,220.87	$ 64.42	$ 3,156.45	$ 5.04	$ 22.57	$ 3,184.06	$ 3,215.41	$ 3,280.46
0	Children's Mental Health HCBS Waiver	13,870	$ 3,220.87	$ 64.42	$ 3,156.45	$ 5.04	$ 5.93	$ 3,167.42	$ 3,198.61	$ 3,263.66
D	CHIP - Children 0-59 days M&F	878	$ 2,541.53	$ 50.83	$ 2,490.70	$ -	$ 3.88	$ 2,494.58	$ 2,519.14	$ 2,570.47
D	CHIP - Children 60-364 days M&F	3,069	$ 355.40	$ 7.11	$ 348.29	$ -	$ 2.46	$ 350.75	$ 354.20	$ 361.38
D	CHIP - Children 1-4 M&F	919	$ 191.08	$ 3.82	$ 187.26	$ -	$ 1.29	$ 188.55	$ 190.41	$ 194.26
D	CHIP - Children 5-14 M&F	137,252	$ 185.89	$ 3.72	$ 182.17	$ -	$ 0.77	$ 182.94	$ 184.74	$ 188.50
D	CHIP - Children 15-20 F	30,165	$ 324.70	$ 6.49	$ 318.21	$ -	$ 3.16	$ 321.37	$ 324.53	$ 331.09
D	CHIP - Children 15-20 M	30,224	$ 216.51	$ 4.33	$ 212.18	$ -	$ 2.50	$ 214.68	$ 216.79	$ 221.17
	TANF Maternity Case Rate	7,595	$ 6,665.36	$ 133.31	$ 6,532.05	$ -	$ -	$ 6,532.05	$ 6,596.36	$ 6,730.99
	Pregnant Women Maternity Case Rate	5,499	$ 5,899.74	$ 117.99	$ 5,781.75	$ -	$ -	$ 5,781.75	$ 5,838.68	$ 5,957.83
	Total	**9,857,007**	**$ 748.22**	**$ 14.96**	**$ 733.25**	**$ 2.78**	**$ 4.67**	**$ 740.71**	**$ 748.00**	**$ 763.11**

MED-24-005 Molina Healthcare AMD 5 full

Final Audit Report 2024-06-27

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