Seventh Amendment to the Iowa Health Link Contract

This Amendment to Contract Number MED-24-005 is effective as of January 1, 2025, 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. Agency Contract Owner (hereafter "Contract Owner")/Address, is hereby replaced as follows:
Kera Oestreich
Iowa Department of Health and Human Services
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-1002
Email: kera.oestreich@hhs.iowa.gov

Revision 2. Section 1.3.3.1 Pricing, the last two paragraphs are hereby removed.

Revision 3. Section A.29. Participation in Hope and Opportunity in Many Environments (HOME) Project Design and Implementation Activities, is hereby added as follows:
As directed by the Agency, the Contractor shall:

a) Participate in MCO workgroups convened by the Agency related to the design and implementation of HOME;
b) Provide input and feedback to the MCO workgroups convened by the Agency related to Member and Provider materials, policy guidance, and specifications;
c) Educate the Contractor's staff, including but not limited to Member Services and Community-Based Case Managers, about HOME implementation;
d) Provide information about HOME implementation to Enrolled Members;
e) Develop HOME project-related Provider communications, trainings, and guidance per Sections E.01, E.04, E.1.03, E.1.04;
f) Perform provider education activities related to HOME implementation;
g) Perform Health Information System updates related to HOME implementation; and
h) Participate in Readiness Review activities related to HOME implementation, as further defined by the Agency.

All expenses related to this subsection are considered to be included in the capitation rates and shall be at no additional cost to the Agency.

Revision 4. Section D.1.09. Payment for Services in IMD Setting, CFR reference, is hereby amended as follows:
See: 42 C.F.R. § 438.3(e)(2)(i) - (v); 42 C.F.R. § 457.1201(e).

Revision 5. Section D.4.18. Reporting Requirements, is hereby replaced as follows:
Contractor shall submit a report in accordance with MLR standards and Agency instructions outlined in the reporting manual that includes at least the following information for each MLR reporting year:

a) Total incurred claims with IBNR reported separately.
b) Expenditures on quality improving activities.

c) Expenditures related to activities compliant with 42 C.F.R. § 438.608(a)(1) through (5), (7), (8) and (b).
d) Non-claims costs.
e) Premium revenue.
f) Community benefit expenditures (subject to Agency review and/or disallowance in part of whole)
g) Taxes, licensing and regulatory fees.
h) Methodology(ies) for allocation of expenditures.
i) Any credibility adjustment applied.
j) The calculated MLR.
k) Any remittance owed to the Agency, if applicable.
l) A comparison of the information reported in this paragraph with the audited financial report required under 42 C.F.R. § 438.3(m).
m) A description of the aggregation method used.
n) The number of member months.

See: 42 C.F.R. § 438.8(k)(1)(xii) and 42 C.F.R. § 438.8(i)

Revision 6. Section F.3.01. Covered Abortions, is hereby replaced as follows:

Abortions in the following situations are covered Medicaid Benefits:

a) If the pregnancy is the result of an act of rape or incest. If the pregnancy is the result of a rape which is reported within forty-five days of the incident to a law enforcement agency or to a public or private health agency which may include a family physician. 653 IAC 13.17(2) and 13.17(4)(a) and the HHS Provider Manual set forth additional requirements for health care providers.

b) If the pregnancy is the result of a rape which is reported within one hundred forty days of the incident to a law enforcement agency or to a public or private health agency which may include a family physician. 653 IAC 13.17(2) and 13.17(4)(a) and the HHS Provider Manual set forth additional requirements for health care providers.

c) If the pregnancy was ended as the result of a "spontaneous abortion" or miscarriage, and not all of the products of conception are expelled.

d) If the attending physician certifies that the fetus has a fetal abnormality that in the physician's reasonable medical judgment is incompatible with life. 653 IAC 13.17(4)(b) and the HHS Provider Manual set forth additional requirements for health care providers.

e) If the pregnancy must be ended as a result of a medical emergency. A medical emergency is a situation in which an abortion is performed to preserve the life of the pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy, but not including psychological conditions, emotional conditions, familial conditions, or the woman's age; or when continuation of the pregnancy will create a serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman.

See: 42 C.F.R. § 441.202; Consolidated Appropriations Act of 2008. {From CMSC F.3.01}; Iowa Code 146, 146A, 146B, 146C, 146D, 146E

Revision 7. Section F.6.32. Contractor may cover services or settings for Enrolled Members that are in lieu of those covered under that State Plan, CFR reference is hereby amended as follows:

See: 42 C.F.R. § 438.3(e)(2)(i) - (v); 42 C.F.R. § 457.1201(e). {From CMSC F.6.16 - F.6.20}.

Revision 8. Section F.8.07 Exempt Populations f), is hereby replaced as follows:

f). Pregnant women, during pregnancy and through the postpartum period;

Revision 9. 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 on a pharmacy 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. The Contractor shall not require as a condition for participation in its pharmacy Network any limitations that would exclude independent retail pharmacies. The Contractor or its PBM shall not steer or require any Providers or Enrollees to use a specific pharmacy for regular prescriptions, refills, or specialty drugs. The Contractor's pharmacy Network under this Contract must be contracted and administered separately from the Contractor's or Subcontractor's commercial network.

A contracted entity or a subcontractor of a contracted entity shall not enforce a policy or contract term with a provider that requires the provider to contract for all products that are currently offered or that may be offered in the future by the contracted entity or subcontractor.

Revision 10. F.12B.03. Waiting List, third paragraph is hereby replaced as follows:
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. Enrollee rights and protections apply to ILOS, including short-term IMD stays. These include the right to choose not to receive ILOS, retention of the right to state plan services or settings, the right to informed decisions about health care and to receive information on available treatment options and alternatives, and the right to not have state plan-covered services or settings denied because an ILOS was offered. This also applies to section D.1.09 Payment for services in IMD setting. §§ 438.3(e)(2)(i) – (v), 438.10(g), 457.1201(e) and 457.1207.

Revision 11. Section F.12B.05. Comprehensive Assessments, is hereby replaced as follows:
Upon notification from the Agency of availability of an open 1915 (c) waiver slot, the Contractor shall conduct a comprehensive assessment, in accordance with 42 C.F.R. § 438.208(c)(2), as described, using a tool and process prior approved by the Agency, for the waitlisted Enrolled Member unless otherwise directed by the Agency per Section F.12.B.23. The Contractor shall refer individuals who are identified as potentially eligible for LTSS to the Agency or its designee for level of care determination, if applicable.

Revision 12. Section F.12B.06. HCBS Level of Care and Needs-based Assessments, is hereby replaced as follows:
Contractor shall perform level of care and needs-based assessments for their Enrolled Members unless otherwise directed by the Agency per Section F.12B.23. The Agency has designated the tools that will be used to determine the level of care and comprehensively assessed supports needed for individuals wishing to Access HCBS. The intention of the multi-purpose evaluation is to provide uniformity and streamline the documents completed to determine the appropriate level of care or needs-based eligibility and outline the assessed needs of the individual. The tool is also used to evaluate the Enrolled Members strengths, needs, and level of supports needed to maintain health and safety while residing in the community. The tools currently designated by the Agency are contained in the approved 1915(c) Waiver Applications and 1915(i) SPA. The Contractor shall not revise or add to the tools without express approval from the Agency.

Revision 13. Section F.12B.08. Initial Assessment and Annual Reassessment, is hereby replaced as follows:
The Contractor shall perform level of care and needs-based eligibility assessments for Enrolled Members potentially eligible for 1915(c) and 1915(i) HCBS programs including an assessment of the Enrolled Member's ability to have their needs met safely and effectively in the community and at a reasonable cost to the Agency unless otherwise directed by the Agency per Section F.12.B.23. If an Enrolled Member's needs exceed limits established in Iowa Administrative Code or the approved 1915(c) waivers, the Contractor has discretion to authorize services that exceed those limits. If required, the Contractor can submit an exception to policy to the Agency to exceed limits outlined in the Iowa Administrative Code. If an Enrolled Member does not appear to meet enrollment criteria, the Contractor shall comply with the requirements related to the appearance of ineligibility. The Contractor will establish Agency-approved timelines that will promptly assess the Enrolled Member's needs and ensure Enrolled Member safety.

Revision 14. Section F.12.B.23 Transitioning Comprehensive Assessment, HCBS Level of Care, and Needs-based Assessment functions for Enrolled Members in 1915(c) HCBS Waiver(s), is hereby added as follows:
Effective January 1, 2025, the Contractor will not be required to complete Comprehensive Assessments, HCBS Level of Care, and Needs-Based Assessments for the Intellectual Disability HCBS Waiver, and effective July 1, 2025, for all of the remaining 1915 (c) HCBS Waivers and Habilitation. The Contractor will be responsible for the following:

a) Communicating changes regarding the assessment process to Enrolled Members.

b) Collaborating with the Agency's assessment contractor which includes communication strategies about assessment needs and a plan for sending and receiving assessment data, and the proposed effective date.

Revision 15. G.7.03. NCQA Accreditation Obligation, is hereby retitled as follows:
G.7.03. Accreditation Obligation

Revision 16. G.7.03. Accreditation Obligation, is hereby replaced as follows:
The Contractor shall attain and maintain accreditation from the NCQA or the Utilization Review Accreditation Commission (URAC). If not already accredited, the Contractor shall demonstrate it has initiated the accreditation process as of the Contract effective date. The Contractor shall achieve accreditation at the earliest date allowed by NCQA. Accreditation shall be maintained throughout the life of the Contract at no additional cost to the Agency. When accreditation standards conflict with the standards set forth in the Contract, the Contract prevails unless the accreditation standard is more

stringent. Contractors providing services to LTSS services to Enrolled Members shall pursue NCQA LTSS Distinction for Health Plans or URAC Health Plan Accreditation with Long-Term Services and Supports. The Contractor shall report LTSS quality measures to the Agency in accordance with the Contractor's accreditation and the reporting requirements outlined in the Reporting Manual.

Revision 17. I.8.02. Recovery of Improper Payments, is hereby replaced as follows:
The Contractor shall initiate administrative action and recover improper payments or overpayments related to claims paid by the Contractor within twenty-four (24) months from the date the claim was paid or from the date of any applicable reconciliation, whichever is later. Except for Overpayments identified under a Credible Allegation of Fraud, the Contractor shall confer with the Agency before pursuing Overpayment recoveries for Claims where more than twenty-four (24) months have passed since the claims were paid or adjudicated. The Contractor shall not subject these claims to repayment or offset against future claim reimbursements without prior consent from the Agency.

a). Payment Disputes- Request for Agency Review:
Should a provider ask the Agency to review the Contractor's post-payment activity once the provider has exhausted the Contractor's dispute or grievance process, the Contractor shall cooperate with the Agency by providing information that supports the recovery activity. If the Agency, in the review of information from the Provider and the Contractor, finds evidence of erroneous findings by the Contractor, the Agency will instruct the Contractor to amend or overturn the provider's dispute and reimburse the provider any funds that have been recovered. The Contractor shall collaborate with the Agency in the creation of Standard Operating Procedures for this process. If the Contractor's decision is amended or overturned, the Agency may require the Contractor to waive timely filing requirements and allow the Provider to reprocess claims for payment.

Revision 18. I.9.08. Contact Before Proceeding, is hereby retitled as follows:
Agency-Identified Overpayments

Revision 19. I.9.08. Agency-Identified Overpayments, is hereby replaced as follows:
If the Agency discovers and identifies an improper payment or overpayment after twenty-four (24) months from the date the claim was paid, the Agency will recover the identified Overpayment from the Contractor, unless the improper payment or overpayment was the result of an Agency error. The Contractor shall not recover Overpayments for which it did not discover or issue a, overpayment finding to the Provider. The Contractor may dispute the Agency's notice of findings in accordance with the Payment Integrity Audit process.

Revision 20. Special Contract Exhibit B. Glossary of Terms/Definitions, is hereby added as follows:
In Lieu of Services (ILOS): a service or setting that is provided to an enrollee as a substitute for a covered service or setting under the State Plan in accordance with 42 C.F.R 438.3(e)(2). An ILOS can be used as an immediate or longer-term substitute for a covered service or setting under the State plan, or when the ILOS can be expected to reduce or prevent the future need to utilize the covered service or setting under the State Plan.

Revision 21. Special Contract Exhibit D. Eligible Enrollees and Excluded Populations Table D.01: Eligible Enrollees, Hawki, is hereby replaced as follows:

Hawki	The State's separate Children's Health Insurance (CHIP) program. Children under age nineteen (19), with no other health insurance and income at or below 300% FPL. Premium requirements apply. For pregnant or postpartum women, the age limit may extend past the age of 19.

Revision 22. Exhibit E. Table E.01: Full Medicaid Covered Benefits & Limitations, ABORTIONS is hereby replaced as follows:

ABORTIONS	Abortions in the following situations are covered Medicaid Benefits: a) If the pregnancy is the result of an act of rape or incest. If the pregnancy is the result of a rape which is reported within forty-five days of the incident to a law enforcement agency or to a public or private health agency which may include a family physician. 653 IAC 13.17(2) and 13.17(4)(a) and the HHS Provider Manual set forth additional requirements for health care providers. b) If the pregnancy is the result of a rape which is reported within one hundred forty days of the incident to a law enforcement agency or to a public or private health agency which may include a family physician. 653 IAC 13.17(2) and 13.17(4)(a) and the HHS Provider Manual set forth additional requirements for health care providers. c) If the pregnancy was ended as the result of a "spontaneous abortion" or miscarriage, and not all of the products of conception are expelled. d) If the attending physician certifies that the fetus has a fetal abnormality that in the physician's reasonable medical judgment is incompatible with life. 653 IAC 13.17(4)(b) and the HHS Provider Manual set forth additional requirements for health care providers. e) If the pregnancy must be ended as a result of a medical emergency. A medical emergency is a situation in which an abortion is performed to preserve the life of the pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy, but not including psychological conditions, emotional conditions, familial conditions, or the woman's age; or when continuation of the pregnancy will create a serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman.

Revision 23. Special Contract Exhibits - Exhibit G: Pandemic-Related Provisions. COVID 19 Vaccination Administration Carve-Out, is hereby deleted and reserved.

Revision 24. Section H.5. ARPA Section 9817 Home and Community Based Services (HCBS) - Description of Arrangement, is hereby added as follows:

The State Medicaid Agency directs the contracted MCOs to make payments to eligible HCB providers for targeted projects approved in Iowa's Spending Plan for Implementation of the American Rescue Plan Act (ARPA) of 2021, Section 9817.

The Contractor shall make a one-time payment to eligible HCBS providers for the **Provider Capacity Building and Service Waitlist Reduction Grant**.

Eligible providers will receive a portion of the funds based on their total number of claims paid during State Fiscal Year 2024 (SFY 2024). Payments will be calculated on a per-claim basis for HCBS, Applied Behavior Analysis (ABA), and Behavioral Health Intervention Services (BHIS) procedure codes. Iowa Medicaid will reconcile payments at both the MCO and HCBS provider levels to ensure the investment supports capacity expansion and reduced waitlists.

Payment information, including identifiable HCBS provider details and payment dates, will be reconciled with actual claims from the SFY 2025 rating period. Iowa Medicaid retains auditing rights to verify that payments are made to the correct providers.

Iowa Medicaid is distributing funds to MCOs for eligible providers under the ARPA Section 9817 Provider Capacity Building and Service Waitlist Reduction Grant. These funds are intended to help providers increase service capacity, reduce waitlists, expand service types, and increase the number of participants served. Eligible providers include:

- 1915(c) HCBS Waiver and 1915(i) State Plan HCBS Habilitation service providers with paid claims during SFY 2024 for specified procedure codes, and
- State Plan Applied Behavior Analysis (ABA) and Behavioral Health Intervention Services (BHIS)

Revision 25. 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	
ALN #: 93.778 **Grant Name:** Title XIX: The Medical Assistance Program	**Federal Awarding Agency Name:** Centers for Medicare and Medicaid Services (CMS)
ALN #: 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:	Signature of Authorized Representative:	Date:
	12/30/2024		01/02/2025
Printed Name: Jennifer H. Vermeer		Printed Name: Kelly Garcia	
Title: Iowa Plan President		Title: Director	