Tenth Amendment to the Iowa Health Link Contract

This Amendment to Contract Number MED-24-006 is effective as of July 1, 2025, between the Iowa Department of Health and Human Services (Agency) and Wellpoint, Iowa, Inc (Contractor).

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

Revision 1. Contract Cover Page, under "Contractor's Contract Manager Name/Address ("Notice Address"), the title of the Contractor's Contract Manager is hereby replaced as follows:
Compliance Director/Plan Compliance Officer

Revision 2. Table of Contents. C.6: Provider Terminations and Incentives, is hereby amended as follows:
C.6: Provider Terminations and Incentive Payment Programs

Revision 3. Table of Contents.E.8 Physician Incentive Plan, is hereby amended as follows:
E.8: Provider Incentive Payment Programs

Revision 4. Table of Contents. Exhibit I: Memorandum of Understanding of State Directed Payments Between the Agency and the Iowa Hospital Association, is hereby added as follows:
Exhibit I: Memorandum of Understanding of State Directed Payments Between the Agency and the Iowa Hospital Association

Revision 5. A.07(e)(16). Program Integrity Manager and Special Investigations Unit Staffing, the term "at least," is hereby removed.

Revision 6. A.17.g) Coordination with Other State Agencies and Program Contractors, g) Community Based Agencies, is hereby replaced as follows:
g) Community Based Agencies. The Contractor is expected to support community-based efforts to build better interfaces with agencies, such as: (i) school districts; (ii) area education agencies, (iii) Decategorization Boards; (iv) local public health entities; (v) job training, placement and vocational service agencies; (vi) judicial districts;(vii) Behavioral Health Administrative Services Organizations (BH – ASOs); (viii) Iowa's Aging and Disability Resource Centers (ADRCs); (ix) Disability Access Points (DAPs); and (x) the Iowa Department of Corrections. The Agency will work with the Contractor to prioritize community-based efforts to support the success of the Program.

Revision 7. B.1.03. Other Discrimination Prohibited, is hereby replaced as follows:
B.1.03. *Other Discrimination Prohibited*. The Contractor shall not discriminate against individuals eligible 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; and sex stereotypes. See: 42 C.F.R. § 438.3(d)(4); 42

C.F.R. § 457.1201(d); 45 C.F.R. § 92.

Revision 8. B.1.04. Non-Discriminatory Policies, is hereby replaced as follows:
B.1.04. *Non-Discriminatory Policies.* The 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; and sex stereotypes. See: 42 C.F.R. § 438.3(d)(4); 42 C.F.R. § 457.1201(d); 45 C.F.R. § 92.

Revision 9. C.6. Provider Terminations and Incentives, is hereby replaced as follows:
C.6 Provider Terminations and Incentives Payment Programs
C.6.01. *Provider Terminations – Timeline.* The Contractor shall make a good faith effort to give written notice of termination of a contracted Provider to each Enrolled Member who received their primary care from, or was seen on a regular basis by, the terminated provider no later than thirty (30) calendar days prior to the effective date of the termination, or fifteen (15) calendar days after receipt or issuance of the termination notice. See: 42 C.F.R. § 438.10(f)(1); 42 C.F.R. § 457.1207. {From CMSC C.6.01}.

C.6.02. *Information Regarding Provider Incentive Payment Programs.* The Contractor shall make available, upon request, any physician incentive plans, defined as provider incentive payment programs within Section C.6, Section D.4, Section E.8, and Section G.5 in place. See: 42 C.F.R. § 438.10(f)(3); 42 C.F.R. § 438.3(i); 42 C.F.R. § 457.1207. {From CMSC C.6.02}.

C.6.03. *Provider Incentive Payment Programs.* The Contractor shall establish performance-based incentive programs for its Providers. The Contractor shall follow the requirements for developing Provider incentive payment programs within this section and subsections. These programs shall include clearly defined, objectively measurable and well-documented clinical or quality improvement standards that the provider must meet to receive the incentive plan. The Contractor shall obtain the Agency approval prior to implementing any Provider incentive payment program and before making any changes to an approved incentive. The Agency encourages creativity in designing incentive programs that encourage positive Enrolled Member engagement and health Outcomes tailored to issues prevalent among Enrolled Membership as identified by the Contractor. The Contractor shall provide information concerning its Provider incentive payment program plan, upon request, to its Enrolled Members and in any Marketing Materials in accordance with the disclosure requirements stipulated in federal regulations. See: 42 C.F.R. § 438.3(i); 42 C.F.R § 438.8(e)(2)(iii)(A)

C.6.04. *Provider Incentive Payment Program Contract Requirements*. The Contractor's Provider incentive payment program contracts with network Providers shall:

a) Have a defined performance period that can be tied to the applicable MLR reporting period(s).
b) Be signed and dated by all appropriate parties prior to the commencement of the applicable performance period.
c) Include clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards the provider must meet to receive the incentive payment.

d) Specify a dollar value or percentage of a verifiable dollar amount that can be clearly linked to successful completion of the metrics defined in the incentive payment contract, include a date of payment.

See: 42 C.F.R. § 438.3(i)(3); 42 C.F.R. § 457.1201(h).

C.6.05. *Provider Incentive Payment Program Documentation Requirements.* The Contractor's Provider incentive payment programs shall:

a) Maintain detailed documentation to support the provider incentive payment programs and all requested data elements in accordance with the Agency instructions outlined in the Reporting Manual.
    1. Detailed documentation should include, but is not limited to:
        a. Contracts
        b. Provider incentive payment listings
        c. Payment calculations
        d. Scorecards, including detail to demonstrate metrics are met and reconcile to payment terms within the calculations
        e. Copy of paid checks
        f. Estimates or anticipated payments
        g. Reconciliations to the general ledger
b) Prohibit the use of attestations as supporting documentation for data that factors into the MLR Calculation.
c) Make Provider incentive payment program contracts and other supporting documentation as detailed in C.6.03.02(a) available, upon request and at any routine frequency in accordance with the Agency instructions outlined in the Reporting Manual.

See: 42 C.F.R. § 438.3(i)(4); 42 C.F.R. § 457.1201(h).

Revision 10. C.11.03. Costs, the below is hereby added to the end of the paragraph as follows:
Reference Agency instructions outlined in the Reporting Manual for Value-Added Services treatment for MLR and Risk Corridor reporting.

Revision 11. D.4. Medical Loss Ratio (MLR), is hereby replaced as follows:
D.4.01. *Medical Loss Ratio (MLR) Applicability.* The Contractor shall calculate and report an MLR for each MLR reporting year in accordance with the MLR standards (at 42 C.F.R. § 438.8) and the Agency instructions outlined in the Reporting Manual. The following MLR standards apply to both Title XIX and Title XXI capitation payments. Contractor shall report separate MLRs for the Title XIX and Title XXI populations and aggregate across both populations for minimum MLR application. The timeline is outlined in the Reporting Manual and record-keeping requirements are outlined in 42 C.F.R. § 438.3(u).
See: 42 C.F.R. § 438.8(a); 42 C.F.R. § 457.1203.

D.4.02. *MLR Requirement.* A minimum MLR of eighty-eight percent (88%) is required for each MLR Reporting Year of the Contractor. See: 42 C.F.R § 438.8(c).

D.4.03. *MLR Calculation*. The MLR calculation for each Contractor in a MLR reporting year is the ratio of the numerator (as defined in accordance with 42 CFR § 438.8(e)) to the denominator (as defined in accordance with 42 CFR § 438.8(f)). See: 2 CFR § 438.8(d) - (f)and Section C.6 regarding Provider incentive payment programs requirements.

D.4.04. Contractor *Expenses.* Each Contractor expense type and allocation for multiple contract or population expenditures are in alignment with 42 CFR § 438.8(g)(1)(i) - (ii).

D.4.05. *Expense Allocation*. Expense allocations, shared expenses, and reporting entity operation expenses will be in accordance with 42 CFR § 438.8(g)(2)(i) - (iii). {From CMSC I.D.4.06-.08}.

D.4.06. *Credibility Adjustment*. Credibility adjustments will align with the standards in 42 CFR § 438.8(h)(1) - (3). {From CMSC I.D.4.09-.12}.

D.4.07. *Data Aggregation*. The Contractor will aggregate data for all Medicaid eligibility groups covered under the contract with the Agency unless the state requires separate reporting and a separate MLR calculation for specific populations. See: 42 CFR § 438.8(i) {From CMSC I.D.4.13}.

D.4.08. *Remittance*. If required by the Agency outlined in the Reporting Manual, the Contractor must provide a remittance for an MLR reporting year if the MLR for that MLR reporting year does not meet the minimum MLR of eighty-eight percent (88%). See: 42 CFR § 438.8(j); 42 CFR § 438.8(c) {From CMSC I.D.4.14}.

D.4.09. The Contractor must submit a MLR report to the state that includes reporting components outlined in 42 CFR § 438.8(k)(1)(i) - (xiii); 42 CFR § 438.3(m); 42 CFR § 438.8(i); and 45 CFR Part 158. {From CMSC I.D.4.15-.29}.

D.4.10. *MLR Reporting Year*. The MLR Reporting Year will be considered a twelve (12) month period, consistent with the Rating Period. The MLR shall be prepared using all data available from the MLR Reporting Year. See: 42 C.F.R. § 438.8(b); 42 CFR § 438.8(k)(2); 42 CFR § 438.8(k)(1) {From CMSC I.D.4.30}.

D.4.11. *Third Party Vendors.* The Contractor must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to that Contractor within 180 days of the end of the MLR Reporting Year or within 30 days of being requested by the Contractor whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting. See: 42 C.F.R. § 438.8(k)(3) {From CMSC I.D.4.31}.

D.4.12. *Newer Experience*. The Agency, in its discretion, may exclude a Contractor that is newly contracted from the requirements in this section for the first year of the Contractor's operation. Such Contractors must comply with the requirements in this section during the next MLR reporting year in which the Contractor is in business with the Agency, even if the first year was not a full 12 months. See: 42 C.F.R. § 438.8(l).

D.4.13. *Recalculation of MLR*. In any instance where the Agency makes a retroactive change to the capitation payments for a MLR reporting year where the report has already been submitted to the Agency, the Contractor must re-calculate the MLR for all MLR reporting years affected by the change and submit a new report meeting the requirements in 42 C.F.R. § 438.8(k). See: 42 C.F.R. § 438.8(m). {From CMSC I.D.4.32-.33}.

D.4.14. *MLR Attestation*. The Contractor must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports. See: 42 CFR § 438.8(n); 42 CFR § 438.8(k) {From CMSC I.D.4.34}.

D.4.15. *Risk Corridor*. The Agency shall include a Risk Corridor for the rate period beginning July 1, 2025, running through June 30, 2026. The Agency reserves the right to prospectively modify the terms of the Risk Corridor though a contract amendment.

D.4.16. *Overview.* The risk corridor settlement is the calculated gain or loss determined when comparing the Risk Corridor Percentage to the risk corridor target percentages outlined in the table as reflected on the capitation rate sheets. The Risk Corridor Percentage is calculated as the total adjusted medical expenditures divided by the total capitation revenue for all populations. Items may be disallowed from the Risk Corridor Percentage at the discretion of the Agency.

D.4.17. *Total Capitation Revenue.* Revenue represents the capitation rates paid by the Agency to the Contractor for the contract period and shall exclude:

a) Taxes and fees explicitly built into the capitation rates, including premium taxes,
b) Amounts related to the UIHC Physician ACR directed payments, UIHC Hospital ACR directed payments, All Hospital ACR directed payments, GEMT payment, and GME payments.
c) Any unearned withhold amounts will not be included within the capitation revenue for purposes of the risk corridor calculation.

The capitation rates utilized in the revenue calculation have been determined to be actuarially sound by an actuary that meets the qualifications and standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board. See: 42 CFR § 438.4; 42 CFR § 438.5.

D.4.18. *Total Adjusted Medical Expenditures.* Total adjusted medical expenditures shall be determined by Agency/Agency's contracted actuaries based on Contractor submitted financial data in a format prescribed by the Agency and compared to encounter data.

Adjusted medical expenditures include services covered by the Agency and the Contractor, except the following:

a) Expenditures associated with carved-out services as reflected in Special Contract Exhibits, Exhibit A and Section 5.
b) Expenditures for services that were incurred before or after the reporting period.
c) Expenditures for services rendered to enrollees who are not eligible on the incurred date of service.
d) Administrative expenditures that are related to pharmacy services, health care quality improvement or health information technology costs, including case management or

care coordination, and other administrative costs claimed in medical expenditures. These administrative expenditures will be removed for purposes of the Risk Corridor calculation.

e) Expenditures for value-added services.
f) Expenditures related to the UIHC Physician ACR directed payment, UIHC Hospital ACR directed payments, All Hospital ACR directed payments, GEMT payment, and GME payments.

The Agency reserves the right to audit claims expenditures. For purposes of the Risk Corridor, the Agency will limit the overall level of reimbursement to 103% of the Medicaid fee schedule, excluding any Provider incentive payment programs (Section C.6), and will sample the submitted encounter data to ensure compliance with the Medicaid fee schedule.

The data used by the Agency and the Agency's contracted actuaries for the risk corridor settlement will be the accepted MMIS encounter data and financial data submitted by the Contractor. The Agency and the Contractor agree that to the extent there are differences between claims expenditures as reflected in the encounter data and the financial data submitted by the Contractor, the Agency and Contractor will confer and make a good faith effort to reconcile those differences before the calculation of the final settlement as described below and include, if any, audit adjustments related to the expenditures.

D.4.19. *Risk Corridor Percentage.* The Risk Corridor Percentage is calculated as the total adjusted medical expenditures divided by the total capitation revenue for all populations.

Risk Corridor Minimum Percentage	Risk Corridor Maximum Percentage	Contractor Share	State / Federal Share
0.00%	88.9%	0%	100%
88.9%	90.9%*	100%	0%
90.9%*	92.9%	100%	0%
92.9%	92.9%+	0%	100%

**The target MLR of 90.9% is based on the weighted average of total non-medical load amounts built into the SFY26 rates using the SFY24 enrollment distribution. The actual target used for the final reconciliation will vary slightly based on the actual population distribution for the MCO during the SFY26 contract period. To the extent the target MLR varies from 90.9% using the actual MCO contract period enrollment mix, the risk corridor bands will still be +/- 2.0% from the revised target MLR.*

D.4.20. *Timelines.* The Contractor shall submit the required information based on Agency instructions and timeline outlined in the Reporting Manual, 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.

Prior to eighteen (18) months following contract period, Agency shall provide the Contractor with a final settlement under the risk share program for the contract period. Any balance due

between Agency and the Contractor, as the case may be, will be paid within sixty (60) days of receiving the final reconciliation from Agency.

Revision 12. D.5.01. Timely Payment Obligation, is hereby replaced as follows:
D.5.01. *Timely Payment Obligation*. The Contractor shall meet the requirements of fee for service (FFS) timely payment for all Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) Providers in its network, including the paying of 90% of all Clean Claims from practitioners (i.e. those who are in individual or group practice or who practice in shared health facilities) within thirty (30) Days of the date of receipt; and paying 99% of all Claims from practitioners (who are in individual or group practice or who practice in shared health facilities) within ninety (90) Days of the date of receipt. Fully adjudicate (pay or deny) 100% of all Claims within 180 Days of the date of receipt. See: 42 C.F.R. § 438.14(b)(2)(iii); ARRA § 5006(d); 42 C.F.R. § 447.45; 42 C.F.R. § 447.46; SMDL 10-001); 42 C.F.R. § 457.1209. {From CMSC D.5.01}.

Revision 13. D.6.01. Timely Payment Obligation, is hereby replaced as follows:
D.6.01. *Timely Payment Obligation*. The Contractor shall meet the requirements of FFS timely payment (see also D.6.04), including the paying of 90% of all Clean Claims from practitioners (i.e. those who are in individual or group practice or who practice in shared health facilities) within thirty (30) Days of the date of receipt; paying 95% of all Clean Claims within forty-five (45) Days of the date of receipt; and paying 99% of all Claims from practitioners (who are in individual or group practice or who practice in shared health facilities) within ninety (90) Days of the date of receipt. Fully adjudicate (pay or deny) 100% of all Claims within 180 Days of the date of receipt. The obligation for timely payment shall be met at both an aggregate and provider type level (*e.g.*, hospital, home health, waiver, nursing facility, etc.). Final provider type levels will be determined by the Agency. See: 42 C.F.R. § 447.45(d)(2) - (3); 42 C.F.R. § 447.46; sections 1902(a)(37)(A) and 1932(f) of the Social Security Act). {From CMSC D.6.01}.

Revision 14. D.6.02. Claims Reprocessing and Adjustment, is hereby replaced as follows:
D.6.02. *Claims Reprocessing and Adjustment.* The Contractor shall accurately adjudicate 90% of all clean identified adjustments including Reprocessed Claims within thirty (30) business days of receipt and 99% of all identified adjustments including Reprocessed Claims within ninety (90) business days of receipt and fully adjudicate (pay or deny) 100% of all Claims within 180 Days of the date of receipt. (see also D.6.04). The Contractor shall also reprocess all claims processed in error within thirty (30) business days of identification of the error or upon a scheduled approved by the Agency. Except in cases in which system configuration is necessary, the start time begins when the Contractor identifies, or is made aware of the error, and has received all necessary information to validate the error; identification of the error could be brought forward by a Provider, the Agency, or internal Contractor staff. In the event the Contractor requests clarification from the Agency regarding a Claim reprocessing project, the time for reprocessing will begin to run on the day the Contractor receives all information necessary to accurately reprocess the Claims. The Contractor shall reprocess mass adjustments of Claims upon a schedule approved by the Agency and the Contractor. *See:* Sections 1902(a)(37)(A) and 1932(f) of the Social Security Act; 42 C.F.R. § 447.45(d)(2) - (3); 42 C.F.R. § 447.46.

Revision 15. E.1.13. Health Homes, the term Chronic Condition Health Home, is hereby

removed.

Revision 16. E.1.24. Capacity Assurances, changing State to Agency, is hereby replaced as follows:
E.1.24. *Capacity Assurances.* The Contractor shall give assurances and provide supporting documentation that demonstrates it has the capacity to serve the expected enrollment in its service area in accordance with the Agency's standards for Access and timeliness of care. See: 42 C.F.R. § 438.207(a); 42 C.F.R. § 438.68; 42 C.F.R. § 438.206(c)(1); 42 C.F.R. § 457.1230(b). {From CMSC E.1.06}.

Revision 17. E.1.26. Appropriate Range of Services, is hereby replaced as follows:
E.1.26. *Appropriate Range of Services.* Contractor shall submit documentation to the Agency, in a format specified by the Agency, to demonstrate it offers an appropriate range of preventive, Primary Care, specialty services, and LTSS that is adequate for the anticipated number of Enrolled Members for the service area. See: 42 C.F.R. § 438.207(b)(1); 42 C.F.R. § 457.1230(b). {From CMSC E.1.07}.

Revision 18. E.1.27. Appropriate Provider Mix, all instances of the term State are replaced with Agency.

Revision 19. E.8. Physician Incentive Plan, is hereby amended, as follows:
E.8 Provider Incentive Payment Programs
For the below sections in E.8, reference additional clarifications and requirements in Section C.6.

Revision 20. E.8.01. Restriction on Reducing or Limiting Services, is hereby replaced as follows:
E.8.01. *Restriction on Reducing or Limiting Services.* The Contractor may only operate a Provider incentive payment program if no specific payment can be made directly or indirectly under a Provider incentive payment program to a physician or physician group as an incentive to reduce or limit Medically Necessary Services to an Enrolled Member. See: Section 1903(m)(2)(A)(x) of the Social Security Act; 42 C.F.R. § 422.208(c)(1); 42 C.F.R. § 438.3(i); 42 C.F.R. § 457.1201(h). {From CMSC E.8.01}.

Revision 21. E.8.03. Value-Based Purchasing Arrangement, is hereby replaced as follows:
E.8.03. *Value-Based Purchasing Arrangement*. The Contractor must have at least 40% of the population defined by the Agency in a value-based purchasing (VBP) arrangement with the healthcare delivery system by the end of the first year of any managed care contract. By the end of the second year, the Contractor shall have 50% VBP enrollment. Thereafter, the Contractor shall maintain or exceed 50% VBP enrollment.

All incentives and/or value-based purchasing (VBP) arrangements must be agreed upon with the Participating Provider(s) and approved by the Agency prospectively before implementation. The Contractor's incentives and/or VBP arrangement will be monitored by the Agency at a minimum semiannually; however (based on the Agency discretion) may be monitored more frequent and must demonstrate to the Agency how the incentive and/or VBP program(s)

improves member outcomes and is not solely administrative efficiencies to qualify as an incentive and/or VBP program.
The Contractor must share performance outcomes including Claims data and lists of attributed members with the Agency semiannually (or more frequent as directed by the Agency) for the membership that is attributed to the provider in incentive and/or VBP arrangements.

The VBP arrangement shall recognize population health outcome improvement as measured through Agency-approved metrics combined with a total cost of care measure for the population in the VBP arrangement. Driving population health through delivery system reform under VBP means that Providers need a clear understanding of the specific lives for which they are accountable. As such, any Enrolled Members that are part of a VBP must be assigned by the Contractor to a designated PCP. This PCP information shall be immediately reported by the Contractor for use in system wide coordination enhancements as specified by the Agency. The Contractor shall also require that all contracted hospitals report admission and discharge information to support this exchange and coordination. Contractor shall use an Agency-approved tool, to provide a consistent, real-time notification platform for hospitals to uniformly report inpatient and ED events for Enrolled Members to the Contractor and care teams participating in VBP agreements. The Contractor shall notify the Agency of any risk sharing agreements it has arranged with a Provider and require in the Provider agreement for any Providers who are paid on a capitated basis the submission of encounter data within ninety (90) Days of the date of service. As applicable, the Provider agreements shall comply with the requirements set forth in this Contract for subcontracts and in accordance with 42 C.F.R. § 434.6. The Contractor shall maintain all Provider agreements in accordance with the provisions specified in 42 C.F.R. § 438.12, 438.214 and this Contract.

Revision 22. F.6.24. a) Screening, Diagnosis and Treatment, the below is hereby added to the end of the paragraph as follows
The contractor must, as determined medically necessary, make available health care, treatment, or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services as states are required to provide any additional 1905(a) services that are coverable under the Federal Medicaid program. It is the responsibility of the Agency to determine medical necessity on a case-by-case basis. For request of services outside of the state covered benefits, the exception to policy process should be followed.

Revision 23. F.12.01. Contractor Service Obligations, is hereby replaced as follows:
F.12.01. *Contractor Service Obligations.* The Contractor shall deliver LTSS to all Enrolled Members meeting the eligibility criteria and authorized to be served by these programs. The Contractor shall provide for: (i) assessment of LTSS (with the exception of 1915(c) and 1915(i) HCBS programs) needs-based eligibility; (ii) service plan review and authorization; (iii) Claims payment; (iv) Provider recruitment; (v) Provider agreement execution; (vi) rate setting; and (vii) providing training and technical assistance to Providers.

Revision 24. F.12.12. LTSS in General, language added in the last sentence, is hereby amended as follows:

For Enrolled Members who require individualized, enhanced staffing patterns to support them in a less-restrictive setting, the Contractor shall not reduce the enhanced staffing arbitrarily without supporting documentation including Provider service documentation and reassessment results of the Enrolled Member's needs.

Revision 25. F.12A.08. Community Transition Activities, the last two paragraph are hereby replaced as follows:

The provider shall complete the MDS, per 42 C.F.R. § 483.112, on Enrolled Members and shall otherwise report transition outcomes related to Enrolled Member transitions to the community from facility settings. The transition assessment shall include, at minimum, an assessment of the Enrolled Member's desire and ability to transition to the community as well as an identification of risks. The Contractor shall develop a transition plan and engage the Enrolled Member and representatives of the Enrolled Member's choosing in the transition plan development process. The transition plan shall address all transition needs and services necessary to safely transition the Enrolled Member to the community including but not limited to: (i) physical and behavioral health needs; (ii) selection of Providers in the community; (iii) housing needs; (iv) financial needs; (v) interpersonal skills; and (vi) safety. The transition plan shall also identify any barriers to a safe transition and strategies to overcome those barriers. If as part of the transition plan the Enrolled Member enrolls in a 1915(c) HCBS Waiver, or 1915(i) state plan HCBS Habilitation program, the needs assessment and service plan requirements described in Iowa Admin. Code chs. 441-78, 441-83 and 441-90 shall apply.

The State currently operates an MFP grant, which provides opportunities for individuals in Iowa to move out of ICF/IDs, Psychiatric Mental Institution for Children (PMIC), inpatient hospital living, and nursing facilities and into their own homes in the community of their choice. During the individual's Demonstration year (365 days), MFP is responsible for leading the IDT and all case management related responsibilities. Therefore, the Contractor shall implement Agency-approved strategies to coordinate care with the MFP transition specialist prior to and during the demonstration year to prevent duplication and fragmentation of care. The Contractor shall document strategies in its PPM. If the MFP grant is no longer authorized by CMS, the Contractor shall assist with the development and implementation of the sustainability plan, subject to the Agency's approval.

Revision 26. F.12B.03. Waiting Lists, is hereby replaced as follows:

F.12B.03. *Waiting Lists.* 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. The 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. 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.

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, and shall be documented in the Member's record consistent with 42 CFR 438.16(d)(1)(iv):

1) Pre-tenancy and tenancy sustaining services: these are services that include tenant rights, education, and eviction prevention. Code: H0043 SC
    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. Code: H0043 SC
    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. Code: T1016 SC
    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. Code: Respite Care 15 minutes – S5150 SC and Group Respite Care 15 minutes – T1005 SC
    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. Code: Personal Care Services delivered by and individual – T1019 SC and Personal Care Services delivered by an agency – S5125 SC
    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). Code: S5170 SC
    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. Code: S5199 SC

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 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. Code: Home Modifications per service – S5165 SC

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. Code: Vehicle Modifications per service – T2039 SC

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. Code: H2015 SC

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. Code: Individual Supported Employment – T2018 SC and Job Coaching – H2025 SC

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. Code: Emergency Response System One Time Installation – S5160 SC and Emergency Response System Service Fee Per Month (excludes installation and testing) - S5161 SC

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. Code: T2029 SC

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. Codes: Day Care Services – Adult Per Diem – S5102 SC and Day Care Services – Adult Per Haf Day – S5101 SC and Day Care Services - Adult Per 15 Minutes – S5100 SC
    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. Code: Per Mile – S0215 SC and Per Trip – T2003 SC
    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.

    This service does not include transportation to medical services.

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 27. F.12B.05. Comprehensive Assessments, is hereby replaced as follows:
F.12B.05. *Comprehensive Assessments*. Upon notification from the Agency of availability of an open 1915(c) waiver slot, the Contractor shall work with the Core Standardized Assessment (CSA) vendor to (i) support assessment completion; (ii) access comprehensive assessment, results, and (iii) ensure seamless data sharing of assessment results.

Revision 28. F.12B.06. HCBS Level of Care and Needs-based Assessments, is hereby replaced as follows:
F.12B.06. *HCBS Level of Care and Needs-based Assessments*. The Contractor shall work

with the CSA vendor to access initial assessment and annual reassessment results. When needed, the Contractor will gather documentation to support level of care determinations.

Revision 29. F.12B.07. Initial Level of Care Assessments, is hereby replaced as follows:
F.12B.07. *Initial Level of Care Assessments.* The Agency is responsible for working with the CSA vendor to perform initial level of care assessments for 1915(c) HCBS Waiver and needs-based eligibility assessments for 1915(i) Habilitation Enrolled Members who are applying for initial Medicaid LTSS eligibility. The Contractor shall provide Enrolled Members any necessary information regarding the waiver application and level of care assessment process.

Revision 30. F.12B.08. Initial Assessment and Annual Reassessment, is hereby replaced as follows:
F.12B.08. *Initial Assessment and Annual Reassessment*. The Contractor shall ensure level of care and needs-based eligibility assessments conducted by the Agency identified vendor 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.12B.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 may submit a wavier to administrative rule 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 for the prompt gathering of supporting documentation needed for assessment and ensure Enrolled Member safety.

Revision 31. F.12B.09. Submission of Level of Care, is hereby replaced as follows:
F.12B.09. *Submission of Level of Care*. The Agency will notify the Contractor when an Enrolled Member has been enrolled in a 1915(c) HCBS Waiver eligibility category or 1915(i) HCBS program and any applicable Client Participation amounts.

Revision 32. F.12B.10. Assessment Requirements, is hereby removed and reserved.

Revision 33. F.12B.11. Timeliness of Level of Care and Needs-based Eligibility Results, is hereby removed and reserved.

Revision 34. F.12B.12. Assessment Policies and Procedures, is hereby replaced as follows:
F.12B.12. *Assessment Policies and Procedures*. The Contractor shall develop policies and procedures for accessing CSA vendor assessment and reassessment results, gathering supporting documentation for assessment, and requesting assessments from the CSA vendor when Enrolled Members have a significant change in condition or situation, or, if there is another reason for an assessment to be conducted. The Contractor shall document such policies and procedures in its PPM.

Revision 35. F.12B.13. Level of Care and Needs-based Eligibility Changes, is hereby replaced as follows:

F.12B.13. *Level of Care and Needs-based Eligibility Changes*. The Contractor shall submit documentation to the CSA vendor, when requested, for all reassessments that indicate change in the Enrolled Member's 1915(c) level of care or needs-based eligibility for the 1915(i) HCBS programs. If the level of care reassessment or needs-based eligibility reassessment conducted by the CSA vendor indicates no change in level of care or needs-based eligibility, the Enrolled Member is approved to continue participation in the 1915(i) or 1915(c) HCBS program at the already established level of care for the particular waiver.

Revision 36. F.12B.17. Service Plan Content, is hereby replaced as follows:

F.12B.17. *Service Plan Content.* In accordance with 42 C.F.R. § 441.301 and § 441.725, Iowa Admin. Code ch. 441-90, Iowa Admin. Code ch. 441-83, and Iowa Admin. Code ch. 441-78, the Contractor shall ensure the service plan reflects the services and supports that are important for the Enrolled Member to meet the needs identified through the needs assessment, and any corresponding clinical assessment protocols, as well as what is important to the Enrolled Member with regard to preferences for the delivery of such services and supports. The service plan shall reflect the Enrolled Member's needs and preferences and how those needs will be met by a combination of covered services and available community supports. The Person-Centered Service Planning process shall be holistic in addressing the full array of medical and non-medical services and supports regardless of funder to ensure the maximum degree of integration and the best possible health Outcomes and participant satisfaction.

Revision 37. F.12B.23. Transitioning Comprehensive Assessment, HCBS Level of Care, and Needs-based Assessment functions for Enrolled Members in 1915(c) HCBS Waiver(s), is hereby replaced as follows:

F.12B.23. *Transitioning Comprehensive Assessment, HCBS Level of Care, and Needs-based Assessment functions for Enrolled Members in 1915(c) and 1915(i) HCBS Programs.* Effective July 1, 2025, for all of the remaining 1915(c) HCBS Waivers and Habilitation, the Contractor shall 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 38. F.12C.06. Discharge Planning, is hereby removed and replaced as follows:

F.12C.06. *Discharge Planning.* The Contractor shall develop, implement, and adhere to policies and procedures to ensure that community-based case managers are actively involved in Discharge Planning when an LTSS Enrolled Member is hospitalized or otherwise served outside of the home. In the event an Enrolled Member is identified as needing an assessment due to change in condition in accordance with the discharge plan, the contractor will alert the CSA vendor of the need for assessment, and the contractor will proceed with updating the Enrolled Member's plan of care. The Contractor shall document its policies and

procedures in its PPM.

Revision 39. F.12C.10. Community-Based Case Management Monitoring, is hereby replaced as follows:

F.12C.10.*Community-Based Case Management Monitoring.* 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) Monitoring to ensure completion of level of care and reassessments and facilitation of documentation gathering and submission of additional information to the CSA vendor;
c) Care plans are developed in accordance with 42 C.F.R. § 438.208(c)(3)(i)-(v), by a person trained in person-centered planning using a person-centered process and plan, with Enrolled Member participation and Provider consultation; and updated on schedule and in compliance with the Contract;
d) 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.
e) Care plans reflect needs identified in the comprehensive needs assessment and reassessment process;
f) Care plans address all of the Enrolled Member's needs;
g) Services are delivered as described in the care plan and authorized by the Contractor;
h) 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;
i) Services are delivered in a timely manner;
j) Service utilization is appropriate;
k) Service gaps are identified and addressed;
l) Minimum community-based case manager contacts are conducted;
m) Case management training and reporting requirements are facilitated in accordance with the Reporting Manual and other Agency guidance.
n) 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.

o) 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.

p) 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 40. F.17.01. Telehealth, is hereby replaced as follows:

F.17.01. *Telehealth.* An in-person contact between a health care professional and an Enrolled Member is not required as a prerequisite for payment for otherwise-covered services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services are provided, as well as being in accordance with provisions under IAC 653-13.11 (147, 148, 272C). Health care services provided through in-person consultations or through telehealth shall be treated as equivalent services for the purposes of reimbursement. There is no additional payment for telehealth components of service associated with the underlying service being rendered. Payment for a service rendered via telehealth is the same as payment made for that service when rendered in an in-person setting. Telehealth services will be as the Agency prescribes. As additional information develops, the Agency will provide guidance to the Contractor and Providers as needed.

Revision 41. G.5.27. Value-Based Purchasing Programs, is hereby replaced as follows:

G.5.27. *Value-Based Purchasing Programs.* Contractor shall identify the goals the Contractor has set to address its strategy for improving the delivery of health care Benefits and services to its Enrolled Members via value-based purchasing programs. The Contractor shall identify the steps to be taken including a timeline with target dates and providing reporting on such timelines and targets consistent with the obligations in the Reporting Manual. The Contractor's VBP programs shall align with the Agency's Quadruple Aim Strategy, including specific detail for the value-based purchasing requirements described in Section E.8 and C.6.

Revision 42. G.5.29. Value-Based Purchasing – PCPs, is hereby replaced as follows:

G.5.29. *Value-Based Purchasing – PCPs*. The specific PCP designation is required for those Enrolled Members under a value-based purchasing arrangement described in Section E.8 and C.6. If using a PCP model, Contractor shall describe the types of physicians eligible to serve as a PCP, any panel size limits or requirements, and proposed policies and procedures to link Enrolled Members to PCPs in its PPM.

Revision 43. G.6.01. Cultural Competence Obligation, is hereby replaced as follows:

G.6.01. *Cultural Competence Obligation*. The 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; and sex stereotypes. See: 42 C.F.R. § 438.206(c)(2);

42 C.F.R. § 457.1230(a); 45 C.F.R. § 92.

Revision 44. I.1.01. Excluded Providers, is hereby replaced as follows:
I.1.01. *Excluded Providers*. The Contractor shall not employ or contract with Providers excluded from participation in Federal and State health care programs. See: 42 C.F.R. § 438.214(d)(1)]. {From CMSC I.1.01}.

Revision 45. I.5.02. Reporting, is hereby replaced as follows:
I.5.02. *Reporting.* The Contractor shall fulfill the reporting requirements in this section, as well as I.5.03, I.5.04, I.5.05, and I.5.06, which include, but are not limited to prompt reporting of all Overpayments identified or recovered within thirty (30) days to the Agency, specifying the Overpayments due to Fraud. The Contractor must submit all reporting in accordance with Agency instructions outlined in the Reporting Manual. The Contractor shall certify all reports in accordance with the requirements of Section I.2.11. See: 42 C.F.R. § 438.608(a)(2); 42 C.F.R. § 457.1285.{From CMSC I.5.08}.

Revision 46. I.5.03. Annual Reports, the CFR references, are hereby amended as follows:
See: 42 C.F.R. § 438.604(a)(7); 42 C.F.R. § 438.606; 42 C.F.R. § 438.608(d)(3); 42 C.F.R. § 457.1285. {From CMSC I.6.05}.

Revision 47. J.2.01. e) The Americans with Disabilities Act, is hereby replaced as follows:
e) The Americans with Disabilities Act

1. The Agency requires the Contractor to comply with the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act. This requirement for compliance includes Contractor compliance with an Interim Memorandum of Understanding (MOU) between Iowa HHS and the National Federation for the Blind, which clarifies expectations for the Contractor to provide accessible documents and information to Blind and seeing-impaired individuals.
2. Specifically, it is the Agency's expectation that the Contractor will comply with Sections VII(a), VII(d), and IX(h) of the MOU.
3. Section VII(a) of the MOU requires HHS and its MCO partners to provide documents in accessible formats when requested by Blind or seeing-impaired individuals. Further, the MOU requires that documents translated into Braille or other accessible formats are mailed within seven (7) business days or emailed within two (2) business days of a request being made. Section VII(d) requires that Iowa HHS ensure contractor compliance with Section VII(a).
4. Section IX(h) requires Iowa HHS to notify its MCO contractors of its expectation that all public-facing websites shall be and remain in compliance with the ADA and Section 504.

Revision 48. Exhibit A. *Exhibit A: Capitation* Rate Information, MLR, Pay for Performance, Liquidated Damages, and Excluded Pharmaceuticals, item 2., is hereby replaced as follows:

2. MLR Information

Revision 49. Exhibit A. Section 3: SFY 2024 Payment for Performance Chart is hereby renamed as follows:
Payment for Performance Chart

Revision 50. Exhibit A. Section 3: Payment for Performance Chart, 4th paragraph is hereby replaced as follows:

The Agency has established a set of Pay For Performance measures with the exception of Performance Standard 5, Performance Standard 5 will may vary for newly accredited Contractors.

Revision 51. Exhibit A. Section 4: Payment for Performance Chart, for SFY2025, is hereby replaced as follows:
Table A: SFY 2026 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 2026 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 first two quarters of SFY2026, 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: Q1 SFY2026 – 10% of withhold earned Q2 SFY2026 – 10% of withhold earned	
Performance Standard 2	**Amount of Performance Withhold at Risk**

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E) -Blood Glucose testing	10%
Standard Description	
The percentage of children and adolescents 1 to 17 years of age with two or more antipsychotic prescriptions who had metabolic testing. Percentage of children and adolescents on antipsychotics who received blood glucose testing.	
Standard Required to Receive Incentive Payment	
The Contractor must calculate this HEDIS measure based on the timeframe of SFY2026 (7/1/25-6/30/26), and the contractor must obtain validation of the SFY2026 results through an authorized NCQA representative. For children and adolescents on antipsychotics who received blood glucose testing, the Contractor must increase from their CY2024 results (Measurement Year 2024 results, to be reported in 2025) by the percentage identified in the chart below to accrue the corresponding withhold payment. •Increase by 3% or more – 100% of withhold earned •Increase by 2.0-2.99% – 75% of withhold earned •Increase by 1.0-1.99% – 50% of withhold earned •Increase by 0.99% or less – 0% of withhold earned	
Performance Standard 3	**Amount of Performance Withhold at Risk**
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM–E) - Cholesterol testing	10%
Standard Description	
The percentage of children and adolescents 1 to 17 years of age with two or more antipsychotic prescriptions who had metabolic testing. Percentage of children and adolescents on antipsychotics who received cholesterol testing.	
Standard Required to Receive Incentive Payment	
The Contractor must calculate this HEDIS measure based on the timeframe of SFY2026 (7/1/25-6/30/26), and the contractor must obtain validation of the SFY2026 results through an authorized NCQA representative. For children and adolescents on antipsychotics who received cholesterol testing, the Contractor must increase from their CY2024 results (Measurement Year 2024 results, to be reported in 2025) by the percentage identified in the chart below to accrue the corresponding withhold payment. • Increase by 3% or more – 100% of withhold earned • Increase by 2.0-2.99% – 75% of withhold earned	

- Increase by 1.0-1.99% – 50% of withhold earned
- Increase by 0.99% or less – 0% of withhold earned

Performance Standard 4	Amount of Performance Withhold at Risk
Prenatal and Postpartum Care: Timeliness of Prenatal Care	20%

Standard Description

Percentage of deliveries of live births within the period under review that received a prenatal care visit in the first trimester, on or before the enrollment start date or within forty-two (42) days of enrollment in Medicaid or CHIP.

Standard Required to Receive Incentive Payment

The Contractor must calculate this HEDIS measure based on the timeframe of SFY2026 (7/1/25-6/30/26), and the contractor must obtain validation of the SFY2026 results through an authorized NCQA representative. This measure shall be calculated using administrative data only and compared to the baseline (administrative data only) measurement of CY2024.

For deliveries of live births within the period under review that received a prenatal care visit in the first trimester, on or before the enrollment start date or within forty-two (42) days of enrollment in Medicaid or CHIP, the Contractor must increase from their CY2024 results (Measurement Year 2024 results, to be reported in 2025) by the percentage identified in the chart below to accrue the corresponding withhold payment.

•Increase by 2% or more – 100% of withhold earned
•Increase by 1.1-1.99% – 75% of withhold earned
•Increase by 0.75-1.09% – 50% of withhold earned
•Increase by 0.74% or less – 0% of withhold earned

Performance Standard 5	Amount of Performance Withhold at Risk
NCQA Health Plan Ratings	20%

Standard Description

Maintaining high quality health plan experiences as measured by NCQA Health Plan Ratings.

Standard Required to Receive Incentive Payment

The Contractor will achieve and maintain or improve their scores for each of the following NCQA Health Plan Ratings categories for MY2025, also known as CY2025 (1/1/25-12/31/25) which is due to be reported by NCQA in September 2026:

Overall Star Rating

Patient Experience

Prevention and Equity

Treatment

100% of the amount of performance withhold at risk will be earned for achieving ONE of the following in their MY2025 NCQA Health Plan Ratings:

1. Achieving a 4-star rating for the Overall Rating

2. Achieving a 3.5-star rating for any TWO of the following three categories:

a) Patient Experience

b) Prevention and Equity

c) Treatment

75% of the amount of performance withhold at risk will be earned for achieving the following in their MY2025 NCQA Health Plan Ratings (Newly Accredited Contractors Only):

1. Achieving a 3.5-star rating for the Overall Rating

50% of the amount of performance withhold at risk will be earned for achieving the following in their MY2025 NCQA Health Plan Ratings:

Achieving a 3.0-star rating for ALL THREE of the following categories:

a) Patient Experience

b) Prevention and Equity

c) Treatment

The Contractor will earn the highest single percentage achieved – multiple percentages will not be earned.

Performance Standard 6	**Amount of Performance Withhold at Risk**
Reporting for LTSS Measures	20%
Standard Description	
Reporting on LTSS measures, including mandatory measures, HCBS 10, MLTSS Plan All Cause Readmission, and MLTSS 4.	
Standard Required to Receive Incentive Payment	
The Contractor must calculate all the following measures based on the timeframe of CY2025 (1/1/25-12/31/25), and the Contractor must obtain and submit to HHS validation of the CY2025 results by an authorized NCQA representative: 1. LTSS-2: LTSS Comprehensive Care Plan and Update 2. MLTSS-4: LTSS Reassessment/Care Plan Update after Inpatient Discharge 3. LTSS-6: LTSS Admission to a Facility from the Community 4. LTSS-7: LTSS Minimizing Facility Length of Stay	

5. LTSS-8: LTSS Successful Transition After Long-Term Facility Stay
6. HCBS-10: Self-Direction of services and supports among Medicaid beneficiaries receiving LTSS through managed care organizations
7. MLTSS: Plan All Cause Readmission (HEDIS)

The Contractor must submit NCQA-validated calculations (not just policies and procedures) for all eight measures listed above to earn 100% of the amount of performance withhold at risk. Missing measures or calculations will result in earning 0% of the amount of withhold at risk.

Revision 52. Exhibit A. Section 4: Liquidated Damages, item 15 Member Services, is hereby amended as follows:

15	Member Services	1915(c) and 1915(i) HCBS Programs Care Plan Development	Contractor shall complete ninety-seven percent (97%) of all plans of care and authorize and initiate all long-term care services specified in the plan of care for a 1915(c) and 1915(i) HCBS program enrollees within the timeframe outlined by the Agency. Exceptions will be allowed as identified in the reporting manual.	$1,000 per occurrence lower than the 97% threshold

Revision 53. Exhibit B. Glossary of Terms/Definitions, Case Management definition, is hereby replaced as follows:

Provides service coordination and monitoring. Available as a 1915 (i) Habilitation service when the individual is not enrolled in an Integrated Health Home and does not otherwise qualify for targeted case management.

Revision 54. Exhibit B. Glossary of Terms/Definitions, CSA, is hereby added as follows:

CSA: Core Standardized Assessment

Revision 55. Exhibit B. Glossary of Terms/Definitions, Chronic Condition Health Home ("CCHH") is hereby removed.

Revision 56. Exhibit B. Glossary of Terms/Definitions, Clean Claim definition, is hereby replaced as follows:

Clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in the Contractor's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. See: 42 CFR § 447.45(b)

Revision 57. Exhibit B. Glossary of Terms/Definitions, Health Insurance, is hereby added as follows:

Health Insurance: Financial coverage to cover a portion of the cost of a policyholder's medical bills. May be a public coverage program such as Medicare, Medicaid, MCO's; CHIP, Indian Health Services. May be private health care such as provided by an employers or purchased in the market.

Revision 58. Exhibit B. Glossary of Terms/Definitions, Iowa Medicaid Portal Access, is hereby added as follows:
IMPA: Iowa Medicaid Portal Access

Revision 59. Exhibit B. Glossary of Terms/Definitions, Prescription Drug Coverage, is hereby added as follows:
Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Revision 60. Exhibit B. Glossary of Terms/Definitions, Reporting Manual definition, is hereby replaced as follows:
The document to be distributed by the Agency detailing the reporting requirements for the Program. Reference the State of Iowa Department of Health and Human Services, Iowa Medicaid Managed Care Organization (MCO) Reporting Manual.

Revision 61. Exhibit B. Glossary of Terms/Definitions, Readily Accessible, the below two paragraphs are hereby added to the definition as follows:
The Agency requires the Contractor to comply with the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act. This requirement for compliance includes Contractor compliance with an Interim Memorandum of Understanding (MOU) between Iowa HHS and the National Federation for the Blind, which clarifies expectations for the Contractor to provide accessible documents and information to Blind and seeing-impaired individuals.
Specifically, it is the Agency's expectation that the Contractor will comply with Sections VII(a), VII(d), and IX(h) of the MOU.

Section VII(a) of the MOU requires HHS and its MCO partners to provide documents in accessible formats when requested by Blind or seeing-impaired individuals. Further, the MOU requires that documents translated into Braille or other accessible formats are mailed within seven (7) business days or emailed within two (2) business days of a request being made. Section VII(d) requires that Iowa HHS ensure contractor compliance with Section VII(a).

Section IX(h) requires Iowa HHS to notify its MCO contractors of its expectation that all public-facing websites shall be and remain in compliance with the ADA and Section 504.

Revision 62. Exhibit D. Table D.01: Eligible Enrollees, Pregnant Women, is hereby replaced as follows:

POPULATION	DESCRIPTION
Pregnant Women	Individuals eligible in accordance with 42 C.F.R. § 435.116. A woman who is pregnant with income at or below 215% FPL or at or below 300% FPL for Hawki.

Revision 63. Exhibit E. Table E.01: Full Medicaid Covered Benefits and Limitations, is hereby replaced as follows:

SERVICE	LIMITATIONS
1915(C) SERVICES	The Contractor shall cover 1915(c) waiver services as authorized in accordance with the federal waiver.
1915(I) HABILITATION SERVICES	The Contractor shall cover 1915(i) State Plan services as authorized in accordance with the federal State Plan amendment.
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.

ALLERGY TESTING AND INJECTIONS	Contractor to use UM guidelines established.
ANESTHESIA	Contractor to use UM guidelines established.
B3 SERVICES	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.
BARIATRIC SURGERY	Contractor to use UM guidelines established.
BHIS (INCLUDING ABA)	Contractor to use UM guidelines established.
BREAST RECONSTRUCTION	Contractor to use UM guidelines established.
BREAST REDUCTION	Contractor to use UM guidelines established.
CARDIAC REHABILITATION	Contractor to use UM guidelines established.
CHEMOTHERAPY	Contractor to use UM guidelines established.
CHIROPRACTIC CARE (THERAPEUTIC ADJUSTIVE MANIPULATION)	Refer to the Iowa Health and Human Services Chiropractic Serves Provider Manual.
COLORECTAL CANCER SCREENING	Contractor to use UM guidelines established.
CONGENITAL ABNORMALITIES CORRECTION	Contractor to use UM guidelines established.
DAIBETIES EQUIP AND SUPPLIES	Contractor to use UM guidelines established.
DIAGNOSTIC GENGETIC TESTING	Contractor to use UM guidelines established.
DIALYSIS	Contractor to use UM guidelines established.
DURABLE MEDICAL EQUIPMENT AND SUPPLIES	Refer to the Iowa Health and Human Services Medical Equipment and Supply Dealer Provider Manual.
EMERGENCY ROOM SERVICES	Contractor to use UM guidelines established.
EPSDT	Refer to Iowa Health and Human Services Pediatric Provider Manual-EPSDT section.
FAMILY PLANNING	Contractor to use UM guidelines established.
FOOT CARE	Contractor to use UM guidelines established.
GENERAL INPATIENT HOSPITAL CARE	Contractor to use UM guidelines established.
GENETIC COUNSELING	Contractor to use UM guidelines established.

GYNOCOLOGICAL EXAMS	Contractor to use UM guidelines established.
HEARING AIDS	Contractor to use UM guidelines established.
HEARING EXAMS	Refer to Iowa Health and Human Services Audiologist and Hearing Aid Dispenser Provider Manual.
HOME HEALTH	• Skilled nursing is limited to five (5) visits per week. • Home health aide is limited to visits that do not exceed twenty-eight (28) hours per week • Occupational therapy is limited to physician-authorized visits within guidelines for restorative, maintenance or trial therapy • Physical therapy is limited to physician-authorized visits within guidelines defined for restorative, maintenance or trial therapy • Speech pathology is limited to physician-authorized visits within guidelines defined for restorative, maintenance or trial therapy
HOSPICE	Contractor to use UM guidelines established.
ICF/ID	Must meet level of care.
IMAGING/DIAGNOSTICS (MRI, CT, PET)	Contractor to use UM guidelines established.
IMMUNIZATIONS	Contractor to use UM guidelines established.
INFERTILITY DIAGNOSIS AND TREATMENT	Contractor to use UM guidelines established.
INHALATION THERAPY	Contractor to use UM guidelines established.
INPATIENT PHYSICIAN SERVICES	Contractor to use UM guidelines established.
INPATIENT SURGICAL SERVICES	Contractor to use UM guidelines established.
IV INFUSION SERVICES	Contractor to use UM guidelines established.
LAB TESTS	Contractor to use UM guidelines established.
MATERNITY AND PREGNANCY SERVICES	Contractor to use UM guidelines established.
MEDICAL TRANSPORTATION	Contractor to use UM guidelines established.
MENTAL HEALTH/BEHAVIORAL HEALTH OUTPATIENT TREATMENT	Contractor to use UM guidelines established.
MENTAL/BEHAVIORAL HEALTH INPATIENT TREATMENT	Contractor to use UM guidelines established.
MIDWIFE SERVICES	Contractor to use UM guidelines established.

NEMT	Contractor to use UM guidelines established. See standards in Special Contract Exhibit F.
NEWBORN CHILD COVERAGE	Contractor to use UM guidelines established.
NON-COSMETIC RECONSTRUCTIVE SURGERY	Contractor to use UM guidelines established.
NURSING FACILITY	Must meet level of care.
NURSING SERVICES	• Private duty nursing and personal care services are covered as a benefit under EPSDT as provided through a home health agency for up to sixteen (16) hours per day.
NUTRITIONAL COUNELING	Contractor to use UM guidelines established.
OCCUPATIONAL THERAPY	Contractor to use UM guidelines established.
ORTHOTICS	Refer to the Iowa Health and Human Services Medical Equipment and Supply Dealer Provider Manual.
OUTPATIENT SURGERY	Contractor to use UM guidelines established.
PATHOLOGY	Contractor to use UM guidelines established.
PHARMACY	• Prior Authorization is required as specified in the PDL: http://www.iowamedicaidpdl.com/ • Reimbursement is only for drugs marketed by manufacturers with a signed rebate agreement. • Coverage of drugs in the following categories is excluded: (1) Drugs whose prescribed use is not for a Medically Accepted Indication as defined by Section 1927(k)(6) of the Social Security Act. (2) Drugs used for anorexia, weight gain, or weight loss. (3) Drugs used for cosmetic purposes or hair growth. (4) Otherwise covered outpatient drugs if the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or the manufacturer's designee. (5) Drugs described in Section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the C.F.R. (drugs identified through the Drug Efficacy Study Implementation (DESI) review)). (6) "Covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any "Part D eligible individual" as defined by 42 U.S.C. Section 1395w-101(a)(3)(A), including an Enrolled Member who is not enrolled in a Medicare Part D plan. (7) Drugs prescribed for fertility purposes, except when prescribed

	for a Medically Accepted Indication other than infertility (8) Drugs used for sexual or erectile dysfunction (9) Drugs for symptomatic relief of cough and colds, except listed nonprescription drugs • Only certain nonprescription (OTC) drugs and non-drugs are covered as listed on www.iowamedicaidpdl.com. • Quantity: A one-month supply of covered prescription and nonprescription medication or a three-month supply for any medication on the 90-Day Supply Allowance Prescription List. Some drugs are limited to an initial 15-day supply. Guidelines can be found on the HHS website: www.iowamedicaidpdl.com • Monthly quantity limits by drug list: www.iowamedicaidpdl.com • Reimbursement consistent with Iowa Admin. Code r. 441-79.1(8).
PHYSICAL THERAPY	Contractor to use UM guidelines established.
PMIC	Contractor to use UM guidelines established.
PRIMARY CARE ILLNESS/INJURY PHYSICIAN SERVICES	Contractor to use UM guidelines established.
PROSTATE CANCER SCREEING	Contractor to use UM guidelines established.
PROSTETICS	Contractor to use UM guidelines established.
PULMONARY REHABILITATION	Contractor to use UM guidelines established.
RADIATION THERAPY	Contractor to use UM guidelines established.
SCREEING PAP TESTS	Contractor to use UM guidelines established.
SCREENING MAMMOGRAPHY	Contractor to use UM guidelines established.
SECOND SURGICAL OPTION	Contractor to use UM guidelines established.
SKILLED NURSING SERVICES	Contractor to use UM guidelines established.
SLEEP STUDIES	Contractor to use UM guidelines established.
SPECIALTY PHYSICIAN SERVICES	Contractor to use UM guidelines established.
SPEECH THERAPY	Contractor to use UM guidelines established.
SUBSTANCE USE DISORDER INPATIENT TREATMENT	Contractor shall use The ASAM Criteria as the UM guidelines for substance use disorder services.
SUBSTANCE USE DISORDER	Contractor shall use The ASAM Criteria as the UM guidelines for substance use disorder services.

OUTPATIENT TREATMENT	
TOBACCO CESSATION	Contractor to use UM guidelines established.
TOBACCO CESSATION FOR PREGNANT WOMEN	Contractor to use UM guidelines established.
TRANSPLANT - ORGAN AND TISSUE	Contractor to use UM guidelines established.
URGENT CARE CENTERS/FACILITIES EMERGENCY CLINICS (NON-HOSPITAL BASED)	Contractor to use UM guidelines established.
VISION CARE EXAMS	Refer to the Iowa Health and Human Services Optometrist and Optician Provider Manual.
VISION FRAMES AND LENSES	Refer to the Iowa Health and Human Services Optometrist and Optician Provider Manual.
WALK-IN CENTER SERVICES	Contractor to use UM guidelines established.
X-RAYS	Contractor to use UM guidelines established.
**ALL OTHER SERVICES IN STATE PLAN OR APPLICABLE WAIVERS THAT ARE NOT LISTED ABOVE OR ARE ADDED IN THE FUTURE	Contractor to use UM guidelines established.

Revision 64. Exhibit E. Table E.02: Iowa Wellness Plan Benefits Coverage List, is hereby replaced as follows:

Table E.02: Iowa Wellness Plan Benefits Coverage List

Service Category	Covered	Duration, Scope, exclusions, and Limitations	Excluded Coding
1. Ambulatory Services			
Primary Care Illness/injury Physician Services	□		Athletic Trainers are not covered.
Specialty Physician Visits	□		

Home Health Services	☐	Private Duty Nursing/Personal Care Services are only available to 19 and 20 year olds through EPSDT	Not Covered: Custodial home care services and supplies, which help with daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel. Some examples of custodial care are assistance in walking and getting in and out of bed; aid in bathing, dressing, feeding and other forms of assistance with normal bodily functions; preparation of special diets; and supervision of medication that can usually be self-administered. In order for care to be approved, must be approved by physician.
Chiropractic Care therapeutic adjustive manipulative	☐		
Outpatient surgery	☐		
Second Surgical Opinion	☐		
Allergy Testing & Injections	☐		
Chemotherapy-Outpatient	☐		
IV Infusion Services	☐		
Radiation Therapy Outpatient	☐		

Dialysis	□	Covered as an inpatient or in a Medicare approved dialysis center (outpatient).	
Anesthesia	□		
Walk-in Centers	□		
AIDS/HIV parity	□		
Access to clinical trials	□	Medical necessity will be determined on a case-by-case basis through the Prior Authorization process.	
TMJ	□		
Genetic Counseling	□	Prior Authorization required. Must be an appropriate candidate and outcome is expected to determine a covered course of treatment and not just informational.	
2. Emergency Services			
Emergency Room Services	□		

Emergency Transportation-Ambulance and Air Ambulance	☐	No other method of transportation is appropriate. Services required to treat patient illness or injury are not available in the facility where the patient is currently receiving care if patient is an inpatient at a facility. Patient is transported to the nearest hospital or nursing facility in network with adequate facilities to treat condition. In emergency situation, patient may seek care at the nearest appropriate facility whether the facility is in or out of network.	
Urgent Care Centers/Facilities Emergency Clinics (non-hospital)	☐		
3. Hospitalization			
General Inpatient Hospital Care	☐		
Inpatient Physician Services	☐		

Inpatient Surgical Services	□		
Non-Cosmetic Reconstructive Surgery	□	Cosmetic services, supplies or drugs are not covered unless provided primarily to restore function lost or impaired as the result of an illness, accidental injury, or a birth defect including treatment for any complications resulting from noncovered cosmetic procedures.	
Transplant Organ and Tissue	□	Covered- certain bone marrow/stem cell transfers from a living donor, heart, heart/lung, kidney, liver, lung, pancreas, pancreas/kidney, small bowel. Not Covered- transport of living donor, services/supplies related to mechanical or non- human organs, transplant services and supplies not listed in this section including complications.	
Congenital Abnormalities Correction	□		
Anesthesia	□		
Hospice Care – Inpatient and Outpatient	□	Terminally ill patient and have a life expectancy of six months or less.	

Hospice Respite - Inpatient	☐	Limited to fifteen (15) Days per lifetime for inpatient respite care. Fifteen (15) Days per lifetime for outpatient hospice respite care. Hospice respite care must be used in increments of not more than five (5) Days at a time.	Revenue code for Hospice Respite: 655
Chemotherapy - Inpatient	☐		
Radiation Therapy - Inpatient	☐		
Breast Reconstruction	☐		
4. Maternity & Newborn Care			
Maternity/Pregnancy Services - Pre & Postnatal Care - Delivery & Inpatient maternity - Nutritional	☐	Enrolled Member is required to report pregnancy and eligibility for consideration of Benefits under the Medicaid State Plan. If length of stay is less than 48 hours, a follow-up postpartum home visit by an RN is covered.	Maternity care and newborn care not covered if mother is a surrogate mother. Would not cover a person for surrogate only purposes.
Tobacco Cessation for Pregnant Women	☐		
Midwife Services	☐		
5. Mental Health Behavioral Health Substance Use Disorder			
Mental Health/Behavioral Health Inpatient Treatment	☐	Those with disabling mental disorders will be considered Medically Exempt and enrolled in the Medicaid State Plan. Residential treatment is not covered.	Not covered: Code H0019

Mental Health/Behavioral Health Outpatient Treatment	☐	Those with disabling mental disorders will be considered Medically Exempt and enrolled in the Medicaid State Plan.	
Substance Use Disorder Inpatient Treatment	☐	Enrolled Members with disabling substance use disorder will be considered Medically Exempt and enrolled in the Medicaid State Plan. Residential treatment is not covered.	Not covered: Code H0017, H0018, H2034
Substance Use Disorder Outpatient Treatment	☐	Enrolled Members with disabling substance use disorder will be considered Medically Exempt and enrolled in the Medicaid State Plan.	
6. Prescription Drugs			
Prescription Drugs	☐	Iowa's ABP prescription drug benefit plan is the same (duplication of plan) as the approved Medicaid State Plan for prescribed drugs.	
7. Rehabilitative and Habilitative Services and Devices			
Physical Therapy, Occupational Therapy, Speech Therapy	☐	Rehabilitative speech therapy services are covered when related to a specific illness, injury, or impairment and involve the mechanics of phonation, articulation or swallowing. Services must be provided by a	Each therapy is limited to sixty (60) per year: Therapy services must be billed with the GP, GO, or GN modifier. Refer to Medicare's guidance on billing of therapy services.

		licensed or certified speech pathologist. Speech therapy requires prior approval. Not Covered: Physical therapy and occupational therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization. Speech therapy not provided by licensed or certified speech therapist. PT, OT and ST are considered rehab/hab services. The 60-visit limit is combined between habilitation and rehabilitation; however, the limit may be exceeded based on medical necessity.	
Inhalation therapy	□	Limit of sixty (60) visits in a twelve (12) month period.	N/A
Medical and Surgical supplies	□	Non-covered- elastic stockings or bandages including trusses, lumbar braces, garter belts and similar items that can be purchased without a prescription	

Durable Medical Equipment	□	Non-covered items include: elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that are available for purchase without a prescription.	
Orthotics	□		
Prosthetics	□		
Cardiac Rehabilitation	□		
Pulmonary Rehabilitation	□		
Skilled Nursing Services	□	Covered in nursing facilities, skilled nursing facilities and hospital swing beds.	This service is limited to one hundred twenty (120) Days per year.
8. Laboratory Services			
Lab Tests	□		
X-Rays	□		
Imaging/Diagnostics MRI CT PET	□		
Sleep Studies	□	Treatment for snoring not covered. Claims must be for a diagnosis of sleep apnea.	Services 95800-95811 are covered but not with a diagnosis of respiratory impairment.
Diagnostic Genetic Tests	□	Requires Prior Authorization. Genetic molecular testing and related counseling are covered if appropriate candidate for a test under medically recognized standards (i.e. family background, past diagnosis etc.) and outcome of test is expected to determine a	

		covered course of treatment or prevention and is not merely informational.	
Pathology	□		
9. Preventive Wellness Chronic Disease Management			
Preventive Care	□	Limited to ACA required preventive services.	
Nutritional Counseling	□	Max forty (40) units allowed for twelve (12) month period	
Counseling and Education Services	□	Not covered: Bereavement, family, or marriage counseling. Education other than diabetes.	N/A
Family Planning	□		
Vision Care Exams (Adult)	□	Not covered - Surgery to correct a refractive error, eyeglasses or contact lenses including charges related to fitting, prescribing of corrective lenses, eye examinations for the fitting of eye wear. This does not limit the medical exams for Enrolled Members. Medical exams should be coded properly for accurate Claim adjudication.	Not covered: V2020, V2025, V2100-V2115, V2118, V2121, V2199, V2200- V2221, V2299, V2300-V2315, V2318-V2321, V2399, V2410, V2430, V2499, V2500-V2503, V2510-V2513, V2520-V2523, V2530-V2531, V2599, V2600, V2610, V2615, V2700-V2799, 76512, 92015, 92310, 92314, 92325, 92326, 92340, 92341, 92342, 92370, 92390, 92391, V2399, V2410, V2430, V2499, V2500-V2503, V2510-V2513, V2520-V2523, V2530-

			V2531, V2599, V2600, V2610, V2615, V2700-V2799, 76512, 92015, 92310, 92314, 92325, 92326,92340, 92341, 92342, 92370, 92390, 92391
Immunizations	□	Not covered-immunizations for travel	Not covered: 90476, 90477, 90581, 90585, 90586, 90690, 90691, 90717, 90738
Colorectal Cancer Screening	□		
Screening Mammography	□	One (1) per year.	
Hearing Exam (Adult)	□	Limit of one (1) hearing exam per year. Hearing aids not covered.	Not covered: V5010, V5014,V5030, V5040, V5050, V5060, V5070, V5080, V5090, V5120, V5130, V5140, V5150, V5160, V5170, V5180, V5190, V5200, V5210, V5220, V5230, V5266, V5267, V5298, V5299, V5240, V5264, V5266, V5267, V5298, V5299
Diabetes - med necessary equip & supplies Education	□		

Screening Pap tests	□		
Gynecological exam	□	One (1) per year	
Prostate cancer screening	□	One (1) per year for men age fifty (50) to sixty-four (64) years	
Foot Care	□	Must be related to medical condition, routine services are not covered.	
Tobacco Cessation	□	Immunizations and medical eval for nicotine dependence	
10. Pediatric Services including oral & vision			
EPSDT Ages 19 and 20	□	Covered for ages nineteen (19) to twenty (20)	
EPSDT - Multi-Systemic Therapy	□	Covered up to age 20	
EPSDT - Family Functional Therapy	□	Covered up to age 20	
Benefits Not Provided			
Acupuncture	**X**	Not covered	
Infertility Diagnosis and Treatment	**X**	Not covered- infertility treatment resulting from voluntary sterilization, relating to collection/purchase of donor semen or eggs, freezing of the same, surrogate services, infertility diagnosis and treatment, and tubal/vasectomy reversals, fertility drugs.	

Bariatric Surgery	**X**	Not covered.	Not covered: 00797, 43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774,43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888, S2083 DRGs:619, 620, 621
Residential Services	**X**		
Non-emergency Transportation Services	**X**	Covered only for Enrolled Members determined Medically Exempt.	Covered only for Enrolled Members determined Medically Exempt.
Tobacco Cessation	**X**	Not covered	
Breast Reduction	**X**		CPT codes 19318 or 19316, ICD proc codes: 85.31, 85.32, 85.6. Code 00402 not covered if billed with diagnosis 611.1.
Hearing Aid	**X**	Not covered	
Frames and lenses	**X**	Not covered	

Revision 65. Exhibit H. State Directed Payments H.1, is hereby replaced as follows:
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 pre-print approval by CMS for SFY26

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, 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. The supplemental (directed) payment brings the final reimbursement to an Average Commercial Rate level, which is approximately 378.05% of Medicaid.

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 SFY26 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.

Revision 66. Exhibit H. State Directed Payments H.2, is hereby replaced as follows:

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. Currently, only the University of Iowa Hospitals and Clinics (UIHC) meets the eligibility criteria for this directed payment arrangement.

For the SFY26 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 SFY26 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 SFY26

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 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 74.57% of Medicare for Inpatient services and 83.71% of Medicare for Outpatient services. The supplemental (directed) payment brings the final reimbursement to an Average Commercial Rate level, which is approximately 260.51% of Medicare for Inpatient services and 294.75% for Outpatient services

Revision 67. Exhibit H. State Directed Payments H.3, is hereby replaced as follows:
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. 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 SFY25 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 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 SFY26 contract period will be based on actual emergency transportation service utilization within the contract period and is structured such that the MCOs pay both the customary Medicaid rate and the supplemental provider-specific prospective rate when adjudicating claims. The provider-specific prospective payment rate, billed under procedure code A0999,

represents the additional uncompensated actual costs necessary to perform EMS transports based on submitted cost reports. Base reimbursement for the eligible emergency transportation services is Iowa Medicaid reimbursement. The supplemental (directed) payment brings the final reimbursement to approximately 10 times the standard Medicaid reimbursement.

Revision 68. Exhibit J. Managed Care Premium Tax item 6., is hereby added as follows:

6. The Premium Tax Supplemental Guide is available to the Contractor in the Iowa Medicaid Portal Access (IMPA) under "MCO Reporting and Resources."

Revision 69. Effective January 1, 2025, the state is updating the rates for SFY26. Updated Special Contract Amendment below.

Revision 70. Federal Funds. The following federal funds information is provided

Contract Payments include Federal Funds? Yes **UEI#:** N5Y6EB7R3FS8 **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, Wellpoint Iowa, Inc.		**Agency, Iowa Department of Health and Human Services**	
Signature of Authorized Representative: Teresa T Hussey	Date: 6/18/2025	Signature of Authorized Representative: Kelly Garcia	Date: 06/20/2025

Printed Name: Theresa Hursey	Printed Name: Kelly Garcia
Title: CEO and Plan President	Title: Director

Special Contract Amendment- SFY2026 Rates

SFY26 Rating Withhold Summary

Paid to MCOs

			Wellpoint Rates						Premium Tax	
Cap Group	Rate Cell	SFY24 Statewide MMs	Rates - Less Add-ons	Withhold PMPM	Rates - Less Withhold, Less Add-ons	GME PMPM	GEMT PMPM	Rates - Less Withold, Plus Add-ons	Loaded Rates - Less Withold, Plus Add-ons	Loaded Rates - Plus Add-ons
Reference			(A)	(B) = (A) * 2%	(C) = (A) - (B)	(D)	(E)	(F) = (C) + (D) + (E)	(G) = (F) / (1 - 0.950%)	(H) = [(A) + (D) + (E)] / (1 - 0.950%)
H	Children 0-59 days M&F	50,469	$ 3,045.98	$ 60.92	$ 2,985.06	$ 5.04	$ 4.10	$ 2,994.20	$ 3,022.92	$ 3,084.42
H	Children 60-364 days M&F	189,102	$ 349.07	$ 6.98	$ 342.09	$ 5.04	$ 2.29	$ 349.42	$ 352.77	$ 359.82
H	Children 1-4 M&F	723,137	$ 228.53	$ 4.57	$ 223.96	$ 5.04	$ 1.50	$ 230.50	$ 232.71	$ 237.32
H	Children 5-14 M&F	1,528,605	$ 223.52	$ 4.47	$ 219.05	$ 5.04	$ 0.93	$ 225.02	$ 227.18	$ 231.69
H	Children 15-20 F	319,187	$ 379.52	$ 7.59	$ 371.93	$ 5.04	$ 4.21	$ 381.18	$ 384.84	$ 392.50
H	Children 15-20 M	307,109	$ 284.61	$ 5.69	$ 278.92	$ 5.04	$ 2.77	$ 286.73	$ 289.48	$ 295.22
1	CHIP - Hawki	675,431	$ 215.53	$ 4.31	$ 211.22	$ -	$ 0.81	$ 212.03	$ 214.06	$ 218.41
H	Non-Expansion Adults 21-34 F	327,411	$ 543.84	$ 10.88	$ 532.96	$ 5.04	$ 6.41	$ 544.41	$ 549.63	$ 560.62
H	Non-Expansion Adults 21-34 M	76,215	$ 327.50	$ 6.55	$ 320.95	$ 5.04	$ 5.00	$ 330.99	$ 334.16	$ 340.78
H	Non-Expansion Adults 35-49 F	229,650	$ 837.84	$ 16.76	$ 821.08	$ 5.04	$ 7.53	$ 833.65	$ 841.65	$ 858.57
H	Non-Expansion Adults 35-49 M	91,304	$ 586.00	$ 11.72	$ 574.28	$ 5.04	$ 5.72	$ 585.04	$ 590.65	$ 602.48
H	Non-Expansion Adults 50+ M&F	45,126	$ 1,035.44	$ 20.71	$ 1,014.73	$ 5.04	$ 7.55	$ 1,027.32	$ 1,037.17	$ 1,058.08
I	Pregnant Women	135,961	$ 388.96	$ 7.78	$ 381.18	$ 5.04	$ 3.46	$ 389.68	$ 393.42	$ 401.27
J	WP 19-24 F (Medically Exempt)	9,476	$ 1,949.29	$ 38.99	$ 1,910.30	$ -	$ 27.78	$ 1,938.08	$ 1,956.67	$ 1,996.03
J	WP 19-24 M (Medically Exempt)	7,641	$ 2,050.43	$ 41.01	$ 2,009.42	$ -	$ 22.86	$ 2,032.28	$ 2,051.77	$ 2,093.18
J	WP 25-34 F (Medically Exempt)	34,644	$ 1,891.03	$ 37.82	$ 1,853.21	$ -	$ 31.10	$ 1,884.31	$ 1,902.38	$ 1,940.57
J	WP 25-34 M (Medically Exempt)	34,526	$ 1,644.64	$ 32.89	$ 1,611.75	$ -	$ 34.47	$ 1,646.22	$ 1,662.01	$ 1,695.21
J	WP 35-49 F (Medically Exempt)	58,263	$ 2,049.41	$ 40.99	$ 2,008.42	$ -	$ 30.00	$ 2,038.42	$ 2,057.97	$ 2,099.35
J	WP 35-49 M (Medically Exempt)	55,976	$ 1,801.37	$ 36.03	$ 1,765.34	$ -	$ 46.19	$ 1,811.53	$ 1,828.90	$ 1,865.28
J	WP 50+ M&F (Medically Exempt)	85,612	$ 2,679.32	$ 53.59	$ 2,625.73	$ -	$ 47.10	$ 2,672.83	$ 2,698.47	$ 2,752.57
K	WP 19-24 F (Non-Medically Exempt)	230,316	$ 357.82	$ 7.16	$ 350.66	$ -	$ 4.07	$ 354.73	$ 358.13	$ 365.36
K	WP 19-24 M (Non-Medically Exempt)	198,303	$ 242.66	$ 4.85	$ 237.81	$ -	$ 3.75	$ 241.56	$ 243.88	$ 248.77
K	WP 25-34 F (Non-Medically Exempt)	287,549	$ 463.92	$ 9.28	$ 454.64	$ -	$ 4.51	$ 459.15	$ 463.55	$ 472.92
K	WP 25-34 M (Non-Medically Exempt)	258,250	$ 391.33	$ 7.83	$ 383.50	$ -	$ 5.55	$ 389.05	$ 392.78	$ 400.69
K	WP 35-49 F (Non-Medically Exempt)	302,449	$ 737.96	$ 14.76	$ 723.20	$ -	$ 6.28	$ 729.48	$ 736.48	$ 751.38
K	WP 35-49 M (Non-Medically Exempt)	288,760	$ 589.80	$ 11.80	$ 578.00	$ -	$ 8.95	$ 586.95	$ 592.58	$ 604.49
K	WP 50+ M&F (Non-Medically Exempt)	464,419	$ 1,023.44	$ 20.47	$ 1,002.97	$ -	$ 9.70	$ 1,012.67	$ 1,022.38	$ 1,043.05
M	ABD Non-Dual <21 M&F	127,575	$ 1,415.25	$ 28.31	$ 1,386.94	$ 5.04	$ 6.75	$ 1,398.73	$ 1,412.15	$ 1,440.73
M	ABD Non-Dual 21+ M&F	229,723	$ 2,449.59	$ 48.99	$ 2,400.60	$ 5.04	$ 39.48	$ 2,445.12	$ 2,468.57	$ 2,518.03
N	Residential Care Facility	3,998	$ 8,245.77	$ 164.92	$ 8,080.85	$ 5.04	$ 33.49	$ 8,119.38	$ 8,197.25	$ 8,363.76
O	Breast and Cervical Cancer	1,076	$ 2,462.86	$ 49.26	$ 2,413.60	$ -	$ 6.48	$ 2,420.08	$ 2,443.29	$ 2,493.02
P	Dual Eligible 0-64 M&F	293,195	$ 908.91	$ 18.18	$ 890.73	$ -	$ 1.15	$ 891.88	$ 900.43	$ 918.79
P	Dual Eligible 65+ M&F	126,471	$ 327.15	$ 6.54	$ 320.61	$ -	$ 0.69	$ 321.30	$ 324.38	$ 330.98
Q	Custodial Care Nursing Facility <65	20,633	$ 5,977.60	$ 119.55	$ 5,858.05	$ 5.04	$ 28.55	$ 5,891.64	$ 5,948.15	$ 6,068.84
Q	Custodial Care Nursing Facility 65+	108,742	$ 4,390.95	$ 87.82	$ 4,303.13	$ -	$ 1.43	$ 4,304.56	$ 4,345.85	$ 4,434.51
R	Elderly HCBS Waiver	89,574	$ 4,390.95	$ 87.82	$ 4,303.13	$ -	$ 2.89	$ 4,306.02	$ 4,347.32	$ 4,435.98
S	Non-Dual Skilled Nursing Facility	1,942	$ 5,977.60	$ 119.55	$ 5,858.05	$ 5.04	$ 89.03	$ 5,952.12	$ 6,009.21	$ 6,129.90
T	Dual HCBS Waivers: PD; H&D	16,259	$ 5,977.60	$ 119.55	$ 5,858.05	$ -	$ 0.65	$ 5,858.70	$ 5,914.89	$ 6,035.59
U	Non-Dual HCBS Waivers: PD; H&D; AIDS	19,394	$ 5,977.60	$ 119.55	$ 5,858.05	$ 5.04	$ 27.79	$ 5,890.88	$ 5,947.38	$ 6,068.08
V	Brain Injury HCBS Waiver	15,540	$ 5,977.60	$ 119.55	$ 5,858.05	$ 5.04	$ 13.41	$ 5,876.50	$ 5,932.86	$ 6,053.56
W	ICF/ID	10,741	$ 8,148.91	$ 162.98	$ 7,985.93	$ 5.04	$ 11.77	$ 8,002.74	$ 8,079.50	$ 8,244.04
X	State Resource Center	2,122	$ 8,148.91	$ 162.98	$ 7,985.93	$ 5.04	$ 4.97	$ 7,995.94	$ 8,072.63	$ 8,237.17
Y	Intellectual Disability HCBS Waiver	140,460	$ 8,148.91	$ 162.98	$ 7,985.93	$ 5.04	$ 6.27	$ 7,997.24	$ 8,073.94	$ 8,238.49
Z	PMIC	3,175	$ 3,677.72	$ 73.55	$ 3,604.17	$ 5.04	$ 12.83	$ 3,622.04	$ 3,656.78	$ 3,731.03
0	Children's Mental Health HCBS Waiver	13,881	$ 3,677.72	$ 73.55	$ 3,604.17	$ 5.04	$ 6.38	$ 3,615.59	$ 3,650.27	$ 3,724.52
D	CHIP - Children 0-59 days M&F	1,020	$ 3,045.98	$ 60.92	$ 2,985.06	$ -	$ 4.10	$ 2,989.16	$ 3,017.83	$ 3,079.33
D	CHIP - Children 60-364 days M&F	3,338	$ 349.07	$ 6.98	$ 342.09	$ -	$ 2.29	$ 344.38	$ 347.68	$ 354.73
D	CHIP - Children 1-4 M&F	1,254	$ 228.53	$ 4.57	$ 223.96	$ -	$ 1.50	$ 225.46	$ 227.62	$ 232.24
D	CHIP - Children 5-14 M&F	144,992	$ 223.52	$ 4.47	$ 219.05	$ -	$ 0.93	$ 219.98	$ 222.09	$ 226.60
D	CHIP - Children 15-20 F	30,856	$ 379.52	$ 7.59	$ 371.93	$ -	$ 4.21	$ 376.14	$ 379.75	$ 387.41
D	CHIP - Children 15-20 M	30,163	$ 284.61	$ 5.69	$ 278.92	$ -	$ 2.77	$ 281.69	$ 284.39	$ 290.14
	TANF Maternity Case Rate	6,084	$ 6,607.16	$ 132.14	$ 6,475.02	$ -	$ -	$ 6,475.02	$ 6,537.12	$ 6,670.53
	Pregnant Women Maternity Case Rate	6,437	$ 6,173.13	$ 123.46	$ 6,049.67	$ -	$ -	$ 6,049.67	$ 6,107.69	$ 6,232.34