Eleventh Amendment to the Iowa Health Link Contract

This Amendment to Contract Number MED-24-006 is effective as of January 1, 2026 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. Page 1. Agency of the State (hereafter "Agency"), is hereby amended as follows:

Agency of the State (hereafter "Agency")	
Name/Principal Address of Agency: Iowa Department of Health and Human Services Lucas State Office Building 321 E. 12th Street Des Moines, IA 50319-1002	**Agency Billing Contact Name / Address:** Becky Blum Iowa Department of Health and Human Services Lucas State Office Building 321 E. 12th Street Des Moines, Iowa 50319-1002 **Phone:** 515-322-0899
Agency Contract Manager (hereafter "Contract Manager") /Address ("Notice Address"): Becky Blum Lucas State Office Building Iowa Department of Health and Human Services 321 E. 12th Street Des Moines, IA 50319-1002 **Phone:** 515-322-0899 **E-Mail:** becky.blum@hhs.iowa.gov	**Agency Contract Owner (hereafter "Contract Owner") / Address:** Lee Grossman Iowa Department of Health and Human Services Lucas State Office Building 321 E. 12th Street Des Moines, Iowa 50319-1002 **E-Mail:** lee.grossman@hhs.iowa.gov

Revision 2. Section 1.3.3.1. Pricing, is hereby amended as follows:
1.3.3.1 Pricing. In accordance with the payment terms outlined in this section and the Contractor's completion of the Scope of Work as set forth in this Contract, the Agency will make capitation payments to the Contractor on a monthly basis (as outlined in Section 1.3.3.2 below) or upon occurrence of a qualifying maternity delivery. The capitation payments include both per member per month capitation rates and maternity case rate payments, as further defined in this section. The capitation payments and any Case rate shall be payment in full for goods and services provided pursuant to this Contract. Retroactive adjustments to the capitation rates/payments to reflect the actual cost of goods and services provided pursuant to the Contract are prohibited. For more information on retroactive adjustments please see Sections 1.3.3.4, 1.3.3.6, and Special Contract Exhibits, Exhibits A and G.

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

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

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

Examples:

Example 1: Current agreed rates expire June 30, 2026. The MCO determines that it does not want to agree to continue with the managed care contract and provides Notice of Termination on January 1, 2026. Because the parties are currently performing under agreed rates that run through June 30, 2026, the first day of the ninety (90) day notice period is July 1, 2026 – the first day of the new rate period. The effective date of contract termination is September 30, 2026 – the last day of the month that is ninety (90) days from the first day of the notice period.

Example 2: Rates expired on June 30, 2027. The Agency and MCP are unable thereafter to come to terms on new rates after expiration of the current rates. The MCO provides Notice of Termination on August 1, 2027. The first day of the ninety (90) day notice period is August 1, 2027. The last day of the notice period is October 31, 2027 – the last day of the month that is ninety (90) days from the beginning of the notice period.

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

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

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

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

1) Supply documentation of the birth in a form and format determined by the Agency in accordance with the specifications described in the MCO Interface Guide.
2) Attest that the Contractor paid the provider for the entire delivery. If the delivery was covered entirely by a third-party insurer the Agency will not reimburse the Contractor for the 'maternity case rate payment'.
3) Ensure that the delivery and payment to the provider are recorded in accepted encounter data.
4) Ensure that 'maternity case rate payment' is submitted in accordance with Section G.2.05 of the Contract.
   a. When an enrolled member disenrolls to another contractor during an inpatient stay, the contractor of record maintains financial responsibility. For example, delivery and newborn expenses that occur prior to July 1 will be the responsibility of the contractor of record on June 30.

Upon verification by the Agency of the birth, the Agency shall cause the maternity case rate payment to be made separately and apart from the usual capitation payment for contracted services. Contractor shall diligently monitor births in its assigned Medicaid population and claim a maternity case rate payment for each birth in the assigned Medicaid population for which a maternity case rate payment is available no later than sixty (60) Days following the date on which

the Contractor was made aware of the birth. The Agency shall have no obligation to pay a maternity case rate payment for a birth that occurred more than two hundred ten (210) Days prior to Contractor's claim for a maternity case rate payment.

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

The capitation rates will be subject to a withhold amount as shown in the capitation rate sheet. The withhold will be retained by the Agency until the period for determination of return of the withhold to the Contractor. The determination of the return of the withhold is outlined in Special Contract Exhibits, Exhibit A.

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

Revision 3. A.13. Staff Training and Qualifications, (ix), is hereby amended as follows:
(ix) assessment processes, service coordination processes, person-centered planning and population specific training relevant to the enrolled populations for all care managers;

Revision 4. C.1.03. New Member Communications m) 1. and 2., is hereby amended as follows:

m) For Enrolled Members enrolled in a 1915(c) HCBS Waiver or 1915(i) State Plan, the Contractor shall also provide the following information:
   1. A description of the Community-Based Case Management's roles and responsibilities;
   2. Information on how to change Community-Based Case Management; and

Revision 5. E.1.01. Network Adequacy Obligations, is hereby amended as follows:
Contractor shall:

a. Provide reasonable and adequate hours of operation, including twenty-four (24) hour availability of information, referral, and treatment for Emergency Medical Conditions.
b. Make arrangements with or referrals to, a sufficient number of physicians and other practitioners to ensure that the services under the Contract can be furnished promptly and without compromising the Quality of care.
c. The Contractor shall maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities.

See: 42 C.F.R. § 438.3(q)(1); 42 C.F.R. § 438.3(q)(3); 42 C.F.R. § 457.1201(m). {From CMSC E.1.01 - E.1.02}, 42 C.F.R. § 438.206(b)(1)

Revision 6. E.1.13. Health Homes, is hereby removed and renamed as reserved as follows:
E.1.13. Reserved.

Revision 7. E.3.06. Licensed & Non-Licensed Providers, is hereby amended as follows:
The Contractor shall ensure each Provider's service delivery site or services meets all applicable requirements of Iowa law and have the necessary and current licenses, certification, accreditation, and/or designation approval per State requirements. When individuals providing services are not required to be licensed, accredited or certified, the Contractor shall ensure, based on applicable State licensure rules and/or Program standards, that they are appropriately educated, trained, qualified, and competent to perform their job responsibilities. In addition, the Contractor shall ensure that all required criminal history record checks and child and dependent adult abuse background checks are conducted for LTSS Providers who are not employees of a Provider agency or licensed/accredited by a board that conducts background checks. This includes but is not limited to, the Contractor ensuring criminal history checks and child and dependent adult background checks are conducted for non-agency affiliated self-direction CCO employees. Each of the State's 1915(c) HCBS waivers and 1915(i) State Plan HCBS Habilitation program, delineate the minimum Provider qualifications for each covered service. The Contractor shall ensure all HCBS Providers meet these qualifications in accordance with Iowa Admin. Code Ch. 441-77.

Revision 8. F.6.10, Prior Authorizations, is hereby amended as follows:
At any point that the Agency redistributes membership within the IA Health Link program or following open enrollment, the Contractor shall honor existing authorizations for covered Benefits for a minimum of 90 Days, without regard to whether such services are being provided by contract or non-contract Providers, when an Enrolled Member transitions to the Contractor from another source of coverage. LTSS, residential services and certain services rendered to dual diagnosis populations, which are addressed in F.13.28, are excluded from this 90-Day period. The Contractor shall honor existing Waivers of Administrative Rule granted by the Director for the scope and duration designated. At all other times outside of Agency member redistribution and following open enrollment, the Contractor shall honor existing authorizations

for a minimum of 30 Days when an Enrolled Member transitions to the Contractor from another source of coverage, without regard to whether services are being provided by contract or non-contract Providers. The Contractor shall obtain Agency approval for policies and procedures to identify existing Prior Authorizations at the time of enrollment. The Contractor shall implement and adhere to the Agency-approved policies and procedures. Additionally, when an Enrolled Member transitions to another Program Contractor, the Contractor shall provide the receiving entity with information on any current service authorizations, utilization data and other applicable clinical information such as disease management or Care Coordination notes.

Revision 9. F.6.24a). EPSDT Services, Screening, Diagnosis and Treatment is hereby amended as follows:
The Contractor shall implement strategies to ensure the completion of health screens and preventive visits in accordance with the EPSDT periodicity schedule. Screening exams consist of a health history, developmental history, complete physical exam, vision screening, hearing test, appropriate laboratory tests, immunizations, nutrition screen, health education including anticipatory guidance, oral health assessment, other tests as needed and referrals for treatment. 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. For request of services outside of the state covered benefits, the Waiver of Administrative Rule process should be followed.

Revision 10. F.12B.01. Overview, is hereby amended as follows:
The State currently operates 1915(c) and 1915(i) HCBS programs. The Contractor shall deliver the HCBS services to all Enrolled Members meeting the eligibility criteria and authorized to be served by these programs. The Contractor shall provide: (i) screening of Enrolled Members who appear to be eligible; (ii) timely completion of the initial and annual comprehensive functional assessment for needs-based eligibility and level of care; (iii) monitoring of Enrolled Members on the HCBS wait list; (iv) completion of a Social History; (v) annual redetermination of needs-based eligibility and level of care; (vi) service plan review, services monitoring, and authorization; (vii) Claims payment; (viii) network capacity; (ix) Provider agreement execution; (x) rate setting; and (xi) Provider training and technical assistance. The Home and Community-Based Services (HCBS) Provider Manuals can be found here: Provider Policy Manuals | Health & Human Services

Revision 11. F.12B.08. Initial Assessment and Annual Reassessment, is hereby amended as follows:
The Contractor shall provide information as needed to support the 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. The Contractor shall use assessment results and other information available to ensure that Enrolled Members have their needs met safely and effectively in the community and at a reasonable cost to the Agency. 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 waiver 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 12. F.12B.16. Person-Centered Planning Process, is hereby amended as follows:

The Contractor shall ensure that the HCBS service plan is established through a Person-Centered Service Planning process that is led by the Enrolled Member or representative. The Enrolled Member's representative shall have a participatory role, as needed and as defined by the Enrolled Member. The Contractor shall establish a team for the Enrolled Member that shall include the case manager, Enrolled Member, family, Providers, and others as appropriate and desired by the Enrolled Member. The Contractor shall implement the level of services and supports as identified by the interdisciplinary team's assessment of the Enrolled Member's needs and as documented in the Enrolled Member's comprehensive person-centered service plan. The Contractor shall ensure that the comprehensive person-centered service plan identifies an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or when the Enrolled Member's needs change. The Contractor shall ensure compliance with the Person-Centered Planning Process. *See* Iowa Admin. Code chs. 441-78, and 441-90; 42 C.F.R. § 441.301 and § 441.725.

Revision 13. F.12C.01. Community-Based Case Management Requirements, is hereby amended as follows:

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

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

Revision 14. F.12C.02. Community-Based Case Manager Qualifications, is hereby amended as follows:

Contractor shall submit the required qualifications, experience and training of community-based

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

The Contractor shall ensure that all case managers serving LTSS populations that are hired on or after November 1,2024 complete the Agency-identified initial training curriculum on the Agency's Learning Management System (LMS) platform within six (6) months of hire. The Contractor shall also ensure that existing case managers hired prior to November 1, 2024, complete the required Case Manager (CM) Certification before July 1, 2025. All case managers serving the LTSS populations will be required to complete the CM Refresher, which is a subset of the CM Certification, on an annual basis within three-hundred sixty-five (365) days since the most recent completion date of the initial or refresher curriculum.

Additionally, the Contractor will be required to administer employer-provided case manager trainings for designated training topics. The Contractor must provide and document staff completion of employer-provided trainings on the designated topics, listed below, for new hires within their first six months of employment as well as on an annual basis for all case managers serving LTSS populations. The Contractor is required to submit their employer-provided case manager training materials to HHS for review and approval by August 16, 2024, and annually thereafter.

At a minimum, the Contractor-administered, HHS-approved training topics for new hires includes the following:

a. Sub-population specific needs, challenges, and resources based on caseload composition including:
    1. I/DD
    2. Older adults
    3. Children
    4. Behavioral health
    5. HIV/AIDS
    6. Chronic health conditions

At a minimum, the Contractor-administered, HHS-approved training topics for all case managers, including new hires, includes the following:

a. Motivational interviewing and basic counseling skills
b. Cultural competency
   Setting boundaries and staying safe in the field
c. Care plan documentation
d. Care coordination
e. Completing environmental assessment and working with members in their homes

Provision of the case manager training requirements detailed above must be consistent with and are in addition to related requirements within the Iowa Administrative Code (IAC).

The Contractor must also ensure subcontracted case managers providing support to the community-based LTSS populations also adhere to all training requirements.

The Contractor shall submit all training content to the agency for prior approval. The Contractor must maintain documentation of staff names and completion dates of all Agency-identified training for LTSS case managers that will be available to the Agency upon request.

Revision 15. F.12C.08. Frequency of Community-Based Case Manager and Care Coordination Contact, is hereby amended as follows:
The Contractor shall ensure that case management contacts occur as frequently as necessary and that contacts are conducted and documented consistent with the following:

a. Community-based case managers must have at least one (1) face-to-face contact per month with Enrolled Members for the first three (3) months when Enrolled Members first become eligible for the Habilitation or HCBS waiver program and the Contractor's CBCM case management. This requirement applies when a case management-eligible member newly enrolls with the Contractor or when an existing member first becomes eligible for the Contractor's case management services.
b. After the first three (3) months of case management services with the Contractor, the community-based case manager shall consult the Enrolled Member, their authorized representative and their care team to identify the appropriate frequency of community-based case manager and member communication.

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

a. At least one, in-home, face-to-face contact every other month with Enrolled Members who have a diagnosis of intellectual and/or developmental disability, children under the age of 18 receiving residential services outside of the family home, and every three (3) months for all other community-based LTSS members.
b. At least one contact per month with the member or the member's authorized representative. This contact may be face-to-face or by telephone. Written communication does not constitute a contact unless there are extenuating circumstances outlined in the Enrolled Member's person-centered service plan.

Revision 16. F.13.27. Services for Children with Serious Behavioral Conditions, is hereby amended as follows:
The Contractor shall implement a screening protocol and comprehensive treatment approach to be used by its Provider Network for serious, behavioral health conditions for children. These protocols require Agency approval and shall be developed using Industry Standards for the detection of behavioral health conditions, which, if untreated, may cause serious disruption in a child's development and success in the community. The Contractor shall work with Providers to help the family to identify informal and natural community supports that can help stabilize a child's behavioral health symptoms as an integral component of Discharge Planning. The Contractor shall work with Providers to develop a crisis plan that helps the family to identify

triggers and timely interventions to reduce the risk to the child and family and offer family-identified supports and interventions. The Contractor shall work collaboratively with child welfare and juvenile justice Providers and systems to develop effective trainings, interventions and supports for child welfare and juvenile justice Providers and systems to respond effectively to needs of children with behavioral health issues. Services may include telephonic consultations provided by a child psychiatry team or with the Contractor, emergency stabilization response to crisis situations, on-site mental health counseling, follow-up with a child's family, identification and mobilization of community resources, and appropriate community mental health agencies.

Revision 17. F.16.09. Exceptions to Policy, is hereby retitled as follows:
Waiver of Administrative Rule.

Revision 18. F.16.09. Waiver of Administrative Rule, is hereby amended as follows:
Under the Waiver of Administrative Rule (formerly known as the "exceptions to policy") process, an Enrolled Member can request an item or service not otherwise covered by the Agency or the Contractor, including but not limited to a drug that is not on the State's PDL or FFS fee schedule but is approved by the FDA. Waiver of Administrative Rule may be granted to Contractor policies, but they cannot be granted to federal or State law or regulations. Contractor may forward requests for waivers to Agency policy to the Agency for consideration. A Waiver of Administrative Rule is a last resort request and is not appealable to the extent the request is for services outside of State Plan or waiver Benefits.

A Waiver of Administrative Rule may be granted in individual cases upon the HHS Director's own initiative or upon request. A Waiver of Administrative Rule is only specifically granted by the HHS Director with the recommendation of the Medicaid Director. The Department issues written decisions for all requests for a Waiver of Administrative Rule.

The Contractor is not responsible for decisions regarding a Waiver of Administrative Rule under state rule and should not present themselves as such and shall not use the term "Waiver of Administrative Rule" to describe their own internal medical necessity review decisions when communicating with Enrolled Member.

The Contractor on their own and by their own determination may make an exception to their own policies, but shall not refer to these actions as a Waiver of Administrative Rule. Any scenario in which the Contractor determines to provide coverage for items or services outside of their own policies must not be referred to as a Waiver of Administrative Rule.

The Contractor on their own may determine that a Waiver of Administrative Rule, such as a request for an item or service not typically covered by Medicaid or a request to exceed service limits is appropriate to meet an Enrolled Member's assessed needs may initiate a Waiver to Administrative Rule request following the process outlined in 441 IAC 6.1.

Any scenarios in which the Contractor determines to approve, deny, reduce, or terminate an Enrolled Member's services remains subject to all applicable Iowa Administrative Code (IAC), Iowa Code and the Code of Federal Regulations, including timely notification, content of the notification, and appeal rights.

Revision 19. G.2.36, Prior Authorization, is hereby amended as follows:
During the first year following Contractor's entry into the IA Health Link marketplace, with the exception of LTSS, residential services and certain services rendered to dual diagnosis populations, which are addressed in Section F.13.28, the Contractor shall honor all existing authorizations for covered Benefits for a minimum of ninety (90) Days, without regard to whether such services are being provided by contract or non-contract Providers, when an Enrolled Member transitions to the Contractor from another source of coverage. The Contractor shall honor existing Waivers of Administrative Rule granted by the Director for the scope and duration designated. At all other times, the Contractor shall honor all existing authorizations for a minimum of thirty (30) Days when an Enrolled Member transitions to the Contractor from another source of coverage, without regard to whether services are being provided by contract or non-contract Providers. The Contractor shall obtain Agency approval for policies and procedures to identify existing Prior Authorizations at the time of enrollment. The Contractor shall implement and adhere to the Agency approved policies and procedures. Additionally, when an Enrolled Member transitions to another Program Contractor, the Contractor shall provide the receiving entity with information on any current service authorizations, utilization data and other applicable clinical information such as disease management or Care Coordination notes.

Revision 20. G.2.45. Dual Eligible Special Needs Plan Coordination, is hereby amended as follows:
Contractor shall coordinate with all Dual Eligible Special Needs Plans with which the Agency has contracted by coordinating the delivery of all benefits covered by both Medicare and the Iowa Medicaid Program consistent with the coordination obligations set forth in the D-SNP agreements entered into between the Agency and the individual D-SNP Health Plans.

The Contractor shall take all required steps to obtain Centers for Medicare & Medicaid Services (CMS) approval to operate a Dual Eligible Special Needs Plan (D-SNP) that will start January 1, 2027. The Contractor seeking D-SNP status for the first time shall be aware of this general timeline as it intersects with the Health Link program.

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

Revision 21. G.3.17. Notice - Timeframe, is hereby amended as follows:
For standard authorization decisions, Contractor shall provide Notice as expeditiously as the Enrolled Member's condition requires and within State-established timeframes that may not exceed seven (7) Days after receipt of request for service, with a possible extension of up to fourteen (14) Days if the Enrolled Member requests an extension or the Contractor justifies the need for additional information and how the extension is in the Enrolled Member's interest. See: 42 C.F.R. § 438.210(d)(2)(ii); 42 C.F.R. § 457.1230(d). {From CMSC G.3.07}.

Revision 22. G.3.19. PA Performance Metric, is hereby amended as follows:
Ninety-nine percent (99%) of standard authorization decisions shall be rendered within seven (7) Days of the request for service, or seventy-two (72) hours for expedited authorization decisions. For outpatient prescription drug PA, one hundred percent (100%) of authorization decisions shall be rendered within twenty-four (24) hours of the request. Requests for extensions approved in accordance with previous sections of the Contract shall be removed from this timeliness measure.

Revision 23. H.1.03, Eligibility, Effective Date of Coverage, Premiums, Copayments, Client Participation and Exceptions to Policy, is hereby retitled as follows:
Eligibility, Effective Date of Coverage, Premiums, Copayments, Client Participation, and Waiver of Administrative Rule.

Revision 24. H.1.03, Eligibility, Effective Date of Coverage, Premiums, Copayments, Client Participation and Waiver of Administrative Rule, is hereby amended as follows:
Contractor shall direct the following types of Appeal or Grievance requests to the Agency:

a. Enrolled Member eligibility including termination of eligibility;
b. Effective dates of coverage;
c. Determinations of premium, copayment, and Client Participation responsibilities; and
d. Waiver of Administrative Rule regarding services outside of State Plan or waiver Benefits.

Revision 25. H.3.05, Fourteen (14) Day Notice Deadline, is hereby retitled as follows:
Seven (7)Day Notice Deadline

Revision 26. H.3.05. Seven (7) Day Notice Deadline, is hereby amended as follows:
Contractor shall give Notice of an Adverse Benefit Determination as expeditiously as the Enrolled Member's condition requires and not to exceed seven (7) Days following receipt of the request for service, for standard authorization decisions that deny or limit services. See: 42 C.F.R. § 438.210(d)(1); 42 C.F.R. § 438.404(c)(3); 42 C.F.R. § 457.1230(d). {From CMSC H.3.05}.

Revision 27. H.3.06. Extensions of Fourteen (14) Day Deadline, is hereby retitled as follows:
Extensions of Seven (7) Day Deadline

Revision 28. H.3.06. Extensions of Seven (7) Day Deadline, is hereby amended as follows:
Contractor may extend the seven (7) calendar-day Notice of Adverse Benefit Determination timeframe for standard authorization decisions that deny or limit services up to fourteen (14) additional Days if the Enrolled Member or the Provider requests extension. See: 42 C.F.R. § 438.404(c)(4); 42 C.F.R. § 438.210(d)(1)(i); 42 C.F.R. § 457.1230(d). {From CMSC H.3.06}.

Revision 29. H.3.07. Extensions of Standard Authorizations, is hereby amended as follows:
Contractor may extend the seven (7) calendar-day Notice of Adverse Benefit Determination timeframe for standard authorization decisions that deny or limit services up to fourteen (14)

additional Days if the Contractor justifies a need (to the Agency, upon request) for additional information and shows how the extension is in the Enrolled Member's best interest. See: 42 C.F.R. § 438.210(d)(1)(ii); 42 C.F.R. § 438.404(c)(4); 42 C.F.R. § 457.1260; 42 C.F.R. § 457.1230(d). {From CMSC H.3.07}.

Revision 30. H.3.08. Written Notice Obligation, is hereby amended as follows:
If Contractor extends the seven (7) calendar-day Notice of Adverse Benefit Determination timeframe for standard authorization decisions that deny or limit services, Contractor shall give the Enrolled Member written Notice of the reason for the extension and inform the Enrolled Member of the right to file a Grievance if the Enrolled Member disagrees with the decision. See: 42 C.F.R. § 438.210(d)(1)(ii); 42 C.F.R. § 438.404(c)(4)(i); 42 C.F.R. § 457.1260; 42 C.F.R. § 457.1230(d). {From CMSC H.3.08}.

Revision 31. H.3.09. Duty to Make the Determination Expeditiously, is hereby amended as follows:
If Contractor extends the seven (7) calendar-day Notice of Adverse Benefit Determination timeframe for standard authorization decisions that deny or limit services, Contractor shall issue and carry out its determination as expeditiously as the Enrolled Member's health condition requires and no later than the date the extension expires. See: 42 C.F.R. § 438.210(d)(1)(ii); 42 C.F.R. § 438.404(c)(4)(ii); 42 C.F.R. § 457.1260; 42 C.F.R. § 457.1230(d). {From CMSC H.3.09}.

Revision 32. I.5.03. Annual Reports, is hereby amended as follows:
Annually, on the date identified by the Agency, the Contractor shall submit the reports included in the Program Integrity Reporting Companion Guide.
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 33. I.5.04. Quarterly Reports, is hereby amended as follows:
Quarterly, on the date identified by the Agency, the Contractor shall submit the reports included in the Program Integrity Reporting Companion Guide.

Revision 34. I.5.05. Monthly Reports, is hereby amended as follows:
Monthly, on the date identified by the Agency, the Contractor shall submit the reports included in the Program Integrity Reporting Companion Guide.

Revision 35. J.2.04 Data Sharing Requirements - Supplemental Nutrition Assistance Program (SNAP) is hereby added:
In the event that the Agency determines a need to share confidential client information from the Iowa SNAP program, the Contractor agrees to not use, further disclose, or permit others to use or disclose the Iowa SNAP Data received through this Contract except as directed by the Agency. The Contractor shall allow only those members of its workforce who have a legitimate business need for the Data to access the Data.

SNAP data are confidential and the use or disclosure of information obtained from SNAP applicant or recipient households shall be restricted to: Persons directly connected with the administration or enforcement of the provisions of the Food and Nutrition Act of 2008 or

regulations, other Federal assistance programs, federally-assisted State programs providing assistance on a means-tested basis to low income individuals, or general assistance programs which are subject to the joint processing requirements in § 273.2(j) (7CFR 272.1(c)(1)(i)). Data may be shared with the User pursuant to 441 IAC 9.10(4).

The Contractor shall maintain the confidentiality of and protect from unauthorized access, use, and disclosure all Iowa SNAP Data shared through this Contract (7 CFR 272.1(c)(2)). Except as authorized through this Contract or as required by law, the User shall not disclose, release, sell, loan, or otherwise grant access to the Iowa SNAP Data shared through this Contract, either during the period of this Agreement or hereafter.

Revision 36. Section 5. Special Contract Exhibits. Exhibit A, Capitation Rate Information, MLR, Pay for Performance, Liquidated Damages, and Excluded Pharmaceuticals, is hereby retitled as follows:
Exhibit A: Capitation Rate Information, Pay for Performance, Liquidated Damages, and Excluded Pharmaceuticals

Revision 37. Section 5. Special Contract Exhibits. Exhibit A, Capitation Rate Information, Pay for Performance, Liquidated Damages, and Excluded Pharmaceuticals, 2. MLR Information, is hereby amended as follows:
Exhibit A: Capitation Rate Information, Pay for Performance, Liquidated Damages, and Excluded Pharmaceuticals

1. Capitation Rate Information
2. Sample Payment for Performance Chart
3. Liquidated Damages
4. Excluded Pharmaceuticals

Revision 38. Section 5: Special Contract Exhibits. Exhibit A, Capitation Rate Information, Pay for Performance, Liquidated Damages, Section 2: is hereby removed and reserved as follows:
Section 2: Reserved

Revision 39. Section 5: Special Contract Exhibits. Exhibit A, Capitation Rate Information, Pay for Performance, Liquidated Damages, Section 3: Pay for Performance Chart, Performance Standard 6, Standard to Receive Incentive Payment, is hereby amended as follows:

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. LTSS-6: LTSS Admission to a Facility from the Community
3. LTSS-7: LTSS Minimizing Facility Length of Stay
4. LTSS-8: LTSS Successful Transition After Long-Term Facility Stay
5. HCBS-10: Self-Direction of services and supports among Medicaid beneficiaries receiving LTSS through managed care organizations
6. MLTSS: Plan All Cause Readmission (HEDIS)

The Contractor must submit NCQA-validated calculations (not just policies and procedures) for all six 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 40. Exhibit B. Glossary of Terms/Definitions, is hereby added as follows:
Adult Day Care: adult day care services provide an organized program of supportive care in a group or individual environment to persons who need a degree of supervision and assistance on regular or intermittent basis in a day care center or in the home due to the absence of the primary caregiver. Supports provided during day care would be protective oversight, supervision, ADLs and IADLs. Included are personal cares (i.e.: ambulation, toileting, feeding, medications), behavioral support, or intermittent health-related cares, not otherwise paid under other waiver or state plan programs.

Revision 41. Exhibit B. Glossary of Terms/Definitions, is hereby amended as follows:
Case management: Provides service coordination and monitoring. Available as a 1915 (i) Habilitation service when the individual does not otherwise qualify for targeted case management.

Revision 42. Exhibit B. Glossary of Terms/Definitions, is hereby added as follows:
Certified Community Behavioral Health Clinic (CCBHC): a specially designated clinic that provides a comprehensive range of mental health and substance use services. CCBHCs are designed to ensure access to coordinated care for anyone who requests it, regardless of their ability to pay, place of residence, or age.

Revision 43. Exhibit E. Table E.01. Full Medicaid Covered Benefits & Limitations, Pharmacy, is hereby amended as follows:

Table E.01: Full Medicaid Covered Benefits & Limitations

SERVICE	LIMITATIONS
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 (10) Drugs prescribed with intention to alter primary or secondary sex characteristics related to a member's gender dysphoria • Only certain nonprescription (OTC) drugs and non-drugs are covered as listed on http://www.iowamedicaidpdl.com • Quantity: a one (1) month supply of covered prescription and non-prescription medication or a three-month supply for any medication on the 90-Day Supply Allowance Prescription List. Some drugs are limited to an initial fifteen (15) day supply. Guidelines can be found on the HHS website list at: http://www.iowamedicaidpdl.com • Monthly quantity limits by drug list at: http://www.iowamedicaidpdl.com • Reimbursement consistent with Iowa Admin. Code r. 441-79.1(8).

Revision 44. 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

Iowa Wellness Plan Benefit Limits			
Service Category	**Covered**	**Duration, Scope, exclusions, and Limitations**	**Excluded Coding**
1. Ambulatory Services			
Primary Care Illness/injury Physician Services	Yes		Athletic Trainers are not covered.
Specialty Physician Visits	Yes	Iowa's Benchmark does not mention prior authorizations for this service but Iowa will be following Medicaid prior authorization guidelines where only some services will require prior authorization.	
Home Health Services	Yes	Private Duty Nursing/Personal Care Services are only available to 19- and 20-year-olds through EPSDT	Not Covered: Procedure code S9122 or REV codes 570 or 571. 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**	Yes		
Outpatient surgery	Yes		
Second Surgical Opinion	Yes		
Allergy Testing & Injections	Yes		

Chemotherapy-Outpatient	Yes	-	-
IV Infusion Services	Yes	-	-
Radiation Therapy Outpatient	Yes	-	-
Dialysis	Yes	Covered as an inpatient or in a Medicare approved dialysis center (outpatient).	-
Anesthesia	Yes	-	-
Walk-in Centers	Yes	-	-
AIDS/HIV parity	Yes	-	-
Access to clinical trials	Yes	Medical necessity will be determined on a case-by-case basis through the Prior Authorization process.	Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial. 2. A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2). 3. A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3). General Condition of Coverage
Genetic Counseling/Diagnostic Testing	Yes	Prior authorization required. Must be an appropriate candidate and outcome is expected to determine a covered course of tx and not just informational.	-
TMJ	Yes	-	-
2. Emergency Services			
Emergency Room Services	Yes	-	-
Emergency Transportation-Ambulance and Air Ambulance	Yes	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)	Yes	-	-
3. Hospitalization			
General Inpatient Hospital Care	Yes	-	-
Inpatient Physician Services	Yes	-	-
Inpatient Surgical Services	Yes	-	-
Non-Cosmetic Reconstructive Surgery	Yes	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	Yes	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	Yes	-	-
Anesthesia	Yes	-	-
Hospice Care - Inpatient & Outpatient	Yes	Terminally ill patient and have a life expectancy of six months or less. In accordance with Section 2302 of the Affordable Care Act, individuals under age 21 (age 19 and 20 for purposes of this benchmark plan), must receive hospice care concurrently with curative care.	-

Hospice Respite - Inpatient	Yes	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	Yes	-	-
Radiation Therapy - Inpatient	Yes	-	-
Breast Reconstruction	Yes	-	-
4. Maternity & Newborn Care			
Maternity/Pregnancy Services - Pre & Postnatal Care - Delivery & Inpatient maternity - Nutritional	Yes	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 or 96 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	Yes		-
Midwife Services	Yes		-
Newborn child coverage	Yes		-
5. Mental Health Behavioral Health Substance Abuse			
Mental Health/Behavioral Health Inpatient Treatment	Yes	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	Yes	Those with disabling mental disorders will be considered Medically Exempt and enrolled in the Medicaid State Plan.	-
Substance Abuse Inpatient Treatment	Yes	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 H0019
Substance Abuse Outpatient Treatment	Yes	Enrolled Members with disabling substance use disorder will be considered	-

		Medically Exempt and enrolled in the Medicaid State Plan.	
6. Prescription Drugs			
Prescription Drugs	Yes	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	Yes	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 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.	Each therapy is limited to 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.
Inhalation therapy	Yes	Limit of sixty (60) visits in a twelve (12) month period.	
Medical and Surgical supplies	Yes	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	Yes	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	Yes		
Prosthetics	Yes		
Cardiac Rehabilitation	Yes		
Pulmonary Rehabilitation	Yes		

Skilled Nursing Services	Yes	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	Yes	-	-
X-Rays	Yes	-	-
Imaging/Diagnostics MRI CT PET	Yes	-	-
Sleep Studies	Yes	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.
Pathology	Yes	-	-
9. Preventive Wellness Chronic Disease Management			
Preventive Care	Yes	Limited to ACA required preventive services.	-
Nutritional Counseling	Yes	Max forty (40) units allowed for twelve (12) month period	Not covered: 97802, 97804, 97803, G0270 or G0271
Counseling and Education Services	Yes	Not covered: Bereavement, family, or marriage counseling. Education other than diabetes.	-
Family Planning	Yes	-	
Vision Care Exams (Adult)	Yes	Codes only allowed once per year: 92002, 92004, 92012, 92014 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	Yes	Not covered- immunizations for travel	Not covered: 90476, 90477, 90581, 90585, 90586, 90665, 90690, 90691, 90692, 90693, 90717, 90725, 90727, 90735, 90738
Colorectal Cancer Screening	Yes	-	-
Screening Mammography	Yes	One (1) per year. 77057, 77052, G0202	-

Hearing Exam (Adult)	Yes	Limit of one (1) hearing exam per year. Codes only allowed once per year: 92551, 92552, 92553, 92555, 92556, 92557 92558, 92559, 92560, V5008 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, V5299V5240, V5264, V5266, V5267, V5298, V5299
Diabetes - med necessary equip & supplies Education	Yes	-	-
Screening Pap tests	Yes	-	-
Gynecological exam	Yes	One (1) per year	-
Prostate cancer screening	Yes	One (1) per year for men age fifty (50) to sixty-four (64) years	-
Foot Care	Yes	Must be related to medical condition, routine services are not covered.	-
Tobacco Cessation	Yes	Treatment and medical eval for nicotine dependence	-
10. Pediatric Services including oral & vision			
EPSDT Ages 19 and 20	Yes	Covered for ages 19-20	-
Benefits Not Provided			
Acupuncture	**No**	Not covered	-
Infertility Diagnosis and Treatment	**No**	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 tx, and tubal/vasectomy reversals, fertility drugs.	-
Bariatric Surgery	**No**	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	**No**	-	-
Non-emergency Transportation Services	**No**	-	-
Tobacco Cessation	**No**	Not covered	-

Breast Reduction	**No**	-	CPT codes 19318 or 19316, ICD proc codes: 85.31, 85.32, 85.6. Code 00402 not covered if billed with diagnosis 611.1.

Revision 45. Exhibit E. Table E.03: Hawki Covered Benefits, is hereby amended as follows:

Table E.03: Hawki Covered Benefits

Inpatient hospital services • Medical • Surgical • Intensive care unit • Mental health • Substance use disorder
Physician services • Surgical • Medical • Office visits • Newborn care • Well-baby • Well-child • Immunizations • Urgent care • Specialist care • Allergy testing and treatment • Mental health visits • Inpatient Substance use disorder visits • Residential substance abuse treatment services • Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services • Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28)) The Contractor shall use the Recommended Childhood Immunization Schedule approved by the Advisory Committee on Immunization Practices (ACIP), The American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), as the immunization schedule. The Contractor shall incorporate the "Recommendations for Preventive Pediatric Health Care" by the AAP as the schedule for preventive care for children and adolescents. In lieu of the above, the Contractor may use the most current version of the U.S. Preventive Task Force, “Guide to Clinical Preventive Services” as the immunization and preventive care schedule for children and adolescents.
Outpatient hospital services

• Emergency room • Surgery • Lab • X-ray • Other services
Ambulance services
Physical therapy
Nursing care services (including skilled nursing facility services)
Speech therapy
Durable medical equipment
Home health care
Hospice services
Prescription drugs
Hearing services
Vision services (including corrective lenses)
Maternity and mental health services not inconsistent with 42 U.S.C.A § 1396u-2(b)(8)
Outpatient mental health services including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)
Behavioral Health Services: • Behavioral Health Screening and Assessments • Outpatient Psychosocial Treatment for: Mental Health and SUD • Tobacco Cessation for: SUD • Medication Assisted Treatment for: SUD, Opioid Use Disorder, Alcohol Use Disorder • Intensive Outpatient for: Mental Health, SUD • Day Treatment for: Mental Health, SUD • Partial Hospitalization for: Mental Health, SUD • Inpatient Services for: Mental Health, SUD • Residential Treatment for: Mental Health, SUD • Detoxification for: SUD • Emergency Services for: Mental Health, SUD • Crisis Intervention and Stabilization for: Mental Health, SUD • Care Coordination for: Mental Health, SUD • Case Management for: Mental Health, SUD

Revision 46. Exhibit I. Memorandum of Understanding of State Directed Payments Between the Agency and the Iowa Hospital Association, is hereby amended.

Revision 47. 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:	Date: 12/24/2025	Signature of Authorized Representative:	Date: 12/31/2025
Printed Name: Teresa Hursey		Printed Name: Lee Grossman	
Title: CEO and Plan President		Title: Iowa Medicaid Director	

MOU 1st Amendment to the June 12, 2025 Memorandum of Understanding between IHHS and IHA

First Amendment to the June 12, 2025 Memorandum of Understanding Between the Iowa Department of Health and Human Services and the Iowa Hospital Association

This First Amendment to the June 12, 2025 Memorandum of Understanding ("MOU") ("Amendment") is effective upon full execution, between the Iowa Department of Health and Human Services ("Agency") and the Iowa Hospital Association ("Liaison").

Section 1: Amendment to MOU

Section 2(D), is hereby replaced as follows:

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

Section 2: No Other Amendment
Except as expressly amended herein, all other provisions of the Agreement remain the same, and the Agreement will continue in full force and effect. This Amendment is not intended to alter or amend any other terms and conditions set forth in the Agreement referenced above.

Section 3: Execution
The receipt, adequacy and legal sufficiency of which are hereby acknowledged and in accordance with the terms of the MOU, the parties have entered into this Amendment and have caused their duly authorized representatives to execute this Amendment.

Liaison, Iowa Hospital Association		**Agency, Iowa Department of Health and Human Services**	
Signature of Authorized Representative:	Date: 11/14/2025	Signature of Authorized Representative:	Date: 11/14/2025
Printed Name: Chris Mitchell		Printed Name: Larry Johnson	
Title: President and CEO		Title: Director	