Seventh Amendment to the MED-20-001 Contract

This Seventh Amendment to Contract Number MED-20-001 is effective as of July 1, 2021, between the Iowa Department of Human Services (Agency) and Iowa Total Care, Inc. (Contractor).

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

Revision 1 Contract Declarations and Execution Page. The following fields in the Contract Declarations and Execution Page(s) are modified as set forth below:

Agency of the State (hereafter "Agency")	
Name/Principal Address of Agency: Iowa Department of Human Services 1305 E. Walnut Des Moines, IA 50319-0114	**Agency Billing Contact Name / Address:** Mary Tavegia 1305 E. Walnut Des Moines, IA 50319-0114 **Phone:** 515-782-0310
Agency Contract Manager (hereafter "Contract Manager") /Address ("Notice Address"): Mary Tavegia 1305 E. Walnut Des Moines, IA 50319-0114	**Agency Contract Owner (hereafter "Contract Owner") / Address:** Julie Lovelady 1305 E, Walnut Des Moines, IA 50319-0114
E-Mail: mtavegi@dhs.state.ia.us	**E-Mail: jlovela@dhs.state.ia.us**
Phone: 515-782-0310	

Revision 2. Contract Section 7.2.2 is amended to read as follows:

New enrollees shall be auto-assigned to a Contractor in accordance with the auto-assignment process set forth in Section 7.2.3. Information shall be provided to new enrollees in accordance with Section 8.2.1

Revision 3. Contract Section 7.2.3 is amended to delete the following sentence:

Due to planning for staffing and operations for Iowa Total Care implementation, the Agency will provide the Contractor a projected July 2019 minimum enrollment no later than November 1, 2018.

Revision 4. Contract Section 13.1.1 is amended to add Section 13.1.1.20 as follows:

13.1.1.20 Beneficiary access to and exchange of data**.**
The Contractor shall comply with standards-based Application Programming Interface (API) requirements as mandated by federal regulation. Compliance with the API requirements will be evaluated by the Agency. See 42 C.F.R. § 431.60 and 42 C.F.R. § 457.30.

Revision 5. Contract Section 13.5.2 is amended as follows:

The Contractor shall submit encounter claims in an electronic format that adheres to the data Specifications set forth by the Agency and in any State or federally mandated electronic claims submission standards. The Agency will have all of the remedies provided to it under the Contract, including liquidated damages, for failure to comply with these requirements. Drug encounter data shall be submitted by the Contractor once every other week for adjudicated claims in support of the IME's drug rebate invoicing process identified in section 3.2.6.11. Ninety-nine percent (99%) of encounter data shall be submitted by the 20th of the month subsequent to the month for which data are reflected. The remaining one percent (1%) must be submitted by the 20th of the following month. All corrections to the monthly encounter data submission shall be finalized within forty-five (45) days from the date the initial error report for the month was sent to the Contractor or fifty-nine (59) days from the date the initial encounter data were due. The error rate for encounter data cannot exceed one percent (1%). The Agency will notify the Contractor of changes made to calculate encounter data timeliness, accuracy, and quality sixty (60) days prior to implementation.

Revision 6. Table F1 of Exhibit F of the Contract is amended to read as follows:

Table F1: SFY 2022 PAY FOR PERFORMANCE MEASURES

The Agency will provide a document with the full description of the guidelines and data definitions for the SFY 2022 Pay for Performance Measures.

Performance Measure 1	Amount of Performance Withhold at Risk
Encounter Data	10%
Required Contractual Standard	
Drug encounter data shall be submitted by the Contractor once every other week for adjudicated claims in support of the IME's drug rebate invoicing process. Encounter data shall be submitted by the twentieth (20th) of the month subsequent to the month for which data are reflected. All corrections to the monthly encounter data submission shall be finalized within forty-five (45) days from the date the initial error report for the month was sent to the Contractor or fifty-nine (59) days from the date the initial encounter data were due. The error rate for encounter data cannot exceed one percent (1%). For every service provided, providers must submit corresponding claim or encounter data with claim detail identical to that required for fee-for-service claims submissions	
Standard Required to Receive Incentive Payment	
Within ninety (90) days of the end of each quarter the Contractor's accepted encounter data shall match the Contractor's submitted financial information within ninety-eight percent (98%) using reporting criteria set forth in the F1 reporting template.	

Performance Measure 2	Amount of Performance Withhold at Risk

Timely Claims Reprocessing	10%
Required Contractual Standard	
The Contractor shall also reprocess all claims processed in error within thirty (30) calendar days of identification of the error or upon a schedule approved by the Agency. Except in cases in which system configuration is necessary, the start time begins when the Contractor identifies, or is made aware of the error, and has received all necessary information to validate the error; identification of the error could be brought forward by a provider, the Agency, or internal Contractor staff. In the event the Contractor requests clarification from the Agency regarding a claims reprocessing project, the time for reprocessing will begin to run on the day the Contractor receives all information necessary to accurately reprocess the claims. In cases in which a system configuration is necessary, the Contractor shall make corrections to the system and reprocess claims within sixty (60) calendar days unless an extension is approved by the Agency.	
Standard Required to Receive Incentive Payment	
The Contractor will achieve a measure of ninety percent (90%) of all reprocessed claims within fifteen (15) business days of discovery of an error not related to a system configuration and ninety-five percent (95%) of all claims reprocessed within thirty (30) business days when a system configuration change is required.	

Performance Measure 3	Amount of Performance Withhold at Risk
Follow-up After Hospitalization for Mental Illness (ages 6+)	30%
Standard Description	
Percent of discharges for children and adults who were hospitalized for treatment of selected diagnoses who had a follow up visit with a MH practitioner within seven (7) days of discharge and within thirty (30) days of discharge.	
CMS Core Set Measure #3-1	Amount of Performance Withhold at Risk
Follow-up After Hospitalization for Mental Illness	7.5%
Standard Description – Core Set Measure #3-1	
Percentage of discharges for children ages 6-17 years old who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. • Percentage of discharges for which the child received follow-up within seven (7) days after Discharge. (CMS Core Health Care Quality Measure "FUH" (child, seven (7) days).)	
Standard Required to Receive Incentive Payment #3-1	
For hospitalization for mental illness for children ages 6-17 years old who are discharged and have a follow up within seven (7) days after discharge, the Contractor must meet or exceed 49.7%.	
CMS Core Set Measure #3-2	Amount of Performance Withhold at Risk
Follow-up After Hospitalization for Mental Illness	7.5%
Standard Description – Core Set Measure #3-2	

Percentage of discharges for children ages 6 -17 years old who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner: • Percentage of discharges for which the child received follow-up within thirty (30) days after Discharge. (CMS Core Health Care Quality Measure "FUH" (child, thirty (30) days).)
Standard Required to Receive Incentive Payment #3-2
For hospitalization for mental illness for children ages 6 -17 years old who are discharged and have a follow-up within thirty (30) days of discharge, the Contractor must meet or exceed 72.1%

CMS Core Set Measure #3-3	Amount of Performance Withhold at Risk
Follow-up After Hospitalization for Mental Illness	7.5%

Standard Description – Core Set Measure #3-3
Percentage of discharges for beneficiaries 18-64 years old who were hospitalized for treatment of selected mental illness diagnoses or intentional self-harm and who had a follow up visit with a mental health practitioner. • Percentage of discharges for which the beneficiary received follow-up within seven (7) days after discharge (CMS Core Health Care Quality Measure "FUH" (adult, 7-days).)
Standard Required to Receive Incentive Payment #3-3
For hospitalization for mental illness for beneficiaries 18-64 years old who are discharged and have a follow-up within seven (7) days of discharge, the Contractor must meet or exceed 43.0%.

CMS Core Set Measure #3-4	Amount of Performance Withhold at Risk
Follow-up After Hospitalization for Mental Illness	7.5%

Standard Description – Core Set Measure #3-4
Percentage of discharges for beneficiaries, 18 – 64 years old who were hospitalized for treatment of selected mental illness diagnoses or intentional self-harm and who had a follow up visit with a mental health practitioner. (CMS Core Health Care Quality Measure "FUH" (adult, 30-days).) • Percentage of discharges for which the beneficiary received follow-up within thirty (30) days after discharge
Standard Required to Receive Incentive Payment #3-4
For hospitalization for mental illness for beneficiaries, 18 – 64 years old who are discharged and have a follow-up within thirty (30) days of discharge, the Contractor must meet or exceed 63.6%.

Performance Measure 4	Amount of Performance Withhold at Risk
Follow-up After Emergency Department Visit for Mental Health	30%
Standard Description	

Percentage of emergency department (ED) visits for beneficiaries 18-64 years old with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported.

CMS Core Set Measure #4-1	Amount of Performance Withhold at Risk
Follow-up After Emergency Department Visit for Mental Health	15%

Standard Description – Core Set Measure #4-1

Percentage of emergency department (ED) visits for beneficiaries 18-64 years old with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness.
• Percentage of ED visits for mental illness for which the beneficiary received follow-up within seven (7) days of the ED visit (eight (8) total days)
(CMS Core Health Care Quality Measure "FUM" (seven (7) days).)

Standard Required to Receive Incentive Payment #4-1

For ED visits for mental illness for which the beneficiary received follow-up within seven (7) days of the ED visit (eight (8) total days) the Contractor must meet or exceed 43.4%.

CMS Core Set Measure #4-2	Amount of Performance Withhold at Risk
Follow-up After Emergency Department Visit for Mental Health	15%

Standard Description – Core Set Measure #4-2

Percentage of emergency department (ED) visits for beneficiaries,18 - 64 years old with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness.
• Percentage of ED visits for mental illness for which the beneficiary received follow-up within thirty (30) days of the ED visit (thirty-one (31) total days)
(CMS Core Health Care Quality Measure "FUM" (thirty (30) days).)

Standard Required to Receive Incentive Payment #4-2

For ED visits for mental illness for which the beneficiary received follow-up within thirty (30) days of the ED visit (thirty-one (31) total days) the Contractor must meet or exceed 59.5%.

Performance Measure 5	Amount of Performance Withhold at Risk
Health Equity Plan	20%

Standard Description

The contractor will submit a plan to address Health Equity including the following elements:

1. The Health Equity Plan must cover a three (3) year timeframe (July 1, 2022 through June 30, 2025).
2. Submit current organizational policies and procedures that demonstrate organizational attention to the health equity focus area. This includes any policies that support the health system and provider network accountability for each health equity focus area (i.e., delegate policies for provider contracts, complaints, and grievance policy).
3. Define a strategic goal(s) which must include a background and context narrative that will explain the selection of goals under each priority area. Background information

should include a complete description including identified issues or barriers. 4. Identify key system elements necessary to achieve the strategic goals. Anticipate impact. 5. Identify data streams, including the Social Determinants of Health Project (SDOH) data. Include quantitative or qualitative data used to identify such issues or barriers. 6. Identify clear measures of success: Goals under each strategy need to be clear and measurable. 7. Define measures and metrics to be used to track progress toward the strategic goal(s). The monitoring and evaluation of each goal should be set up from the beginning (baseline) to measure changes and progress to target. 8. Define who will be responsible for monitoring progress. 9. Identify how often the plan for each focus area will be revisited and updated based on progress. 10. Contractor must include a description of the resources (internal and external) needed to achieve that goal.
Standard Required to Receive Incentive Payment
• September 30, 2021 - A draft Health Equity must be submitted to IME. Timely submission of a complete draft plan with all elements listed above is worth 10% of the performance withhold. • October 31, 2021 - Once the draft plan has been reviewed by IME, the IME will schedule a meeting with the contractor. The contractor will come to this meeting prepared to identify all 10 required elements within their draft plan and engage IME staff to answer questions and discuss. • November 30, 2021 - IME will provide written feedback and/or questions on the draft Health Equity Plans submitted. • December 31, 2021 - The contractor will address any feedback and/or questions from IME and submit a final plan to IME. • January 31, 2022 - The final plan will be reviewed by IME, and if determined by the Department to meet all requirements, will be worth the remaining 10% of the performance withhold. • June 30, 2022 - The contractor will implement all aspects of their health equity plan.

Revision 7. The paragraph in Exhibit G is amended to read as follows:

Continuing into SFY 2022, the Agency will exclude from the capitation rates the select prescription drugs and treatments as set forth in Exhibit G. Contractor shall continue to provide coverage for these Exhibit G pharmaceuticals and treatments, and the Agency will reimburse the Contractor based on Contractor's invoice to the Agency for Exhibit G 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.

Revision 8. Special Contract Attachment 2.7 entitled "Attachment 2.7 Medical Loss Ratio" is amended by revising the paragraphs entitled "Risk Corridor" to read as follows:

Risk Corridor
Agency shall perform a settlement of the payments made by the MCO to Agency or by Agency to the MCO for the rate period beginning July 1, 2021, and running through June 30, 2022. The

settlement is the calculated gain or loss determined when comparing the actual MLR developed from the emerging experience to the risk sharing corridor percentages in the table below. The actual MLR is calculated as the total adjusted medical expenditures divided by the total capitation rate for all populations. The total capitation rate excludes taxes and fees, as well as amounts related to the Physician ACR payment, Hospital Directed Payments, GEMT payment, GME, and NF CRR payments.

Adjusted medical expenditures shall be determined by Agency/Agency's-contracted actuaries based on encounter data and plan financial data submitted by the MCO.

Adjusted medical expenditures only include services covered by the Agency and the MCO and will exclude all expenditures associated with carve-out services such as Zolgensma and the administrative costs of COVID-19 vaccinations. Administrative expenditures included in the pharmacy claims expenditures will be removed from the pharmacy claims for purposes of this Risk Corridor. Adjusted medical expenditures will not include quality improvement expenses, case management expenses, or other administrative expenses. Adjusted medical expenditures will not include amounts related to the Physician ACR payment, Hospital Directed Payments, GEMT payment, GME, and NF CRR payments.

The Agency reserves the right to audit claims expenditures. For purposes of the Risk Corridor, the State will limit the overall level of reimbursement to 103% of the fee schedule target and will sample the submitted encounter data to ensure compliance with that target. The data used by the Agency and its actuaries for the reconciliation will be the MMIS encounter data. The Agency and the MCO agree that to the extent there are differences between claims expenditures as reflected in the encounter data and the financial data submitted by the MCO, the Agency and MCO will confer and make a good faith effort to reconcile those differences before the calculation of the final settlement as described below.

The Risk Corridor Percentage is calculated as the total adjusted medical expenditures divided by the total capitation rate. The total capitation rate excludes applicable taxes for the July 2021 – June 2022 period.

The Risk Sharing Corridor is defined as follows:

Risk Corridor Minimum Percentage	Risk Corridor Maximum Percentage	MCO Share	State/Fed Share
0.0%	89.2%	0%	100%
89.2%	92.2%*	100%	0%
92.2%*	95.2%	100%	0%
95.2%	95.2% +	0%	100%

**The target MLR of 92.2% is based on the weighted average of total non-medical load amounts built into SFY22 rates using the CY19 enrollment distribution. The actual target used for the final reconciliation may vary slightly based on the actual population distribution for the MCO during the twelve-month contract period. To the extent the target MLR varies from 92.2% using the actual enrollment mix during the contract period, the risk corridor bands will still be +/- 3.0% from the revised target.*

Within 230 days following the end of the contract period, the MCO shall provide Agency with a complete and accurate report of actual medical expenditures, by category of service, for enrollees, 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. The report will be a detailed claim-level record.

Prior to 9 months following contract period, Agency shall provide the MCO with a final settlement under the risk share program for the contract period. Any balance due between Agency and the MCO, as the case may be, will be paid within 60 days of receiving the final reconciliation from Agency.

For the July 1, 2021 – June 30, 2022 contract period, the capitation rates 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.

The MCO may provide services to enrollees that are in addition to those covered under the State plan although, the cost of these services cannot be included when determining rates or risk corridor.

Notwithstanding the above, for a period beginning July 1, 2021 through June 30, 2022, the minimum medical loss ratio (MLR) will be 88%.

Revision 9. The document attached to this Amendment as Exhibit 1 is hereby incorporated into the Contract as Special Contract Attachment 3.2-04.

Revision 10. Federal Funds. The following federal funds information is provided:

<table>
<tr><td colspan="2">Contract Payments include Federal Funds? Yes
DUNS #: 809245525
The Name of the Pass-Through Entity: Iowa Department of Human Services</td></tr>
<tr><td>CFDA #: 93.778
Title XIX: The Medical Assistance Program</td><td>Federal Awarding Agency Name:
Centers for Medicare and Medicaid Services (CMS)</td></tr>
</table>

CDFA #: 93.767 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, Iowa Total Care, Inc.		**Agency, Iowa Department of Human Services**	
Signature of Authorized Representative: 	Date: 04.12.21	Signature of Authorized Representative: Kelly Garcia Kelly Garcia (Apr 14, 2021 17:10 CDT)	Date:
Printed Name: Mitch Wasden		Printed Name: Kelly Garcia	
Title: Plan President and CEO		Title: Director	

Exhibit 1

Special Contract Attachment 3.2-04

	Iowa Total Care Rates, Net Withhold							
Rate Cell	**CY19 Proxy MMs**	**SFY22 Rates Net Additional Payments**	**Withhold PMPM**	**SFY22 Rates Net Withhold, Net Additional Payments**	**GME PMPM**	**GEMT PMPM**	**NF CRR PMPM**	**SFY22 Rates, Net Withhold Gross Additional Payments**
Children 0-59 days M&F	24,001	$ 2,248.07	$ 44.96	$ 2,203.11	$ 5.28	$ 4.91	$ -	$ 2,213.30
Children 60-364 days M&F	92,450	$ 315.89	$ 6.32	$ 309.58	$ 5.28	$ 1.78	$ -	$ 316.64
Children 1-4 M&F	294,566	$ 152.11	$ 3.04	$ 149.07	$ 5.28	$ 0.94	$ -	$ 155.29
Children 5-14 M&F	605,647	$ 158.02	$ 3.16	$ 154.86	$ 5.28	$ 0.59	$ -	$ 160.73
Children 15-20 F	102,703	$ 261.73	$ 5.23	$ 256.49	$ 5.28	$ 2.75	$ -	$ 264.53
Children 15-20 M	95,041	$ 205.01	$ 4.10	$ 200.91	$ 5.28	$ 1.81	$ -	$ 208.01
CHIP - Hawk-i	208,401	$ 158.67	$ 3.17	$ 155.49	$ -	$ 0.42	$ -	$ 155.92
Non-Expansion Adults 21-34 F	141,222	$ 397.74	$ 7.95	$ 389.78	$ 5.28	$ 4.66	$ -	$ 399.72
Non-Expansion Adults 21-34 M	30,609	$ 238.62	$ 4.77	$ 233.85	$ 5.28	$ 2.80	$ -	$ 241.92
Non-Expansion Adults 35-49 F	79,511	$ 580.99	$ 11.62	$ 569.37	$ 5.28	$ 5.22	$ -	$ 579.86
Non-Expansion Adults 35-49 M	32,124	$ 415.86	$ 8.32	$ 407.54	$ 5.28	$ 3.67	$ -	$ 416.49
Non-Expansion Adults 50+ M&F	15,339	$ 719.85	$ 14.40	$ 705.45	$ 5.28	$ 5.27	$ -	$ 716.01
Pregnant Women	34,789	$ 398.98	$ 7.98	$ 391.00	$ 5.28	$ 4.13	$ -	$ 400.41
WP 19-24 F (Medically Exempt)	4,082	$ 808.11	$ 16.16	$ 791.95	$ -	$ 15.68	$ -	$ 807.63
WP 19-24 M (Medically Exempt)	3,530	$ 918.03	$ 18.36	$ 899.67	$ -	$ 10.70	$ -	$ 910.37
WP 25-34 F (Medically Exempt)	11,920	$ 984.14	$ 19.68	$ 964.45	$ -	$ 13.73	$ -	$ 978.18
WP 25-34 M (Medically Exempt)	12,146	$ 974.60	$ 19.49	$ 955.11	$ -	$ 20.72	$ -	$ 975.82
WP 35-49 F (Medically Exempt)	17,772	$ 1,319.20	$ 26.38	$ 1,292.82	$ -	$ 16.91	$ -	$ 1,309.73
WP 35-49 M (Medically Exempt)	16,236	$ 1,166.72	$ 23.33	$ 1,143.38	$ -	$ 22.81	$ -	$ 1,166.20
WP 50+ M&F (Medically Exempt)	24,392	$ 1,567.19	$ 31.34	$ 1,535.84	$ -	$ 22.96	$ -	$ 1,558.80
WP 19-24 F (Non-Medically Exempt)	96,350	$ 243.77	$ 4.88	$ 238.89	$ -	$ 3.05	$ -	$ 241.94

WP 19-24 M (Non-Medically Exempt)	82,426	$ 191.35	$ 3.83	$ 187.52	$ -	$ 3.00	$ -	$ 190.52
WP 25-34 F (Non-Medically Exempt)	110,052	$ 320.86	$ 6.42	$ 314.45	$ -	$ 2.79	$ -	$ 317.24
WP 25-34 M (Non-Medically Exempt)	98,648	$ 289.07	$ 5.78	$ 283.29	$ -	$ 4.57	$ -	$ 287.86
WP 35-49 F (Non-Medically Exempt)	106,870	$ 527.36	$ 10.55	$ 516.82	$ -	$ 3.99	$ -	$ 520.81
WP 35-49 M (Non-Medically Exempt)	101,627	$ 478.10	$ 9.56	$ 468.54	$ -	$ 5.92	$ -	$ 474.46
WP 50+ M&F (Non-Medically Exempt)	175,113	$ 842.67	$ 16.85	$ 825.82	$ -	$ 5.76	$ -	$ 831.58
ABD Non-Dual <21 M&F	39,711	$ 944.59	$ 18.89	$ 925.70	$ 5.28	$ 4.90	$ -	$ 935.88
ABD Non-Dual 21+ M&F	92,818	$ 1,703.55	$ 34.07	$ 1,669.48	$ 5.28	$ 21.96	$ -	$ 1,696.72
Residential Care Facility	1,482	$ 4,183.53	$ 83.67	$ 4,099.86	$ 5.28	$ 9.56	$ -	$ 4,114.70
Breast and Cervical Cancer	743	$ 2,179.79	$ 43.60	$ 2,136.20	$ -	$ 0.99	$ -	$ 2,137.18
Dual Eligible 0-64 M&F	125,436	$ 512.39	$ 10.25	$ 502.14	$ -	$ 1.33	$ -	$ 503.47
Dual Eligible 65+ M&F	39,325	$ 213.93	$ 4.28	$ 209.65	$ -	$ 1.24	$ -	$ 210.89
Custodial Care Nursing Facility <65	8,396	$ 4,481.55	$ 89.63	$ 4,391.92	$ 5.28	$ 11.86	$ 5.70	$ 4,414.76
Custodial Care Nursing Facility 65+	54,273	$ 3,531.74	$ 70.63	$ 3,461.10	$ -	$ 1.26	$ 5.70	$ 3,468.06
Elderly HCBS Waiver	37,754	$ 3,531.74	$ 70.63	$ 3,461.10	$ -	$ 3.35	$ -	$ 3,464.45
Non-Dual Skilled Nursing Facility	796	$ 4,481.55	$ 89.63	$ 4,391.92	$ 5.28	$ 20.08	$ 5.70	$ 4,422.98
Dual HCBS Waivers: PD; H&D	6,341	$ 4,481.55	$ 89.63	$ 4,391.92	$ -	$ 3.71	$ -	$ 4,395.62
Non-Dual HCBS Waivers: PD; H&D; AIDS	5,645	$ 4,481.55	$ 89.63	$ 4,391.92	$ 5.28	$ 16.51	$ -	$ 4,413.71
Brain Injury HCBS Waiver	6,241	$ 4,481.55	$ 89.63	$ 4,391.92	$ 5.28	$ 6.13	$ -	$ 4,403.33
ICF/ID	5,852	$ 6,711.45	$ 134.23	$ 6,577.22	$ 5.28	$ 5.53	$ -	$ 6,588.03
State Resource Center	1,680	$ 6,711.45	$ 134.23	$ 6,577.22	$ 5.28	$ 0.33	$ -	$ 6,582.83
Intellectual Disability HCBS Waiver	54,164	$ 6,711.45	$ 134.23	$ 6,577.22	$ 5.28	$ 3.08	$ -	$ 6,585.57
PMIC	1,395	$ 2,952.52	$ 59.05	$ 2,893.47	$ 5.28	$ 12.70	$ -	$ 2,911.45
Children's Mental Health HCBS Waiver	3,223	$ 2,952.52	$ 59.05	$ 2,893.47	$ 5.28	$ 5.36	$ -	$ 2,904.12
CHIP - Children 0-59 days M&F	191	$ 2,248.07	$ 44.96	$ 2,203.11	$ -	$ -	$ -	$ 2,203.11

CHIP - Children 60-364 days M&F	1,076	$ 315.89	$ 6.32	$ 309.58	$ -	$ 0.31	$ -	$ 309.89
CHIP - Children 1-4 M&F	2	$ 152.11	$ 3.04	$ 149.07	$ -	$ -	$ -	$ 149.07
CHIP - Children 5-14 M&F	61,681	$ 158.02	$ 3.16	$ 154.86	$ -	$ 0.48	$ -	$ 155.33
CHIP - Children 15-20 F	9,536	$ 261.73	$ 5.23	$ 256.49	$ -	$ 1.29	$ -	$ 257.78
CHIP - Children 15-20 M	9,687	$ 205.01	$ 4.10	$ 200.91	$ -	$ 1.38	$ -	$ 202.29
TANF Maternity Case Rate	3,257	$ 6,568.98	$ 131.38	$ 6,437.60	$ -	$ -	$ -	$ 6,437.60
Pregnant Women Maternity Case Rate	3,081	$ 5,771.30	$ 115.43	$ 5,655.88	$ -	$ -	$ -	$ 5,655.88
Total	**3,185,014**	**$ 666.64**	**$ 13.33**	**$ 653.31**	**$ 2.93**	**$ 3.54**	**$ 0.11**	**$ 659.89**