Twelfth Amendment to the MED-20-001 Contract

This Twelfth Amendment to Contract Number MED-20-001 is effective as of July 1, 2022, 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. Section 1.3.3.1 Pricing.
In paragraph beginning with "Beginning December 1, 2020, the Agency will exclude…" is amended to read as follows:

Beginning December 1, 2020, the Agency will exclude from the capitation rates the costs associated with COVID 19 vaccine administration services. Contractor shall continue to provide coverage for COVID 19 vaccine administration services. The Agency will reimburse the Contractor on a retrospective basis for such claims using the Medicare payment methodology and rates for the same services and consistent with CMS guidance and Agency policy as published in any and all provider informational letters (IL).
However, payments to Contractor under this provision shall be limited to the lower of (1) what Medicare would have paid for the same services for a Medicare eligible individual and consistent with all published ILs, or (2) the Contractor's actual out-of-pocket payments for such services. All invoices for reimbursement under this paragraph must be submitted no later than 12 months from the date of service. All adjustments made to invoices shall be submitted to the Agency within 90 days from the date of the invoice being adjusted and must be backed by claim level detail sufficient to support the invoice.

Revision 2: Section 3.2.5(c)(1)(i) is amended to read as follows:
(i) shall cover and pay for emergency services regardless of whether the provider that furnishes the services is Iowa Medicaid enrolled or has a contract with the Contractor; and

Revision 3: Section 3.2.5(3)(f) is amended to read as follows
(f) Availability
Emergency services shall be available twenty-four (24) hours a day, seven (7) days a week. Contractor shall pay non-contracted and/or non-Iowa Medicaid Enrolled. providers for emergency services at the amount that would have been paid if the service had been provided under the Agency's fee-for-service Medicaid program.

Revision 4: 13.4.1 Claims Dispute Renumbered to 13.4.2

Revision 5: 13.4.2 Compliance with State and Federal Claims Processing Regulations renumbered to 13.4.3

Revision 6: 13.4.3 Out-of-Network Claims renumbered to 13.4.4

Revision 7: 13.4.4 Coordination among Contractors renumbered to 13.4.5

Revision 8: 13.4.5 Claims Payment Timeliness renumbered to 13.4.6

Revision 9: 13.4.6 Claims Reprocessing and Adjustments renumbered to 13.4.7

Revision 10: 13.4.7 Member Financial Participation and Cost Sharing renumbered to 13.4.8

Revision 11: 13.4.8 Audit renumbered to 13.4.9

Revision 12: 13.6.1 TPL Responsibility is amended to read as follows:

Pursuant to law, the Agency is the payer of last resort for all covered services. To the extent of medical assistance paid by the Contractor, the Agency assigns all of its rights to recover for such medical assistance against liable third parties under Iowa code ch. 249A, including but not limited to the rights of the Agency under Iowa Code §§ 249A.37 and 249A.54. Notwithstanding the foregoing sentence, the Contractor shall, upon request of the Agency, release the assignment to the Agency. The Agency reserves the right to identify, pursue, and retain any recovery of third party resources that remain uncollected.

The Contractor shall exercise full assignment rights as applicable and shall make every reasonable effort to determine the liability of third parties to pay for services rendered to members under the Contract and cost avoid and/or recover any such liability from the third party. The Contractor shall develop and implement policies and procedures, subject to Agency review and approval, to meet its obligations regarding third party liability when the third party pays a cash benefit to the member for medical claim expenses, regardless of services used, or does not allow the member to assign his/her benefits. When there is a liable third party, the Contractor shall pay the member's coinsurance, deductibles, co-payments and other cost-sharing expenses up to the Contractor's allowed amount. The Contractor's total liability shall not exceed the Contractor's allowed amount minus the amount paid by the primary payer. The Contractor shall follow all activities laid out in the most recent Agency Medicaid TPL Action Plan, and most recent CMS handbook called, Coordination of Benefits and Third Party Liability (COB/TPL) In Medicaid.

Revision 13. Section 13.6.1.1 is amended as follows:

Applicable liable third parties include any insurance company, individual, corporation or business that can be held legally responsible for the payment of all or part of the medical costs of a member. Examples of liable third parties can include: (i) health insurance, including Medicare, and TRICARE; (ii) worker's compensation; (iii) homeowner's insurance; (iv) automobile liability insurance; (v) non-custodial parents or their insurance carriers; or (vi) settlements or court awards for casualty/tort (accident) claims including settlements paid through insurance. Contractor shall be able to identify trauma and accident cases where funds expended can be recovered from liable third parties and recover the funds.

Revision 14 Section 13.6.1.2 is amended as follows:

The Contractor shall share information regarding its members with these other payers as specified by the Agency and in accordance with 42 C.F.R. § 438.208(b). In the process of coordinating care, the Contractor shall protect each member's privacy in accordance with the confidentiality requirements stated in 45 C.F.R. Parts 160 and 164, including confidentiality of family planning services. In addition, the Contractor must follow all applicable provisions under 42 C.F.R. §§ 59.2 and 59.11 relating specifically to confidentiality of family planning services. In particular, if an enrolled member requests confidentiality related to any family planning services sought and/or received, and also requests such confidentiality extend to any notification

to a policy holder of any third-party coverage to which the enrolled member is also covered, the Contractor may not provide any notifications to the policy holder, related to such family planning services sought and/or received by the enrolled member. The Agency will provide information to the Contractor on member TPL that was collected at the time of Medicaid application. The Contractor shall report weekly any new TPL to the Agency, in the preferred method as described by the Agency, to retain in the TPL system. The information collected on members shall contain the following:

(a) First and last name of the policyholder
(b) Social security number of the policyholder
(c) Full insurance company name
(d) Group number, if available
(e) Name of policyholder's employer (if known)
(f) Insurance carrier ID
(g) Type of policy and coverage

Additionally, the Contractor shall implement Agency approved strategies and methodologies to ensure the collection and maintenance of current TPL data, for example, recoveries from direct billing, disallowance projects, and yield management activities.

Revision 15: 13.6.2.3 is amended as follows:

Cost avoidance exceptions in accordance with 42 C.F.R. § 433.139 include the following situations in which the Contractor shall first pay the provider and then coordinate with the liable third party. Providers are not required to bill the third party prior to the Contractor in these situations:(i) the claim is for coverage derived from a parent whose obligation to pay support is being enforced by the State Title IV-D Agency or (ii) the claim is for preventive pediatric services (including EPSDT) that are covered by the Medicaid program. Following reimbursement to the provider in these cost avoidance exception cases, the Contractor shall actively seek reimbursement from responsible third parties and adjust claims accordingly.

Revision 16: 14.11 Call Center Performance Metrics is amended as follows:

Call Center Performance Metrics. In addition to any performance metrics identified in relation to a specific subset of call centers, Contractor shall ensure that all call centers operated by Contractor or a subcontractor that performs services under this Contract meet the following performance metrics:

a) Abandonment rates must be five percent or less. Calls are considered abandoned if the caller hangs up after 30 seconds and does not talk with a Customer Service Representative.
b) Service levels must be at least 80% for incoming calls. The service level is calculated by the following formula:
   Service Level = ((T – (A + B)/T)) * 100, where:
   T = all calls that enter the queue
   A = calls that are answered after 30 seconds
   B = calls that are abandoned after 30 seconds
c) 90% of telephone inquiries, excluding billing inquiries, must be responded to during the initial call.
d) 99% of calls will be answered by an individual or an electronic device without receiving a busy signal.

e) 90% of written, faxed, or e-mailed inquires must be responded to within three business days of receipt excluding bill inquiries. If a complete response cannot be made within three business days, an interim response shall be provided within the first three business days and every three days thereafter until resolved. All inquiries must be resolved within 15 business days.
f) 95% of all bill inquiries will be responded to by phone or in writing within two business days. 100% of bill inquiries will be responded to by phone or in writing within three business days.

Revision 17: Exhibit B General Access Standards is modified to read as follows:

F. Behavioral Health Access Standards

a. Time and Distance:
i. Outpatient services: Thirty (30) minutes or thirty (30) miles from the personal residence of members except where community standards and documentation shall apply.

ii. Inpatient, residential, intensive outpatient and partial hospitalization: Sixty (60) minutes or sixty (60) miles from the personal residence of members in urban areas and ninety (90) minutes or ninety (90) miles from the personal residence of members in rural areas using GeoAccess standards for rural and urban travel time.

b. Appointment Times: The Contractor shall require that network providers have procedures for the scheduling of member appointments in accordance with their scope of practice in response to the following occurrences:

i. Emergency: Members with emergency needs shall be seen or referred to an appropriate provider, upon presentation at a service delivery site.

ii.Mobile Crisis: Members in need of mobile crisis services shall receive services within one (1) hour of presentation or request.

iii.Urgent: Members with urgent non-emergency needs shall be seen or referred to an appropriate provider within one (1) hour of presentation at a service delivery site or within twenty-four (24) hours of telephone contact with provider or the Contractor.

iv.Persistent symptoms: Members with persistent symptoms shall be seen or referred to an appropriate provider within forty-eight (48) hours or reporting symptoms.

v.Routine: Members with need for routine services shall be seen or referred to an appropriate provider within three (3) weeks of the request for an appointment.

vi.Substance Use Disorder & Pregnancy: Members who are pregnant women in need of routine substance use disorder services must be admitted within forty-eight (48) hours of seeking treatment.

vii.Intravenous drug use: Members who are intravenous drug users must be admitted not later than fourteen (14) days after making the request for admission, or one-hundred and twenty (120) days after the date of such request if no program has the capacity to admit the individual on the date of such request and if interim services are made available to the individual not later than forty-eight (48) hours after such request.

Revision 18: Exhibit E Non-Compliance Remedies is modified to read as follows:

NON-COMPLIANCE REMEDIES

It is the Agency's primary goal to ensure that the Contractor is delivering quality care to members. To assess attainment of this goal, the Agency monitors certain quality and performance standards, and holds the Contractor accountable for being in compliance with Contract terms. The Agency accomplishes this by working collaboratively with the Contractor to maintain and improve programs, and not to impair Contractor stability.

In the event that the Contractor fails to meet performance requirements or reporting standards set forth in the Contract or other standards established by the Agency, the Agency will provide the Contractor with a written notice of non-compliance and may require any of the corrective actions or remedies discussed below. The Agency will provide written notice of non-compliance to the Contractor within ninety (90) calendar days of the Agency's discovery of such non-compliance.

If the Agency elects not to exercise a corrective action clause contained anywhere in the Contract in a particular instance, this decision shall not be construed as a waiver of the Agency's right to pursue future assessment of that performance requirement and associated damages, including damages that, under the terms of the Contract, may be retroactively assessed.

Revision 19. Attachmnet 2.7 Medical Loss Ratio, Part B is amended to read as follows:

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, 2022 and running through June 30, 2023. 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 GME or directed payments implemented as a separate payment term and the MCO is not at risk (e.g., Physician ACR payment, Hospital Directed Payments, or ARPA funds).

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, Mepservii 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 GME or directed payments implemented as a separate payment term and the MCO is not at risk (e.g., Physician ACR payment, Hospital Directed Payments, or ARPA funds).

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 rates. The total capitation rate excludes applicable taxes for the July 2022 – June 2023 period.

The Risk Sharing Corridor is defined as follows:

Risk Corridor Minimum Percentage	Risk Corridor Maximum Percentage	MCO Share	State/Fed Share
0.0%	89.3%	0%	100%
89.3%	92.3%*	100%	0%
92.3%*	95.3%	100%	0%
95.3%	95.3% +	0%	100%

**The target MLR of 92.3% is based on the weighted average of total non-medical load amounts built into SFY23 rates using 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 92.3% 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, 2022 – June 30, 2023 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, 2022 through June 30, 2023, the minimum medical loss ratio (MLR) will be 88%.

Revision 20. Exhibit G is amended to read as follows:

Continuing into SFY 2023, the Agency will exclude from the capitation rates the select prescription drugs and treatments as set forth in Exhibit G. Prescription drugs and treatments that cost more than $1.5 million per year will be excluded from capitation rates. 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.

Pharmaceuticals excluded from capitation payments
(to be billed to the Agency by MCO via invoice)

NDC	Drug Name
71894-120-02	Zolgensma
71894-121-03	
71894-122-03	
71894-123-03	
71894-124-04	
71894-125-04	
71894-126-04	
71894-127-05	
71894-128-05	
71894-129-05	
71894-130-06	
71894-131-06	
71894-132-06	
71894-133-07	
71894-134-07	
71894-135-07	
71894-136-08	
71894-137-08	
71894-138-08	
71894-139-09	
71894-140-09	
71894-141-09	
69794-0001-01	Mepsevii

Revision 21. Exhibit F of the Contract is amended to read as follows:

PAY FOR PERFORMANCE

Withhold Arrangement. The Agency will implement a withhold arrangement to reward the Contractor's efforts to improve quality and outcomes as described in the relevant yearly rate certification. See: Special Contract Attachment Section 3.2 (Rate Sheets).

General. For all withhold arrangements authorized by this Contract:

a) The arrangement is for a fixed period of time.
b) The withhold amount shall be two percent (2%) of capitation payments.
c) That performance is measured during the rating period under the Contract in which the withhold arrangement is applied.
d) The arrangement is not to be renewed automatically.
e) The arrangement is made available to both public and private contractors under the same terms of performance.
f) The arrangement does not condition Contractor participation in the withhold arrangement on the Contractor entering into or adhering to intergovernmental transfer agreements.
g) The arrangement is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the State's quality strategy.

See: 42 C.F.R. § 438.6(b)(3)(i) - (v); 42 C.F.R. § 438.340.

Table F1: SFY 2023 PAY FOR PERFORMANCE MEASURES

The Agency will provide a document with the full description of the guidelines and data definitions for the SFY 2023 Pay for Performance Measures.

Performance Standard 1	**Amount of Performance Withhold at Risk**
Timely Claims Reprocessing	20%
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 claim reprocessing project, the time for reprocessing will begin to run on the day the Contractor receives all information necessary to accurately reprocess the claims. In cases	

in which a system configuration is necessary, the Contractor shall make corrections to the system and reprocess claims within sixty (60) calendar days unless an extension is approved by the Agency.
Standard Required to Receive Incentive Payment
The Contractor will achieve a measure of ninety percent (90%) of all reprocessed claims within fifteen (15) business days of discovery of an error not related to a system configuration and ninety-five percent (95%) of all claims reprocessed within thirty (30) business days when a system configuration change is required.

Performance Standard 2	**Amount of Performance Withhold at Risk**
Follow-up After Hospitalization for Mental Illness (Child)	20%

Standard Description
The percentage of discharges for children ages 6 to 17 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. Two rates are reported: the percentage of discharges for which beneficiary received follow-up within 30 days of discharge, and the percentage of discharges for which beneficiary received follow-up within 7 days of discharge.
Standard Required to Receive Incentive Payment
The Contractor must calculate this HEDIS measure based on the timeframe of SFY2023 (7/1/22-6/30/23), and the contractor must obtain validation of the SFY2023 results through an authorized NCQA representative. For hospitalizations for mental illness for children ages 6 to 17 who are discharged and have a follow-up within 7 days after discharge, the Contractor must increase from their CY2021 results by the percentage identified in the chart below to accrue the corresponding withhold payment. For hospitalizations for mental illness for children ages 6-17 who are discharged and have a follow-up within 30 days after discharge, the Contractor must increase from their CY2021 results by the percentage identified in the chart below to accrue the corresponding withhold payment. The Contractor must achieve the same level of increase on <u>both</u> the 7 day and 30 day measures to earn the corresponding withhold. If the Contractor achieves differing levels of increase on the two measures, the Contractor will receive the lower percentage of withhold achieved. Increase by 3% or more – 100% of withhold earned Increase by 2-2.99% – 75% of withhold earned Increase by 1-1.99% – 50% of withhold earned Increase by 0.99% or less – 0% of withhold earned

Performance Standard 3	**Amount of Performance Withhold at Risk**
Follow-up After Hospitalization for Mental Illness (Adult)	20%

Standard Description
The percentage of discharges for patients 18 to 64 years of age 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. Two rates are reported: the percentage of discharges for which the patient received follow-up within 30 days of discharge; and the percentage of discharges for which the patient received follow-up within 7 days of discharge.
Standard Required to Receive Incentive Payment
The Contractor must calculate this HEDIS measure based on the timeframe of SFY2023 (7/1/22-6/30/23), and the contractor must obtain validation of the SFY2023 results through an authorized NCQA representative. For hospitalizations for mental illness for adults ages 18 to 64 who are discharged and have a follow-up within 7 days after discharge, the Contractor must increase from their CY2021 results by the percentage identified in the chart below to accrue the corresponding withhold payment. For hospitalizations for mental illness for adults ages 18 to 64 who are discharged and have a follow-up within 30 days after discharge, the Contractor must increase from their CY2021 results by the percentage identified in the chart below to accrue the corresponding withhold payment. The Contractor must achieve the same level of increase on <u>both</u> the 7 day and 30 day measures to earn the corresponding withhold. If the Contractor achieves differing levels of increase on the two measures, the Contractor will receive the lower percentage of withhold achieved. Increase by 3% or more – 100% of withhold earned Increase by 2-2.99% – 75% of withhold earned Increase by 1-1.99% – 50% of withhold earned Increase by 0.99% or less – 0% of withhold earned

Performance Standard 4	**Amount of Performance Withhold at Risk**
Prenatal and Postpartum Care: Timeliness of Prenatal Care	20%
Standard Description	
Percentage of deliveries of live births within the period under review that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in Medicaid or CHIP.	
Standard Required to Receive Incentive Payment	
The Contractor must calculate this HEDIS measure based on the timeframe of SFY2023 (7/1/22-6/30/23), and the contractor must obtain validation of the SFY2023 results through an authorized NCQA representative. For deliveries of live births within the period under review that received a prenatal care visit in the first trimester, on or before the enrollment start date or within forty-two (42) days of enrollment in Medicaid or CHIP, the Contractor must increase from their CY2021 results by the percentage identified in the chart below to accrue the corresponding withhold payment. Increase by 2% or more – 100% of withhold earned	

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

Performance Standard 5	**Amount of Performance Withhold at Risk**
Service Level for the MCO NEMT Helpline	10%
Standard Description	
MCO will consistently reach a service level for the NEMT helpline of eighty-two percent (82%).	
Standard Required to Receive Incentive Payment	
MCO shall maintain an eighty-two percent (82%) or greater service level. The amount of withhold earned by the Contractor will be determined by the total number of months within SFY2023 that the Contractor achieves this service level threshold: 0 months – 0% of withhold earned 1-3 months – 25% of withhold earned 4-6 months – 50% of withhold earned 7-9 months – 75% of withhold earned 10-12 months – 100% of withhold earned	

Performance Standard 6	**Amount of Performance Withhold at Risk**
Wait Time for NEMT Members	10%
Standard Description	
MCO will reduce the percentage of members waiting fifteen (15) minutes or more for an NEMT trip.	
Standard Required to Receive Incentive Payment	
The percentage of members waiting for fifteen (15) minutes or more is reduced at least five (5) percent for SFY2023 from the baseline of the same percentage for SFY2022. <u>Percentage calculation:</u> Numerator: Measure Order #7 on current NEMT reporting template Denominator: Measure Order #4 on current NEMT reporting template To earn 100% of the withhold for this measure, the percentage calculated for all combined 12 months of SFY2023 must be reduced at least 5% from the percentage calculated for all combined 12 months of SFY2022.	

Revision 22. Exhibit H Section B NF &SNF COVID-19 Relief Rate Directed Payments is no longer effective as of July 1, 2022.

Revision 23. The document attached to this Amendment as Exhibit 1 is hereby incorporated into the Contract as Special Contract Attachment 3.2-05.

Revision 24. Federal Funds. The following federal funds information is provided:

Contract Payments include Federal Funds? Yes **DUNS #:** 809245525 **The Name of the Pass-Through Entity:** Iowa Department of Human Services	
CFDA #: 93.778 Title XIX: The Medical Assistance Program	**Federal Awarding Agency Name:** Centers for Medicare and Medicaid Services (CMS)
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: 06.23.2022	Signature of Authorized Representative: Kelly Garcia Kelly Garcia (Jun 29, 2022 21:44 CDT)	Date: Jun 29, 2022
Printed Name: Mitch Wasden		Printed Name: Kelly Garcia	
Title: Plan President and CEO		Title: Director	

Special Contract Attachment 3.2-05

	Iowa Total Care Rates, Net Withhold						
Rate Cell	CY19 Proxy MMs	SFY23 Rates Net Additional Payments	Withhold PMPM	SFY23 Rates Net Withhold, Net Additional Payments	GME PMPM	GEMT PMPM	SFY23 Rates, Net Withhold Gross Additional Payments
Children 0-59 days M&F	24,253	$2,297.76	$45.96	$2,251.81	$4.45	$4.07	$2,260.32
Children 60-364 days M&F	93,890	$329.54	$6.59	$322.95	$4.45	$1.71	$329.12
Children 1-4 M&F	314,290	$172.30	$3.45	$168.85	$4.45	$0.95	$174.25
Children 5-14 M&F	617,110	$166.13	$3.32	$162.81	$4.45	$0.59	$167.84
Children 15-20 F	104,202	$274.94	$5.50	$269.44	$4.45	$2.66	$276.55
Children 15-20 M	95,865	$208.35	$4.17	$204.18	$4.45	$1.76	$210.40
CHIP - Hawki	193,806	$162.60	$3.25	$159.35	$ -	$0.44	$159.79
Non-Expansion Adults 21-34 F	146,774	$423.35	$8.47	$414.89	$4.45	$4.61	$423.94
Non-Expansion Adults 21-34 M	32,601	$273.98	$5.48	$268.50	$4.45	$2.77	$275.72
Non-Expansion Adults 35-49 F	82,566	$612.38	$12.25	$600.14	$4.45	$5.22	$609.81
Non-Expansion Adults 35-49 M	34,238	$469.39	$9.39	$460.00	$4.45	$3.81	$468.26
Non-Expansion Adults 50+ M&F	15,993	$756.63	$15.13	$741.50	$4.45	$5.39	$751.34
Pregnant Women	35,546	$276.35	$5.53	$270.83	$4.45	$4.03	$279.31

WP 19-24 F (Medically Exempt)	4,043	$961.99	$19.24	$942.75	$ -	$15.31	$958.06
WP 19-24 M (Medically Exempt)	3,598	$1,182.73	$23.65	$1,159.07	$ -	$10.53	$1,169.60
WP 25-34 F (Medically Exempt)	12,594	$1,039.10	$20.78	$1,018.32	$ -	$13.50	$1,031.82
WP 25-34 M (Medically Exempt)	12,658	$1,074.32	$21.49	$1,052.83	$ -	$20.45	$1,073.28
WP 35-49 F (Medically Exempt)	18,553	$1,406.64	$28.13	$1,378.51	$ -	$16.85	$1,395.36
WP 35-49 M (Medically Exempt)	16,802	$1,275.28	$25.51	$1,249.78	$ -	$22.94	$1,272.72
WP 50+ M&F (Medically Exempt)	26,321	$1,741.70	$34.83	$1,706.87	$ -	$22.90	$1,729.77
WP 19-24 F (Non-Medically Exempt)	98,274	$252.62	$5.05	$247.56	$ -	$2.95	$250.51
WP 19-24 M (Non-Medically Exempt)	81,045	$189.45	$3.79	$185.66	$ -	$2.97	$188.63
WP 25-34 F (Non-Medically Exempt)	113,937	$335.86	$6.72	$329.14	$ -	$2.76	$331.91
WP 25-34 M (Non-Medically Exempt)	99,569	$295.67	$5.91	$289.76	$ -	$4.52	$294.27
WP 35-49 F (Non-Medically Exempt)	109,923	$550.33	$11.01	$539.33	$ -	$3.99	$543.32
WP 35-49 M (Non-Medically Exempt)	104,975	$488.67	$9.77	$478.90	$ -	$5.89	$484.78
WP 50+ M&F (Non-Medically Exempt)	181,018	$853.84	$17.08	$836.77	$ -	$5.79	$842.56
ABD Non-Dual <21 M&F	41,000	$1,028.91	$20.58	$1,008.33	$4.45	$4.82	$1,017.60
ABD Non-Dual 21+ M&F	95,092	$1,750.44	$35.01	$1,715.44	$4.45	$21.94	$1,741.82
Residential Care Facility	2,083	$7,438.65	$148.77	$7,289.88	$4.45	$9.82	$7,304.15
Breast and Cervical Cancer	800	$2,252.74	$45.05	$2,207.68	$ -	$0.67	$2,208.36
Dual Eligible 0-64 M&F	128,275	$613.12	$12.26	$600.86	$ -	$1.35	$602.21

Dual Eligible 65+ M&F	38,893	$223.88	$4.48	$219.40	$ -	$1.22	$220.62
Custodial Care Nursing Facility <65	8,392	$4,845.67	$96.91	$4,748.75	$4.45	$11.39	$4,764.59
Custodial Care Nursing Facility 65+	55,785	$3,681.91	$73.64	$3,608.27	$ -	$1.29	$3,609.56
Elderly HCBS Waiver	39,317	$3,681.91	$73.64	$3,608.27	$ -	$3.38	$3,611.64
Non-Dual Skilled Nursing Facility	770	$4,845.67	$96.91	$4,748.75	$4.45	$19.48	$4,772.69
Dual HCBS Waivers: PD; H&D	6,259	$4,845.67	$96.91	$ 4,748.75	$ -	$3.79	$4,752.54
Non-Dual HCBS Waivers: PD; H&D; AIDS	5,619	$4,845.67	$96.91	$4,748.75	$4.45	$17.16	$4,770.36
Brain Injury HCBS Waiver	6,319	$4,845.67	$96.91	$4,748.75	$4.45	$6.02	$4,759.22
ICF/ID	5,822	$7,146.87	$142.94	$7,003.94	$4.45	$5.43	$7,013.81
State Resource Center	1,714	$7,146.87	$142.94	$7,003.94	$4.45	$0.71	$7,009.10
Intellectual Disability HCBS Waiver	54,700	$7,146.87	$142.94	$7,003.94	$4.45	$3.29	$7,011.68
PMIC	1,408	$3,714.26	$74.29	$3,639.97	$4.45	$12.62	$3,657.04
Children's Mental Health HCBS Waiver	3,442	$3,714.26	$74.29	$3,639.97	$4.45	$5.59	$3,650.02
CHIP - Children 0-59 days M&F	193	$2,297.76	$45.96	$2,251.81	$ -	$4.07	$2,255.87
CHIP - Children 60-364 days M&F	1,092	$329.54	$6.59	$322.95	$ -	$1.71	$324.67
CHIP - Children 1-4 M&F	3	$172.30	$3.45	$168.85	$ -	$0.95	$169.80
CHIP - Children 5-14 M&F	62,849	$166.13	$3.32	$162.81	$ -	$0.59	$163.39
CHIP - Children 15-20 F	9,676	$274.94	$5.50	$269.44	$ -	$2.66	$272.10
CHIP - Children 15-20 M	9,771	$208.35	$4.17	$204.18	$ -	$1.76	$205.95
TANF Maternity Case Rate	3,257	$6,628.73	$132.57	$6,496.16	$ -	$ -	$6,496.16

Pregnant Women Maternity Case Rate	3,081	$5,823.95	$116.48	$5,707.47	$ -	$ -	$5,707.47
Total	**3,253,713**	**$706.83**	**$14.14**	**$692.70**	**$2.49**	**$3.56**	**$698.75**