Second Amendment to the Iowa Health Link Contract

This Amendment to Contract Number MED-24-005 is effective as of July 1, 2023, between the Iowa Department of Human Services (Agency) and Molina Healthcare of Iowa, Inc. (Contractor).

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

Revision 1. Section Agency of the State, Agency Billing Contact, is hereby amended as follows:
Shannon Garland
515-393-8408

Revision 2. Section Agency of the State, Agency Contract Manager, is hereby amended as follows:
Shannon Garland
515-393-8408
sgarlan@dhs.state.ia.us

Revision 3. Section Contractor, Contractors Principal Street Address, is hereby amended as follows:
500 SW 7th, Suite 304

Revision 4. Section Contractor, Contractors Contract Manager Street Address, is hereby amended as follows:
500 SW 7th, Suite 304

Revision 5. Section Contractor, Contractor's Billing Street Address, is here by amended as follows:
500 SW 7th, Suite 304

Revision 6. Section A.17 Coordination with Other State Agencies and Program Contractors, subheading b), is deleted and replaced as follows:
Family Well Being and Protection. This department has oversight of: Child Care; Child Protection and Services; and Early Intervention and Support.

Revision 7. Section A.17 Coordination with Other State Agencies and Program Contractors, subheading d), is deleted and replaced as follows:
Behavioral Health and Disability Services. This department has oversight of: Community-Based Prevention, Services, and Integration for People with Disabilities; Performance, Innovation and Mental Health.

Revision 8. Section A.17 Coordination with Other State Agencies and Program Contractors, subheading e), is deleted and replaced as follows:

Community Access. This department has oversight of: Child Support Services; Eligibility; Wellness and Preventive Health.

Revision 9. Section C.2.02. Obligation to Provide Handbook, is hereby amended as follows:

Contractor shall provide each Enrolled Member and their authorized representative an Enrollee handbook, which serves as a summary of Benefits and coverage, within seven (7) days after receiving notice of the beneficiary's enrollment. See: 42 C.F.R. § 438.10(g)(1); 45 C.F.R. § 147.200(a); 42 C.F.R. § 457.1207. {From CMSC C.2.02}.

Revision 10. Section C.8.07 Definition of terms, is hereby amended as follows:
Habilitation services and devices is replaced with habilitation services. Rehabilitation services and devices has been removed.

Revision 11. Section C.8.08. Additional Definitions, is hereby amended as follows:
Preauthorization is replaced with prior authorization.

Revision 12. Section D.4.01 Medical Loss Ratio (MLR) Applicability, is hereby amended as follows:
The Contractor shall submit the MLR in accordance with MLR standards and the Agency instructions outlined in the reporting manual. The following MLR standards apply to both Title XIX and Title XXI capitation payments. Contractor shall report separate MLRs for the Title XIX and Title XXI populations and aggregate across both populations for minimum MLR application.

Revision 13. Section D.4.06 Incurred claims, Amounts that must be deducted from incurred claims, is hereby amended as follows:
a) Premiums and overpayment recoveries received from network providers.
b) Prescription drug rebates received and accrued.

Revision 14. Section D.4.07 Activities that improve health care quality, is hereby amended as follows:
Activities that improve health care quality must be in one of the following categories. See: 42 C.F.R. § 438.8(e)(3):

a) A Contractor activity that meets the requirements of 45 C.F.R. § 158.150(b) and is not excluded under 45 C.F.R. § 158.150(c).
b) A Contractor activity related to any EQR-related activity as described in 42 C.F.R. § 438.358(b) and (c).
c) Any Contractor expenditure that is related to Health Information Technology and meaningful use, meets the requirements placed on issuers found in 45 C.F.R. § 158.151, and is not considered incurred claims.

Revision 15. Section D.4.15.f Credibility Adjustment, is hereby amended as follows:

CMS may adjust the number of member months necessary for a MCO's, PIHP's, or PAHP's experience to be non-credible, partially credible, or fully credible so that the standards are rounded for the purposes of administrative simplification. The number of member months will be rounded to one hundred (100) or a different degree of rounding as appropriate to ensure that the credibility thresholds are consistent with the objectives outlined herein.

Revision 16. Section D.4.18 Reporting Requirements, is hereby amended as follows:
Contractor shall submit a report in accordance with MLR standards and Agency instructions outlined in the reporting manual that includes at least the following information for each MLR reporting year:

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

Revision 17. Section D.4.32 . Risk Corridor Percentage, is hereby deleted and replaced as follows:
The Risk Corridor Percentage is calculated as the total adjusted medical expenditures divided by the total capitation revenue for all populations.

The Risk Sharing Corridor is defined as follows:

Risk Corridor Minimum Percentage	Risk Corridor Maximum Percentage	Contractor Share	State / Federal Share
0.0%	88.1%	0.0%	100.0%
88.1%	91.1%*	100.0%	0.0%
91.1%*	94.1%	100.0%	0.0%
94.1%	94.1%+	0.0%	100.0%

**Risk corridor bands reflected in the risk corridor table are +/- 3.0%. The target MLR of 91.1% is based on the weighted average of total non-medical load amounts built into capitated rates for July 1, 2023 to June 30, 2024, based on SFY22 statewide enrollment distribution.*

In the circumstance that during the contract period the Agency implements programmatic changes that results in a change, (increase or decrease), to the total capitation rate but does not impact the non-medical load the risk corridor target may change to reflect the non-medical load reflected in the adjusted rates; however, the risk corridor bands will remain +/- 3.0% from the revised target.

The actual target MLR used for the risk corridor reconciliation may vary slightly based on the actual population distribution for the Contractor during the twelve-month contract period. To the extent the actual target MLR varies from 91.1% using the actual enrollment mix and revised capitation rates during the contract period, the risk corridor bands will still be +/- 3.0% from the revised target.

Revision 18. Section E.1.04. Provider Website, the following sentence is hereby added to the end of the section as follows:
The Contractor shall update the Provider Relations regional maps at least quarterly, or more frequently as staffing changes occur.

Revision 19. Section E.1.30. Provider Recredentialing Performance Metric, is hereby amended as follows:
Contractor shall complete recredentialing of all contracted Providers no less than every three (3) years. The agency will conduct an annual audit to ensure compliance with recredentialing requirements. For contracts new to Iowa health Link program the audit will occur on the third year of the contract. Failure to comply with the audit or recredentialing requirements may result in corrective actions in accordance with contract section J.8.08.

Revision 20. Section E.3.03. Credentialing Policies and Procedures, is hereby deleted and replaced as follows:
Contractor shall develop, implement, and adhere to written policies and procedures, subject to Agency review and approval, related to Provider Credentialing and re-Credentialing, which shall include standards of conduct that articulate Contractor's understanding of the requirements and that direct and guide Contractor's and Subcontractors' compliance with all applicable federal and State standards and performance metrics related to Provider Credentialing, including those required in 42 C.F.R. Parts 438 and 455, Subpart E, which shall include the following: (i) a training plan designed to educate staff in the Credentialing and re-Credentialing requirements; (ii) provisions for monitoring and auditing compliance with Credentialing standards; (iii) provisions for prompt response and corrective action when non-compliance with Credentialing standards is detected; (iv) a description of the types of Providers that are credentialed; (v) methods of verifying Credentialing assertions, including any evidence of prior Provider sanctions; and (vi) prohibition against employment or contracting with Providers excluded from participation in federal health care programs. The Contractor shall ensure that the Credentialing process provides for mandatory re-Credentialing at a minimum of every three (3) years. Contractor shall document its Credentialing Policies and Procedures in the PPM.

Revision 21. Section F.1.10 Post-Stabilization Care Coverage, b) is hereby amended as follows:
Preauthorization is replaced with prior authorization.

Revision 22. Section F.6.14 Deemed Granting of Prior Authorization Requests, is hereby deleted.

Revision 23. The subsequent sections have been renumbered as follows:
F.6.14. Covered Services
F.6.15. Benefit Package

F.6.16. Hawki Enrollees
F.6.17. Iowa Health and Wellness Plan Benefits.
F.6.18. Medically Exempt.
F.6.19. Identification of Medically Exempt Members.
F.6.20. Benefits for Medically Exempt Members.
F.6.21. Changes in Covered Services.
F.6.22. Integrated Care.
F.6.23. QTL & NQTL.
F.6.24. EPSDT Services:
F.6.25. Prior Authorization - EPSDT.
F.6.26. Newborn and Mothers Health Protection.
F.6.27. Sufficiency of Services.
F.6.28. Age-Appropriate Growth and Development.
F.6.29. Functional Capacity.
F.6.30. Living Setting of Enrollee's Choice.
F.6.31. Mental Health Parity.
F.6.32. Contractor may cover services or settings for Enrolled Members that are in lieu of those covered under the State Plan if:

Revision 24. Section F.11.02 Pharmacy Network is hereby amended as follows:
The Contractor shall provide a pharmacy network that complies with Special Contract Exhibit C requirements and at a minimum includes pharmacies licensed with the Iowa Board of Pharmacy.

Revision 25. Section F.11.13. 340B Drug Pricing Program, 340B Covered Entities, the below is hereby added to the end of this section as follows:

MCOs shall be required to meet the same, or substantially similar, timeframes and metrics for reimbursement, prior approval responses and clean claims for 340B prescription drugs as for non-340B prescription drugs. MCOs shall reimburse covered entities in the same timeframe and manner as non-340B covered entities and shall not have a decreased timeframe for timely filing, unless otherwise permitted by federal law. Further, MCO shall not treat 340B claims or entities any differently than non-340B Medicaid entities or claims and shall not have additional restrictions (fees, chargebacks, claw backs, adjustments, or other assessments not already required or permitted by Iowa law or Administrative Code).

Revision 26. Section F.11.18. Drug Encounter Claims Submission, is hereby deleted and replaced as follows:
F.11.18. *Drug Encounter Claims Submission.* Contractor shall submit pharmacy encounter data in compliance with the Iowa Medicaid Encounter Companion Guide, inclusive of all fields listed in the guide. The Contractor shall submit a Claim-level detail file once a week of drug encounters to the Agency or its Designee, unless otherwise approved. The Contractor shall provide this reporting to the Agency in the manner and timeframe prescribed by the Agency, including, but not limited to, the submission of complete and accurate drug encounter data rebate file and required Attestation Form to the Agency or its Designee. The detail must provide the basis for comparing the actual amount paid to pharmacies to the amount that the PBM charged

the Contractor for the transaction. The Contractor shall comply with spread pricing prohibition and if pass through pricing is used for PBM contracting, any administrative fee the PBM charges the Contractor, cannot be sent as part of the encounter claim pricing. The Contractor shall comply with all file layout requirements including, but not limited to, format and naming conventions and submission of Provider paid amount. A complete listing of Claim fields required will be determined by the Agency. The Contractor shall ensure that its pharmacy Claims process recognizes Claims from 340B pharmacies for products purchased through the 340B Program at the Claim level utilizing the NCPDP field designed for this purpose. The Contractor shall ensure that the Physician/Provider administered drug Claims process recognizes Claims from 340B Providers at the Claim level.
See: CMS CIB 050519 and 42 C.F.R. § 438.8(e)(2)(v)(A) and 42 CFR 438.8(k)(3)

Revision 27. Section F.11.20. Disputed Drug Encounter Submissions, is hereby deleted and replaced as follows:
The Contractor shall assist the Agency or the Agency's Designee in resolving Drug Rebate disputes with a manufacturer in a timely manner and at the Contractor's expense. The process must be followed as indicated in the Drug Rebate Dispute Information/Communication Process including any subsequent revisions. On a monthly basis, the Agency will review the Contractor's drug encounter Claims and provide a file to the Contractor of disputed encounters that were identified through the Drug Rebate invoicing process. Within sixty (60) Days of receipt of the disputed encounter file from the Agency, the Contractor must resolve any disputed encounters and send a response file to the Agency indicating the specific resolution action taken and date of completion. In addition to the administrative sanctions of this Contract, failure of the Contractor to submit, once a week, drug encounter Claims files and/or a response file to the disputed encounters file within sixty (60) Days as detailed above for each disputed encounter shall result in a quarterly offset to the Capitation Payment equal to the value of the Provider reimbursement amount on the disputed encounters.

Revision 28. Section F.13.16. Individual Service Coordination and Treatment Planning Requirements, is hereby amended to add the following language:
a) The Contractor shall ensure the provision of care for Enrolled Members, which includes coordinating with inpatient mental health and substance use disorder treatment facilities including but not limited to PMICS, MHIs, subacute mental health facilities, psychiatric hospitals, and substance use disorder treatment facilities. The Contractor shall initiate and lead transitional care coordination to Enrolled Members residing in a facility to ensure transition into the community where appropriate. Transitional care activities include but are not limited to the Contractor's development and implementation of a transitional care plan and securing placement and services with community providers that are able to meet the Enrolled Member's needs. The Contractor shall implement strategies, as approved by the Agency, to monitor transition and ensure that services and supports are made available to ensure transition success.

b) Monitoring of Community Transition Activities. The Contractor shall monitor all aspects of the transition process and take immediate action to address any issues that arise. The Contractor shall monitor hospitalizations and MH/SUD facility readmissions for Enrolled Members who transition to the community to identify issues and implement strategies to improve Outcomes. The Contractor shall conduct face-to-face visits with the Enrolled Member, at minimum: (i)

within two (2) Days of the transition to the community; (ii) every two (2) weeks for the first two (2) months from discharge; and (iii) once per month for the first year after transition. More frequent contact shall occur based on an individualized assessment of the Enrolled Member's needs and risk factors.

c) MH/SUD Facilities; Case Management Requirements. Contractor shall obtain Agency approval of strategies for monitoring services for Enrolled Members in MH/SUD facilities. Community Based Case management must meet the requirements contained in Section F.12C of this Contract.

d) Discharge Planning. Contractor shall develop, implement, and adhere to policies and procedures to ensure that community-based case managers are actively involved in Discharge Planning when an Enrolled Member is hospitalized, receiving inpatient mental health or substance use disorder treatment or otherwise served outside of the home. The Contractor shall define circumstances that require that hospitalized/ inpatient Enrolled Members receive an in-person visit to complete a needs reassessment and an update to the Enrolled Member's plan of care. Contractor shall document its policies and procedures in its PPM.

Revision 29. Section I.5.03, b) Single Case Agreements is hereby deleted.

Revision 30. Section I.5.04 Quarterly Reports, d) Single Case Agreements is hereby added to the section.

Revision 31. Exhibit B: Glossary of Terms/Definitions, the following have been added to the Exhibit:
Day Habilitation: Day habilitation services are services that assist or support the consumer in developing or maintaining life skills and community integration.

Durable Medical Equipment: Durable medical equipment. DME is equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services that a member receives in an emergency room.

Excluded Services: Services that are not covered on the members identified plan.

Functional Family Therapy (FFT): An evidenced based family therapy that provides clinical assessment and treatment for the youth and their family to improve communication, problem solving, and conflict management in order to reduce problematic behavior of the youth.

Habilitation Services: Habilitation Services means the 1915(i) State Plan Home and Community Based Services. Habilitation services are provided to maintain persons with functional deficits

typically associated with chronic mental illness in their own homes and communities.

Home Based Habilitation: Habilitation Services means the 1915(i) State Plan Home and Community Based Services. Habilitation services are provided to maintain persons with functional deficits typically associated with chronic mental illness in their own homes and communities.

Home Health Care: Home health care is a wide range of health care services that can be given in a member's home for an illness or an injury.

Hospice: Services to provide comfort and support for members in the last stages of a terminal illness, and their families.

Hospitalization: Inpatient care based on diagnosis-related groups.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

Multi-Systemic Therapy (MST): An evidenced based intensive treatment process that focuses on diagnosed behavioral health disorders and on environmental systems (family, school, peer groups, culture, neighborhood, and community) that contribute to, or influences a youth's involvement, or potential involvement in the juvenile justice system.

Non-participating provider: A provider that is enrolled with Iowa Medicaid, is credentialed, but not contracted, with a managed care plan. Participating Provider: A provider that is enrolled with Iowa Medicaid, and is credentialed and contracted with a managed care plan.

Physician Services: Health care services a licensed medical physician provides or coordinates.

Plan: An individual or group plan that provides, or pays the cost of, medical care.

Premium: A health insurance premium is the amount that policyholders pay for health coverage.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prevocational Services: Prevocational services means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

Supported Employment: Supported employment means the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state's minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals. Supported employment services can be provided through many different service models.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.

Revision 32. Exhibit C: General Access Standards, B. Specialty Care Standards a), has been deleted and replaced as follows:

Specialty Network: The Contractor shall contract with a sufficient number of specialists with the applicable range of expertise to ensure that the needs of Enrolled Members are met within the Contractor's Provider Network. The Contractor shall also have a system to refer Enrolled Members to, and pay for, non-Network Providers when medically necessary. The Contractor shall also pay for non-Network Providers when an Enrolled Member has medical needs that would be adversely affected by a change in service Providers. All non-Network Providers referred to and reimbursed shall have the necessary qualifications or certifications to provide the medically necessary service. At minimum, the Contractor shall have Provider agreements with Providers practicing the following specialties: (i) allergy; (ii) cardiology; (iii) dermatology; (iv) endocrinology; (v) gastroenterology; (vi) general surgery; (vii) hematology (viii) neonatology; (ix) nephrology; (x) neurology; (xi) neurosurgery; (xii) obstetrics and gynecology; (xiii) occupational therapy; (xiv) oncology; (xv) ophthalmology; (xvi) orthopedics; (xvii) otolaryngology; (xviii) pathology; (xix) physical therapy; (xx) pulmonology; (xxi) psychiatry; (xxii) radiology; (xxiii) reconstructive surgery; (xxiv) rheumatology; (xxv) speech therapy; (xxvi) urology; and (xxvii) pediatric specialties. The Contractor shall analyze the clinical needs of the Enrolled Membership to identify additional specialty Provider types to enroll.

Revision 33. Exhibit E: Covered Benefits, Table E.02: Iowa Wellness Plan Benefits Coverage List, 1. ambulatory services, the following was added:

TMJ

Revision 34. Exhibit E: Covered Benefits, Table E.02: Iowa Wellness Plan Benefits Coverage List, 9. Preventive Wellness Chronic Disease Management, removed excluded coding from Nutritional Counseling.

Revision 35. Exhibit E: Covered Benefits, Table E.02: Iowa Wellness Plan Benefits Coverage List, 10. Pediatric Services including oral & vision, the following was added:

EPSDT - Multi-Systemic Therapy Covered up to age 20

EPSDT - Family Functional Therapy Covered up to age 20

Revision 36. Exhibit E: Covered Benefits, Table E.02: Iowa Wellness Plan Benefits Coverage List, 10. Pediatric Services including oral & vision, the following was deleted:

TMJ

Revision 37. Exhibit E: B, Table E.02: the following was removed from the Benefits Not Provided:
TMJ

Revision 38. Special Contract Amendment was hereby added.

Revision 39. Federal Funds. The following federal funds information is provided

Contract Payments include Federal Funds? Yes **UEI: S419DSARU593** **The Name of the Pass-Through Entity:** Iowa Department of Human Services	
CFDA #: 93.778 **Grant Name:** Title XIX: The Medical Assistance Program	**Federal Awarding Agency Name:** Centers for Medicare and Medicaid Services (CMS)
CFDA #: 93.767 **Grant Name:** Children's Health Insurance Program	**Federal Awarding Agency Name:** Centers for Medicare and Medicaid Services (CMS)

Section 2: Ratification & Authorization
Except as expressly amended and supplemented herein, the Contract shall remain in full force and effect, and the parties hereby ratify and confirm the terms and conditions thereof. Each party to this Amendment represents and warrants to the other that it has the right, power, and authority to enter into and perform its obligations under this Amendment, and it has taken all requisite actions (corporate, statutory, or otherwise) to approve execution, delivery and performance of this Amendment, and that this Amendment constitutes a legal, valid, and binding obligation.

Section 3: Execution
IN WITNESS WHEREOF, in consideration of the mutual covenants set forth above and for other good and valuable consideration, the receipt, adequacy and legal sufficiency of which are hereby acknowledged, the parties have entered into the above Amendment and have caused their duly authorized representatives to execute this Amendment.

Contractor, Molina Healthcare of Iowa, Inc.		**Agency, Iowa Department of Human Services**	
Signature of Authorized Representative: [signature]	Date: 6/22/23	Signature of Authorized Representative: Kelly Garcia Kelly Garcia (Jun 27, 2023 19:49 CDT)	Date: Jun 27, 2023
Printed Name: Jennifer Vermeer		Printed Name: Kelly Garcia	
Title: Iowa Plan President		Title: Director	

Special Contract Amendment

	Molina Healthcare Rates, Net Withhold						
Rate Cell	SFY22 Statewide MMs	Rates - Net Additional Payments	Withhold PMPM	Rates - Net Withhold, Net Additional Payments	GME PMPM	GEMT PMPM	Rates - Net Withhold, Gross Additional Payments
Children 0-59 days M&F	51,954	$2,546.81	$ 50.94	$2,495.88	$4.45	$ 3.01	$2,503.34
Children 60-364 days M&F	188,355	$ 334.64	$ 6.69	$ 327.95	$4.45	$ 1.61	$ 334.01
Children 1-4 M&F	827,054	$ 172.65	$ 3.45	$ 169.19	$4.45	$ 0.96	$ 174.60
Children 5-14 M&F	1,706,648	$ 170.03	$ 3.40	$ 166.63	$4.45	$ 0.62	$ 171.69
Children 15-20 F	350,013	$ 280.59	$ 5.61	$ 274.98	$4.45	$ 2.68	$ 282.11
Children 15-20 M	336,259	$ 207.15	$ 4.14	$ 203.01	$4.45	$ 1.78	$ 209.24
CHIP - Hawk-i	647,114	$ 165.29	$ 3.31	$ 161.98	$ -	$ 0.52	$ 162.50
Non-Expansion Adults 21-34 F	393,502	$ 428.09	$ 8.56	$ 419.53	$4.45	$ 4.54	$ 428.52
Non-Expansion Adults 21-34 M	93,296	$ 267.59	$ 5.35	$ 262.24	$4.45	$ 3.30	$ 269.99
Non-Expansion Adults 35-49 F	258,815	$ 631.36	$ 12.63	$ 618.73	$4.45	$ 4.68	$ 627.86
Non-Expansion Adults 35-49 M	107,659	$ 443.86	$ 8.88	$ 434.98	$4.45	$ 4.18	$ 443.61
Non-Expansion Adults 50+ M&F	53,075	$ 770.34	$ 15.41	$ 754.93	$4.45	$ 4.75	$ 764.14
Pregnant Women	138,854	$ 269.95	$ 5.40	$ 264.55	$4.45	$ 1.95	$ 270.95
WP 19-24 F (Medically Exempt)	11,421	$1,118.15	$ 22.36	$1,095.79	$ -	$ 15.63	$1,111.42
WP 19-24 M (Medically Exempt)	9,036	$1,242.72	$ 24.85	$1,217.86	$ -	$ 12.25	$1,230.11
WP 25-34 F (Medically Exempt)	41,983	$1,123.62	$ 22.47	$1,101.15	$ -	$ 14.38	$1,115.53
WP 25-34 M (Medically Exempt)	39,700	$1,100.07	$ 22.00	$1,078.07	$ -	$ 20.87	$1,098.93
WP 35-49 F (Medically Exempt)	62,802	$1,385.13	$ 27.70	$1,357.42	$ -	$ 16.91	$1,374.34
WP 35-49 M (Medically Exempt)	57,448	$1,234.28	$ 24.69	$1,209.59	$ -	$ 25.11	$1,234.70
WP 50+ M&F (Medically Exempt)	90,090	$1,752.98	$ 35.06	$1,717.92	$ -	$ 27.08	$1,745.00
WP 19-24 F (Non-Medically Exempt)	290,185	$ 276.84	$ 5.54	$ 271.30	$ -	$ 2.51	$ 273.81
WP 19-24 M (Non-Medically Exempt)	257,827	$ 163.70	$ 3.27	$ 160.42	$ -	$ 2.38	$ 162.80
WP 25-34 F (Non-Medically Exempt)	334,869	$ 347.51	$ 6.95	$ 340.56	$ -	$ 2.40	$ 342.96
WP 25-34 M (Non-Medically Exempt)	309,115	$ 301.26	$ 6.03	$ 295.23	$ -	$ 3.89	$ 299.12
WP 35-49 F (Non-Medically Exempt)	338,344	$ 570.56	$ 11.41	$ 559.15	$ -	$ 3.84	$ 562.99
WP 35-49 M (Non-Medically Exempt)	325,219	$ 469.33	$ 9.39	$ 459.95	$ -	$ 5.44	$ 465.39
WP 50+ M&F (Non-Medically Exempt)	520,871	$ 853.17	$ 17.06	$ 836.11	$ -	$ 6.35	$ 842.46
ABD Non-Dual <21 M&F	126,038	$1,047.09	$ 20.94	$1,026.15	$4.45	$ 4.75	$1,035.35
ABD Non-Dual 21+ M&F	243,679	$1,939.01	$ 38.78	$1,900.23	$4.45	$ 27.23	$1,931.91
Residential Care Facility	4,291	$6,362.46	$ 127.25	$6,235.21	$4.45	$ 15.74	$6,255.41
Breast and Cervical Cancer	1,633	$2,869.82	$ 57.40	$2,812.42	$ -	$ 2.95	$2,815.37
Dual Eligible 0-64 M&F	365,294	$ 634.85	$ 12.70	$ 622.15	$ -	$ 1.86	$ 624.01
Dual Eligible 65+ M&F	150,272	$ 261.01	$ 5.22	$ 255.79	$ -	$ 1.42	$ 257.21
Custodial Care Nursing Facility <65	21,268	$5,301.28	$ 106.03	$5,195.26	$4.45	$ 20.72	$5,220.43
Custodial Care Nursing Facility 65+	109,797	$4,346.79	$ 86.94	$4,259.85	$ -	$ 2.66	$4,262.52
Elderly HCBS Waiver	90,926	$4,346.79	$ 86.94	$4,259.85	$ -	$ 3.43	$4,263.28
Non-Dual Skilled Nursing Facility	1,811	$5,301.28	$ 106.03	$5,195.26	$4.45	$ 21.94	$5,221.64
Dual HCBS Waivers: PD; H&D	16,517	$5,301.28	$ 106.03	$5,195.26	$ -	$ 1.77	$5,197.03

Non-Dual HCBS Waivers: PD; H&D; AIDS	18,927	$5,301.28	$ 106.03	$5,195.26	$4.45	$ 17.20	$5,216.91
Brain Injury HCBS Waiver	15,724	$5,301.28	$ 106.03	$5,195.26	$4.45	$ 10.04	$5,209.75
ICF/ID	14,742	$7,829.69	$ 156.59	$7,673.10	$4.45	$ 6.75	$7,684.30
State Resource Center	3,342	$7,829.69	$ 156.59	$7,673.10	$4.45	$ 2.57	$7,680.11
Intellectual Disability HCBS Waiver	137,201	$7,829.69	$ 156.59	$7,673.10	$4.45	$ 4.14	$7,681.69
PMIC	3,429	$2,905.70	$ 58.11	$2,847.58	$4.45	$ 20.71	$2,872.74
Children's Mental Health HCBS Waiver	12,852	$2,905.70	$ 58.11	$2,847.58	$4.45	$ 5.81	$2,857.84
CHIP - Children 0-59 days M&F	875	$2,546.81	$ 50.94	$2,495.88	$ -	$ 3.01	$2,498.89
CHIP - Children 60-364 days M&F	2,931	$ 334.64	$6.69	$ 327.95	$ -	$ 1.61	$ 329.56
CHIP - Children 1-4 M&F	832	$ 172.65	$3.45	$ 169.19	$ -	$ 0.96	$ 170.15
CHIP - Children 5-14 M&F	138,786	$ 170.03	$3.40	$ 166.63	$ -	$ 0.62	$ 167.24
CHIP - Children 15-20 F	27,236	$ 280.59	$5.61	$ 274.98	$ -	$ 2.68	$ 277.66
CHIP - Children 15-20 M	27,214	$ 207.15	$4.14	$ 203.01	$ -	$ 1.78	$ 204.79
TANF Maternity Case Rate	7,655	$6,888.71	$ 137.77	$6,750.94	$ -	$-	$6,750.94
Pregnant Women Maternity Case Rate	4,851	$6,174.82	$ 123.50	$6,051.33	$ -	$-	$6,051.33
Total	9,377,125	$ 693.03	$ 13.86	$ 679.17	$2.42	$ 3.81	$ 685.40