Fourth Amendment to the Iowa Health Link Contract

This Fourth Amendment to Contract Number MED-16-020 between the Iowa Department of Human Services (Agency) and United Healthcare Plan of the River Valley, Inc. (Contractor) amends the Contract as set forth below. This Fourth Amendment is effective July 1, 2017.

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

Revision 1. Section 3.2.6.10.3 of the Contract's Scope of Work is amended to read as follows:

> The Agency participates in the federal supplemental drug rebate program, as such the Contractor and its subcontractors including their PBM are prohibited from obtaining manufacturer drug rebates or other form of reimbursement on the Medicaid enrollees. This provision excludes the hawk-i program.

Revision 2. Section 3.2.9 of the Contract's Scope of Work as well as all subsections of Section 3.2.9 are amended to read as follows:

> 3.2.9 *Health Homes*
>
> The Contractor shall administer and fund the State's Health Home services, or like functions, within the approved State Plan Amendment. If the Contractor chooses to meet the State Plan Amendment criteria related to the functions that provide comprehensive care coordination in a manner other than use of Health Home provider types, this shall be communicated to the Agency and shall be subject to periodic monitoring to ensure all functions are met. In accordance with federal requirements, the Contractor shall ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) HCBS waivers, other forms of community-based case management, or value-based purchasing arrangements. If supplemental services are required to ensure quality of Health Home services to members, the cost of such supplemental services provided to ensure quality may be deducted from Health Home payments.

Revision 3. Section 3.2.11.2.2 of the Contract's Scope of Work is amended to read as follows:

> 3.2.11.2.2 *Initial Assessment and Annual Support Assessment*
>
> The Contractor shall ensure that level of care and needs-based assessments for members potentially eligible for 1915(i) Habilitation Program and 1915(c) Children's Mental Health Waiver enrollment include an assessment of the individual's ability to have his or her needs met safely and effectively in the community and at a cost that does not exceed the limits established in each 1915(i) Habilitation Program and 1915(c) Children's Mental Health Waiver. If the Contractor determines a member's needs cannot be safely met in the community and within the monthly costs and service limits defined in the 1915 (i) Habilitation Program or 1915(c) HCBS Children's Mental Health Waiver in which the member is enrolled, the Contractor shall determine if additional services may be otherwise available through the Contractor's own Exception to Policy process as described in Section 8.15.10, to allow the member to continue to reside safely in the community. If the Contractor determines that it is not reasonable or appropriate to provide an exception to cost or service limits, the Contractor shall provide seamless transition to another setting. A Contractor denial of an exception to cost or service limits is not appealable.

If a member does not appear to meet enrollment criteria such as meeting the target population group, the Contractor shall comply with the requirements. The Contractor shall obtain Agency approval of timeframes in which the level of care or functional eligibility assessment shall occur. The Agency will establish timelines which will promptly assess the member's needs and ensure member safety.

The Contractor shall conduct level of care and needs-based eligibility reassessments, using the Agency designated tools by population annually and when the Contractor becomes aware that the member's functional or medical status has changed in a way that may affect the member's level of care eligibility. The Contractor may perform needs-based eligibility reassessments annually and when the member's function or medical status has changed. The Contractor shall track level of care and needs-based eligibility expiration dates to ensure this requirement is met. This requirement applies to all members on a 1915(i) Habilitation Program and 1915(c) Children's Mental Health Waiver. The Contractor shall obtain Agency approval of timeframes in which reassessments shall occur for individuals identified as having a medical or functional status change. The Agency will establish timelines, which the Contractor shall adhere to, for the Contractor to promptly assess the member's needs and ensure member safety.

Once the assessment is completed, the Contractor shall submit the level of care or functional eligibility assessment to the Agency in the manner prescribed by the Agency. The Agency will retain all authority for determining Medicaid categorical, financial, level of care or needs-based eligibility and enrolling members into a Medicaid eligibility category. The Agency will notify the Contractor when a member has been enrolled in a 1915(i) Habilitation Program and 1915(c) Children's Mental Health Waiver eligibility category and any applicable patient liability amounts.

The Contractor shall administer all needs assessments in a conflict free manner consistent with Balancing Incentive Program (BIP) requirements.

In any Work Plan required by Section 2.13, the Contractor shall develop policies and procedures

(a) identifying a timeline in which all needs assessments shall be completed: (i) upon initial enrollment with the Contractor; and (ii) when the Contractor becomes aware of a change in the member's circumstances which necessitates a new assessment;

(b) providing that reassessments shall be conducted, at least every twelve (12) months; and

(c) identifying a mechanism for completing needs assessments in an appropriate and timely manner.

Revision 4. Section 3.3.2 of the Contract's Scope of Work is amended to read as follows:

3.3.2 *Transition Period-Out of Network Care*

During the first ninety (90) days of the Contract, with the exception of LTSS, residential services and certain services rendered to dual diagnosis populations, which are addressed in Sections 3.3.4 – 3.3.5 and Section 3.3.7, the Contractor shall allow a member who is receiving covered benefits from a non-network provider at the time of Contractor enrollment to continue accessing that provider, even if the network has been closed due to the Contractor meeting the network access requirements. The Contractor is permitted to establish single case agreements or otherwise authorize non-network care past the initial ninety (90) days of the Contract to provide continuity

of care for members receiving out-of-network services. The Contractor shall make commercially reasonable attempts to contract with providers from whom an enrolled member is receiving ongoing care. Out of network providers will be reimbursed a percentage of the network rate unless otherwise agreed upon through a single case agreement.

Revision 5. Section 3.3.4 of the Contract's Scope of Work is amended to read as follows:

3.3.4 *Long Term Services and Supports (LTSS)*

The Contractor shall not be reduce, modify or terminate LTSS services in the absence of an up-to-date assessment of needs that supports the reduction, modification or termination. Identification of duplication of services, use of like state plan services in place of LTSS, or other efforts to address over-utilization shall be documented by the Contractor as part of the service planning process. The Contractor shall ensure members receiving LTSS will be permitted to see all current providers on their approved service plan, when they initially enroll with the Contractor, even on a non-network basis, until an updated service plan is completed, either agreed upon by the member or resolved through the appeals or fair hearing process, and implemented. The Contractor shall extend the authorization of LTSS from a non-contracted provider as necessary to ensure continuity of care pending the provider's contracting with the Contractor, or the member's transition to a contract provider. The Contractor shall facilitate a seamless transition to new services and/or providers, as applicable, in the plan of care developed by the Contractor without any disruption in services.

Revision 6. Section 3.3.5.2 of the Contract's Scope of Work is amended to read as follows:

3.3.5.2 *Ongoing Operations*

Effective one (1) year after the Contract effective date, the Contractor shall not transition members using residential providers, as defined in Section 3.3.5.1, to another residential provider unless the following conditions are met: (i) the member or his/her representative specifically requests to transition; (ii) the member or his/her representative provides written consent to transition based on quality or other concerns raised by the Contractor, which shall not include the residential provider's rate of reimbursement; (iii) the residential provider has chosen not to contract with the Contractor; or (iv) the residential provider chooses to not serve the member at the reimbursement rate offered.

If the residential provider is a non-contract provider, the Contractor may: (i) authorize continuation of the services pending contracting with the provider; (ii) authorize continuation of the services, for at least thirty (30) days pending facilitation of the member's transition to a contracted provider, subject to the member's agreement with such transition; or (iii) continue to reimburse services from the non-contract provider. If a member is transitioned to a contract provider, the Contractor shall extend the authorization of services with the non-contracted provider beyond the minimum thirty (30) day requirement as necessary to ensure continuity of care and the member's seamless transition to a new provider. The Contractor shall permit a member with a dual diagnosis of a behavioral health condition and developmental disorder to remain with their residential provider for at least one year or with their inpatient psychiatric provider, regardless of network status, as long as the services continue to be medically necessary. If, for whatever reason, a member can no longer be served by his/her residential provider the Contractor shall find and make available to the member an alternative residential provider that can meet the member's needs so there is no break in services.

Revision 7. Reserved. [1]
Revision 8. Reserved.

Revision 9. Section 4.3 of the Contract's Scope of Work is amended to read as follows. This Revision does not impact the subsections under Section 4.3:

4.3 *Community-Based Case Management Requirements*

The Contractor shall provide for the delivery of community-based case management. Community-based case management is all of the activities described in this section and the equivalent of: (i) targeted case management to members who are eighteen (18) years of age or over and have a primary diagnosis of mental retardation or who have a developmental disability as defined in 441 Iowa Administrative Code Chapter 90 whether or not the member is receiving LTSS; and (ii) case management to members who are receiving services under the 1915(c) HCBS waivers and any amendments thereto as a result of this Contract except the 1915(c) HCBS waiver for children with a serious emotional disturbance who may be receiving case management services through an IHH. Adult members with a severe mental illness or members that are children with a serious emotional disturbance, as described in Section 3.2.8, shall receive care coordination via the Integrated Health Home in lieu of community-based case management described in this section.

The Contractor shall assign to each member receiving home and community-based LTSS a community-based case manager who is the member's main point of contact with the Contractor and their service delivery system. The Contractor shall establish mechanisms to ensure ease of access and a reasonable level of responsiveness for each member to their community-based case manager during regular business hours. Community-based case manager staff shall have knowledge of community alternatives for the target populations and the full range of long-term care resources as well as specialized knowledge of the conditions and functional limitations of the target populations served by the Contractor, and of the individual members to whom they are assigned. The Contractor shall provide community-based case management services to all members receiving community-based LTSS in accordance with this section. The Contractor shall also ensure that additional requirements are met including Section 4.4 applicable to members receiving 1915(c) HCBS waivers.

The Contractor shall ensure community-based case management shall be provided in a conflict free manner that administratively separates the final approval of 1915(c) HCBS waiver plans of care and approval of funding amount done by the Contractor. Community-based case management efforts made by the Contractor or its designee shall avoid duplication of other coordination efforts provided within the members' system of care.

Revision 10. Section 4.3.1 of the Contract's Scope of Work is amended to read as follows:

4.3.1 *Community-Based Case Manager Qualifications*

In any Work Plan required by 2.13, the Contractor shall submit the required qualifications, experience and training of community-based case managers. The assigned community-based case manager for members who choose to self-direct services, as described in Section 4.4.8, shall have specific experience with self-direction and additional training regarding self-direction. The

[1] Change moved to Amendment 3.

Agency will not prescribe specific community-based case manager to member ratios that shall be maintained. However, the Agency reserves the right to require the Contractor to hire additional community-based case managers if it is determined, at the sole discretion of the Agency, the Contractor has insufficient community-based case management staff to properly and timely perform its obligations under the Contract. Community-based case management shall meet all of the applicable qualifications and requirements as specified in 441 Iowa Administrative Chapter 90.

Revision 11. Section 4.3.12.1 of the Contract's Scope of Work is amended to read as follows:

4.3.12.1 *Case Management Requirements*

In any Work Plan required under Section 2.13, the Contractor shall obtain Agency approval of strategies for monitoring services for members in nursing facilities and ICF/IDs that meet the requirements of this section.

The Contractor shall work with nursing facilities and ICF/IDs to coordinate the provision of care for members. The Contractor shall participate, as appropriate, and allowed by the member, in the nursing facility and ICF/ID care planning process and advocate for the member. The Contractor shall evaluate the nursing facility and ICF/ID care plans to determine adequacy and ensure timely discharge planning is addressed and implemented. The Contractor shall develop a care plan for members in a nursing facility or ICF/ID but may use the care plan developed by the facility to supplement the care plan. The Contractor shall develop and implement targeted strategies to improve the health, functional and quality of life outcomes of members residing in a nursing facility or ICF/ID. The Contractor shall develop and implement policies and procedures, subject to Agency review and approval, to escalate and report concerns regarding nursing facility and ICF/ID quality. The Contractor shall provide nursing facility members' options counseling and transition activities when a member has been identified through the quarterly screening of MDS Section Q, Participation in Assessment and Goal Setting, to return to their home and/or community of their choice.

Revision 12. Section 4.4.5.2 of the Contract's Scope of Work is amended to read as follows:

4.4.5.2 *Service Needs*

The Contractor shall continually monitor 1915(c) HCBS waiver member's service needs are met to assist the member in remaining in the least restrictive setting of the member's choice. If the Contractor determines a member's needs cannot be safely met in the community and within the monthly costs and service limits defined in the 1915(c) HCBS waiver in which the member is enrolled, the Contractor shall determine if additional services may be otherwise available through the Contractor's own Exception to Policy process as described in Section 8.15.10, to allow the member to continue to reside safely in the community. If the Contractor determines that it is not reasonable or appropriate to provide an exception to cost or service limits, the Contractor shall provide seamless transition to another setting. A Contractor denial of an exception to cost or service limits is not appealable.

Revision 13. Section 6.2.2.7 of the Contract's Scope of Work is amended to read as follows:

6.2.2.7 For all provider types, not described in Section 6.2.2.6, in developing the provider network during the first six (6) months of the Contract, the Contractor shall extend contract offers, at minimum, at the current Agency defined Iowa Medicaid floor.

During and after this six month time period, for in-network providers the Contractor shall reimburse these provider types at a rate that is equal to or exceeds the current Agency defined Iowa Medicaid floor, or as otherwise mutually agreed upon by the Contractor and the provider. The Contractor may use national or multi-state contracts for Durable Medical Equipment or Medical Supplies. Pharmacy providers shall be reimbursed in accordance with Section 3.2.6.9.1.1;

Revision 14. Section 14.3.5 of the Contract's Scope of Work is amended to read as follows:

14.3.5 *Member Enrollment*

The Contractor shall report total member enrollment count for the reporting period.

Revision 15. The definition of Adverse Benefit Determination in Exhibit A to the Contract is amended to read as follows:

Adverse Benefit Determination.[2] In the case of Contractor any of the following:

(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

(2) The reduction, suspension, or termination of a previously authorized service.

(3) The denial, in whole or in part, of payment for a service.

(4) The failure to provide services in a timely manner, as defined by the Agency.

(5) The failure of Contractor to act within the timeframes provided in 42 C.F.R. § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

(6) Reserved.

(7) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Revision 16. The definition of Appeal in Exhibit A to the Contract is amended to read as follows:

Appeal. Review by Contractor of an adverse benefit determination. No appeal is granted when a request for an exception to policy (such as requests that exceed service or reimbursement limits) has been denied by the Contractor.

Revision 17. The following definition of "Director Decision" is hereby added to the Contract's Exhibit A:

Director Decision. The Agency Director's Final Decision is the final agency action on any Member appeal. The Agency will defend final Agency action on petition for judicial review filed by the member. The Contractor does not have the right of judicial review.

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[2] Amend. 4, Rev. 109.

Revision 18. Table D1 of Exhibit D to the Contract is amended by removing every reference to the phrase "and approved by the Agency."

Revision 19. The row of Table E1 of Exhibit E to the Contract entitled "Timely Claims Processing" is amended to read as follows:

Timely Claims Processing	The Contractor fails to pay or deny ninety percent (90%) of clean claims within thirty (30) calendar days of receipt, ninety- five percent (95%) of clean claims within forty-five (45) calendar days of the date of receipt or ninety-nine percent (99%) of all claims within ninety (90) calendar days of receipt.	$5,474 per reporting period

Revision 20. The row of Table E1 of Exhibit E to the Contract entitled "Provider Credentialing" is amended to read as follows:

Provider Credentialing	The Contractor fails to credential eighty-five percent (85%) of providers within thirty (30) days and ninety-eight percent (98%) of providers within forty-five (45) days as outlined in Section 6.1.3.	$3,069 per month

Revision 21. Section 1.3.3.1 of the Contract is amended to read as follows:

1.3.3.1. Pricing In accordance with the payment terms outlined in this section and the Contractor's completion of the Scope of Work as set forth in this Contract, the Agency will make capitation payments to the Contractor on a monthly basis or upon occurrence of a qualifying maternity delivery. The capitation payments include both per member per month capitation rates and maternity case rate payments. The capitation payments and any Case rate shall be payment in full for goods and services provided pursuant to this Contract. Retroactive adjustments to reflect the actual cost of goods and services provided pursuant to the Contract are prohibited. The parties anticipate Contractor to begin providing managed care services to its assigned Medicaid population on March 1, 2016. However, if the implementation date is delayed for any reason, Contractor shall not be entitled to payments pursuant to this Contract until Contractor begins providing managed care services for its patient population consistent with the Scope of Work as set forth in this Contract. The Agency has sole discretion to determine the implementation date.

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

For the initial rate period spanning from April 1, 2016 to June 30, 2017, the parties agree to the rates set forth in Special Contract Attachment 3.2-01. Note, the capitation rates shown in the

Attachment will be subject to risk adjustment as outlined in Appendix 1 Section 2.3.3 Risk Adjustment. In each subsequent rate period, the Agency's actuarial contractor will analyze data to determine actuarially sound rates to be offered to Contractor. The Agency and Contractor may discuss proposed capitation rates, but the Agency's actuarial contractor will ultimately be responsible for establishing the actuarially-sound rates to be offered and attesting to the capitation rates to be presented to CMS. After the first rate period, subsequent capitated rates will be added to the Contract in sequentially numbered Special Contract Attachments (i.e., Attachment 3.2-02, Attachment 3.2-03, etc.). Contractor and the Agency must mutually agree to the capitation rates and signify this agreement by executing the Contract amendment. Capitation rates within any rate period are subject to amendment, which shall only occur through formal Contract amendment and only after the proposed rate changes have been approved by CMS.

The parties agree to work diligently and in good faith to establish and agree to capitation rates before the expiration of any rate period. If the parties are unable to establish new capitation rates for a subsequent rate period due to delays or disagreements, the Agency will either terminate the Contract or continue paying Contractor based on the last rates from the then expired rate period until such time as the newly established capitation rates are incorporated into the Contract. Upon agreement to the capitation rates, the Agency will perform a reconciliation between the capitation rates paid and the newly agreed upon rates for the rate period. Any discrepancy will be reconciled through the capitation rate payment process.

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

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

In addition to the monthly capitation payment made to Contractor, the Agency will also make a payment to Contractor when a Medicaid member assigned to the Contractor gives birth and the member is in the population designated in the Contract's then current rate sheet as subject to a payment for giving birth. The amount of this payment, commonly referred to as a "maternity case rate payment," shall be in an amount established as part of the capitation rate-setting process and included in the rate matrix applicable to the given Contract period. The Contractor shall supply documentation of the birth in a form and format determined by the Agency. Upon verification by the Agency of the birth, the Agency shall cause the maternity case rate payment to be made separately and apart from the usual capitation payment for contracted services. Contractor shall diligently monitor births in its assigned Medicaid population and claim a

maternity case rate payment for each birth in the assigned Medicaid population for which a maternity case rate payment is available no later than 60 Days following the date on which the Contractor was made aware of the birth. The Agency shall have no obligation to pay a maternity case rate payment for a birth that occurred more than 210 Days prior to Contractor's claim for a maternity case rate payment.

The capitation rates will be subject to a withhold amount as shown in the capitation rate matrix. The withhold will be retained by the Agency until the period for determination of return of the withhold to the Contractor. The determination of the return of the withhold is outlined in Appendix 1 Exhibit F, Pay-for-Performance requirements.

The actuarially sound capitation rates will include an amount for payment of the health insurer fee, as outlined in Section 9010 of the Affordable Care Act. The health insurer fee will be paid on a retrospective basis upon receipt of information regarding the amount of the fee due by the Contractor for the premium earned under the terms of this contract. The retrospective payment will include an adjustment for related income taxes and other adjustments, including tax credits. The Contractor will be responsible for submitting any requested documentation to the Agency regarding the amount of the fee. A corporate officer for the Contractor will also need to attest to the accuracy of the documentation.

For the rating period July 1, 2017 through June 30, 2018, the Agency will implement a risk pool for the Home Based Habilitation services (H2016 U4-U9) for the Habilitation program members that are not otherwise enrolled in an LTSS program. The Contractor will continue to manage the Habilitation program and authorize services as appropriate using practice guidelines. The Contractor will submit claims paid to providers for H2016 U4-U9 (non-LTSS members) on a quarterly basis to the Agency for reimbursement. The agency will reimburse the health plans at a rate of 75% of the Iowa Medicaid fee-for-service fee schedule amount for the submitted claims. The Agency will not reimburse the Contractor for claims submitted that are duplicate submissions, for members not eligible for the Habilitation program, or for other reasons that are consistent with correct coding standards.

A reconciliation process will occur upon completion of SFY 2018 to maintain budget neutrality of the habilitation services risk pool to the state. The final risk pool amount will be determined using SFY 2018 enrollment and the habilitation risk pool PMPMs specified in the contract. The habilitation risk pool PMPMs applied will be gross of the withhold; no withhold reduction will be applied. The final risk pool amount will be allocated to the MCOs proportionally based on the aggregated Iowa Medicaid fee-for-service fee schedule amount for the submitted and accepted habilitation claims. The reconciliation payment amount will calculated as the MCO-specific habilitation services risk pool amount minus the interim amounts paid to the MCO.

All habilitation services claims must be submitted to the state by January 1, 2019. The reconciliation amounts for each amount MCO will be calculated by February 1, 2019 and paid or recouped from the MCOs by March 1, 2019.

Beginning in SFY2018, the Agency will exclude from the capitation rates the select prescriptions drugs as set forth in Exhibit G from the pharmacy and/or the medical benefits included in the capitation rates. Contractor shall continue to provide coverage for these Exhibit G pharmaceuticals, and the Agency will reimburse the Contractor based on Contractor's invoice to the Agency for Exhibit G pharmaceuticals paid for. Contractor may only invoice for the actual pharmaceutical cost incurred by Contractor. All such invoices must be submitted by Contractor within 12 months of the date of service, with the exception of coordination of benefits situations,

in which Contractor shall invoice for Exhibit G pharmaceuticals within six (6) months from the Contractor's receipt date of the claim and explanation of benefits from a primary carrier. The Agency will pay Contractor the lesser of the amount that would be paid under the fee-for-service system for the pharmaceutical or the amount the Contractor actually paid for the pharmaceutical. Contractor must include with the invoice detailed as required by the Agency to document that the claim was appropriately paid, as well as verification regarding oversight to ensure appropriate utilization of these drugs. At minimum, Contractor's invoice must include claim level detail sufficient to support the invoices

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: CMS Contingency.
This Amendment is contingent on the approval of CMS.

Section 4: 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, United Healthcare Plan of the River Valley, Inc.
Signature of Authorized Representative:
Date: 10/23/17 10:25 AM
Printed Name: Kimberly S Fouts
Title: CEO

Iowa Department of Human Services
Signature of Authorized Representative:
Date: 10/23/17
Printed Name: Jerry Foxhoven
Title: Director, Iowa Dept. of Human Services

State of Iowa - Department of Human Services, Division of Medical Assistance
IA Health Link
July 1, 2017 to June 30, 2018 Capitation Rate Summary
Health Plan: United Healthcare

Medical Gross Capitation

Capitation Rate Cell	Gross Base Medical Capitation	Habilitation Services Risk Pool	Gross Base Medical Capitation Less Habilitation	Gross Base Risk Adjusted Medical Capitation	1915b(3)	GME Supplemental PMPM	UIHC Supplemental PMPM	Gross Total State Plan Rate, Excluding Habilitation	1915b(3)	Gross Total State Plan, Excluding Habilitation, plus 1915b(3) Rate	Habilitation Services Risk Pool
Children 0-59 days M&F	$ 1,838.52	$ 0.00	$ 1,838.52	$ 1,838.52	$ 0.00	$ 5.28	$ 50.24	$ 1,894.04	$ 0.00	$ 1,894.04	$ 0.00
Children 60-364 days M&F	210.02	-	210.02	210.02	-	5.28	8.69	223.99	-	223.99	-
Children 1-4 M&F	127.97	-	127.97	125.92	-	5.28	3.58	134.79	-	134.79	-
Children 5-14 M&F	141.72	(0.04)	141.68	139.41	(0.42)	5.28	2.37	148.64	0.42	147.08	0.04
Children 15-20 F	229.96	(2.55)	227.41	223.77	(2.94)	5.28	3.77	229.88	2.94	232.82	2.55
Children 15-20 M	203.44	(2.81)	200.63	197.42	(4.00)	5.28	2.84	201.54	4.00	205.54	2.81
Non-Expansion Adults 21-34 F	336.65	(0.45)	336.21	333.25	(8.67)	5.28	8.29	338.15	8.67	346.82	0.45
Non-Expansion Adults 21-34 M	218.14	(0.27)	217.87	215.85	(1.73)	5.28	5.06	224.58	1.73	226.31	0.27
Non-Expansion Adults 35-49 F	517.44	(0.53)	516.91	512.36	(5.12)	5.28	8.53	522.05	5.12	527.17	0.53
Non-Expansion Adults 35-49 M	388.49	(0.27)	388.22	382.82	(1.54)	5.28	11.52	398.06	1.54	399.62	0.27
Non-Expansion Adults 50+ M&F	635.65	(0.38)	635.27	629.68	(1.89)	5.28	13.13	646.20	1.89	648.09	0.38
Pregnant Woman	351.63	(0.22)	351.41	351.41	(5.63)	5.28	19.12	370.18	5.63	375.81	0.22
CHIP - Children 0-59 days M&F	$ 1,838.52	$ 0.00	$ 1,838.52	$ 1,838.52	$ 0.00	$ 0.00	$ 0.00	$ 1,838.52	$ 0.00	$ 1,838.52	$ 0.00
CHIP - Children 60-364 days M&F	210.02	-	210.02	210.02	-	-	-	210.02	-	210.02	-
CHIP - Children 1-4 M&F	127.97	-	127.97	125.92	-	-	-	125.92	-	125.92	-
CHIP - Children 5-14 M&F	141.72	(0.04)	141.68	139.41	(0.42)	-	-	138.99	0.42	139.41	0.04
CHIP - Children 15-20 F	229.96	(2.55)	227.41	223.77	(2.94)	-	-	220.83	2.94	223.77	2.55
CHIP - Children 15-20 M	203.44	(2.81)	200.63	197.42	(4.00)	-	-	193.42	4.00	197.42	2.81
CHIP - Hawk-I	131.99	-	131.99	129.88	-	-	-	129.88	-	129.88	-
TANF Maternity Case Rate	$ 6,258.82	$ 0.00	$ 6,258.82	$ 6,258.82	$ 0.00	$ 0.00	$ 0.00	$ 6,258.82	$ 0.00	$ 6,258.82	$ 0.00
Pregnant Women Maternity Case Rate	5,707.37	-	5,707.37	5,707.37	-	-	-	5,707.37	-	5,707.37	-
Wellness Plan 19-24 F (Medically Exempt)	$ 595.76	$ (41.41)	$ 554.37	$ 546.89	$ (24.10)	$ 0.00	$ 7.40	$ 530.19	$ 24.10	$ 554.29	$ 41.41
Wellness Plan 19-24 M (Medically Exempt)	544.29	(50.76)	493.53	486.87	(8.05)	-	4.67	483.49	8.05	491.54	50.76
Wellness Plan 25-34 F (Medically Exempt)	776.16	(12.33)	763.83	753.52	(43.64)	-	11.55	721.43	43.64	765.07	12.33
Wellness Plan 25-34 M (Medically Exempt)	725.80	(28.13)	697.67	688.25	(16.82)	-	8.75	678.38	16.82	697.00	28.13
Wellness Plan 35-49 F (Medically Exempt)	1,086.85	(12.78)	1,073.67	1,059.97	(23.59)	-	18.62	1,054.40	23.59	1,077.99	12.78
Wellness Plan 35-49 M (Medically Exempt)	1,054.35	(24.31)	1,030.04	1,016.13	(15.61)	-	19.15	1,019.71	15.61	1,035.32	24.31
Wellness Plan 50+ M &F (Medically Exempt)	1,328.04	(22.20)	1,306.84	1,289.20	(2.62)	-	27.52	1,314.10	2.62	1,316.72	22.20
Wellness Plan 19-24 F (Non-Medically Exempt)	$ 204.96	$ 0.00	$ 204.96	$ 202.19	$ 0.00	$ 0.00	$ 3.89	$ 206.08	$ 0.00	$ 206.08	$ 0.00
Wellness Plan 19-24 M (Non-Medically Exempt)	155.52	-	155.52	153.42	-	-	3.84	157.26	-	157.26	-
Wellness Plan 25-34 F (Non-Medically Exempt)	266.04	-	266.04	262.45	-	-	5.99	268.44	-	268.44	-
Wellness Plan 25-34 M (Non-Medically Exempt)	232.34	-	232.34	229.20	-	-	6.02	235.22	-	235.22	-
Wellness Plan 35-49 F (Non-Medically Exempt)	453.27	-	453.27	447.15	-	-	9.99	457.14	-	457.14	-
Wellness Plan 35-49 M (Non-Medically Exempt)	406.02	-	406.02	400.54	-	-	9.85	410.39	-	410.39	-
Wellness Plan 50+ M&F (Non-Medically Exempt)	665.26	-	665.26	656.28	-	-	16.72	673.00	-	673.00	-
ABD Non-Dual <21 M&F	$ 774.81	$ (46.31)	$ 728.50	$ 695.23	$ (2.96)	$ 5.28	$ 27.40	$ 725.95	$ 2.96	$ 728.91	$ 46.31
ABD Non-Dual 21+ M&F	1,332.01	(122.49)	1,209.52	1,185.49	(10.54)	5.28	26.11	1,216.34	10.54	1,226.88	122.49
Breast and Cervical Cancer	1,827.28	-	1,827.28	1,806.06	(1.81)	-	34.05	1,838.33	1.81	1,840.14	-
Residential Care Facility	2,718.79	(1,430.05)	1,288.74	1,271.61	(45.65)	5.28	5.06	1,236.50	45.65	1,282.15	1,430.05
Dual Eligible 0-64 M&F	$ 475.59	$ (176.02)	$ 299.57	$ 292.80	$ (15.34)	$ 0.00	$ 0.00	$ 277.46	$ 15.34	$ 292.80	$ 176.02
Dual Eligible 65+ M&F	216.80	(46.79)	170.01	166.17	(1.06)	-	-	165.11	1.06	166.17	46.79
Custodial Care Nursing Facility 65+	$ 127.56	$ 0.00	$ 127.56	$ 130.15	$ (0.13)	$ 0.00	$ 0.00	$ 130.02	$ 0.13	$ 130.15	$ 0.00
Hospice 65+	127.56	-	127.56	130.15	(0.13)	-	-	130.02	0.13	130.15	-
Elderly HCBS Waiver	239.66	-	239.66	244.53	(1.47)	-	-	243.06	1.47	244.53	-
LTSS with MCO-Specific Rebalancing and Risk Adjustment											
Custodial Care Nursing Facility <65	$ 803.78	$ 0.00	$ 803.78	$ 819.81	$ (2.46)	$ 5.28	$ 14.42	$ 836.85	$ 2.46	$ 839.31	$ 0.00
Hospice <65	803.78	-	803.78	819.81	(2.46)	5.28	14.42	836.85	2.46	839.31	-
Non-Dual Skilled Nursing Facility	2,288.14	-	2,288.14	2,333.22	-	5.28	30.71	2,369.21	-	2,369.21	-
Dual HCBS Waivers: PD; H&D	321.50	-	321.50	327.83	(5.24)	-	0.01	322.60	5.24	327.84	-
Non-Dual HCBS Waivers: PD; H&D; AIDS	1,356.83	-	1,356.83	1,383.56	(1.39)	5.28	37.01	1,424.46	1.39	1,425.85	-
Brain Injury HCBS Waiver	719.99	-	719.99	734.17	(5.87)	5.28	14.62	748.20	5.87	754.07	-
LTSS with MCO-Specific Rebalancing and Risk Adjustment											
ICF/MR	$ 473.04	$ 0.00	$ 473.04	$ 519.97	$ 0.00	$ 5.28	$ 3.81	$ 529.06	$ 0.00	$ 529.06	$ 0.00
State Resource Center	147.55	-	147.55	162.19	-	5.28	0.12	167.59	-	167.59	-
Intellectual Disability HCBS Waiver	357.89	-	357.89	393.39	(4.33)	5.28	7.01	401.35	4.33	405.68	-
LTSS with MCO-Specific Rebalancing and Risk Adjustment											
Children in a Psychiatric Mental Institute (PMIC)	$ 814.70	$ 0.00	$ 814.70	$ 757.28	$ (28.02)	$ 5.28	$ 3.15	$ 737.67	$ 28.02	$ 765.69	$ 0.00
Children's Mental Health HCBS Waiver	732.86	-	732.86	681.19	(3.40)	5.28	6.00	689.07	3.40	692.47	-
LTSS with MCO-Specific Rebalancing and Risk Adjustment											

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Medical Net Capitation

Capitation Rate Cell	Net Base Medical Capitation	Habilitation Services Risk Pool	Net Base Medical Capitation Less Habilitation	Net Base Risk Adjusted Medical Capitation	1915b(3)	GME Supplemental PMPM	UIHC Supplemental PMPM	Net Total State Plan Rate, Excluding Habilitation	1915b(3)	Total Paid Medical Rate	Habilitation Services Risk Pool
Children 0-59 days M&F	$ 1,792.56	$ 0.00	$ 1,792.56	$ 1,792.56	$ 0.00	$ 5.28	$ 50.24	$ 1,848.08	$ 0.00	$ 1,848.08	$ 0.00
Children 60-364 days M&F	204.77	-	204.77	204.77	-	5.28	8.69	218.74	-	218.74	-
Children 1-4 M&F	124.77	-	124.77	122.77	-	5.28	3.59	131.64	-	131.64	-
Children 5-14 M&F	138.18	(0.04)	138.14	135.93	(0.41)	5.28	2.37	143.17	0.41	143.58	0.04
Children 15-20 F	224.21	(2.49)	221.72	218.17	(2.87)	5.28	3.77	224.35	2.87	227.22	2.49
Children 15-20 M	198.35	(2.74)	195.61	192.48	(3.91)	5.28	2.84	195.69	3.91	200.60	2.74
Non-Expansion Adults 21-34 F	328.24	(0.44)	327.80	324.92	(6.45)	5.28	6.29	330.04	6.45	336.49	0.44
Non-Expansion Adults 21-34 M	212.69	(0.27)	212.42	210.55	(1.69)	5.28	5.06	219.22	1.69	220.91	0.27
Non-Expansion Adults 35-49 F	504.50	(0.51)	503.99	499.55	(5.00)	5.28	9.53	509.36	5.00	514.36	0.51
Non-Expansion Adults 35-49 M	376.83	(0.27)	376.56	373.25	(1.50)	5.28	11.52	388.55	1.50	390.05	0.27
Non-Expansion Adults 50+ M&F	619.76	(0.37)	619.39	613.94	(1.84)	5.28	13.13	630.51	1.84	632.35	0.37
Pregnant Women	342.84	(0.22)	342.62	342.62	(5.49)	5.28	19.12	361.53	5.49	367.02	0.22
CHIP - Children 0-59 days M&F	$ 1,792.56	$ 0.00	$ 1,792.56	$ 1,792.56	$ 0.00	$ 0.00	$ 0.00	$ 1,792.56	$ 0.00	$ 1,792.56	$ 0.00
CHIP - Children 60-364 days M&F	204.77	-	204.77	204.77	-	-	-	204.77	-	204.77	-
CHIP - Children 1-4 M&F	124.77	-	124.77	122.77	-	-	-	122.77	-	122.77	-
CHIP - Children 5-14 M&F	138.18	(0.04)	138.14	135.93	(0.41)	-	-	135.52	0.41	135.93	0.04
CHIP - Children 15-20 F	224.21	(2.49)	221.72	218.17	(2.87)	-	-	215.30	2.87	218.17	2.49
CHIP - Children 15-20 M	198.35	(2.74)	195.61	192.48	(3.91)	-	-	188.57	3.91	192.48	2.74
CHIP - Hawk-i	128.69	-	128.69	126.63	-	-	-	126.63	-	126.63	-
TANF Maternity Case Rate	$ 6,102.35	$ 0.00	$ 6,102.35	$ 6,102.35	$ 0.00	$ 0.00	$ 0.00	$ 6,102.35	$ 0.00	$ 6,102.35	$ 0.00
Pregnant Women Maternity Case Rate	5,564.69	-	5,564.69	5,564.69	-	-	-	5,564.69	-	5,564.69	-
Wellness Plan 19-24 F (Medically Exempt)	$ 580.89	$ (40.38)	$ 540.51	$ 533.21	$ (23.50)	$ 0.00	$ 7.40	$ 517.11	$ 23.50	$ 540.61	$ 40.38
Wellness Plan 19-24 M (Medically Exempt)	530.68	(49.49)	481.19	474.69	(7.85)	-	4.67	471.51	7.85	479.36	49.49
Wellness Plan 25-34 F (Medically Exempt)	756.76	(12.03)	744.73	734.68	(42.55)	-	11.55	703.68	42.55	746.23	12.03
Wellness Plan 25-34 M (Medically Exempt)	707.65	(27.42)	680.23	671.05	(18.15)	-	8.75	661.65	18.15	679.80	27.42
Wellness Plan 35-49 F (Medically Exempt)	1,059.48	(12.46)	1,047.02	1,032.89	(23.00)	-	18.62	1,028.51	23.00	1,051.51	12.46
Wellness Plan 35-49 M (Medically Exempt)	1,027.99	(23.70)	1,004.29	990.73	(15.21)	-	19.19	994.71	15.21	1,009.92	23.70
Wellness Plan 50+ M &F (Medically Exempt)	1,295.81	(21.64)	1,274.17	1,256.97	(2.56)	-	27.52	1,281.93	2.56	1,284.49	21.64
Wellness Plan 19-24 F (Non-Medically Exempt)	$ 198.84	$ 0.00	$ 198.84	$ 197.14	$ 0.00	$ 0.00	$ 3.89	$ 201.03	$ 0.00	$ 201.03	$ 0.00
Wellness Plan 19-24 M (Non-Medically Exempt)	151.83	-	151.83	149.58	-	-	3.84	153.42	-	153.42	-
Wellness Plan 25-34 F (Non-Medically Exempt)	259.39	-	259.39	255.89	-	-	5.99	261.88	-	261.88	-
Wellness Plan 25-34 M (Non-Medically Exempt)	226.53	-	226.53	223.47	-	-	6.02	229.49	-	229.49	-
Wellness Plan 35-49 F (Non-Medically Exempt)	441.94	-	441.94	435.97	-	-	9.99	445.96	-	445.96	-
Wellness Plan 35-49 M (Non-Medically Exempt)	395.87	-	395.87	390.53	-	-	9.85	400.38	-	400.38	-
Wellness Plan 50+ M&F (Non-Medically Exempt)	648.63	-	648.63	639.87	-	-	16.72	656.59	-	656.59	-
ABD Non-Dual <21 M&F	$ 755.44	$ (45.15)	$ 710.29	$ 678.82	$ (2.89)	$ 5.28	$ 27.40	$ 706.61	$ 2.89	$ 711.50	$ 45.15
ABD Non-Dual 21+ M&F	1,298.71	(119.43)	1,179.28	1,165.80	(10.27)	5.28	26.11	1,186.72	10.27	1,196.99	119.43
Breast and Cervical Cancer	1,761.60	-	1,761.60	1,760.93	(1.76)	-	34.06	1,793.23	1.76	1,794.99	-
Residential Care Facility	2,648.87	(1,394.30)	1,254.57	1,240.02	(44.52)	5.28	5.06	1,205.84	44.52	1,250.36	1,394.30
Dual Eligible 0-64 M&F	$ 463.70	$ (171.62)	$ 292.08	$ 285.48	$ (14.96)	$ 0.00	$ 0.00	$ 270.53	$ 14.96	$ 285.48	$ 171.62
Dual Eligible 65+ M&F	211.38	(45.62)	165.76	162.01	(1.03)	-	-	160.98	1.03	162.01	45.62
Custodial Care Nursing Facility 65+	$ 124.37	$ 0.00	$ 124.37	$ 126.69	$ (0.13)	$ 0.00	$ 0.00	$ 126.76	$ 0.13	$ 126.89	$ 0.00
Hospice 65+	124.37	-	124.37	126.69	(0.13)	-	-	126.76	0.13	126.89	-
Elderly HCBS Waiver	233.67	-	233.67	238.41	(1.43)	-	-	236.98	1.43	238.41	-
LTSS with MCO-Specific Rebalancing and Risk Adjustment											
Custodial Care Nursing Facility <65	$ 783.69	$ 0.00	$ 783.69	$ 798.13	$ (2.40)	$ 5.28	$ 14.42	$ 816.43	$ 2.40	$ 818.83	$ 0.00
Hospice <65	783.69	-	783.69	798.13	(2.40)	5.28	14.42	816.43	2.40	818.83	-
Non-Dual Skilled Nursing Facility	2,230.94	-	2,230.94	2,274.69	-	5.28	30.71	2,310.68	-	2,310.68	-
Dual HCBS Waivers: PD; H&D	313.46	-	313.46	319.64	(5.11)	-	0.01	314.54	5.11	319.65	-
Non-Dual HCBS Waivers: PD; H&D; AIDS	1,322.91	-	1,322.91	1,348.97	(1.36)	5.28	37.01	1,389.90	1.36	1,391.26	-
Brain Injury HCBS Waiver	701.89	-	701.89	715.82	(5.73)	5.28	14.62	729.99	5.73	735.72	-
LTSS with MCO-Specific Rebalancing and Risk Adjustment											
ICF/MR	$ 461.21	$ 0.00	$ 461.21	$ 505.96	$ 0.00	$ 5.28	$ 3.81	$ 515.05	$ 0.00	$ 515.05	$ 0.00
State Resource Center	143.86	-	143.86	158.13	-	5.28	0.12	163.53	-	163.53	-
Intellectual Disability HCBS Waiver	348.94	-	348.94	383.55	(4.22)	5.28	7.01	391.62	4.22	395.84	-
LTSS with MCO-Specific Rebalancing and Risk Adjustment											
Children in a Psychiatric Mental Institute (PMIC)	$ 794.33	$ 0.00	$ 794.33	$ 739.33	$ (27.32)	$ 5.28	$ 3.15	$ 716.44	$ 27.32	$ 746.76	$ 0.00
Children's Mental Health HCBS Waiver	714.54	-	714.54	664.16	(3.32)	5.28	5.00	672.12	3.32	675.44	-
LTSS with MCO-Specific Rebalancing and Risk Adjustment											

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	LTSS Gross Capitation		LTSS Net Capitation	
Capitation Rate Cell	Gross Base LTSS Capitation	Risk Adjusted LTSS Capitation	Net Base LTSS Capitation	Total Paid LTSS Rate
Children 0-59 days M&F	N/A	N/A	N/A	N/A
Children 60-364 days M&F	N/A	N/A	N/A	N/A
Children 1-4 M&F	N/A	N/A	N/A	N/A
Children 5-14 M&F	N/A	N/A	N/A	N/A
Children 15-20 F	N/A	N/A	N/A	N/A
Children 15-20 M	N/A	N/A	N/A	N/A
Non-Expansion Adults 21-34 F	N/A	N/A	N/A	N/A
Non-Expansion Adults 21-34 M	N/A	N/A	N/A	N/A
Non-Expansion Adults 35-49 F	N/A	N/A	N/A	N/A
Non-Expansion Adults 35-49 M	N/A	N/A	N/A	N/A
Non-Expansion Adults 50+ M&F	N/A	N/A	N/A	N/A
Pregnant Women	N/A	N/A	N/A	N/A
CHIP - Children 0-59 days M&F	N/A	N/A	N/A	N/A
CHIP - Children 60-364 days M&F	N/A	N/A	N/A	N/A
CHIP - Children 1-4 M&F	N/A	N/A	N/A	N/A
CHIP - Children 5-14 M&F	N/A	N/A	N/A	N/A
CHIP - Children 15-20 F	N/A	N/A	N/A	N/A
CHIP - Children 15-20 M	N/A	N/A	N/A	N/A
CHIP - Hawki	N/A	N/A	N/A	N/A
TANF Maternity Case Rate	N/A	N/A	N/A	N/A
Pregnant Women Maternity Case Rate	N/A	N/A	N/A	N/A
Wellness Plan 19-24 F (Medically Exempt)	N/A	N/A	N/A	N/A
Wellness Plan 19-24 M (Medically Exempt)	N/A	N/A	N/A	N/A
Wellness Plan 25-34 F (Medically Exempt)	N/A	N/A	N/A	N/A
Wellness Plan 25-34 M (Medically Exempt)	N/A	N/A	N/A	N/A
Wellness Plan 35-49 F (Medically Exempt)	N/A	N/A	N/A	N/A
Wellness Plan 35-49 M (Medically Exempt)	N/A	N/A	N/A	N/A
Wellness Plan 50+ M &F (Medically Exempt)	N/A	N/A	N/A	N/A
Wellness Plan 19-24 F (Non-Medically Exempt)	N/A	N/A	N/A	N/A
Wellness Plan 19-24 M (Non-Medically Exempt)	N/A	N/A	N/A	N/A
Wellness Plan 25-34 F (Non-Medically Exempt)	N/A	N/A	N/A	N/A
Wellness Plan 25-34 M (Non-Medically Exempt)	N/A	N/A	N/A	N/A
Wellness Plan 35-49 F (Non-Medically Exempt)	N/A	N/A	N/A	N/A
Wellness Plan 35-49 M (Non-Medically Exempt)	N/A	N/A	N/A	N/A
Wellness Plan 50+ M&F (Non-Medically Exempt)	N/A	N/A	N/A	N/A
ABD Non-Dual <21 M&F	N/A	N/A	N/A	N/A
ABD Non-Dual 21+ M&F	N/A	N/A	N/A	N/A
Breast and Cervical Cancer	N/A	N/A	N/A	N/A
Residential Care Facility	N/A	N/A	N/A	N/A
Dual Eligible 0-64 M&F	N/A	N/A	N/A	N/A
Dual Eligible 65+ M&F	N/A	N/A	N/A	N/A
Custodial Care Nursing Facility 65+	N/A	N/A	N/A	N/A
Hospice 65+	N/A	N/A	N/A	N/A
Elderly HCBS Waiver	N/A	N/A	N/A	N/A
LTSS with MCO-Specific Rebalancing and Risk Adjustment	$ 3,098.42	$ 3,124.76	$ 3,036.45	$ 3,062.26
Custodial Care Nursing Facility <65	N/A	N/A	N/A	N/A
Hospice <65	N/A	N/A	N/A	N/A
Non-Dual Skilled Nursing Facility	N/A	N/A	N/A	N/A
Dual HCBS Waivers: PD; H&D	N/A	N/A	N/A	N/A
Non-Dual HCBS Waivers: PD; H&D; AIDS	N/A	N/A	N/A	N/A
Brain Injury HCBS Waiver	N/A	N/A	N/A	N/A
LTSS with MCO-Specific Rebalancing and Risk Adjustment	$ 2,879.68	$ 2,901.85	$ 2,822.09	$ 2,843.82
ICF/MR	N/A	N/A	N/A	N/A
State Resource Center	N/A	N/A	N/A	N/A
Intellectual Disability HCBS Waiver	N/A	N/A	N/A	N/A
LTSS with MCO-Specific Rebalancing and Risk Adjustment	$ 6,918.29	$ 6,449.92	$ 6,779.92	$ 6,320.92
Children in a Psychiatric Mental Institute (PMIC)	N/A	N/A	N/A	N/A
Children's Mental Health HCBS Waiver	N/A	N/A	N/A	N/A
LTSS with MCO-Specific Rebalancing and Risk Adjustment	$ 2,386.65	$ 2,386.65	$ 2,339.11	$ 2,339.11