# Second Amendment to the Iowa Health Link Contract

This Second Amendment to Contract Number MED-16-018 between the Iowa Department of Human Services (Agency) and Amerigroup Iowa, Inc. (Contractor) is hereby amended as noted below. This Second Amendment is effective as of April 1, 2016.

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

**Revision 1. Section 1.5 of the Special Terms Appendix 1 – Scope of Work (hereafter "Scope of Work"), as well as all subpart of Section 1.5, are amended to read as follows:**

**1.5 General Contractor Responsibilities**

**1.5.1 Federal and State Laws and Regulations**

Contractor shall:

(1) Comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; and section 1557 of the Patient Protection and Affordable Care Act.

(2) Comply with the conflict of interest safeguards described in 42 C.F.R. § 438.58 and with the prohibitions described in section 1902(a)(4)(C) of the Social Security Act applicable to contracting officers, employees, or independent contractors.

**1.5.2 Qualifications**

The Contractor represents and warrants that it is experienced in the business of furnishing Medicaid and CHIP capitated services comparable in size and complexity to the requirements of this Contract.

**Revision 2. Scope of Work section 2.2.6 is amended to read as follows:**

*2.2.6 Protecting Members Against Liability for Payment*

In compliance with 42 C.F.R. § 438.106, Contractor's Medicaid Members shall not be held liable for any of the following:
(a) The Contractor's debts, in the event of Contractor's insolvency.
(b) Covered services provided to the Member, for which—
(1) The Agency does not pay the Contractor; or

(2) The Agency, or the Contractor does not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement.

(c) Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Member would owe if the Contractor covered the services directly.

**Revision 3. Scope of Work section 2.3.1 is amended to read as follows:**

*2.3.1 Solvency*

The Contractor shall maintain a fiscally solvent operation in accordance with federal requirements and Iowa Insurance Division requirements for minimum net worth. The ultimate controlling parent of the Contractor, if any, shall guarantee it will provide financial resources to the Contractor sufficient to maintain a 200% or higher RBC ratio as defined by the NAIC. This guarantee shall be for the term of the Contract and shall be submitted in writing to the Agency prior to Contract signature.

(a) *Assurances.*

(1) Contractor shall provide assurances satisfactory to the Agency showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid Members will not be liable for the Contractor's debts if the Contractor becomes insolvent.

(2) Federally qualified HMOs, as defined in section 1310 of the Public Health Service Act, are exempt from this requirement.

(b) *Other requirements—*

(1) *General rule.* Except as provided in paragraph (b)(2) of this section, if Contractor is an MCO or PIHP, Contractor must meet the solvency standards established by the State for private health maintenance organizations, or be licensed or certified by the State as a risk-bearing entity.

(2) *Exception.* Paragraph (b)(1) of this section does not apply to an MCO or PIHP that meets any of the following conditions:

(i) Does not provide both inpatient hospital services and physician services.

(ii) Is a public entity.

(iii) Is (or is controlled by) one or more Federally qualified health centers and meets the solvency standards established by the State for those centers.

(iv) Has its solvency guaranteed by the State.

**Revision 4. Scope of Work section 2.5.2 is amended to read as follows:**

(a) *The Contractor shall not contract with any of the following entities.*

(1) An entity that could be excluded under section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual.

(2) An entity that has a substantial contractual relationship as defined in 42 C.F.R. § 431.55(h)(3) of this chapter, either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Social Security Act or an individual described in 42 C.F.R. § 438.610(a) and (b).

(3) An entity that employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:

(i) Any individual or entity described in 42 C.F.R. § 438.610(a) and (b).

(ii) Any individual or entity that would provide those services through an individual or entity described in 42 C.F.R. § 438.610(a) and (b).

**Revision 5. Scope of Work section 2.5.13 is amended to read as follows:**

**2.5.13 Prohibited Affiliations**

(a) In compliance with 42 C.F.R. § 438.610, Contractor may not knowingly have a relationship of the type described in paragraph (c) of this section with the following:

(1) An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

(2) An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 C.F.R. § 2.101, of a person described in paragraph (a)(1) of this section.

(b) Contractor may not have a relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act.

(c) The relationships described in paragraph (a) of this section, are as follows:

(1) A director, officer, or partner of the Contractor.

(2) A subcontractor of the Contractor, as governed by 42 C.F.R. § 438.230.

(3) A person with beneficial ownership of 5 percent or more of the Contractor's equity.

(4) A network provider or person with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under the Contract.

(d) If the Agency finds that Contractor is not in compliance with paragraphs (a) and (b) of this section, the Agency:

(1) Will notify the Secretary of the noncompliance.

(2) May continue an existing agreement with the Contractor unless the Secretary directs otherwise.

(3) May not renew or otherwise extend the duration of an existing agreement with the Contractor unless the Secretary provides to the Agency and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.

(4) Nothing in this section must be construed to limit or otherwise affect any remedies available to the U.S. under sections 1128, 1128A or 1128B of the Social Security Act.

(e) *Consultation with the Inspector General.* Any action by the Secretary of HHS described in paragraphs (d)(2) or (3) of this section is taken in consultation with the Inspector General.

**Revision 6. Scope of Work section 2.5.19 is deleted and marked "Reserved."**

**Revision 7. Scope of Work section 2.6 is deleted and marked "Reserved."**

**Revision 8. Scope of Work section 2.15 is amended to read as follows:**

**2.15 Confidentiality of Member Medical Records and Other Information**

The Contractor shall develop, implement, and adhere to written policies and procedures, subject to Agency review and approval, pertaining to maintaining the confidentiality of all medical records and other pertinent information, including, but not limited to, health and enrollment information.

In compliance with 42 C.F.R. § 438.224, for medical records and any other health and enrollment information that identifies a particular Member, Contractor shall only use and disclose such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable.

The Contractor shall also comply with all other applicable State and Federal privacy and confidentiality requirements. The Contractor shall protect and maintain the confidentiality of mental health information by implementing policies for staff and through contract terms with network providers which allow release of mental health information only as allowed by Iowa Code §228. Further, the Contractor shall protect and maintain the confidentiality of substance use disorder information, allowing the release of substance use disorder information only in compliance with policies set forth in 42 C.F.R. Part 2 and other applicable State and Federal law and regulations. The Contractor shall notify the Agency of a HIPAA-related breach in accordance with the terms of Section 1.5 of the Contract's Special Terms. The Contractor shall notify the Agency within one (1) Business Day upon discovery of a non-HIPAA-related breach.

For members enrolled in the Family Planning Waiver demonstration who requested confidentiality, any communications from the Contractor shall go to the address provided by the member with the address identified in the Family Planning system, rather than the address identified in MMIS.

**Revision 9. Scope of Work section 3.2.1 is amended to read as follows:**

### 3.2.1 General

The Contractor shall provide, at minimum, all benefits and services deemed medically necessary services that are covered under the Contract with the Agency. In accordance with 42 C.F.R. § 438.210(a)(3), the Contractor shall furnish covered services in an amount, duration and scope reasonably expected to achieve the purpose for which the services are furnished. The Contractor may not arbitrarily deny or reduce the amount, duration and scope of a required service solely because of diagnosis, type of illness, or condition of the Member. The Contractor may place appropriate limits on a service on the basis of medical necessity criteria for the purpose of utilization control, provided the services can reasonably be expected to achieve their purpose. Further information on allowable and required utilization control measures is outlined in Section 11. The Contractor shall not avoid costs for services covered in the Contract by referring members to publicly supported health care resources. The Contractor shall not deny reimbursement of covered services based on the presence of a pre-existing condition. The Contractor shall ensure that the principles of the Americans with Disabilities Act (ADA) and Olmstead Act principles are incorporated into the delivery and approval of all services.

In compliance with 42 C.F.R. § 438.3(l), Contractor shall allow each Member to choose his or her network provider to the extent possible and appropriate.

**Revision 10. Scope of Work section 3.2.5 is amended to read as follows. This Revision does not impact the subsections under Section 3.2.5:**

### 3.2.5 Emergency Services

(a) *Definitions.* As used in this section—

*Emergency medical condition* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

(i) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

(ii) Serious impairment to bodily functions.

(iii) Serious dysfunction of any bodily organ or part.

*Emergency services* means covered inpatient and outpatient services that are as follows:

(i) Furnished by a provider that is qualified to furnish these services under Title XIX of the Social Security Act.

(ii) Needed to evaluate or stabilize an emergency medical condition.

*Poststabilization care services* means covered services, related to an emergency medical condition that are provided after a Member is stabilized to maintain the stabilized condition, or,

under the circumstances described in paragraph (e) of this section, to improve or resolve the Member's condition.

(b) *Coverage and payment: General rule.* The Contractor is responsible for coverage and payment of emergency services and poststabilization care services.

(c) *Coverage and payment: Emergency services.* (1) Contractor

(i) shall cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor; and

(ii) shall not deny payment for treatment obtained under either of the following circumstances:

(A) A Member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (1), (2), and (3) of the definition of emergency medical condition in paragraph (a) of this section.

(B) A representative of the Contractor instructs the Member to seek emergency services.

(2) Reserved.

(d) *Additional rules for emergency services.* (1) Contractor shall not --

(i) Limit what constitutes an emergency medical condition with reference to paragraph (a) of this section, on the basis of lists of diagnoses or symptoms; and

(ii) Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Member's primary care provider, MCO, PIHP, PAHP or applicable State entity of the Member's screening and treatment within 10 calendar days of presentation for emergency services.

(2) A Member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

(3) The attending emergency physician, or the provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in paragraph (b) of this section as responsible for coverage and payment.

(e) *Coverage and payment: Poststabilization care services.* Poststabilization care services are covered and paid for in accordance with provisions set forth at 42 C.F.R. § 422.113(c). In applying those provisions, reference to "MA organization" and "financially responsible" must be read as reference to the entities responsible for Medicaid payment, as specified in paragraph (b) of this section, and payment rules governed by Title XIX of the Social Security Act and the States.

(f) *Applicability to PIHPs and PAHPs.* Reserved.

Emergency services shall be available twenty-four (24) hours a day, seven (7) days a week. Contractor shall pay non-contracted 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 11. Scope of Work section 3.2.5.2 is amended to read as follows:**

**3.2.5.2 Claim Coverage**

If an emergency screening examination leads to a clinical determination that an actual emergency medical condition exists, the Contractor shall pay for both the services involved in the screening examination and the services required to stabilize the member. The Contractor shall be required to pay for all emergency services which are medically necessary until the clinical emergency is stabilized.

**Revision 12. Scope of Work section 3.2.5.3 is deleted and marked "Reserved."**

**Revision 13. Scope of Work section 3.2.5.4 is amended to read as follows:**

The requirements at 42 C.F.R. § 422.113(c) are applied to the Contractor. This includes all medical and behavioral health services that may be necessary to assure, within reasonable medical probability, that no material deterioration of the member's condition is likely to result from, or occur during, discharge of the member or transfer of the member to another facility.

**Revision 14. Scope of Work section 3.2.15.3 is amended to read as follows:**

**3.2.15.3 Cost Sharing and Patient Liability**

The Contractor and all providers and subcontractors shall not require any cost sharing or patient liability responsibilities for covered services except to the extent that cost sharing or patient liability responsibilities are required for those services in accordance with law and as described in Section 5. Further, the Contractor and all providers and subcontractors shall not charge members for missed appointments.

**Revision 15. Scope of Work section 5.1 is amended to read as follows. This Revision does not impact the subsections under Section 5.1:**

**5.1 General Provisions**

In accordance with 42 C.F.R. § 438.108, Contractor shall not impose any cost sharing on Medicaid Members that is not in accordance with 42 C.F.R. §§ 447.50 through 447.82, all applicable State Plan obligations, and any approved waivers of that State Plan.

**Revision 16. Scope of Work section 6.1.5 is amended to read as follows:**

**6.1.5 Provider-Patient Communications**

(a) *General rules.*

(1) Pursuant to 42 C.F.R. § 438.102, Contractor shall not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of an Member who is his or her patient, for the following:

(i) The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

(ii) Any information the Member needs to decide among all relevant treatment options.

(iii) The risks, benefits, and consequences of treatment or non-treatment.

(iv) The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

(2) Subject to the information requirements of paragraph (b) of this section, if Contractor would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service because of the requirement in paragraph (a)(1) of this section, Contractor is not required to do so if the Contractor objects to the service on moral or religious grounds.

(b) *Information requirements: Contractor responsibility.*

(1)(i) If Contractor elects the option provided in paragraph (a)(2) of this section, Contractor must furnish information about the services it does not cover as follows:

(A) To the Agency—

(1) With its application for a Medicaid contract.

(2) Whenever it adopts the policy during the term of the contract.

(B) Consistent with the provisions of 42 C.F.R. § 438.10, to Members, within 90 days after adopting the policy for any particular service.

(ii) In addition to the provisions and timeframe provided in (b)(1)(i) above, and consistent with the requirements of 42 C.F.R. § 438.10(g)(4), the Contractor shall furnish to the Agency the information as required in section (b)(1) at least 30 days before the effective date of the policy.

(2) As specified in 42 C.F.R. § 438.10(g)(2)(ii)(A) and (B), the Contractor must inform Members how they can obtain information from the Agency about how to access the service excluded under paragraph (a)(2) of this section.

(c) *Information requirements: Agency responsibility.* For each service excluded by an Contractor under paragraph (a)(2) of this section, the Agency will provide information to Members on how and where to obtain the service, as specified in 42 C.F.R. § 438.10.

(d) *Sanction.* If Contractor violates the prohibition of paragraph (a)(1) of this section, it is subject to intermediate sanctions as set forth in 42 C.F.R. part 438, subpart I and this Contract.

**Revision 17. Scope of Work section 6.1.9.4 is deleted in its entirety.**

**Revision 18. Scope of Work section 6.2.2.5 is amended to read as follows:**

6.2.2.5 (a) *General rules.* (1) In accordance with 42 C.F.R. § 438.12, Contractor

shall not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If Contractor declines to include individual or groups of providers in its provider network, it must give the affected providers written notice of the reason for its decision.

(2) In all contracts with network providers, Contractor shall comply with the requirements specified in 42 C.F.R. § 438.214.

(b) *Construction.* Paragraph (a) of this section may not be construed to—

(1) Require the Contractor to contract with providers beyond the number necessary to meet the needs of its Members;

(2) Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

(3) Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Members.

(c) The Contractor shall not limit any providers from providing services to any other IA Health Link MCO.

**Revision 19. Scope of Work section 7.3 is amended to read as follows:**

**7.3 Enrollment Discrimination**

In compliance with 42 C.F.R § 438.3(d), the Contractor:

(1) shall accept individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the Contract.

(2) Reserved.

(3) shall not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll.

(4) shall not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability.

**Revision 20. Scope of Work section 7.4 is amended to read as follows. This Revision does not impact the subsections under Section 7.4:**

**7.4 Member Disenrollment**

(a) *Applicability.* The provisions of this section apply to all managed care programs and applies specifically to Contractor.

(b) *Disenrollment requested by the Contractor.*

(1) Reserved.

(2) Contractor shall not request disenrollment because of an adverse change in the Member's health status, or because of the Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the Contractor seriously impairs the entity's ability to furnish services to either this particular Member or other Members).

(3) Contractor shall assure the Agency that it does not request disenrollment for reasons other than those permitted under the Contract. All requests by the Contractor for the Agency to disenroll a Member shall be in writing and shall specify the basis for the request. The Contractor shall provide evidence to the Agency that continued enrollment of a Member seriously impairs the Contractor's ability to furnish services to either this particular Member or other Members. If applicable, the Contractor's request must document that reasonable steps were taken to educate the Member regarding proper behavior, and that the Member refused to comply. The Agency retains sole authority for determining if conditions for disenrollment have been met and disenrollment will be approved. The Agency will review and approve all MCO initiated requests for disenrollment. The Agency retains sole authority for determining if this condition has been met and disenrollment will be approved.

(c) *Disenrollment requested by the Member.* A Member may request disenrollment as follows:

(1) For cause, at any time.

(2) Without cause, at the following times:

(i) During the 90 days following the date of the Member's initial enrollment into the Contractor, or during the 90 days following the date the Agency sends the Member notice of that enrollment, whichever is later.

(ii) At least once every 12 months thereafter.

(iii) Upon automatic reenrollment under paragraph (g) of this section, if the temporary loss of Medicaid eligibility has caused the Member to miss the annual disenrollment opportunity.

(iv) When the Agency imposes the intermediate sanction specified in 42 C.F.R. § 438.702(a)(4) and this Contract.

(d) *Procedures for disenrollment—*

(1) *Request for disenrollment.* The Member (or his or her representative) must submit an oral or written request, as required by the Agency—

(i) Reserved.

(ii) To the Contractor.

(2) *Cause for disenrollment.* The following are cause for disenrollment:

(i) The Member moves out of the Contractor's service area.

(ii) The Contractor does not, because of moral or religious objections, cover the service the Member seeks.

(iii) The Member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the Member's primary care provider or another provider determines that receiving the services separately would subject the Member to unnecessary risk.

(iv) For Members that use MLTSS, the Member would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the Contractor and, as a result, would experience a disruption in their residence or employment.

(v) Other reasons, including but not limited to poor quality of care, lack of access to services covered under the Contract, or lack of access to providers experienced in dealing with the Member's care needs.

(3) *Contractor action on request.*

(i) If the Contractor receives a Member's request for disenrollment, the Contractor shall address the request through the Contractor's grievance process and, if the Member remains dissatisfied with the result of the grievance process, the Contractor shall thereafter refer the request to the Agency.

(ii) If the Agency fails to make a disenrollment determination so that the Member can be disenrolled within the timeframes specified in paragraph (e)(1) of this section, the disenrollment is considered approved.

(4) *Agency action on request.* For a request received directly from the Member, the Agency will refer the request to the Contractor to be addressed through the Contractor's grievance process. For a request referred by the Contractor following the Contractor's grievance process, the Agency must take action to approve or disapprove the request based on the following:

(i) Reasons cited in the request.

(ii) Information provided by the Contractor at the Agency's request.

(iii) Any of the reasons specified in paragraph (d)(2) of this section.

(5) *Use of the Contractor's grievance procedures.*

(i) The Agency requires that the Member seek redress through the Contractor's grievance system before making a determination on the Member's request.

(ii) The grievance process must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the timeframe specified in paragraph (e)(1) of this section. Contractor shall follow the timelines of an expedited grievance.

(iii) Reserved.

(e) *Timeframe for disenrollment determinations.*

(1) The effective date of an approved disenrollment made by the Agency must be no later than the first day of the second month following the month in which the Member requests disenrollment or Contractor refers the request to the Agency.

(2) If the Agency fails to make the determination within the timeframes specified in paragraph (e)(1) of this section, the disenrollment is considered approved for the effective date that would have been established had the Agency complied with paragraph (e)(1) of this section.

(f) *Notice and appeals.* The Agency will:

(1) Provide that Members and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period. The notice must include an explanation of all of the Member's disenrollment rights as specified in this section.

(2) Ensure timely access to State fair hearing for any Member dissatisfied with an Agency determination that there is not good cause for disenrollment.

(g) *Automatic reenrollment.* Any Member who is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less will be reenrolled with the Contractor.

**Revision 21. Scope of Work section 7.4.1 and all of its subparts is deleted in its entirety and marked "Reserved."**

**Revision 22. Scope of Work section 7.4.2 is amended to read as follows:**

**7.4.2 Agency Initiated Disenrollment**

Agency-initiated disenrollment may occur based on changes in circumstances including: (i) ineligibility for Medicaid; (ii) shift to an eligibility category not covered by the Contract; (iii) change of place of residence to another state; (iv) the Agency has determined that participation in the Health Insurance Premium Payment Program (HIPP) is more cost-effective than enrollment in the Contract; and (v) death.

**Revision 23. Scope of Work section 8.1 and all of its subparts are amended to read as follows:**

**8.1 Marketing**

**8.1.1 Marketing Activities**

(a) *Definitions.* As used in this section, the following terms have the indicated meanings:

*Contractor* includes any of the entity's employees, network providers, agents, or contractors.

*Cold-call marketing* means any unsolicited personal contact by the Contractor with a potential Member for the purpose of marketing as defined in this paragraph (a).

*Marketing* means any communication, from Contractor to a Medicaid Member who is not enrolled in Contractor, that can reasonably be interpreted as intended to influence the Member to enroll in Contractor's Medicaid product, or either to not enroll in or to disenroll from another MCO's, PIHP's, PAHP's, PCCM's or PCCM entity's Medicaid product. Marketing does not include communication to a Medicaid Member from the issuer of a qualified health plan, as defined in 45 CFR § 155.20, about the qualified health plan.

*Marketing materials* means materials that—

(i) Are produced in any medium, by or on behalf of Contractor; and

(ii) Can reasonably be interpreted as intended to market the Contractor to potential Members.

*MCO, PIHP, PAHP, PCCM or PCCM entity* include any of the entity's employees, network providers, agents, or contractors.

*Private insurance* does not include a qualified health plan, as defined in 45 CFR § 155.20.

(b) *Requirements.*

(1) Contractor—

(i) shall not distribute any marketing materials without first obtaining Agency approval.

(ii) shall distribute the materials statewide.

(iii) Reserved.

(iv) shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

(v) shall not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities.

(2) The Contractor shall ensure that a potential member can make his or her own decision as to whether or not to enroll. Contractor's marketing materials shall be accurate and not mislead, confuse, or defraud the beneficiaries or the Agency. Statements that will be considered inaccurate, false, or misleading include, but are not limited to, any assertion or statement (whether written or oral) that—

(i) The Member must enroll with Contractor to obtain benefits or to not lose benefits; or

(ii) The Contractor is endorsed by CMS, the Federal or State government, or similar entity; or

(iii) The Contractor's health plan is the only opportunity to obtain benefits under the program; or

(iv) The Contractor's marketing materials mislead or falsely describe covered or available services, membership or availability of network providers, and qualifications and skills of network providers.

(c) *Agency review.* The Contractor is encouraged to market its products to the general community and potential Members. All marketing activities shall be provided at no additional cost to the Agency. The contractor shall comply with all applicable laws and regulations regarding marketing by health insurance issuers. The Contractor shall obtain Agency approval for all marketing materials at least thirty (30) days or within the timeframe requested by the Agency, prior to distribution. In reviewing the

marketing materials submitted by the entity, the Agency will consult with the Medical Care Advisory Committee established under 42 C.F.R. § 431.12 or an advisory committee with similar membership, for all materials intended for distribution to the Medicaid population.

**8.1.1.1 Permissible Marketing Activities**

The Contractor may market via mail and mass media advertising such as radio, television and billboards. Participation in community oriented marketing such as participation in community health fairs is encouraged. Tokens or gifts of nominal value may be distributed at such events to potential Members, so long as the Contractor acts in compliance with all law and policy guidance regarding inducements in the Medicaid program, including marketing provisions provided for in 42 C.F.R. § 438.104.

**Revision 24. Scope of Work section 8.9 and all of its subparts are amended to read as follows:**

**8.9 Advance Directive Information**

The Contractor shall comply with the advance directive requirements outlined in Section 8.9.1 and Section 8.9.2 below.

**8.9.1 Advance Directives**

(1) If Contractor is an MCO or PIHP as defined in 42 C.F.R. part 438, the Contractor shall comply with the requirements of 42 C.F.R. § 422.128 for maintaining written policies and procedures for advance directives, as if such regulation applied directly to the Contractor.

(2) If Contractor is a PAHP as defined in 42 C.F.R. part 438, the Contractor shall comply with the requirements of 42 C.F.R. § 422.128 for maintaining written policies and procedures for advance directives as if such regulation applied directly to Contractor if the Contractor includes, in its network, any of those providers listed in 42 C.F.R. § 489.102(a).

(3) Contractor shall provide adult Members with written information on advance directives policies, and include a description of applicable State law.

(4) The information provided adult Members must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.

**8.9.2 No Discrimination**
Contractor shall not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive.

**Revision 25. Scope of Work section 8.10 and all of its subparts are amended to read as follows:**

**8.10 Member Rights**

(a) *General rule.* In compliance with 42 C.F.R. §438.100 or 42 C.F.R. § 457.1220, as applicable:

(1) Contractor shall have written policies regarding the Member rights specified herein; and

(2) Contractor shall comply with any applicable Federal and State laws that pertain to Member rights, and ensure that its employees and contracted providers observe and protect those rights.

(b) *Specific rights—*

(1) *Basic requirement.* Contractor shall ensure that each Member is guaranteed the rights as specified in paragraphs (b)(2) and (3) below.

(2) An Member with the Contractor has the following rights: The right to—

(i) Receive information in accordance with 42 C.F.R. § 438.10.

(ii) Be treated with respect and with due consideration for his or her dignity and privacy, including but not limited to the right to fully participate in the community and to work, live and learn to the fullest extent possible; and

(iii) Receive information on available treatment options and alternatives, including treatment in the least restrictive setting, presented in a manner appropriate to the Member's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in 42 C.F.R. § 438.10(g)(2)(ii)(A) and (B).)

(iv) Participate in decisions regarding his or her health care, including the right to refuse treatment.

(v) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

(vi) Request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526.

(3) An Member with the Contractor (consistent with the scope of the contracted services if the Contractor is a PAHP) has the right to be furnished health care services in accordance with 42 C.F.R. §§ 438.206 through 438.210.

(c) *Free exercise of rights.* The Agency must ensure that each Member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Contractor and its network providers or the Agency treat the Member.

(d) *Compliance with other Federal and State laws.* Contractor shall comply with any other applicable Federal and State laws (including: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 C.F.R. part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 C.F.R. part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II

and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.

**Revision 26. Scope of Work section 10.3.2.2 is amended to read as follows:**

**10.3.2.2 Incentive Payment Restrictions**

(1) In compliance with 42 C.F.R. § 438.3(i), Contractor shall comply with the requirements set forth in 42 C.F.R. §§ 422.208 and 422.210 related to physician incentive plans.

(2) In applying the provisions of 42 C.F.R. §§ 422.208 and 422.210, references to "MA organization," "CMS," and "Medicare beneficiaries" must be read as references to "Contractor," "State," and "Medicaid beneficiaries," respectively.

**Revision 27. Scope of Work section 10.5 and all of its subparts are amended to read as follows:**

**10.5 Provider Preventable Conditions**

In accordance with 42 C.F.R. § 438.3(g), Contractor shall comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 C.F.R. § 434.6(a)(12) and 42 C.F.R. § 447.26. Contractor shall report all identified provider-preventable conditions in a form and frequency as specified by the Agency. The Contractor shall comply with any future additions to the list of non-reimbursable provider-preventable conditions.

**Revision 28. Scope of Work section 11.2.8 is deleted in its entirety.**

**Revision 29. Scope of Work, Exhibit A labeled "Definitions" is modified as follows:**

1. The definition of "Cold Call Marketing" is removed.
2. The definition of "Emergency Medical Condition" is removed.
3. The definition of "Emergency Services" is removed.
4. The definition of "Marketing" is removed.
5. The definition of "Marketing Materials" is removed.
6. The definition of "Post-stabilization Services" is removed.

**Revision 30. Scope of Work section 2.20 is hereby added, which reads as follows:**

**2.20 Material Change to Operations**

A material change to operations is any change in overall business operations, such as policy, process or protocol which affects, or can reasonably be expected to affect, more than five percent (5%) of the Contractor's membership or provider network and that a reasonable person would find to be a significant change. Prior to implementing a material

change in operation, the Contractor shall notify the Agency. The notification shall contain, at minimum: (i) information regarding the nature of the change; (ii) the rationale for the change; (iii) the proposed effective date; and (iv) sample member and provider notification materials. All material changes shall be communicated to members or providers at least thirty (30) days prior to the effective date of the change. The Agency reserves the right to deny or require modification to proposed material changes if it is determined, at the sole discretion of the Agency, that such change will adversely impact quality or access.

**Revision 31. Scope of Work section 2.5.1 is deleted and marked "Reserved."**

**Revision 32. Scope of Work section 8.2.8 is amended to read as follows. All subsection under 8.2.8 remain unchanged:**

**8.2.8 Notification of Significant Change**

In addition to notification of a material change in operation as described in Section 2.20, the Contractor shall provide written member notice when there is a significant change, defined as any change that may impact member accessibility to servcies and benefits, in:

**Revision 33. Scope of Work section 6.1.9.1 is amended to read as follows.**

**6.1.9.1 Maintenance and Retention**

The Contractor shall maintain a medical records system which: (i) identifies each medical record by State identification number; (ii) identifies the location of every medical record; (iii) places medical records in a given order and location; (iv) maintains the confidentiality of medical records information and releases the information only in accordance with applicable law; (v) maintains inactive medical records in a specific place; (vi) permits effective professional review in medical audit processes; and (vii) facilitates an adequate system for follow-up treatment including monitoring and follow-up of off-site referrals and inpatient stays.

**Revision 34. Scope of Work section 3.3 is amended to read as follows. This Revision does not impact the subsections under Section 3.3:**

**3.3 Continuity of Care**

The Contractor shall implement mechanisms to ensure the continuity of care of members transitioning in and out of the Contractor's enrollment. Possible transitions include, but are not limited to: (i) initial program implementation; (ii) initial enrollment with the Contractor; (iii) transitions between program Contractors during the first ninety (90) days of a member's enrollment; and (iii) at any time for cause as described in the Section 7.4.

**Revision 35. Reserved.**

**Revision 36. The definition of "Enrollee" in Exhibit A to the Contract is hereby amended to read as follows:**

> **Enrollee.** A person who has been determined eligible by the Agency for Medicaid or a recipient of services provided under the State Children's Health Insurance Program operated by the Agency and who has been enrolled in either program in the Iowa Medicaid Management Information System (see Member, also).

**Revision 37. The definition of "Member" in Exhibit A to the Contract is hereby amended to read as follows:**

> **Member.** A Medicaid recipient or a recipient of services provided under the State Children's Health Insurance Program operated by the Agency who is subject to mandatory enrollment or is currently enrolled in the Contractor's coverage under the Contract for the program.

**Revision 38. Scope of Work section 2.7 is amended to read as follows:**

> **2.7 Medical Loss Ratio**
>
> The Contractor shall maintain, at minimum, an annual Medical Loss Ratio (MLR) as set forth in Attachment 2.7 – Medical Loss Ratio. The Agency will define how the MLR will be calculated within each period's contracted rates. Until such time as future federal regulations or federal guidance the Agency will use the MLR definition outlined in Attachment 2.7 – Medical Loss Ratio. If MLR is defined in federal regulations or federal guidance in the future, such definition shall control over any contrary language in this Contract as of the effective date of such definition as set forth in such regulations or guidance. The Agency reserves the right to adjust this definition after giving written notice to the Contractor. In the event the MLR falls below this target, the Agency shall recoup excess capitation paid to the Contractor.

**Revision 39. Scope of Work section 14.2.7 is amended to read as follows:**

> **14.2.7 Medical Loss Ratio**
>
> The Contractor shall maintain, at minimum, a medical loss ratio as set forth in Attachment 2.7.

**Revision 40. The document attached to the Contract as Attachment 2.7 is hereby deleted and replaced with the document attached to this Second Amendment as Amendment 2, Exhibit B.**

**Revision 41. The document attached to this Amendment as Amendment 2, Exhibit C is hereby incorporated into the Contract as new Special Contract Attachment 3.2-03. Attachment 3.2-01 and Attachment 3.2-02 to the Contract are hereby deleted.**

**Revision 42.** 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. Following CMS approval of the final rates, the Agency will present the approved capitation rates to the Contractor in Contract Amendment form. 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 Contractor'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 forty-five (45) 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 forty-five (45) 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 120 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 updated capitation rates effective April 1, 2016 and July 1, 2016 included in Special Contract Attachment 3.2-03, capitation rates shall be paid in accordance to a reprocessing schedule defined by the

Agency. Reprocessing shall proceed subsequent to CMS approval of the updated capitation rates, but no later than the first contract term ending March 31, 2019.

**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, Amerigroup Iowa, Inc.** | | **Agency, Iowa Department of Human Services** | |
|---|---|---|---|
| Signature of Authorized Representative: | Date: | Signature of Authorized Representative: | Date: |
| Cynthia M. MacDonald | 9/8/17 | | 9-14-17 |
| Printed Name: CYNTHIA M. MACDONALD | | Printed Name: Jerry Foxhoven | |
| Title: PLAN PRESIDENT, AMERIGROUP IOWA | | Title: Director | |

## Amendment 2, Exhibit B:

## Attachment 2.7 Medical Loss Ratio

PART A: Applicable to Contractor Medical Loss Ratio ("MLR") reporting submitted after the end of the State Fiscal Year 2018 (June 30, 2018).

(a) Applicability. 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.

(b) *Definitions.* As used in this section, the following terms have the indicated meanings:

*Credibility adjustment* means an adjustment to the MLR for a partially credible MCO, PIHP, or PAHP to account for a difference between the actual and target MLRs that may be due to random statistical variation.

*Full credibility* means a standard for which the experience of an MCO, PIHP, or PAHP is determined to be sufficient for the calculation of a MLR with a minimal chance that the difference between the actual and target medical loss ratio is not statistically significant. An MCO, PIHP, or PAHP that is assigned full credibility (or is fully credible) will not receive a credibility adjustment to its MLR.

*Member months* mean the number of months a member or a group of members is covered by Contractor over a specified time period, such as a year.

*MLR reporting year* means a period of 12 months consistent with the State fiscal year.3.2

*No credibility* means a standard for which the experience of an MCO, PIHP, or PAHP is determined to be insufficient for the calculation of a MLR. An MCO, PIHP, or PAHP that is assigned no credibility (or is non-credible) will not be measured against any MLR requirements.

*Non-claims costs* means those expenses for administrative services that are not: Incurred claims (as defined in paragraph (e)(2) of this section); expenditures on activities that improve health care quality (as defined in paragraph (e)(3) of this section); or licensing and regulatory fees, or Federal and State taxes (as defined in paragraph (f)(2) of this section).

*Partial credibility* means a standard for which the experience of an MCO, PIHP, or PAHP is determined to be sufficient for the calculation of a MLR but with a non-negligible chance that the difference between the actual and target medical loss ratios is statistically significant. An MCO, PIHP, or PAHP that is assigned partial credibility (or is partially credible) will receive a credibility adjustment to its MLR.

(c) *MLR guarantee.* A minimum MLR of 88% must be achieved for each MLR reporting year by the Contractor, consistent with this section. Contractor has a Target Medical Loss Ratio of eighty-eight percent (88%) aggregate for all covered populations. If the Medical Loss Ratio calculated as set forth below is less than the Target Medical Loss Ratio, Contractor shall refund to the State an amount equal to the difference between the calculated Medical Loss Ratio and the Target Medical Loss Ratio (expressed as a percentage) multiplied by the Coverage Year Revenue. The Agency shall prepare a Medical Loss

Ratio Calculation which shall summarize Contractor's Medical Loss Ratio for Enrollees under this Contract for each Coverage Year. The Medical Loss Ratio Calculation shall be determined as set forth below; however, the Agency may adopt modified reporting standards and protocols after giving written notice to Contractor.

(d) *Calculation of the MLR.* The MLR experienced for Contractor in a MLR reporting year is the ratio of the numerator (as defined in paragraph (e) of this section) to the denominator (as defined in paragraph (f) of this section). A MLR may be increased by a credibility adjustment, in accordance with paragraph (h) of this section.

(e) *Numerator*—(1) *Required elements.* The numerator of Contractor's MLR for a MLR reporting year is the sum of the Contractor's incurred claims (as defined in (e)(2) of this section); the Contractor's expenditures for activities that improve health care quality (as defined in paragraph (e)(3) of this section); and fraud reduction activities (as defined in paragraph (e)(4) of this section).

(2) *Incurred claims.* (i) Incurred claims must include the following:

(A) Direct claims that the Contractor paid to providers (including under capitated contracts with network providers) for services or supplies covered under the contract and services meeting the requirements of 42 C.F.R. § 438.3(e) provided to members.

(B) Unpaid claims liabilities for the MLR reporting year, including claims reported that are in the process of being adjusted or claims incurred but not reported.

(C) Withholds from payments made to network providers to the extent that such withholds have been finalized to be paid or have been paid.

(D) Claims that are recoverable for anticipated coordination of benefits.

(E) Claims payments recoveries received as a result of subrogation.

(F) Incurred but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity.

(G) Changes in other claims-related reserves.

(H) Reserves for contingent benefits and the medical claim portion of lawsuits.

(ii) Amounts that must be deducted from incurred claims include the following:

(A) Overpayment recoveries received from network providers.

(B) Prescription drug rebates received and accrued.

(iii) Expenditures that must be included in incurred claims include the following:

(A) The amount of incentive and bonus payments to network providers to the extent that such bonus payments have been finalized to be paid or have been paid.

(B) The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses must not include activities specified in paragraph (e)(4) of this section.

(iv) Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to State mandated solvency funds.

(v) Amounts that must be excluded from incurred claims:

(A) Non-claims costs, as defined in paragraph (b) of this section, which include the following:

(*1*) Amounts paid to third party vendors for secondary network savings.

(*2*) Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management.

(*3*) Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in 42 C.F.R. § 438.3(e) and provided to a member. Payments under this subsection (3) are only to be considered incurred claims if the following four-factor test is met:

I. The entity contracts with an issuer to deliver, provide, or arrange for the delivery and provision of clinical services to the issuer's enrollees but the entity is not the issuer with respect to those services;

II. The entity contractually bears financial and utilization risk for the delivery, provision, or arrangement of specific clinical services to enrollees;

III. The entity delivers, provides, or arranges for the delivery and provision of clinical services through a system of integrated care delivery that, as appropriate, provides for the coordination of care and sharing of clinical information, and which includes programs such as provider performance reviews, tracking clinical outcomes, communicating evidence-based guidelines to the entity's clinical providers, and other, similar care delivery efforts; and

IV. Functions other than clinical services that are included in the payment (capitated or fee-for-service) must be reasonably related or incident to the clinical services, and must be performed on behalf of the entity or the entity's providers.

(*4*) Fines and penalties assessed by regulatory authorities.

(B) Amounts paid to the Agency as remittance under paragraph (j) of this section.

(C) Amounts paid to network providers under to 42 C.F.R. § 438.6(d).

(vi) Incurred claims paid by one Contractor that is later assumed by another entity must be reported by the assuming Contractor for the entire MLR reporting year and no incurred claims for that MLR reporting year may be reported by the ceding Contractor.

(3) *Activities that improve health care quality.* Activities that improve health care quality are limited to 2% of capitation payments and must be in one of the following categories:

(i) 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).

(ii) A Contractor activity related to any EQR-related activity as described in 42 C.F.R. § 438.358(b) and (c).

(iii) 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, as defined in paragraph (e)(2) of this section.

(4) *Fraud prevention activities.* Contractor expenditures on activities related to fraud prevention as adopted for the private market at 45 C.F.R. part 158. Expenditures under this paragraph must not include expenses for fraud reduction efforts in paragraph (e)(2)(iii)(B) of this section.

(f) *Denominator*—(1) *Required elements.* The denominator of Contractor's MLR for a MLR reporting year must equal the adjusted premium revenue. The adjusted premium revenue is the Contractor's premium revenue (as defined in paragraph (f)(2) of this section) minus the Contractor's Federal, State, and local taxes and licensing and regulatory fees (as defined in paragraph (f)(3) of this section) and is aggregated in accordance with paragraph (i) of this section.

(2) *Premium revenue.* Premium revenue includes the following for the MLR reporting year:

(i) Agency capitation payments, developed in accordance with 42 C.F.R. § 438.4, to the Contractor for all members under a risk contract approved under 42 C.F.R. § 438.3(a), excluding payments made under to 42 C.F.R. § 438.6(d).

(ii) Agency-developed one time payments, for specific life events of members.

(iii) Other payments to the Contractor approved under 42 C.F.R. § 438.6(b)(3).

(iv) Unpaid cost-sharing amounts that the Contractor could have collected from members under the Contract, except those amounts the Contractor can show it made a reasonable, but unsuccessful, effort to collect.

(v) All changes to unearned premium reserves.

(vi) Net payments or receipts related to risk sharing mechanisms developed in accordance with 42 C.F.R. § 438.5 or 42 C.F.R. § 438.6.

(3) *Federal, State, and local taxes and licensing and regulatory fees.* Taxes, licensing and regulatory fees for the MLR reporting year include:

(i) Statutory assessments to defray the operating expenses of any State or Federal department.

(ii) Examination fees in lieu of premium taxes as specified by State law.

(iii) Federal taxes and assessments allocated to Contractor, excluding Federal income taxes on investment income and capital gains and Federal employment taxes.

(iv) State and local taxes and assessments including:

(A) Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State or locality directly.

(B) Guaranty fund assessments.

(C) Assessments of State or locality industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.

(D) State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.

(E) State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes.

(v) Payments made by Contractor that are otherwise exempt from Federal income taxes, for community benefit expenditures as defined in 45 C.F.R. § 158.162(c), limited to the highest of either:

(A) Three percent of earned premium; or

(B) The highest premium tax rate in the State for which the report is being submitted, multiplied by the Contractor's earned premium in the State.

(4) *Denominator when Contractor is assumed.* The total amount of the denominator for Contractor if Contractor is later assumed by another entity must be reported by the assuming MCO, PIHP, or PAHP for the entire MLR reporting year and no amount under this paragraph for that year may be reported by Contractor.

(g) *Allocation of expense*—(1) *General requirements.* (i) Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses.

(ii) Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.

(2) *Methods used to allocate expenses.* (i) Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results.

(ii) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.

(iii) Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

(h) *Credibility adjustment.* (1) Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible. The credibility adjustment must be added to the reported MLR calculation before calculating any remittances.

(2) Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

(3) If Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards in this section.

(4) On an annual basis, CMS will publish base credibility factors for MCOs, PIHPs, and PAHPs that are developed according to the following methodology:

(i) CMS will use the most recently available and complete managed care encounter data or FFS claims data, and enrollment data, reported by the states to CMS. This data may cover more than 1 year of experience.

(ii) CMS will calculate the credibility adjustment so that a MCO, PIHP, or PAHP receiving a capitation payment that is estimated to have a medical loss ratio of 85 percent would be expected to experience a loss ratio less than 85 percent 1 out of every 4 years, or 25 percent of the time.

(iii) The minimum number of member months necessary for a MCO's, PIHP's, or PAHP's medical loss ratio to be determined at least partially credible will be set so that the credibility adjustment would not exceed 10 percent for any partially credible MCO, PIHP, or PAHP. Any MCO, PIHP, or PAHP with enrollment less than this number of member months will be determined non-credible.

(iv) The minimum number of member months necessary for an MCO's, PIHP's, or PAHP's medical loss ratio to be determined fully credible will be set so that the minimum credibility adjustment for any partially credible MCO, PIHP, or PAHP would be greater than 1 percent. Any MCO, PIHP, or PAHP with enrollment greater than this number of member months will be determined to be fully credible.

(v) A MCO, PIHP, or PAHP with a number of member months between the levels established for non-credible and fully credible plans will be deemed partially credible, and CMS will develop adjustments, using linear interpolation, based on the number of member months.

(vi) 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 1,000 or a different degree of rounding as appropriate to ensure that the credibility thresholds are consistent with the objectives outlined herein.

(i) *Aggregation of data.* MCOs, PIHPs, or PAHPs will aggregate data for all Medicaid eligibility groups covered under the contract with the Agency and will aggregate data for all Title XXI eligibility groups covered under the Contract with the Agency consistent with the requirement to report the two populations separately as noted in subsection (a) above.

(j) *Remittance to the Agency if specific MLR is not met.* Contractor must provide a remittance for an MLR reporting year if the MLR for that MLR reporting year does not meet the minimum MLR standard of 88 percent. Contractor shall remit payment to the Agency within 90 days of submission of the MLR report for any MLR falling below the MLR standard.

(k) *Reporting requirements.* (1) Contractor shall submit a report to the Agency that includes at least the following information for each MLR reporting year:

(i) Total incurred claims with IBNR reported separately.

(ii) Expenditures on quality improving activities.

(iii) Expenditures related to activities compliant with 42 C.F.R. § 438.608(a)(1) through (5), (7), (8) and (b).

(iv) Non-claims costs.

(v) Premium revenue.

(vi) Taxes, licensing and regulatory fees.

(vii) Methodology(ies) for allocation of expenditures.

(viii) Any credibility adjustment applied.

(ix) The calculated MLR.

(x) Any remittance owed to the Agency, if applicable.

(xi) A comparison of the information reported in this paragraph with the audited financial report required under 42 C.F.R. § 438.3(m).

(xii) A description of the aggregation method used under paragraph (i) of this section.

(xiii) The number of member months.

(2) Contractor must submit the report required in paragraph (k)(1) of this section in a timeframe and manner determined by the Agency, which must be within 12 months of the end of the MLR reporting year.

(3) Contractor must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to Contractor within 180 days of the end of the

MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

(l) *Newer experience.* The Agency, in its discretion, may exclude a Contractor that is newly contracted with the Agency from the requirements in this section for the first year of the Contractor's operation. Such Contractor's must be required to comply with the requirements in this section during the next MLR reporting year in which the Contractor is in business with the Agency, even if the first year was not a full 12 months.

(m) *Recalculation of MLR.* In any instance where an Agency makes a retroactive change to the capitation payments for a MLR reporting year where the report has already been submitted to the Agency, the Contractor must re-calculate the MLR for all MLR reporting years affected by the change and submit a new report meeting the requirements in paragraph (k) of this section.

(n) *Attestation.* Contractor must attest to the accuracy of the calculation of the MLR in accordance with requirements of this section when submitting the report required under paragraph (k) of this section.

PART B: Medical Loss Ratio Provision Applicable through the end of State Fiscal Year 2017 (6/30/17)
The Medical loss ratio definitions and calculation methodology set forth below are applicable only to contract periods through the end of State Fiscal Year 2017 (6/30/2017) (i.e., for the first contract period from April 1, 2016 to June 30, 2017); thereafter, Part A of this attachment applies.

**Medical Loss Ratio Guarantee:** Contractor has a Target Medical Loss Ratio of eighty-eight percent (88%) aggregate for all covered populations. If the Medical Loss Ratio calculated as set forth below is less than the Target Medical Loss Ratio, Contractor shall refund to the State an amount equal to the difference between the calculated Medical Loss Ratio and the Target Medical Loss Ratio (expressed as a percentage) multiplied by the Coverage Year Revenue. The Agency shall prepare a Medical Loss Ratio Calculation which shall summarize Contractor's Medical Loss Ratio for Enrollees under this Contract for each Coverage Year. The Medical Loss Ratio Calculation shall be determined as set forth below; however, the Agency may adopt modified reporting standards and protocols after giving written notice to Contractor.

**Revenue.** The revenue used in the Medical Loss Ratio calculation will consist of both Capitation and Risk Corridor revenue. Capitation revenue will be the Capitation payments made by the Agency to Contractor adjusted to exclude any supplemental payments, taxes, and regulatory fees due from and or received from the Agency for services provided during the Coverage Year. Capitation payments will be determined on a gross basis without regard to whether the health plan recovers the performance withhold. Any risk corridor payments from the Agency to the Contractor or from the Contractor to the Agency will be considered as premium revenue in the calculation of the contractually required 88% minimum loss ratio.

**Benefit Expense.** The Agency shall determine the Benefit Expense using the following data:

- Paid Claims. Paid Claims shall be included in Benefit Expense. The Agency shall use Encounter Data claims for all dates of service during the Coverage Year and accepted by the Agency within six (6) months after the end of the Coverage Year. If the Contractor and Agency are unable to resolve Encounter Data systems issues prior to calculation of the MLR, a mutually agreed upon alternative method of calculating paid claims expense will be used. Encounter Data claims covered by sub-capitation contracts shall be priced at Contractor's Fee-For-Service rate for Covered Services or the Agency's designated

pricing. Contractor shall provide clear supporting documentation of these sub-capitated arrangements. Incurred expenditures may, at the discretion of the Agency, be repriced at the Agency's Medicaid fee-for-service equivalent rates.

- Incurred But Not Paid Claims. Claims that have been incurred but not paid (IBNP), as submitted by the Contractor. The Agency's actuary will review this submission for accuracy and reasonableness.
- Provider Incentive Payments. Provider incentive payments shall be made within Contract requirements set forth in Section 10.3.2. Incentive payments to providers paid within six (6) months after the end of the Coverage Year for performance measured during the Coverage Year provided the payments are made pursuant to agreements in place at the start of the measurement period under which the benchmarks triggering payments and the methodology for determining payment amounts are clearly set forth shall be included in Benefit Expense.
- Other Benefit Expense. Any service provided directly to an Enrollee not capable of being sent as Encounter Data due to there not being appropriate codes or similar issues may be sent to the Agency on a report identifying the Enrollee, the service and the cost, along with clear documentation of the methodology for determining payment amounts. Such costs will be included in Benefit Expense upon the Agency's approval. Other Benefit Expense will be limited to State Plan approved services and B3 services for the Member and will not include any additional value added services.
- Supplemental Payments. Supplemental payments shall be excluded from the Benefit Expense.

**Data Submission.** Contractor shall submit data to the Agency, in the form and manner prescribed by the Agency in Section 13 of the Contract. The Contractor shall submit information to the State within 30 days following the six (6) month claims run-out period.

**Medical Loss Ratio Calculation and Payment.** Within ninety (90) days following data submission, the Agency shall calculate the Medical Loss Ratio by dividing the Benefit Expense by the Revenue. The Medical Loss Ratio shall be expressed as a percentage rounded to the second decimal point. For example, a Medical Loss Ratio calculated at 87.95% does not meet the minimum Medical Loss Ratio requirements of 88%. Contractor shall have sixty (60) days to review the Agency's Medical Loss Ratio Calculation. The Agency and Contractor shall have the right to review all data and methodologies used to calculate the Medical Loss Ratio.

Any payments due to the Agency are due and payable by the Contractor within 15 days of the end of the third calendar quarter of each Coverage Year.

**Coverage Year.** The Coverage Year will initially be considered a fifteen (15) month period followed by subsequent twelve (12) month periods. The Medical Loss Ratio Calculation shall be prepared using all data available from the Coverage Year, including IBNP and six (6) months of run-out for Benefit Expense.

**Risk Corridor for Long Term Services and Supports.**

In addition, the parties to the Contract agree to impose a LTSS risk corridor (LTSS RC). This risk corridor shall be based on a per member per month basis using incurred expenditures specific to the LTSS categories of service (Institutional & Waiver) and shall be applicable only to the first contract period from April 1, 2016 to June 30, 2017.

The risk corridor amounts utilized as the benchmark shall be the risk-adjusted LTSS gross capitation rates by rate cell for the April to June 2016 and July 2016 to June 2017 time periods excluding the administrative component and member participation component of each rate cell. This benchmark is defined as the target LTSS RC rates.

Risk corridors are defined as follows:

| *IA Health Link Risk Corridor for LTSS* | |
|---|---|
| *Target LTSS RC rate values are presented in Exhibit B* | |
| *+ 2% of target LTSS RC rate* | *Contractor is responsible for 100% of losses greater than target LTSS RC rate and less than or equal to 102% of target LTSS RC rate.* |
| *+ 2% to 4% of target LTSS RC rate* | *Contractor is responsible for 75% of losses greater than 102% of target LTSS RC rate and less than or equal to 104% of target LTSS RC rate.*<br><br>*Agency is responsible for 25% of losses greater than 102% of target LTSS RC rate and less than or equal to 104% of target LTSS RC rate* |
| *+ 4% to 6% of target LTSS RC rate* | *Contractor is responsible for 50% of losses greater than 104% of target LTSS RC rate and less than or equal to 106% of target LTSS RC rate.*<br><br>*Agency is responsible for 50% of losses greater than 104% of target LTSS RC rate and less than or equal to 106% of target LTSS RC rate.* |
| *+ 6% to 8% of target LTSS RC rate* | *Contractor is responsible for 25% of losses greater than 106% of target LTSS RC rate and less than or equal to 108% of target LTSS RC rate.*<br><br>*Agency is responsible for 75% of losses greater than 106% to target LTSS RC rate and less than or equal to 108% of target LTSS RC rate.* |
| *+ 8% to 12.5% of target LTSS RC rate.* | *Agency is responsible for 100% of losses greater than 108% of target LTSS RC rate and less than or equal to 112.5% of target LTSS RC rate.* |
| *≥+ 12.5% of target LTSS RC rate* | *Contractor is responsible for 100% of losses greater than 112.5% of target LTSS RC rate.* |
| *- 2% of the LTSS cost component* | *Contractor retains 100% of gains less than target LTSS RC rate and greater than or equal to 98% of target LTSS RC rate.* |
| *- 2% to 4% of target LTSS RC rate* | *Contractor retains 75% of gains less than 98% of target LTSS RC rate and greater than or equal to 96% of target LTSS RC rate.*<br><br>*Agency retains 25% of gains less than 98% of target LTSS RC rate and greater than or equal to 96% of target LTSS RC rate.* |
| *- 4% to 6% of target LTSS RC rate* | *Contractor retains 50% of gains less than 96% of target LTSS RC rate and greater than or equal to 94% of target LTSS RC rate.*<br><br>*Agency retains 50% of gains less than 96% of target LTSS RC rate and greater than or equal to 94% of target LTSS RC rate.* |
| *- 6% to 8% of target LTSS RC rate* | *Contractor retains 25% of gains less than 94% of target LTSS RC rate and greater than or equal to 92% of target LTSS RC rate.*<br><br>*Agency retains 75% of gains less than 94% of target LTSS RC rate and greater than or equal to 92% of target LTSS RC rate.* |
| *- 8% to 12.5% of target LTSS RC rate* | *Agency retains 100% of gains less than 92% of target LTSS RC rate and greater than or equal to 87.5% of target LTSS RC rate.* |
| *≤-12.5% of target LTSS RC rate* | *Contractor retains 100% of gains less than 87.5% of target LTSS RC rate.* |

The following terms and conditions will apply to the LTSS risk corridor:

The LTSS Risk Corridor shall apply to claims incurred and premium revenue earned during the first contract year from April 1, 2016 through June 30, 2017. The calculation of the LTSS risk corridor shall be a comparison of the claims cost component of the capitation rates to actual incurred expenditures. The calculation of the LTSS risk corridor shall not be a medical loss ratio calculation. The risk corridor amounts utilized as the benchmark are the risk-adjusted LTSS gross capitation rates by rate cell for the April to June 2016 and July 2016 to June 2017 time periods excluding the administrative component. The risk-adjusted LTSS gross capitation rates by rate cell to be utilized for the LTSS risk corridor calculation are presented in Exhibit B. The LTSS risk corridor calculation shall reflect a blend of the April to June 2016 and July 2016 to June 2017 gross capitation rates based on actual enrollment for the 15-month rating period. The LTSS risk corridor is specific to the LTSS component of the capitation rates and shall be performed on a composite basis across all LTSS rate cells.

Capitation revenue used in the LTSS risk corridor calculation shall be the LTSS component of the capitation rates inherent in capitation payments made by the Agency to Contractor adjusted to exclude any supplemental payments, taxes, and regulatory fees, due from and or received from the Agency for services provided during the Coverage Year including amounts withheld. Capitation payments shall be determined on a gross basis without regard to whether the Agency recovers the performance withhold.

**Benefit Expense.** The Agency shall determine the Benefit Expense for the LTSS RC using the following data:

- Paid Claims. Paid Claims shall be included in Benefit Expense. The Agency shall use Encounter Data claims for all dates of service during the Coverage Year and accepted by the Agency within six (6) months after the end of the Coverage Year. If the Contractor and Agency are unable to resolve Encounter Data systems issues prior to calculation of the LTSS RC, a mutually agreed upon alternative method of calculating paid claims expense will be used. Encounter Data claims covered by sub-capitation contracts shall be priced at Contractor's Fee-For-Service rate for Covered Services or the Agency's designated pricing. Contractor shall provide clear supporting documentation of these subcapitated arrangements. Incurred expenditures may, at the discretion of the Agency, be repriced to the Agency's Medicaid fee-for-service equivalent rates.
- Incurred But Not Paid Claims. Claims that have been incurred but not paid (IBNP), as submitted by the Contractor. The Agency's actuary will review this submission for accuracy and reasonableness.
- Incurred expenditures shall include costs for services rendered for long term services and supports. Services identified as long term services and supports shall be consistent with capitation rate setting methodology. Incurred expenditures shall not include costs related to acute care, behavioral health, short term institutional, or short term home and community based services.
- Incurred expenditures will not include quality improvement expenses, case management expenses, or other administrative expenses.
- Incurred expenditures shall be net of patient participation amounts without regard to whether the Contractor collects these amounts. Incurred expenditures will reflect the application of any

member copayments specific to LTSS, without regard to whether the Agency collects these amounts.

- Provider Incentive Payments. Provider incentive payments shall be made within Contract requirements set forth in Section 10.3.2. Incentive payments to providers paid within six (6) months after the end of the Coverage Year for performance measured during the Coverage Year provided the payments are made pursuant to agreements in place at the start of the measurement period under which the benchmarks triggering payments and the methodology for determining payment amounts are clearly set forth shall be included in Benefit Expense.
- Supplemental Payments. Supplemental payments shall be excluded from the Benefit Expense.

**Data Submission.** Contractor shall submit data to the Agency, in the form and manner prescribed by the Agency in Section 13 of the Contract. The Contractor shall submit information to the State within 30 days following the six (6) month claims run-out period.

**LTSS risk corridor Calculation and Payment.** Within ninety (90) days following data submission, the Agency shall calculate the LTSS risk corridor by comparing actual benefit expense to capitation revenue across the applicable services and populations. The capitation revenue used in the risk corridor calculation shall reflect a weighted average of the Target LTSS RC rate values effective April 1, 2016 and July 1, 2016 using actual enrollment for the Contractor for the evaluation period (i.e., April 1, 2016 to June 30, 2017). A sample calculation illustrating the LTSS risk corridor calculation shall be provided by the Agency in Exhibit B.02.

Contractor shall have sixty (60) days to review the Agency's LTSS risk corridor calculation. The Agency and Contractor shall have the right to review all data and methodologies used to calculate the LTSS RC payment obligation.

The payments are due to either the Agency or the Contractor plan no later than October 15, 2018.

Acceptance by Contractor of any Agency risk corridor payment for either the medical risk corridor or the LTSS RC 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 reasonableness of the associated medical risk corridor or LTSS RC calculation and/or payment.

State of Iowa - Department of Human Services, Division of Medical Services
Iowa Medicaid Enterprise
IA Health Link
April 1, 2016 to June 30, 2016 Capitation Rate Summary
Health Plan: Amerigroup

| Capitation Rate Cell | Medical Gross Capitation: Gross Base Medical Capitation | Gross Base Risk Adjusted Medical Capitation | 1915b(3) | GME Supplemental PMPM | UIHC Supplemental PMPM | Gross Total State Plan Rate | 1915b(3) |
|---|---|---|---|---|---|---|---|
| Children 0-59 days M&F | $ 1,844.73 | $ 1,844.73 | $ 0.00 | $ 5.28 | $ 40.14 | $ 1,890.15 | $ 0.00 |
| Children 60-364 days M&F | 216.43 | 216.43 | - | 5.28 | 11.42 | 233.13 | - |
| Children 1-4 M&F | 117.49 | 117.00 | (0.02) | 5.28 | 5.39 | 127.65 | 0.02 |
| Children 5-14 M&F | 129.20 | 128.66 | (0.36) | 5.28 | 3.11 | 136.68 | 0.36 |
| Children 15-20 F | 222.21 | 221.28 | (2.91) | 5.28 | 6.39 | 230.04 | 2.91 |
| Children 15-20 M | 201.29 | 200.44 | (4.08) | 5.28 | 3.32 | 204.96 | 4.08 |
| Non-Expansion Adults 21-34 F | 330.64 | 331.73 | (8.37) | 5.28 | 9.92 | 338.56 | 8.37 |
| Non-Expansion Adults 21-34 M | 222.81 | 223.55 | (1.71) | 5.28 | 4.84 | 231.96 | 1.71 |
| Non-Expansion Adults 35-49 F | 479.94 | 481.52 | (4.74) | 5.28 | 11.80 | 493.86 | 4.74 |
| Non-Expansion Adults 35-49 M | 401.17 | 402.49 | (1.50) | 5.28 | 8.17 | 414.44 | 1.50 |
| Non-Expansion Adults 50+ M&F | 570.27 | 572.16 | (1.84) | 5.28 | 13.75 | 589.34 | 1.84 |
| Pregnant Women | 338.60 | 338.60 | (5.27) | 5.28 | 21.29 | 359.90 | 5.27 |
| CHIP - Children 0-59 days M&F | $ 1,844.73 | $ 1,836.98 | $ 0.00 | $ 0.00 | $ 0.00 | $ 1,836.98 | $ 0.00 |
| CHIP - Children 60-364 days M&F | 216.43 | 215.52 | - | - | - | 215.52 | - |
| CHIP - Children 1-4 M&F | 117.49 | 117.00 | (0.02) | - | - | 116.98 | 0.02 |
| CHIP - Children 5-14 M&F | 129.20 | 128.66 | (0.36) | - | - | 128.30 | 0.36 |
| CHIP - Children 15-20 F | 222.21 | 221.28 | (2.91) | - | - | 218.37 | 2.91 |
| CHIP - Children 15-20 M | 201.29 | 200.44 | (4.08) | - | - | 196.36 | 4.08 |
| CHIP - Hawk-i | $ 155.76 | $ 155.76 | $ 0.00 | $ 0.00 | $ 0.00 | $ 155.76 | $ 0.00 |
| TANF Maternity Case Rate | $ 6,172.05 | $ 6,172.05 | $ 0.00 | $ 0.00 | $ 0.00 | $ 6,172.05 | $ 0.00 |
| Pregnant Women Maternity Case Rate | $ 5,468.90 | $ 5,468.90 | $ 0.00 | $ 0.00 | $ 0.00 | $ 5,468.90 | $ 0.00 |
| Wellness Plan 19-24 F (Medically Exempt) | $ 534.25 | $ 536.01 | $ (1.41) | $ 0.00 | $ 9.74 | $ 544.34 | $ 1.41 |
| Wellness Plan 19-24 M (Medically Exempt) | 517.53 | 519.24 | (0.51) | - | 5.60 | 524.33 | 0.51 |
| Wellness Plan 25-34 F (Medically Exempt) | 761.49 | 764.00 | (2.78) | - | 12.26 | 773.48 | 2.78 |
| Wellness Plan 25-34 M (Medically Exempt) | 756.28 | 758.78 | (1.27) | - | 8.24 | 765.75 | 1.27 |
| Wellness Plan 35-49 F (Medically Exempt) | 1,218.18 | 1,222.20 | (1.74) | - | 18.17 | 1,238.63 | 1.74 |
| Wellness Plan 35-49 M (Medically Exempt) | 1,181.74 | 1,185.64 | (1.13) | - | 14.13 | 1,198.64 | 1.13 |
| Wellness Plan 50+ M &F (Medically Exempt) | $ 1,532.05 | $ 1,537.11 | $ (0.23) | $ 0.00 | $ 21.08 | $ 1,557.96 | $ 0.23 |
| Wellness Plan 19-24 F (Non-Medically Exempt) | $ 202.24 | $ 202.91 | $ (0.54) | $ 0.00 | $ 7.75 | $ 210.12 | $ 0.54 |
| Wellness Plan 19-24 M (Non-Medically Exempt) | 195.87 | 196.52 | (0.18) | - | 4.46 | 200.79 | 0.19 |
| Wellness Plan 25-34 F (Non-Medically Exempt) | 286.78 | 289.73 | (1.06) | - | 9.75 | 298.42 | 1.06 |
| Wellness Plan 25-34 M (Non-Medically Exempt) | 286.80 | 287.75 | (0.48) | - | 6.56 | 293.83 | 0.48 |
| Wellness Plan 35-49 F (Non-Medically Exempt) | 462.72 | 464.25 | (0.66) | - | 14.46 | 478.05 | 0.66 |
| Wellness Plan 35-49 M (Non-Medically Exempt) | 448.84 | 450.32 | (0.43) | - | 11.25 | 461.14 | 0.43 |
| Wellness Plan 50+ M&F (Non-Medically Exempt) | $ 582.25 | $ 584.17 | $ (0.09) | $ 0.00 | $ 16.78 | $ 600.86 | $ 0.09 |
| Family Planning Waiver | $ 18.44 | $ 18.44 | $ 0.00 | $ 0.00 | $ 0.00 | $ 18.44 | $ 0.00 |
| ABD Non-Dual <21 M&F | $ 618.33 | $ 620.06 | $ (2.51) | $ 5.28 | $ 12.18 | $ 635.01 | $ 2.51 |
| ABD Non-Dual 21+ M&F | 1,164.83 | 1,171.35 | (9.76) | 5.28 | 26.27 | 1,193.14 | 9.76 |
| Breast and Cervical Cancer | 1,718.20 | 1,727.82 | (1.20) | - | 22.24 | 1,748.86 | 1.20 |
| Residential Care Facility | $ 1,827.58 | $ 1,827.58 | $ (31.73) | $ 5.28 | $ 11.43 | $ 1,812.56 | $ 31.73 |
| Dual Eligible 0-64 M&F | $ 458.35 | $ 458.35 | $ (15.18) | $ 0.00 | $ 0.00 | $ 443.17 | $ 15.18 |
| Dual Eligible 65+ M&F | $ 229.61 | $ 229.61 | $ (1.15) | $ 0.00 | $ 0.00 | $ 228.46 | $ 1.15 |
| Custodial Care Nursing Facility 65+ | $ 123.96 | $ 123.96 | $ (0.07) | $ 0.00 | $ 0.00 | $ 123.89 | $ 0.07 |
| Hospice 65+ | 123.96 | 123.96 | (0.07) | - | - | 123.89 | 0.07 |
| Elderly HCBS Waiver | $ 242.74 | $ 242.74 | $ (1.50) | $ 0.00 | $ 0.00 | $ 241.24 | $ 1.50 |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | | | | | | |
| Custodial Care Nursing Facility <65 | $ 814.20 | $ 814.20 | $ (2.39) | $ 5.28 | $ 22.50 | $ 839.59 | $ 2.39 |
| Hospice <65 | 814.20 | 814.20 | (2.39) | 5.28 | 22.50 | 839.59 | 2.39 |
| Non-Dual Skilled Nursing Facility | 2,545.58 | 2,545.58 | (0.16) | 5.28 | 60.70 | 2,611.40 | 0.16 |
| Dual HCBS Waivers: PD; H&D | 366.49 | 366.49 | (5.91) | - | - | 360.58 | 5.91 |
| Non-Dual HCBS Waivers: PD; H&D; AIDS | 1,622.81 | 1,622.81 | (2.21) | 5.28 | 38.85 | 1,664.73 | 2.21 |
| Brain Injury HCBS Waiver | $ 826.91 | $ 826.91 | $ (6.43) | $ 5.28 | $ 41.96 | $ 867.72 | $ 6.43 |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | | | | | | |
| ICF/MR | $ 489.45 | $ 489.45 | $ (0.07) | $ 5.28 | $ 10.28 | $ 504.94 | $ 0.07 |
| State Resource Center | 183.25 | 183.25 | (0.01) | 5.28 | 6.47 | 194.99 | 0.01 |
| Intellectual Disability HCBS Waiver | $ 533.61 | $ 533.61 | $ (5.91) | $ 5.28 | $ 29.99 | $ 562.97 | $ 5.91 |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | | | | | | |
| Children in a Psychiatric Mental Institute (PMIC) | $ 585.18 | $ 585.18 | $ (21.49) | $ 5.28 | $ 10.61 | $ 579.58 | $ 21.49 |
| Children's Mental Health HCBS Waiver | $ 974.90 | $ 974.90 | $ (4.71) | $ 5.28 | $ 7.22 | $ 982.69 | $ 4.71 |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | | | | | | |

State of Iowa - Department of Human Services, Division of Medical Services
Iowa Medicaid Enterprise
IA Health Link
April 1, 2016 to June 30, 2016 Capitation Rate Summary
Health Plan: Amerigroup

| Capitation Rate Cell | Gross Total State Plan plus 1915b(3) Rate | Net Base Medical Capitation | Net Base Risk Adjusted Medical Capitation | 1915b(3) | Medical Net Capitation: GME Supplemental PMPM | Medical Net Capitation: UIHC Supplemental PMPM | Net Total State Plan Rate | 1915b(3) |
|---|---|---|---|---|---|---|---|---|
| Children 0-59 days M&F | $ 1,880.15 | $ 1,807.84 | $ 1,807.84 | $ 0.00 | $ 5.28 | $ 40.14 | $ 1,853.26 | $ 0.00 |
| Children 60-364 days M&F | 233.13 | 212.11 | 212.11 | - | 5.28 | 11.42 | 228.81 | - |
| Children 1-4 M&F | 127.67 | 115.15 | 114.67 | (0.02) | 5.28 | 5.39 | 125.32 | 0.02 |
| Children 5-14 M&F | 137.05 | 126.62 | 126.09 | (0.36) | 5.28 | 3.11 | 134.12 | 0.36 |
| Children 15-20 F | 232.95 | 217.76 | 216.65 | (2.86) | 5.28 | 6.39 | 225.66 | 2.86 |
| Children 15-20 M | 209.04 | 197.26 | 196.43 | (3.99) | 5.28 | 3.32 | 201.04 | 3.99 |
| Non-Expansion Adults 21-34 F | 346.93 | 324.03 | 325.10 | (8.21) | 5.28 | 9.92 | 332.09 | 8.21 |
| Non-Expansion Adults 21-34 M | 233.67 | 218.35 | 219.07 | (1.68) | 5.28 | 4.84 | 227.51 | 1.68 |
| Non-Expansion Adults 35-49 F | 498.60 | 470.34 | 471.89 | (4.64) | 5.28 | 11.80 | 484.33 | 4.64 |
| Non-Expansion Adults 35-49 M | 415.94 | 393.14 | 394.44 | (1.47) | 5.28 | 8.17 | 406.42 | 1.47 |
| Non-Expansion Adults 50+ M&F | 591.18 | 558.87 | 560.71 | (1.81) | 5.28 | 13.75 | 577.93 | 1.81 |
| Pregnant Women | 365.17 | 331.83 | 331.83 | (5.17) | 5.28 | 21.29 | 353.23 | 5.17 |
| CHIP - Children 0-59 days M&F | $ 1,836.98 | $ 1,807.84 | $ 1,800.25 | $ 0.00 | $ 0.00 | $ 0.00 | $ 1,800.25 | $ 0.00 |
| CHIP - Children 60-364 days M&F | 215.52 | 212.11 | 211.22 | - | - | - | 211.22 | - |
| CHIP - Children 1-4 M&F | 117.00 | 115.15 | 114.67 | (0.02) | - | - | 114.65 | 0.02 |
| CHIP - Children 5-14 M&F | 126.65 | 126.62 | 126.09 | (0.36) | - | - | 125.73 | 0.36 |
| CHIP - Children 15-20 F | 221.28 | 217.76 | 216.65 | (2.86) | - | - | 213.99 | 2.86 |
| CHIP - Children 15-20 M | 200.44 | 197.26 | 196.43 | (3.99) | - | - | 192.44 | 3.99 |
| CHIP - Hawk-I | $ 155.76 | $ 152.64 | $ 152.64 | $ 0.00 | $ 0.00 | $ 0.00 | $ 152.64 | $ 0.00 |
| TANF Maternity Case Rate | $ 6,172.05 | $ 6,046.61 | $ 6,046.61 | $ 0.00 | $ 0.00 | $ 0.00 | $ 6,046.61 | $ 0.00 |
| Pregnant Women Maternity Case Rate | $ 5,468.90 | $ 5,359.53 | $ 5,359.53 | $ 0.00 | $ 0.00 | $ 0.00 | $ 5,359.53 | $ 0.00 |
| Wellness Plan 19-24 F (Medically Exempt) | $ 545.75 | $ 523.66 | $ 525.29 | $ (1.37) | $ 0.00 | $ 9.74 | $ 533.66 | $ 1.37 |
| Wellness Plan 19-24 M (Medically Exempt) | 524.84 | 507.18 | 508.85 | (0.50) | - | 5.60 | 513.95 | 0.50 |
| Wellness Plan 25-34 F (Medically Exempt) | 776.26 | 746.26 | 748.72 | (2.73) | - | 12.26 | 758.25 | 2.73 |
| Wellness Plan 25-34 M (Medically Exempt) | 767.02 | 741.15 | 743.60 | (1.25) | - | 8.24 | 750.59 | 1.25 |
| Wellness Plan 35-49 F (Medically Exempt) | 1,240.37 | 1,193.82 | 1,197.76 | (1.72) | - | 18.17 | 1,214.21 | 1.72 |
| Wellness Plan 35-49 M (Medically Exempt) | 1,199.77 | 1,158.10 | 1,161.92 | (1.11) | - | 14.13 | 1,174.94 | 1.11 |
| Wellness Plan 50+ M &F (Medically Exempt) | $ 1,558.19 | $ 1,501.41 | $ 1,506.36 | $ (0.24) | $ 0.00 | $ 21.08 | $ 1,527.20 | $ 0.24 |
| Wellness Plan 19-24 F (Non-Medically Exempt) | $ 210.66 | $ 198.20 | $ 198.85 | $ (0.53) | $ 0.00 | $ 7.75 | $ 206.07 | $ 0.53 |
| Wellness Plan 19-24 M (Non-Medically Exempt) | 200.98 | 191.96 | 192.59 | (0.19) | - | 4.46 | 196.86 | 0.19 |
| Wellness Plan 25-34 F (Non-Medically Exempt) | 289.48 | 283.00 | 283.93 | (1.04) | - | 9.75 | 292.64 | 1.04 |
| Wellness Plan 25-34 M (Non-Medically Exempt) | 294.31 | 281.06 | 281.99 | (0.48) | - | 6.56 | 288.07 | 0.48 |
| Wellness Plan 35-49 F (Non-Medically Exempt) | 478.71 | 453.47 | 454.97 | (0.65) | - | 14.46 | 468.78 | 0.65 |
| Wellness Plan 35-49 M (Non-Medically Exempt) | 461.57 | 439.86 | 441.31 | (0.43) | - | 11.25 | 452.13 | 0.43 |
| Wellness Plan 50+ M&F (Non-Medically Exempt) | $ 600.95 | $ 570.61 | $ 572.49 | $ (0.09) | $ 0.00 | $ 16.78 | $ 589.18 | $ 0.09 |
| Family Planning Waiver | $ 18.44 | $ 18.07 | $ 18.07 | $ 0.00 | $ 0.00 | $ 0.00 | $ 18.07 | $ 0.00 |
| ABD Non-Dual <21 M&F | $ 637.52 | $ 605.96 | $ 607.66 | $ (2.46) | $ 5.28 | $ 12.18 | $ 622.68 | $ 2.46 |
| ABD Non-Dual 21+ M&F | 1,202.90 | 1,141.53 | 1,147.92 | (9.57) | 5.28 | 26.27 | 1,169.90 | 9.57 |
| Breast and Cervical Cancer | 1,750.06 | 1,693.84 | 1,693.27 | (1.17) | - | 22.24 | 1,714.34 | 1.17 |
| Residential Care Facility | $ 1,844.29 | $ 1,791.03 | $ 1,791.03 | $ (31.10) | $ 5.28 | $ 11.43 | $ 1,776.64 | $ 31.10 |
| Dual Eligible 0-64 M&F | $ 458.35 | $ 449.18 | $ 449.18 | $ (14.88) | $ 0.00 | $ 0.00 | $ 434.30 | $ 14.88 |
| Dual Eligible 65+ M&F | $ 229.61 | $ 225.01 | $ 225.01 | $ (1.13) | $ 0.00 | $ 0.00 | $ 223.88 | $ 1.13 |
| Custodial Care Nursing Facility 65+ | $ 123.96 | $ 121.48 | $ 121.48 | $ (0.07) | $ 0.00 | $ 0.00 | $ 121.41 | $ 0.07 |
| Hospice 65+ | 123.96 | 121.48 | 121.48 | (0.07) | - | - | 121.41 | 0.07 |
| Elderly HCBS Waiver | $ 242.74 | $ 237.89 | $ 237.89 | $ (1.47) | $ 0.00 | $ 0.00 | $ 236.42 | $ 1.47 |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | | | | | | | |
| Custodial Care Nursing Facility <65 | $ 841.98 | $ 797.91 | $ 797.91 | $ (2.35) | $ 5.28 | $ 22.50 | $ 823.34 | $ 2.35 |
| Hospice <65 | 841.98 | 797.91 | 797.91 | (2.35) | 5.28 | 22.50 | 823.34 | 2.35 |
| Non-Dual Skilled Nursing Facility | 2,511.56 | 2,484.67 | 2,484.67 | (0.16) | 5.28 | 60.70 | 2,560.49 | 0.16 |
| Dual HCBS Waivers: PD; H&D | 368.49 | 359.16 | 359.16 | (5.79) | - | - | 353.37 | 5.79 |
| Non-Dual HCBS Waivers: PD; H&D; AIDS | 1,666.94 | 1,590.35 | 1,590.35 | (2.17) | 5.28 | 38.85 | 1,632.31 | 2.17 |
| Brain Injury HCBS Waiver | $ 874.15 | $ 810.37 | $ 810.37 | $ (5.30) | $ 5.28 | $ 41.96 | $ 851.31 | $ 5.30 |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | | | | | | | |
| ICF/MR | $ 505.01 | $ 479.66 | $ 479.66 | $ (0.07) | $ 5.28 | $ 10.28 | $ 495.15 | $ 0.07 |
| State Resource Center | 195.00 | 179.58 | 179.58 | (0.01) | 5.28 | 6.47 | 191.32 | 0.01 |
| Intellectual Disability HCBS Waiver | $ 568.88 | $ 522.94 | $ 522.94 | $ (5.79) | $ 5.28 | $ 29.99 | $ 552.42 | $ 5.79 |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | | | | | | | |
| Children in a Psychiatric Mental Institute (PMIC) | $ 601.07 | $ 573.48 | $ 573.48 | $ (21.06) | $ 5.28 | $ 10.61 | $ 568.31 | $ 21.06 |
| Children's Mental Health HCBS Waiver | $ 987.40 | $ 955.40 | $ 955.40 | $ (4.62) | $ 5.28 | $ 7.22 | $ 963.28 | $ 4.62 |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | | | | | | | |

State of Iowa - Department of Human Services, Division of Medical Services
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| Capitation Rate Cell | Total Paid Medical Rate | LTSS Gross Capitation: Gross Base LTSS Capitation | LTSS Gross Capitation: Gross Base Risk Adjusted LTSS Capitation | LTSS net Capitation: Net Base LTSS Capitation | LTSS net Capitation: Total Paid LTSS Rate |
|---|---|---|---|---|---|
| Children 0-59 days M&F | $ 1,853.26 | N/A | N/A | N/A | N/A |
| Children 60-364 days M&F | 228.81 | N/A | N/A | N/A | N/A |
| Children 1-4 M&F | 125.34 | N/A | N/A | N/A | N/A |
| Children 5-14 M&F | 134.48 | N/A | N/A | N/A | N/A |
| Children 15-20 F | 226.52 | N/A | N/A | N/A | N/A |
| Children 15-20 M | 205.03 | N/A | N/A | N/A | N/A |
| Non-Expansion Adults 21-34 F | 340.30 | N/A | N/A | N/A | N/A |
| Non-Expansion Adults 21-34 M | 229.19 | N/A | N/A | N/A | N/A |
| Non-Expansion Adults 35-49 F | 488.97 | N/A | N/A | N/A | N/A |
| Non-Expansion Adults 35-49 M | 407.89 | N/A | N/A | N/A | N/A |
| Non-Expansion Adults 50+ M&F | 579.74 | N/A | N/A | N/A | N/A |
| Pregnant Women | 358.40 | N/A | N/A | N/A | N/A |
| CHIP - Children 0-59 days M&F | $ 1,800.25 | N/A | N/A | N/A | N/A |
| CHIP - Children 60-364 days M&F | 211.22 | N/A | N/A | N/A | N/A |
| CHIP - Children 1-4 M&F | 114.67 | N/A | N/A | N/A | N/A |
| CHIP - Children 5-14 M&F | 126.09 | N/A | N/A | N/A | N/A |
| CHIP - Children 15-20 F | 216.85 | N/A | N/A | N/A | N/A |
| CHIP - Children 15-20 M | 196.43 | N/A | N/A | N/A | N/A |
| CHIP - Hawk-I | $ 152.64 | N/A | N/A | N/A | N/A |
| TANF Maternity Case Rate | $ 6,048.61 | N/A | N/A | N/A | N/A |
| Pregnant Women Maternity Case Rate | $ 5,359.53 | N/A | N/A | N/A | N/A |
| Wellness Plan 19-24 F (Medically Exempt) | $ 535.03 | N/A | N/A | N/A | N/A |
| Wellness Plan 19-24 M (Medically Exempt) | 514.45 | N/A | N/A | N/A | N/A |
| Wellness Plan 25-34 F (Medically Exempt) | 760.98 | N/A | N/A | N/A | N/A |
| Wellness Plan 25-34 M (Medically Exempt) | 751.84 | N/A | N/A | N/A | N/A |
| Wellness Plan 35-49 F (Medically Exempt) | 1,215.93 | N/A | N/A | N/A | N/A |
| Wellness Plan 35-49 M (Medically Exempt) | 1,176.06 | N/A | N/A | N/A | N/A |
| Wellness Plan 50+ M &F (Medically Exempt) | $ 1,527.44 | N/A | N/A | N/A | N/A |
| Wellness Plan 19-24 F (Non-Medically Exempt) | $ 206.60 | N/A | N/A | N/A | N/A |
| Wellness Plan 19-24 M (Non-Medically Exempt) | 197.05 | N/A | N/A | N/A | N/A |
| Wellness Plan 25-34 F (Non-Medically Exempt) | 293.68 | N/A | N/A | N/A | N/A |
| Wellness Plan 25-34 M (Non-Medically Exempt) | 288.55 | N/A | N/A | N/A | N/A |
| Wellness Plan 35-49 F (Non-Medically Exempt) | 469.43 | N/A | N/A | N/A | N/A |
| Wellness Plan 35-49 M (Non-Medically Exempt) | 452.56 | N/A | N/A | N/A | N/A |
| Wellness Plan 50+ M&F (Non-Medically Exempt) | $ 589.27 | N/A | N/A | N/A | N/A |
| Family Planning Waiver | $ 18.07 | N/A | N/A | N/A | N/A |
| ABD Non-Dual <21 M&F | $ 625.12 | N/A | N/A | N/A | N/A |
| ABD Non-Dual 21+ M&F | 1,179.47 | N/A | N/A | N/A | N/A |
| Breast and Cervical Cancer | 1,715.51 | N/A | N/A | N/A | N/A |
| Residential Care Facility | $ 1,807.74 | N/A | N/A | N/A | N/A |
| Dual Eligible 0-64 M&F | $ 449.18 | N/A | N/A | N/A | N/A |
| Dual Eligible 65+ M&F | $ 225.01 | N/A | N/A | N/A | N/A |
| Custodial Care Nursing Facility 65+ | $ 121.48 | N/A | N/A | N/A | N/A |
| Hospice 65+ | 121.48 | N/A | N/A | N/A | N/A |
| Elderly HCBS Waiver | $ 237.89 | N/A | N/A | N/A | N/A |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | $ 3,288.97 | $ 3,268.58 | $ 3,223.19 | $ 3,203.21 |
| Custodial Care Nursing Facility <65 | $ 825.69 | N/A | N/A | N/A | N/A |
| Hospice <65 | 825.69 | N/A | N/A | N/A | N/A |
| Non-Dual Skilled Nursing Facility | 2,560.65 | N/A | N/A | N/A | N/A |
| Dual HCBS Waivers: PD; H&D | 359.16 | N/A | N/A | N/A | N/A |
| Non-Dual HCBS Waivers: PD; H&D; AIDS | 1,634.48 | N/A | N/A | N/A | N/A |
| Brain Injury HCBS Waiver | $ 857.61 | N/A | N/A | N/A | N/A |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | $ 3,437.37 | $ 3,346.62 | $ 3,368.62 | $ 3,279.69 |
| ICF/MR | $ 495.22 | N/A | N/A | N/A | N/A |
| State Resource Center | 191.33 | N/A | N/A | N/A | N/A |
| Intellectual Disability HCBS Waiver | $ 556.21 | N/A | N/A | N/A | N/A |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | $ 6,736.38 | $ 6,453.45 | $ 6,601.65 | $ 6,324.38 |
| Children in a Psychiatric Mental Institute (PMIC) | $ 569.37 | N/A | N/A | N/A | N/A |
| Children's Mental Health HCBS Waiver | $ 967.90 | N/A | N/A | N/A | N/A |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | $ 2,979.86 | $ 3,006.08 | $ 2,920.26 | $ 2,945.96 |

State of Iowa - Department of Human Services, Division of Medical Services
Iowa Medicaid Enterprise
IA Health Link
July 1, 2016 to June 30, 2017 Capitation Rate Summary
Health Plan: Amerigroup

| Capitation Rate Cell | Medical Gross Capitation: Gross Base Medical Capitation | Gross Base Risk Adjusted Medical Capitation | 1915b(3) | GME Supplemental PMPM | UIHC Supplemental PMPM | Gross Total State Plan Rate | 1915b(3) |
|---|---|---|---|---|---|---|---|
| Children 0-59 days M&F | $ 1,844.90 | $ 1,844.90 | $ 0.00 | $ 5.28 | $ 40.14 | $ 1,890.32 | $ 0.00 |
| Children 60-364 days M&F | 216.52 | 216.52 | - | 5.28 | 11.42 | 233.22 | - |
| Children 1-4 M&F | 117.53 | 117.04 | (0.02) | 5.28 | 5.39 | 127.69 | 0.02 |
| Children 5-14 M&F | 129.20 | 128.66 | (0.36) | 5.28 | 3.11 | 136.69 | 0.36 |
| Children 15-20 F | 222.21 | 221.28 | (2.91) | 5.28 | 6.39 | 230.04 | 2.91 |
| Children 15-20 M | 201.29 | 200.44 | (4.08) | 5.28 | 3.32 | 204.96 | 4.08 |
| Non-Expansion Adults 21-34 F | 330.64 | 331.73 | (8.37) | 5.28 | 9.92 | 336.56 | 8.37 |
| Non-Expansion Adults 21-34 M | 222.83 | 223.57 | (1.71) | 5.28 | 4.84 | 231.98 | 1.71 |
| Non-Expansion Adults 35-49 F | 479.97 | 481.55 | (4.74) | 5.28 | 11.80 | 493.89 | 4.74 |
| Non-Expansion Adults 35-49 M | 401.19 | 402.51 | (1.50) | 5.28 | 8.17 | 414.46 | 1.50 |
| Non-Expansion Adults 50+ M&F | 570.45 | 572.33 | (1.84) | 5.28 | 13.75 | 589.52 | 1.84 |
| Pregnant Women | 338.63 | 338.63 | (5.27) | 5.28 | 21.29 | 359.93 | 5.27 |
| CHIP - Children 0-59 days M&F | $ 1,844.90 | $ 1,837.15 | $ 0.00 | $ 0.00 | $ 0.00 | $ 1,837.15 | $ 0.00 |
| CHIP - Children 60-364 days M&F | 216.52 | 215.61 | - | - | - | 215.61 | - |
| CHIP - Children 1-4 M&F | 117.53 | 117.04 | (0.02) | - | - | 117.02 | 0.02 |
| CHIP - Children 5-14 M&F | 129.20 | 128.66 | (0.36) | - | - | 128.30 | 0.36 |
| CHIP - Children 15-20 F | 222.21 | 221.28 | (2.91) | - | - | 218.37 | 2.91 |
| CHIP - Children 15-20 M | 201.29 | 200.44 | (4.08) | - | - | 196.36 | 4.08 |
| CHIP - Hawk-i | $ 155.76 | $ 155.76 | $ 0.00 | $ 0.00 | $ 0.00 | $ 155.76 | $ 0.00 |
| TANF Maternity Case Rate | $ 6,172.05 | $ 6,172.05 | $ 0.00 | $ 0.00 | $ 0.00 | $ 6,172.05 | $ 0.00 |
| Pregnant Women Maternity Case Rate | $ 5,468.90 | $ 5,468.90 | $ 0.00 | $ 0.00 | $ 0.00 | $ 5,468.90 | $ 0.00 |
| Wellness Plan 19-24 F (Medically Exempt) | $ 534.28 | $ 536.04 | $ (1.41) | $ 0.00 | $ 9.74 | $ 544.37 | $ 1.41 |
| Wellness Plan 19-24 M (Medically Exempt) | 517.56 | 519.27 | (0.51) | - | 5.60 | 524.36 | 0.51 |
| Wellness Plan 25-34 F (Medically Exempt) | 761.54 | 764.05 | (2.78) | - | 12.26 | 773.53 | 2.78 |
| Wellness Plan 25-34 M (Medically Exempt) | 756.36 | 758.86 | (1.27) | - | 8.24 | 765.83 | 1.27 |
| Wellness Plan 35-49 F (Medically Exempt) | 1,218.21 | 1,222.23 | (1.74) | - | 18.17 | 1,238.66 | 1.74 |
| Wellness Plan 35-49 M (Medically Exempt) | 1,181.79 | 1,185.69 | (1.13) | - | 14.13 | 1,198.69 | 1.13 |
| Wellness Plan 50+ M &F (Medically Exempt) | $ 1,532.23 | $ 1,537.29 | $ (0.23) | $ 0.00 | $ 21.08 | $ 1,558.14 | $ 0.23 |
| Wellness Plan 19-24 F (Non-Medically Exempt) | $ 202.25 | $ 202.92 | $ (0.54) | $ 0.00 | $ 7.75 | $ 210.13 | $ 0.54 |
| Wellness Plan 19-24 M (Non-Medically Exempt) | 196.88 | 196.53 | (0.19) | - | 4.46 | 200.80 | 0.19 |
| Wellness Plan 25-34 F (Non-Medically Exempt) | 288.80 | 289.75 | (1.06) | - | 9.75 | 298.44 | 1.06 |
| Wellness Plan 25-34 M (Non-Medically Exempt) | 286.83 | 287.78 | (0.48) | - | 6.56 | 293.86 | 0.48 |
| Wellness Plan 35-49 F (Non-Medically Exempt) | 462.73 | 464.26 | (0.66) | - | 14.46 | 478.06 | 0.66 |
| Wellness Plan 35-49 M (Non-Medically Exempt) | 448.86 | 450.34 | (0.43) | - | 11.25 | 461.16 | 0.43 |
| Wellness Plan 50+ M&F (Non-Medically Exempt) | $ 582.32 | $ 584.24 | $ (0.09) | $ 0.00 | $ 16.78 | $ 600.93 | $ 0.09 |
| Family Planning Waiver | $ 18.44 | $ 18.44 | $ 0.00 | $ 0.00 | $ 0.00 | $ 18.44 | $ 0.00 |
| ABD Non-Dual <21 M&F | $ 619.19 | $ 620.92 | $ (2.51) | $ 5.28 | $ 12.18 | $ 635.87 | $ 2.51 |
| ABD Non-Dual 21+ M&F | 1,165.38 | 1,171.91 | (9.76) | 5.28 | 26.27 | 1,193.70 | 9.76 |
| Breast and Cervical Cancer | 1,718.47 | 1,725.09 | (1.20) | - | 22.24 | 1,749.13 | 1.20 |
| Residential Care Facility | $ 1,826.06 | $ 1,826.06 | $ (31.73) | $ 5.28 | $ 11.43 | $ 1,813.04 | $ 31.73 |
| Dual Eligible 0-64 M&F | $ 458.79 | $ 458.79 | $ (15.18) | $ 0.00 | $ 0.00 | $ 443.61 | $ 15.18 |
| Dual Eligible 65+ M&F | $ 229.92 | $ 229.92 | $ (1.15) | $ 0.00 | $ 0.00 | $ 228.77 | $ 1.15 |
| Custodial Care Nursing Facility 65+ | $ 123.96 | $ 123.96 | $ (0.07) | $ 0.00 | $ 0.00 | $ 123.89 | $ 0.07 |
| Hospice 65+ | 123.96 | 123.96 | (0.07) | - | - | 123.89 | 0.07 |
| Elderly HCBS Waiver | $ 242.74 | $ 242.74 | $ (1.50) | $ 0.00 | $ 0.00 | $ 241.24 | $ 1.50 |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | | | | | | |
| Custodial Care Nursing Facility <65 | $ 814.20 | $ 814.20 | $ (2.39) | $ 5.28 | $ 22.50 | $ 839.59 | $ 2.39 |
| Hospice <65 | 814.20 | 814.20 | (2.39) | 5.28 | 22.50 | 839.59 | 2.39 |
| Non-Dual Skilled Nursing Facility | 2,545.58 | 2,545.58 | (0.16) | 5.28 | 60.70 | 2,611.40 | 0.16 |
| Dual HCBS Waivers: PD; H&D | 366.49 | 366.49 | (5.91) | - | - | 360.58 | 5.91 |
| Non-Dual HCBS Waivers: PD; H&D; AIDS | 1,622.81 | 1,622.81 | (2.21) | 5.28 | 38.85 | 1,664.73 | 2.21 |
| Brain Injury HCBS Waiver | $ 826.91 | $ 826.91 | $ (6.43) | $ 5.28 | $ 41.99 | $ 867.72 | $ 6.43 |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | | | | | | |
| ICF/MR | $ 489.45 | $ 489.45 | $ (0.07) | $ 5.28 | $ 10.28 | $ 504.94 | $ 0.07 |
| State Resource Center | 183.25 | 183.25 | (0.01) | 5.28 | 6.47 | 194.99 | 0.01 |
| Intellectual Disability HCBS Waiver | $ 533.61 | $ 533.61 | $ (5.91) | $ 5.28 | $ 29.99 | $ 562.97 | $ 5.91 |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | | | | | | |
| Children in a Psychiatric Mental Institute (PMIC) | $ 585.18 | $ 585.18 | $ (21.49) | $ 5.28 | $ 10.61 | $ 579.58 | $ 21.49 |
| Children's Mental Health HCBS Waiver | $ 974.90 | $ 974.90 | $ (4.71) | $ 5.28 | $ 7.22 | $ 982.69 | $ 4.71 |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | | | | | | |

State of Iowa - Department of Human Services, Division of Medical Services
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Health Plan: Amerigroup

| Capitation Rate Cell | Gross Total State Plan plus 1915b(3) Rate | Net Base Medical Capitation | Net Base Risk Adjusted Medical Capitation | 1915b(3) | Medical Net Capitation GME Supplemental PMPM | UIHC Supplemental PMPM | Net Total State Plan Rate | 1915b(3) |
|---|---|---|---|---|---|---|---|---|
| Children 0-59 days M&F | $ 1,890.32 | $ 1,808.01 | $ 1,808.01 | $ 0.00 | $ 5.28 | $ 40.14 | $ 1,853.43 | $ 0.00 |
| Children 60-364 days M&F | 233.22 | 212.18 | 212.18 | - | 5.28 | 11.42 | 228.88 | - |
| Children 1-4 M&F | 127.71 | 115.19 | 114.71 | (0.02) | 5.28 | 5.39 | 125.36 | 0.02 |
| Children 5-14 M&F | 137.05 | 126.62 | 126.09 | (0.36) | 5.28 | 3.11 | 134.12 | 0.36 |
| Children 15-20 F | 232.95 | 217.76 | 216.85 | (2.86) | 5.28 | 6.39 | 225.66 | 2.86 |
| Children 15-20 M | 209.04 | 197.26 | 196.43 | (3.99) | 5.28 | 3.32 | 201.04 | 3.99 |
| Non-Expansion Adults 21-34 F | 346.93 | 324.03 | 325.10 | (8.21) | 5.28 | 9.92 | 332.09 | 8.21 |
| Non-Expansion Adults 21-34 M | 233.69 | 218.37 | 219.09 | (1.68) | 5.28 | 4.84 | 227.53 | 1.68 |
| Non-Expansion Adults 35-49 F | 495.63 | 470.37 | 471.92 | (4.64) | 5.28 | 11.80 | 484.36 | 4.64 |
| Non-Expansion Adults 35-49 M | 415.96 | 393.16 | 394.46 | (1.47) | 5.28 | 8.17 | 406.44 | 1.47 |
| Non-Expansion Adults 50+ M&F | 591.36 | 559.03 | 560.87 | (1.81) | 5.28 | 13.75 | 578.09 | 1.81 |
| Pregnant Women | 355.20 | 331.86 | 331.86 | (5.17) | 5.28 | 21.29 | 353.26 | 5.17 |
| CHIP - Children 0-59 days M&F | $ 1,837.15 | $ 1,808.01 | $ 1,808.42 | $ 0.00 | $ 0.00 | $ 0.00 | $ 1,808.42 | $ 0.00 |
| CHIP - Children 60-364 days M&F | 215.61 | 212.18 | 211.29 | - | - | - | 211.29 | - |
| CHIP - Children 1-4 M&F | 117.04 | 115.19 | 114.71 | (0.02) | - | - | 114.69 | 0.02 |
| CHIP - Children 5-14 M&F | 126.56 | 126.62 | 126.09 | (0.36) | - | - | 125.73 | 0.36 |
| CHIP - Children 15-20 F | 221.28 | 217.76 | 216.85 | (2.86) | - | - | 213.99 | 2.86 |
| CHIP - Children 15-20 M | 200.44 | 197.26 | 196.43 | (3.99) | - | - | 192.44 | 3.99 |
| CHIP - Hawk-I | $ 155.76 | $ 152.64 | $ 152.64 | $ 0.00 | $ 0.00 | $ 0.00 | $ 152.64 | $ 0.00 |
| TANF Maternity Case Rate | $ 6,172.05 | $ 6,048.61 | $ 6,048.61 | $ 0.00 | $ 0.00 | $ 0.00 | $ 6,048.61 | $ 0.00 |
| Pregnant Women Maternity Case Rate | $ 5,468.90 | $ 5,359.53 | $ 5,359.53 | $ 0.00 | $ 0.00 | $ 0.00 | $ 5,359.53 | $ 0.00 |
| Wellness Plan 19-24 F (Medically Exempt) | $ 545.78 | $ 523.60 | $ 525.33 | $ (1.37) | $ 0.00 | $ 9.74 | $ 533.70 | $ 1.37 |
| Wellness Plan 19-24 M (Medically Exempt) | 524.87 | 507.21 | 508.88 | (0.60) | - | 5.60 | 513.88 | 0.60 |
| Wellness Plan 25-34 F (Medically Exempt) | 776.31 | 746.31 | 748.77 | (2.73) | - | 12.26 | 758.30 | 2.73 |
| Wellness Plan 25-34 M (Medically Exempt) | 767.10 | 741.23 | 743.68 | (1.25) | - | 8.24 | 750.67 | 1.25 |
| Wellness Plan 35-49 F (Medically Exempt) | 1,240.40 | 1,193.84 | 1,197.78 | (1.72) | - | 18.17 | 1,214.23 | 1.72 |
| Wellness Plan 35-49 M (Medically Exempt) | 1,199.82 | 1,158.16 | 1,161.98 | (1.11) | - | 14.13 | 1,175.00 | 1.11 |
| Wellness Plan 50+ M &F (Medically Exempt) | $ 1,558.37 | $ 1,501.59 | $ 1,506.55 | $ (0.24) | $ 0.00 | $ 21.08 | $ 1,527.39 | $ 0.24 |
| Wellness Plan 19-24 F (Non-Medically Exempt) | $ 210.67 | $ 198.21 | $ 198.86 | $ (0.53) | $ 0.00 | $ 7.75 | $ 206.08 | $ 0.53 |
| Wellness Plan 19-24 M (Non-Medically Exempt) | 200.99 | 191.97 | 192.60 | (0.19) | - | 4.46 | 196.87 | 0.19 |
| Wellness Plan 25-34 F (Non-Medically Exempt) | 299.50 | 283.02 | 283.95 | (1.04) | - | 9.75 | 292.66 | 1.04 |
| Wellness Plan 25-34 M (Non-Medically Exempt) | 294.34 | 281.09 | 282.02 | (0.48) | - | 6.56 | 288.10 | 0.48 |
| Wellness Plan 35-49 F (Non-Medically Exempt) | 478.72 | 453.46 | 454.98 | (0.65) | - | 14.46 | 468.79 | 0.65 |
| Wellness Plan 35-49 M (Non-Medically Exempt) | 461.59 | 439.88 | 441.33 | (0.43) | - | 11.25 | 452.15 | 0.43 |
| Wellness Plan 50+ M&F (Non-Medically Exempt) | $ 601.02 | $ 570.68 | $ 572.56 | $ (0.09) | $ 0.00 | $ 16.78 | $ 589.25 | $ 0.09 |
| Family Planning Waiver | $ 18.44 | $ 18.07 | $ 18.07 | $ 0.00 | $ 0.00 | $ 0.00 | $ 18.07 | $ 0.00 |
| ABD Non-Dual <21 M&F | $ 636.36 | $ 606.81 | $ 608.51 | $ (2.46) | $ 5.28 | $ 12.18 | $ 623.51 | $ 2.46 |
| ABD Non-Dual 21+ M&F | 1,203.46 | 1,142.07 | 1,148.47 | (9.57) | 5.28 | 26.27 | 1,170.45 | 9.57 |
| Breast and Cervical Cancer | 1,750.33 | 1,684.10 | 1,693.53 | (1.17) | - | 22.24 | 1,714.60 | 1.17 |
| Residential Care Facility | $ 1,844.77 | $ 1,791.50 | $ 1,791.50 | $ (31.10) | $ 5.28 | $ 11.43 | $ 1,777.11 | $ 31.10 |
| Dual Eligible 0-64 M&F | $ 458.79 | $ 449.62 | $ 449.62 | $ (14.88) | $ 0.00 | $ 0.00 | $ 434.74 | $ 14.88 |
| Dual Eligible 65+ M&F | $ 229.92 | $ 225.32 | $ 225.32 | $ (1.13) | $ 0.00 | $ 0.00 | $ 224.19 | $ 1.13 |
| Custodial Care Nursing Facility 65+ | $ 123.96 | $ 121.48 | $ 121.48 | $ (0.07) | $ 0.00 | $ 0.00 | $ 121.41 | $ 0.07 |
| Hospice 65+ | 123.96 | 121.48 | 121.48 | (0.07) | - | - | 121.41 | 0.07 |
| Elderly HCBS Waiver | $ 242.74 | $ 237.89 | $ 237.89 | $ (1.47) | $ 0.00 | $ 0.00 | $ 236.42 | $ 1.47 |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | | | | | | | |
| Custodial Care Nursing Facility <65 | $ 841.98 | $ 797.91 | $ 797.91 | $ (2.35) | $ 5.28 | $ 22.50 | $ 823.34 | $ 2.35 |
| Hospice <65 | 841.98 | 797.91 | 797.91 | (2.35) | 5.28 | 22.50 | 823.34 | 2.35 |
| Non-Dual Skilled Nursing Facility | 2,611.65 | 2,494.67 | 2,494.67 | (0.16) | 5.28 | 60.70 | 2,560.49 | 0.16 |
| Dual HCBS Waivers: PD; H&D | 366.49 | 359.16 | 359.16 | (5.79) | - | - | 353.37 | 5.79 |
| Non-Dual HCBS Waivers: PD; H&D; AIDS | 1,668.94 | 1,590.35 | 1,590.35 | (2.17) | 5.28 | 38.85 | 1,632.31 | 2.17 |
| Brain Injury HCBS Waiver | $ 874.15 | $ 810.37 | $ 810.37 | $ (6.30) | $ 5.28 | $ 41.96 | $ 851.31 | $ 6.30 |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | | | | | | | |
| ICF/MR | $ 505.01 | $ 479.66 | $ 479.66 | $ (0.07) | $ 5.28 | $ 10.28 | $ 495.15 | $ 0.07 |
| State Resource Center | 195.00 | 179.58 | 179.58 | (0.01) | 5.28 | 6.47 | 191.32 | 0.01 |
| Intellectual Disability HCBS Waiver | $ 568.88 | $ 522.94 | $ 522.94 | $ (5.79) | $ 5.28 | $ 29.99 | $ 552.42 | $ 5.79 |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | | | | | | | |
| Children in a Psychiatric Mental Institute (PMIC) | $ 601.07 | $ 573.48 | $ 573.48 | $ (21.06) | $ 5.28 | $ 10.61 | $ 568.31 | $ 21.06 |
| Children's Mental Health HCBS Waiver | $ 967.40 | $ 955.40 | $ 955.40 | $ (4.62) | $ 5.28 | $ 7.22 | $ 963.28 | $ 4.62 |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | | | | | | | |

State of Iowa - Department of Human Services, Division of Medical Services
Iowa Medicaid Enterprise
IA Health Link
July 1, 2016 to June 30, 2017 Capitation Rate Summary
Health Plan: Amerigroup

| | | LTSS Gross Capitation | | LTSS net Capitation | |
|---|---|---|---|---|---|
| Capitation Rate Cell | Total Paid Medical Rate | Gross Base LTSS Capitation | Gross Base Risk Adjusted LTSS Capitation | Net Base LTSS Capitation | Total Paid LTSS Rate |
| Children 0-59 days M&F | $ 1,853.43 | N/A | N/A | N/A | N/A |
| Children 60-364 days M&F | 228.88 | N/A | N/A | N/A | N/A |
| Children 1-4 M&F | 125.38 | N/A | N/A | N/A | N/A |
| Children 5-14 M&F | 134.46 | N/A | N/A | N/A | N/A |
| Children 15-20 F | 228.52 | N/A | N/A | N/A | N/A |
| Children 15-20 M | 205.03 | N/A | N/A | N/A | N/A |
| Non-Expansion Adults 21-34 F | 340.30 | N/A | N/A | N/A | N/A |
| Non-Expansion Adults 21-34 M | 229.21 | N/A | N/A | N/A | N/A |
| Non-Expansion Adults 35-49 F | 469.00 | N/A | N/A | N/A | N/A |
| Non-Expansion Adults 35-49 M | 407.91 | N/A | N/A | N/A | N/A |
| Non-Expansion Adults 50+ M&F | 579.90 | N/A | N/A | N/A | N/A |
| Pregnant Women | 358.43 | N/A | N/A | N/A | N/A |
| CHIP - Children 0-59 days M&F | $ 1,800.42 | N/A | N/A | N/A | N/A |
| CHIP - Children 60-364 days M&F | 211.29 | N/A | N/A | N/A | N/A |
| CHIP - Children 1-4 M&F | 114.71 | N/A | N/A | N/A | N/A |
| CHIP - Children 5-14 M&F | 126.09 | N/A | N/A | N/A | N/A |
| CHIP - Children 15-20 F | 216.85 | N/A | N/A | N/A | N/A |
| CHIP - Children 15-20 M | 196.43 | N/A | N/A | N/A | N/A |
| CHIP - Hawk-i | $ 152.64 | N/A | N/A | N/A | N/A |
| TANF Maternity Case Rate | $ 6,046.61 | N/A | N/A | N/A | N/A |
| Pregnant Women Maternity Case Rate | $ 5,359.53 | N/A | N/A | N/A | N/A |
| Wellness Plan 19-24 F (Medically Exempt) | $ 535.07 | N/A | N/A | N/A | N/A |
| Wellness Plan 19-24 M (Medically Exempt) | 514.48 | N/A | N/A | N/A | N/A |
| Wellness Plan 25-34 F (Medically Exempt) | 761.03 | N/A | N/A | N/A | N/A |
| Wellness Plan 25-34 M (Medically Exempt) | 751.92 | N/A | N/A | N/A | N/A |
| Wellness Plan 35-49 F (Medically Exempt) | 1,215.95 | N/A | N/A | N/A | N/A |
| Wellness Plan 35-49 M (Medically Exempt) | 1,176.11 | N/A | N/A | N/A | N/A |
| Wellness Plan 50+ M &F (Medically Exempt) | $ 1,527.63 | N/A | N/A | N/A | N/A |
| Wellness Plan 19-24 F (Non-Medically Exempt) | $ 206.61 | N/A | N/A | N/A | N/A |
| Wellness Plan 19-24 M (Non-Medically Exempt) | 197.06 | N/A | N/A | N/A | N/A |
| Wellness Plan 25-34 F (Non-Medically Exempt) | 293.70 | N/A | N/A | N/A | N/A |
| Wellness Plan 25-34 M (Non-Medically Exempt) | 288.58 | N/A | N/A | N/A | N/A |
| Wellness Plan 35-49 F (Non-Medically Exempt) | 469.44 | N/A | N/A | N/A | N/A |
| Wellness Plan 35-49 M (Non-Medically Exempt) | 452.58 | N/A | N/A | N/A | N/A |
| Wellness Plan 50+ M&F (Non-Medically Exempt) | $ 589.34 | N/A | N/A | N/A | N/A |
| Family Planning Waiver | $ 18.07 | N/A | N/A | N/A | N/A |
| ABD Non-Dual <21 M&F | $ 625.97 | N/A | N/A | N/A | N/A |
| ABD Non-Dual 21+ M&F | 1,180.02 | N/A | N/A | N/A | N/A |
| Breast and Cervical Cancer | 1,715.77 | N/A | N/A | N/A | N/A |
| Residential Care Facility | $ 1,808.21 | N/A | N/A | N/A | N/A |
| Dual Eligible 0-64 M&F | $ 449.62 | N/A | N/A | N/A | N/A |
| Dual Eligible 65+ M&F | $ 225.32 | N/A | N/A | N/A | N/A |
| Custodial Care Nursing Facility 65+ | $ 121.48 | N/A | N/A | N/A | N/A |
| Hospice 65+ | 121.48 | N/A | N/A | N/A | N/A |
| Elderly HCBS Waiver | $ 237.89 | N/A | N/A | N/A | N/A |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | $ 3,294.73 | $ 3,274.30 | $ 3,228.84 | $ 3,208.82 |
| Custodial Care Nursing Facility <65 | $ 825.69 | N/A | N/A | N/A | N/A |
| Hospice <65 | 825.69 | N/A | N/A | N/A | N/A |
| Non-Dual Skilled Nursing Facility | 2,560.65 | N/A | N/A | N/A | N/A |
| Dual HCBS Waivers: PD; H&D | 359.18 | N/A | N/A | N/A | N/A |
| Non-Dual HCBS Waivers: PD; H&D; AIDS | 1,634.48 | N/A | N/A | N/A | N/A |
| Brain Injury HCBS Waiver | $ 857.61 | N/A | N/A | N/A | N/A |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | $ 3,449.18 | $ 3,358.12 | $ 3,380.20 | $ 3,290.96 |
| ICF/MR | $ 495.22 | N/A | N/A | N/A | N/A |
| State Resource Center | 191.33 | N/A | N/A | N/A | N/A |
| Intellectual Disability HCBS Waiver | $ 558.21 | N/A | N/A | N/A | N/A |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | $ 6,754.41 | $ 6,470.72 | $ 6,619.32 | $ 6,341.31 |
| Children in a Psychiatric Mental Institute (PMIC) | $ 589.37 | N/A | N/A | N/A | N/A |
| Children's Mental Health HCBS Waiver | $ 967.90 | N/A | N/A | N/A | N/A |
| LTSS with MCO-Specific Rebalancing and Risk Adjustment | | $ 2,983.89 | $ 3,009.95 | $ 2,924.02 | $ 2,949.75 |

State of Iowa - Department of Human Services, Division of Medical Assistance
IA Health Link
LTSS Services Risk Corridor Benchmark PMPMs

8/30/2017

*April to June 2016*

| Rate Cell Grouping | Capitation Rate | Net of Admin | Risk Adjustment Factors | | | LTSS Risk Corridor PMPM Benchmarks | | |
|---|---|---|---|---|---|---|---|---|
| | | | Amerigroup | AmeriHealth | United | Amerigroup | AmeriHealth | United |
| Custodial Care Nursing Facility 65+ | $4,285.11 | $4,210.11 | 0.9965 | 0.9951 | 1.0107 | $4,195.37 | $4,189.48 | $4,255.16 |
| Hospice 65+ | 3,143.51 | 3,068.51 | 1.0000 | 1.0000 | 1.0000 | 3,068.51 | 3,068.51 | 3,068.51 |
| Elderly HCBS Waiver | 1,106.45 | 956.45 | 0.9689 | 1.0102 | 0.9755 | 926.70 | 966.21 | 933.02 |
| Custodial Care Nursing Facility <65 | $4,855.82 | $4,780.82 | 0.9886 | 0.9912 | 1.0263 | $4,726.32 | $4,738.75 | $4,906.56 |
| Hospice <65 | 3,052.78 | 2,977.78 | 1.0000 | 1.0000 | 1.0000 | 2,977.78 | 2,977.78 | 2,977.78 |
| Non-Dual Skilled Nursing Facility | 22,611.64 | 22,536.64 | 1.0000 | 1.0000 | 1.0000 | 22,536.64 | 22,536.64 | 22,536.64 |
| Dual HCBS Waivers: PD; H&D | 1,201.73 | 1,051.73 | 0.9841 | 1.0141 | 0.9952 | 1,035.01 | 1,066.56 | 1,046.68 |
| Non-Dual HCBS Waivers: PD; H&D; AIDS | 1,674.12 | 1,524.12 | 0.9105 | 1.0284 | 1.0613 | 1,387.71 | 1,567.41 | 1,617.55 |
| Brain Injury HCBS Waiver | 2,579.54 | 2,379.54 | 0.8867 | 1.0149 | 0.9961 | 2,109.94 | 2,415.00 | 2,370.26 |
| ICF/MR | $10,224.68 | $10,149.68 | 1.0011 | 0.9982 | 1.0051 | $10,161.04 | $10,131.61 | $10,201.64 |
| State Resource Center | 25,825.17 | 25,750.17 | 0.9961 | 1.0017 | 1.0021 | 25,649.74 | 25,793.95 | 25,804.25 |
| Intellectual Disability HCBS Waiver | 3,481.80 | 3,281.80 | 0.8846 | 1.0285 | 0.8215 | 2,903.08 | 3,375.33 | 2,696.00 |
| Children in a Psychiatric Mental Institute | $5,658.04 | $5,583.04 | 1.0000 | 1.0000 | 1.0000 | $5,583.04 | $5,583.04 | $5,583.04 |
| Children's Mental Health HCBS Waiver | 1,041.29 | 891.29 | 1.0432 | 0.9771 | 0.9774 | 929.79 | 870.88 | 871.15 |

*July 2016 to June 2017*

| Rate Cell Grouping | Capitation Rate | Net of Admin | Risk Adjustment Factors | | | LTSS Risk Corridor PMPM Benchmarks | | |
|---|---|---|---|---|---|---|---|---|
| | | | Amerigroup | AmeriHealth | United | Amerigroup | AmeriHealth | United |
| Custodial Care Nursing Facility 65+ | $4,285.57 | $4,210.57 | 0.9965 | 0.9951 | 1.0107 | $4,195.83 | $4,189.94 | $4,255.62 |
| Hospice 65+ | 3,203.18 | 3,128.18 | 1.0000 | 1.0000 | 1.0000 | 3,128.18 | 3,128.18 | 3,128.18 |
| Elderly HCBS Waiver | 1,117.06 | 967.06 | 0.9689 | 1.0102 | 0.9755 | 936.98 | 976.92 | 943.37 |
| Custodial Care Nursing Facility <65 | $4,856.27 | $4,781.27 | 0.9886 | 0.9912 | 1.0263 | $4,726.76 | $4,739.19 | $4,907.02 |
| Hospice <65 | 3,111.88 | 3,036.88 | 1.0000 | 1.0000 | 1.0000 | 3,036.88 | 3,036.88 | 3,036.88 |
| Non-Dual Skilled Nursing Facility | 22,612.95 | 22,537.95 | 1.0000 | 1.0000 | 1.0000 | 22,537.95 | 22,537.95 | 22,537.95 |
| Dual HCBS Waivers: PD; H&D | 1,215.24 | 1,065.24 | 0.9841 | 1.0141 | 0.9952 | 1,048.30 | 1,080.26 | 1,060.13 |
| Non-Dual HCBS Waivers: PD; H&D; AIDS | 1,695.60 | 1,545.60 | 0.9105 | 1.0284 | 1.0613 | 1,407.27 | 1,589.50 | 1,640.35 |
| Brain Injury HCBS Waiver | 2,602.25 | 2,402.25 | 0.8867 | 1.0149 | 0.9961 | 2,130.08 | 2,438.04 | 2,392.88 |
| ICF/MR | $10,224.92 | $10,149.92 | 1.0011 | 0.9982 | 1.0051 | $10,161.08 | $10,131.65 | $10,201.68 |
| State Resource Center | 25,825.18 | 25,750.18 | 0.9961 | 1.0017 | 1.0021 | 25,649.75 | 25,793.96 | 25,804.26 |
| Intellectual Disability HCBS Waiver | 3,507.83 | 3,307.83 | 0.8846 | 1.0285 | 0.8215 | 2,926.11 | 3,402.10 | 2,717.38 |
| Children in a Psychiatric Mental Institute | $5,658.04 | $5,583.04 | 1.0000 | 1.0000 | 1.0000 | $5,583.04 | $5,583.04 | $5,583.04 |
| Children's Mental Health HCBS Waiver | 1,047.88 | 897.88 | 1.0432 | 0.9771 | 0.9774 | 936.67 | 877.32 | 877.59 |

**State of Iowa - Department of Human Services, Division of Medical Services**
**Iowa High Quality Healthcare Initiative (IHQHI)**
**LTSS Risk Corridor Sample Calculation**
**Category of Service: LTSS (Institutional & Waiver)**

***Sample Plan Calculation***

| | Capitation Rates | | Enrollment | | PMPMs for Risk Corridor | |
|---|---|---|---|---|---|---|
| **Rate Cell Grouping** | April to June 2016 Rates | July 2016 to June 2017 Rates | April to June 2016 Rates | July 2016 to June 2017 Rates | Benchmark PMPM | Plan Experience |
| Custodial Care Nursing Facility 65+ | $4,210.11 | $4,210.57 | 9,629 | 38,516 | $4,210.48 | $4,210.48 |
| Hospice 65+ | 3,068.51 | 3,128.18 | 565 | 2,260 | 3,116.25 | 3,116.25 |
| Elderly HCBS Waiver | 956.45 | 967.06 | 7,690 | 30,760 | 964.94 | 1,013.18 |
| Custodial Care Nursing Facility <65 | $4,780.82 | $4,781.27 | 1,725 | 6,900 | $4,781.18 | $4,781.18 |
| Hospice <65 | 2,977.78 | 3,036.88 | 49 | 196 | 3,025.06 | 3,025.06 |
| Non-Dual Skilled Nursing Facility | 22,536.64 | 22,537.95 | 147 | 588 | 22,537.69 | 22,537.69 |
| Dual HCBS Waivers: PD; H&D | 1,051.73 | 1,065.24 | 1,111 | 4,444 | 1,062.54 | 1,275.05 |
| Non-Dual HCBS Waivers: PD; H&D; AIDS | 1,524.12 | 1,545.60 | 1,156 | 4,624 | 1,541.30 | 1,849.56 |
| Brain Injury HCBS Waiver | 2,379.54 | 2,402.25 | 1,084 | 4,336 | 2,397.71 | 2,877.25 |
| ICF/MR | $10,149.88 | $10,149.92 | 1,384 | 5,536 | $10,149.91 | $10,149.91 |
| State Resource Center | 25,750.17 | 25,750.18 | 365 | 1,460 | 25,750.18 | 25,750.18 |
| Intellectual Disability HCBS Waiver | 3,281.80 | 3,307.83 | 11,157 | 44,628 | 3,302.62 | 3,798.02 |
| Children in a Psychiatric Mental Institute | $5,583.04 | $5,583.04 | 399 | 1,596 | $5,583.04 | $5,583.04 |
| Children's Mental Health HCBS Waiver | 891.29 | 897.88 | 580 | 2,320 | 896.56 | 896.56 |

| Risk Corridor Calculation - Sample Plan | Shared Savings/(Losses) | Plan Component | State Component |
|---|---|---|---|
| Total Risk Sharing Claim Cost PMPM | ($189.26) | ($147.29) | ($41.97) |
| Risk Sharing Tier 1 (+/- 2%) | ($70.21) | ($70.21) | $0.00 |
| Risk Sharing Tier 2 (+/- 2%-4%) | ($70.21) | ($52.66) | ($17.55) |
| Risk Sharing Tier 3 (+/- 4%-6%) | ($48.84) | ($24.42) | ($24.42) |
| Risk Sharing Tier 4 (+/- 6%-8%) | $0 | $0.00 | $0.00 |
| Risk Sharing Tier 5 (+/- 8%-12.5%) | $0 | $0 | $0 |