Fifth Amendment to the Iowa Health Link Contract

This Fifth 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. To the extent that there is a conflict between any provision of this Fifth Amendment and the Contract or previous amendments, this Fifth Amendment shall control. This Fifth Amendment is effective as of July 1, 2017.

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

Revision 1. Section 1.3.3.1 of the Special Terms 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.
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> 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.
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> 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.
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> For the initial rate period spanning from April 1, 2016 to June 30, 2017, the parties agree to the rates set forth in Special Contract Attachment 3.2-01. Note, the capitation rates shown in the Attachment will be subject to risk adjustment as outlined in Appendix 1 Section 2.3.3 Risk Adjustment. In each subsequent rate period, the Agency's actuarial contractor will analyze data to determine actuarially sound rates to be offered to Contractor. The Agency and Contractor may discuss proposed capitation rates, but the Agency's actuarial contractor will ultimately be responsible for establishing the actuarially-sound rates to be offered and attesting to the capitation rates to be presented to

CMS. After the first rate period, subsequent capitated rates will be added to the Contract in sequentially numbered Special Contract Attachments (i.e., Attachment 3.2-02, Attachment 3.2-03, etc.). Contractor and the Agency must mutually agree to the capitation rates and signify this agreement by executing the Contract amendment. Capitation rates within any rate period are subject to amendment, which shall only occur through formal Contract amendment and only after the proposed rate changes have been approved by CMS.

The parties agree to work diligently and in good faith to establish and agree to capitation rates before the expiration of any rate period. If the parties are unable to establish new annual capitation rates for a subsequent rate period due to delays or disagreements, the Agency or Contractor may terminate the Contract upon ninety (90) days written notice from expiration of the current rate period and contract amendment term or, if notice is given after the expiration of the current rate period, ninety (90) days written notice from the date of the notice. Upon agreement to the capitation rates, the Agency will perform a reconciliation between the capitation rates paid and the newly agreed upon rates for the rate period. Any discrepancy will be reconciled through the capitation rate payment process.

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

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

In addition to the monthly capitation payment made to Contractor, the Agency will also make a payment to Contractor when a Medicaid member assigned to the Contractor gives birth and the member is in the population designated in the Contract's then current rate sheet as subject to a payment for giving birth. The amount of this payment, commonly referred to as a "maternity case rate payment," shall be in an amount established as part

of the capitation rate-setting process and included in the rate matrix applicable to the given Contract period. The Contractor shall supply documentation of the birth in a form and format determined by the Agency. Upon verification by the Agency of the birth, the Agency shall cause the maternity case rate payment to be made separately and apart from the usual capitation payment for contracted services. Contractor shall diligently monitor births in its assigned Medicaid population and claim a maternity case rate payment for each birth in the assigned Medicaid population for which a maternity case rate payment is available no later than 60 Days following the date on which the Contractor was made aware of the birth. The Agency shall have no obligation to pay a maternity case rate payment for a birth that occurred more than 210 Days prior to Contractor's claim for a maternity case rate payment.

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

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

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

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

reconciliation payment amount will calculated as the MCO-specific habilitation services risk pool amount minus the interim amounts paid to the MCO.

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

Beginning in SFY2018, the Agency will exclude from the capitation rates the select prescriptions drugs as set forth in Exhibit G from the pharmacy and/or the medical benefits included in the capitation rates. Contractor shall continue to provide coverage for these Exhibit G pharmaceuticals, and the Agency will reimburse the Contractor based on Contractor's invoice to the Agency for Exhibit G pharmaceuticals paid for. Contractor may only invoice for the actual pharmaceutical cost incurred by Contractor. All such invoices must be submitted by Contractor within 12 months of the date of service, with the exception of coordination of benefits situations, in which Contractor shall invoice for Exhibit G pharmaceuticals within six (6) months from the Contractor's receipt date of the claim and explanation of benefits from a primary carrier. The Agency will pay Contractor the lesser of the amount that would be paid under the fee-for-service system for the pharmaceutical or the amount the Contractor actually paid for the pharmaceutical. Contractor must include with the invoice detailed as required by the Agency to document that the claim was appropriately paid, as well as verification regarding oversight to ensure appropriate utilization of these drugs. At minimum, Contractor's invoice must include claim level detail sufficient to support the invoices.

Revision 2: Section 1.3.3.7 is added to the Special Terms of the Contract to read as follows:

1.3.3.7 Incentive Payments. For the contract term July 1, 2017 through June 30, 2018, the Agency shall set aside funds to incent Contractors to achieve the defined performance goals below:

Encounter Data: The Contractor shall achieve a +/- 2% reconciliation measurement between the encounters submitted to the Agency when compared to the Encounter Utilization Monitoring Cost Report. The measurement period shall be for claims incurred April 1, 2016 through September 30, 2017, paid through October 31, 2017, submitted to the Agency through December 15, 2017. The +/- 2% shall be measured based on the comparison of per member per month costs between the two sets of reports on a composit basisi across all rate cells. The analysis will be consolidated over the two contract years. The analysis shall require submission of appropriate data elements related to the following encounter data components: DRGs, CPT-4 codes, HCPCs codes, NDC codes, and patient liability amounts. Encounters that do not have appropriate data components, that are the cause of the Contractor, will be excluded from the encounter data in determining the ratio. Issues documented in the encounter data work group determined to be the responsibility of the state will not be included in the measurement. The encounter data work group will identify the party responsible for resolving each issue. If the Contractor meets the +/- 2% threshold requirement, the Contractor is eligible for one

hundred percent (100%) of the incentive payment for this measure, which is equal to 0.45% of capitation payments for Contract Year 2 paid by the Agency for non-LTSS services to the Contractor for all enrollees associated with the Contractor. The incentive earned by the Contractor for this measure will apply to Contract Year 2 and will be paid by the Agency during Contract Year 3.

CAHPS Rating of All Health Care: If the Contractor meets an All Health Care CAHPS rating of 9 or 10 for at least 51% of adults surveyed for the time period of January 2017 through May 2017, the Contractor will be eligible for one hundred percent (100%) of the incentive payment for this measure, which is equal to 0.45% of capitation payments for Contract Year 2 paid by the Agency for non-LTSS services to the Contractor for all enrollees associated with the Contractor. The incentive earned by the Contractor for this measure will apply to Contract Year 2 and will be paid by the Agency during Contract Year 3.

Revision 3. Section 2.13.7 of the General Terms of the Contract is amended to read as follows:

2.13.7 Amendments. This Contract may only be amended by mutual written consent of the parties, with the exception of (1) the Contract end date, which may be extended under the Agency's sole discretion, and (2) the Business Associate Agreement, which may be modified or replaced on notice pursuant to Section 1.5, *Business Associate Agreement.* Amendments shall be executed on a form approved by the Agency that expressly states the intent of the parties to amend this Contract. This Contract shall not be amended in any way by use of terms and conditions in an Invoice or other ancillary transactional document. To the extent that language in a transactional document conflicts with the terms of this Contract, the terms of this Contract shall control. Notwithstanding any language to the contrary contained in the Contract, an expansion of benefits or additions of new services which result in an increased medical or administrative cost to the Contractor, and not known at the time of capitation rate development, shall only take effect through the Contract amendment process.

Revision 4. Section 2.9.7 of the Scope of Work of the Contract is amended to read as follows:

2.9.7 The Contractor shall ensure on an ongoing basis that all staff has the appropriate credentials, education, experience and orientation to fulfill the requirements of their position. The Contractor shall provide initial and ongoing training and shall ensure all staff is trained in the major components of the Contract. As applicable based on the scope of services provided under subcontract, the Contractor shall ensure all subcontractor staff is trained in accordance with this section. Staff training shall include: (i) Contract requirements and State and Federal requirements specific to job functions; (ii) in accordance with 42 C.F.R. § 422.128, training on the Contractor's policies and procedures on advance directives; (iii) initial and ongoing training on identifying and handling quality of care concerns; (iv) cultural sensitivity training; (v) training on fraud and abuse and the False Claims Act as further described in Section 12.2.3; (vi) HIPAA training; (vii) clinical protocol training for all clinical staff; (viii) training regarding

interpretation and application of utilization management guidelines for all utilization management staff; (ix) assessment processes, person-centered planning and population specific training relevant to the enrolled populations for all care managers; and (x) training and education to understand abuse, neglect, exploitation and prevention including the detection, mandatory reporting, investigation and remediation procedures and requirements. Training material shall be updated on a regular basis to reflect any program changes. The Contractor shall maintain documentation to confirm staff training, curriculum, schedules and attendance. The Agency reserves the right as part of the standard remedy process to request the Contractor to implement additional staff training in the event that performance issues are identified by the Agency.

Revision 5. Section 3.2.8.13.3 of the Scope of Work of the Contract is amended by deleting the text and reserving the subsection.

Revision 6. Section 6.1.2 of the Scope of Work of the Contract is amended to read as follows:

6.1.2 Provider Agreements. In accordance with 42 C.F.R. § 438.206, the Contractor shall establish written agreements with all network providers. Contractors shall obtain Agency approval of all template provider agreements. The Contractor shall identify and incorporate the applicable terms of its Contract with the Agency and any incorporated documents in the Contractor's provider agreements. Under the terms of the provider agreement, the provider must agree that all applicable terms and conditions set out in the Contract, the Contract, any incorporated documents and all applicable State and Federal laws, as amended, govern the duties and responsibilities of the provider with regard to the provision of services to members.

The Contractor shall also include in all of its provider agreements provisions to ensure continuation of benefits. The Contractor shall ensure that providers are enrolled with the Agency as a condition for participation in the Contractor's network. The Contractor shall require a signed Business Associates Agreement as part of the provider agreement when required. In addition, the provider agreement shall specify the provider's responsibility regarding third party liability, including the provider's obligations to identify third party liability coverage, including Medicare and long-term care insurance as applicable, and except as otherwise required, seek such third party liability payment before submitting claims to the Contractor. The provider agreement shall require submission of claims, which do not involve a third party payer, within 180 days of the date of service.

The Contractor must have at least 40% of the population defined by the Agency in a value based purchasing (VBP) arrangement with the healthcare delivery system by the end of calendar year 2018. The VBP arrangement shall recognize population health outcome improvement as measured through the VIS combined with a total cost of care measure for the population in the VBP arrangement. Driving population health through delivery system reform under VBP means that providers need a clear understanding of the specific lives for which they are accountable. As such, any members that are part of a VBP must be assigned by the Contractor to a designated primary care provider (PCP).

This PCP information shall be immediately reported by the Contractor for use in system wide coordination enhancements as specified by the Agency, such as provider alerts through the Iowa Health Information Network (IHIN); the Contractor shall also require that all contracted hospitals report admission and discharge information to support this exchange and coordination. Contractors shall use the State-wide Alert Notification (SWAN) system, or other processes as approved by the Agency, to satisfy hospital inpatient reporting requirements for Medicaid members. The Contractor shall use the SWAN system, or other Agency approved tool, to provide a consistent, real-time notification platform for hospitals to uniformly report inpatient and ED events for Medicaid members to the Contractor and care teams participating in VBP agreement. The Contractor shall notify the Agency of any risk sharing agreements it has arranged with a provider and require in the provider agreement for any providers who are paid on a capitated basis the submission of encounter data within ninety (90) days of the date of service. As applicable, the provider agreements shall comply with the requirements set forth for subcontracts as outlined in Section 2.2 and in accordance with 42 C.F.R. § 434.6. The Contractor shall maintain all provider agreements in accordance with the provisions specified in 42 C.F.R. § 438.12, 438.214 and this Contract.

Contractor shall ensure compliance with the obligations set forth in 42 C.F.R. § 438.6(c) by showing that the VBP arrangement with providers:

(a) Is based on utilization and delivery of services;
(b) Directs expenditures equally, and using the same terms of performance, for a class of providers providing the service under the Contract;
(c) Expects to advance at least one of the goals and objectives in the quality strategy in 42 C.F.R. § 438.340;
(d) Has an evaluation plan that measures the degree to which the arrangement advances at least one of the goals and objectives in the quality strategy in 42 C.F.R. § 438.340;
(e) Does not condition network provider participation in contract arrangements under 42 C.F.R. § 438.6(c)(1)(I through (iii) on the network provider entering into or adhering to intergovernmental transfer agreements; and
(f) May not be renewed automatically.

If the Contract directs Contractor's expenditures under 42 C.F.R. §438.6(c)(1)(i) or (c)(1)(ii), the arrangement:

(a) Will make participation in the value-based purchasing initiative, delivery system reform or performance improvement initiative available, using the same terms or performance, to a class of providers providing services under the contract related to the reform or improvement initiative;
(b) Will use a common set of performance measures across all of the payers and providers;
(c) Will not set the amount or frequency o the expenditures; and
(d) Will not allow the State to recoup any unspent funds allocated for these arrangements from Contractor.

Revision 7. Section 9.3.3 of the Scope of Work of the Contract is amended to read as follows:

9.3.3 Care Coordination. The Contractor shall design and operate a care coordination program to monitor and coordinate the care for members identified as having a special health care need. Minimum requirements for the Contractor's care coordination program include: (i) catastrophic case management; (ii) disease management; (iii) programs to target members overusing and/or abusing services; (iv) discharge planning; and (v) transition planning.

Revision 8. Section 9.3.4 of the Scope of Work of the Contract is amended to read as follows:

9.3.4 Risk Stratification. The Contractor shall utilize risk stratification levels to determine the intensity and frequency of follow-up care that is required for each member participating in the care coordination program.

Revision 9. Section 10.2.1 of the Scope of Work of the Contract is amended to read as follows:

10.2.1 State Quality Review. In accordance with 42 C.F.R. § 438.340, the Agency will establish a written strategy for assessing and improving the quality of services offered by program Contractors. The Agency will regularly monitor and evaluate the Contractor's compliance with the Contractor's QM/QI program.

Revision 10. Section 11.2.2 of the Scope of Work of the Contract is struck in its entirety and marked as reserved:

11.2.2 Reserved

Revision 11. Section 11.2.3 of the Scope of Work of the Contract is amended to read as follows:

11.2.3 Medical Necessity Determinations. The Contractor shall use appropriate licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorization and decision making. The Contractor shall develop and implement written procedures documenting access to board certified consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested shall be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease, or in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services.

Revision 12. Section 12.3.2 of the Scope of Work of the Contract is amended to read as follows:

12.3.2 Quarterly Audit Report. In addition to any reporting required by the federal regulations, including 42 C.F.R. § 438.608(d)(3), the Contractor shall provide the Agency

with a quarterly audit report. To the extent that the federal regulations require reporting less frequently than the provisions of this Contract, these reporting requirements of this Contract are in addition to the less frequent reporting requirements under the federal regulations.

On a quarterly basis the Contractor shall submit a detailed audit report to the Agency which outlines the Contractor's program integrity-related activities, as well as identifies the Contractor's progress in meeting program integrity-related goals and objectives. The audit report should also specify individual provider recoupment, repayment schedules, and actions taken for each audit or investigation. The Agency shall review and approve, approve with modifications, or reject the audit report and specify the grounds for rejection. Recoupment totals and summaries for each reporting period (quarterly unless otherwise specified by the Agency) must also be submitted in the audit report.

Revision 13. Section 12.3.3 of the Scope of Work of the Contract is amended to read as follows:

12.3.3 Reporting of Suspected Fraud, Waste or Abuse. The Contractor shall report possible fraud or abuse activity to the Agency. The Contractor shall initiate an immediate investigation to gather facts regarding the possible fraud or abuse. Documentation of the findings of the investigation shall be delivered to the Agency within two (2) days of the identification of suspected fraud or abuse activity. In addition, the Contractor shall provide reports of its investigative, corrective, and legal activities with respect to fraud and abuse to the Agency in accordance with contractual and regulatory requirements. The Contractor and its subcontractors shall cooperate fully in any Agency reviews or investigations and in any subsequent legal action. The Contractor shall implement corrective actions in instances of fraud and abuse detected by the State agency, or other authorized agencies or entities. The Contractor shall report to the Agency the following information monthly and in the manner required by the Agency: (i) the number of complaints of fraud and abuse made to the Agency that warrant preliminary investigation; and (ii) for each complaint which warrants investigation: (a) the name and ID number; (b) source of complaint; (c) type of provider; (d) type of provider; (e) nature of complaint; (f) approximate dollars involved; (g) disposition of the case, (h) service type, and (i) any other relevant information requested by the Agency.

Revision 14. Section 12.4.7 of the Scope of Work of the Contract is amended to read as follows:

12.4.7 The Contractor shall report information to the Agency in a format designated by the Agency. Information shall be reported to the Agency monthly.

Revision 15. Section 13.1.12 of the Scope of Work of the Contract is amended to read as follows:

13.1.12 Electronic Visit Verification System. In any Work Plan required by Section 2.13, if the use of an Electronic Visit Verification (EVV) System is proposed, the Contractor shall develop and describe the system that will be in place within a timeframe determined by the Agency and Contractor to ensure compliance with state and federal

regulations. If an EVV System is not proposed, the Contractor shall develop and describe what methodologies will be used to monitor member receipt and utilization of personal care, Home Health Services, and other services.

Revision 16. Section 13.4.7 of the Scope of Work of the Contract is amended to read as follows:

13.4.7 Claims Reprocessing and Adjustments. The Contractor shall adjudicate ninety percent (90%) of all clean provider-initiated adjustment requests within thirty (30) business days of receipt. The Contractor shall also reprocess all claims processed in error within thirty (30) business days of identification of the error or upon a scheduled mutually agreed upon by the Agency and the Contractor. In the event the Contractor requests clarification from the Agency regarding a claims reprocessing project, the time for reprocessing will begin to run on the day the Contractor receives all information necessary to accurately reprocess the claims. The Contractor shall reprocess mass adjustments of claims upon a schedule mutually agreed upon by the Agency and the Contractor.

Revision 17. Section 14.1.3 of the Scope of Work of the Contract is amended to read as follows:

14.1.3 Meeting with the Agency. The Agency may schedule meetings or conference calls with the Contractor upon receiving the performance data. Meetings or conference calls will be scheduled on days and times that are mutually agreed upon by the Agency and the Contractor. When the Agency identifies potential performance issues, the Contractor shall formally respond in writing to these issues within the timeframe required by the Agency. If the Contractor fails to provide a formal, written response to the feedback or fails to respond within the timeframe established by the Agency, the Agency may consider the Contractor noncompliant in its performance reporting and may implement corrective actions.

Revision 18. Section 14.8.2 of the Scope of Work of the Contract is amended to read as follows:

14.8.2 Prior Authorization Report. Ninety-nine percent (99%) of standard authorization decisions shall be rendered within fourteen (14) calendar days of the request for service, or 72 hours for expedited authorization decisions. For pharmacy prior authorization one hundred percent (100%) of authorization decisions shall be rendered within twenty-four (24) hours of the request for service. Requests for extensions approved in accordance with previous sections of this Contract shall be removed from this timeliness measure.

Revision 19. Exhibit A of the Scope of Work of the Contract is amended to remove the definiton of "Director Decision" in its entirety.

Revision 20. Table E1 of Exhibit E of the Scope of Work of the Contract is amended to read as follows:

Timely Prior Authorization Processing	The Contractor fails to process a prior authorization request within fourteen (14) calendar days of the request for service, or 72 hours for expedited authorization decisions or with twenty-four (24) hours for pharmacy prior authorizations. Requests for extensions approved in accordance with previous sections of this Contract shall be removed from this timeliness measure.	$542 per occurrence

Revision 21. The Contract language prior to the Pay for Permance Meauser table in Exhibit F of the Scope of Work of the Contract is amended to read as follows:

PROGRAM ESTABLISHMENT AND ELIGIBILITY

The Agency has established a pay for performance program under which the Contractor may receive compensation if certain conditions are met. Eligibility for compensation under the pay for performance program is subject to the Contractor's complete and timely satisfaction of its obligations under the Contract.

The Agency may, at its option, reinstate the Contractor's eligibility for participation in the pay for performance program once the Contractor has properly cured all prior instances of non-compliance of its obligations under the Contract, and the Agency has satisfactory assurances of acceptable future performance.

INCENTIVE PAYMENT POTENTIAL

During each measurement year, the Agency will withhold a portion of the approved capitation payments from Contractor. In the first year of the Contract, the withheld amount shall be two percent (2%). The Agency reserves the right to change or increase the withhold amount in future years of the Contract term. Changes shall be made through the Contract amendment process. In the first year of the Contract, the Contractor may be eligible to receive some or all of the withheld funds based on the Contractor's performance in the areas outlined in Table F1 of this Exhibit.

YEAR ONE OUTCOME MEASURES AND INCENTIVE PAYMENT STRUCTURE

The outcome measures, targets and incentive payment opportunities for the first Contract year are set forth in Table F1 below. Operational performance measures have been selected to measure the Contractor's performance during implementation and initial member transition. These performance standards require the Contractor to exceed the minimum performance standard required for Contract compliance and incentivize the Contractor to perform at a higher level in five (5) areas determined by the Agency to be critical for successful program implementation. Measures will be paid based on custom

Specifications developed by the Agency and performance will be determined by the Agency or its designee. The Contractor shall submit information to the Agency, in the format and timeframe specified by the Agency, with respect to each performance measure set forth below. Incentive payments will be payable in the form of release of funds withheld.

Revision 22: Attachment 2.7 of the Contract is amended to read as follows:

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 and aggregated across both populations for minimum MLR application.

(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.

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 requirement.* A minimum MLR of 88% must be reported for each MLR reporting year by the Contractor, consistent with this section. The 88% minimum MLR applies to an aggregate calculation across both Title XIX and Title XXI populations.

(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. MCOs will additional aggregate data for the Title XIX and Title XXI populations for application of the minimum MLR of 88%.

(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.

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: Cynthia M. MacDonald	Date: 10/27/17	Signature of Authorized Representative:	Date:
Printed Name: CYNTHIA MACDONALD		Printed Name: Jerry Foxhoven	
Title: Plan President, Amerigroup Iowa		Title: Director	