STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

REQUEST FOR PROPOSAL (RFP)

SFY26 RATE ESTIMATES

Prepared by

CBIZ OPTUMAS
CONSULTANTS | ACTUARIES | ECONOMISTS

Iowa Health Link
RFP #MED-26-001

Zachary Gillen
Iowa Department of Health and Human Services
1305 East Walnut
Des Moines, IA 50319-0114
Phone: 515-204-5784
RFPMED-26-001@dhs.state.ia.us

Introduction

The Iowa Department of Health and Human Services ("Agency") has prepared estimated capitation rates ("rate estimates") for the state fiscal year (SFY) 2026 (July 1, 2025, to June 30, 2026) contract period as a component of the Iowa Health Link Request for Proposal (RFP) #MED-26-001. This document presents a brief description of the Health Link program rate development, including rate cell structure; basis for the SFY26 rate estimate; and supporting membership, utilization, and cost values by service category in the appendix. The data, adjustments, and rate estimates are based on the Health Link program design, covered populations, and covered services outlined in the RFP and the managed care organization (MCO) contract. Lastly, this document describes the process and considerations for rate adjustment that will be performed to determine the final, actuarially sound capitation rates for awarded bidders for the SFY26 contract period.

Rate Estimate Disclaimer

The SFY26 rate estimates described and presented in this document and appendices were developed in accordance with rate setting guidelines established by CMS; however, they should not be considered actuarially sound nor are they approved by CMS for the SFY26 contract period. The Agency may decline to provide additional cost and utilization data beyond the information provided in this rate estimate document.

Users of the rate estimate information presented acknowledge that the rate estimate is intended for bidders to understand the rate development process and rates under the Health Link program. Use of this information for any other purpose may not be appropriate, and the Agency provides no guarantee that this data is appropriate for any other purpose.

Health Link Program History and Overview

Overview

The Agency implemented the Iowa (IA) Health Link program on April 1, 2016 as part of its Medicaid Modernization initiative. The majority of Medicaid members were enrolled on April 1, 2016, and most newly-eligible Medicaid members continue to be enrolled in IA Health Link in subsequent years. The objectives of the Medicaid Modernization initiative were to improve quality and access to care, promote accountability for patient outcomes, and create a more predictable and sustainable budget. Managed care organizations participating in the IA Health Link program are required to provide benefits that include the following services:

- Acute care/physical health.
- Behavioral health.
- Pharmacy.
- Long-term services and supports (LTSS).

Dental services and the Program of All-Inclusive Care for the Elderly are covered under separate managed care programs for the eligible populations.

Health Link Rate Cells

The Health Link program currently includes 53 individual rate cells. Each rate cell and its major eligibility group description is provided in Table 1 below. MCOs participating in the IA Health Link program are required to provide benefits for all eligible populations. The rate cells are based on the covered populations and grouped by similar risk patterns. Please note that rate cells for the Institutional and Waiver eligibility groups are developed separately and are then blended together to develop final rates. The blended rate cells are identified and discussed following Table 1.

Table 1 – Health Link Rate Cell

Rate Cell	Eligibility Group
Children 0-59 days old (Male and Female)	Medicaid Children
Children 60-364 days (Male and Female)	Medicaid Children
Children 1-4 (Male and Female)	Medicaid Children
Children 5-14 (Male and Female)	Medicaid Children
Children 15-20 (Female)	Medicaid Children
Children 15-20 (Male)	Medicaid Children
Children's Health Insurance Program (CHIP) - Hawki	S-CHIP Children
Non-Expansion Adults 21-34 (Female)	TANF Adult
Non-Expansion Adults 21-34 Male	TANF Adult
Non-Expansion Adults 35-49 (Female)	TANF Adult
Non-Expansion Adults 35-49 Male	TANF Adult
Non-Expansion Adults 50+ (Male and Female)	TANF Adult
Pregnant Women	Pregnant Women
Wellness Plan (WP) 19-24 (Female) - Medically Exempt	Wellness Plan
WP 19-24 (Male) - Medically Exempt	Wellness Plan
WP 25-34 (Female) - Medically Exempt	Wellness Plan
WP 25-34 (Male) - Medically Exempt	Wellness Plan
WP 35-49 (Female) - Medically Exempt	Wellness Plan
WP 35-49 (Male) - Medically Exempt	Wellness Plan
WP 50+ (Male and Female) - Medically Exempt	Wellness Plan
WP 19-24 (Female) - Non-Medically Exempt	Wellness Plan
WP 19-24 (Male) - Non-Medically Exempt	Wellness Plan
WP 25-34 (Female) - Non-Medically Exempt	Wellness Plan
WP 25-34 (Male) - Non-Medically Exempt	Wellness Plan
WP 35-49 (Female) - Non-Medically Exempt	Wellness Plan
WP 35-49 (Male) - Non-Medically Exempt	Wellness Plan
WP 50+ (Male and Female) - Non-Medically Exempt	Wellness Plan
Aged, Blind, and Disabled (ABD) Non-Dual <21 (Male and Female)	Disabled
ABD Non-Dual 21+ (Male and Female)	Disabled

Rate Cell	Eligibility Group
Residential Care Facility	Disabled
Breast and Cervical Cancer	Disabled
Dual Eligible 0-64 (Male and Female)	Dual
Dual Eligible 65+ (Male and Female)	Dual
Custodial Care Nursing Facility <65	Institutional
Custodial Care Nursing Facility 65+	Institutional
Elderly Home- and Community-Based Services (HCBS) Waiver	Waiver
Non-Dual Skilled Nursing Facility	Institutional
Dual HCBS Waivers: Physically Disabled (PD); Health and Disability (H&D)	Waiver
Non-Dual HCBS Waivers: PD; H&D; AIDS	Waiver
Brain Injury HCBS Waiver	Waiver
Intermediate Care Facilities for individuals with Intellectual Disability (ICF/ID)	Institutional
State Resource Center	Institutional
Intellectual Disability HCBS Waiver	Waiver
Psychiatric Mental Institute for Children (PMIC)	Institutional
Children's Mental Health HCBS Waiver	Waiver
CHIP - Children 0-59 days (Male and Female)	M-CHIP Children
CHIP - Children 60-364 days (Male and Female)	M-CHIP Children
CHIP - Children 1-4 (Male and Female)	M-CHIP Children
CHIP - Children 5-14 (Male and Female)	M-CHIP Children
CHIP - Children 15-20 (Female)	M-CHIP Children
CHIP - Children 15-20 (Male)	M-CHIP Children
TANF Maternity Case Rate	Maternity Case Rate[1]
Pregnant Women Maternity Case Rate	Maternity Case Rate[2]

Table 1 notes:

1. *The TANF maternity case rate is a one-time payment made by the Agency to the MCO for the mother's component of a delivery/birth event. The TANF case rate is paid for eligible Non-Expansion Adults and Wellness Plan populations.*
2. *The Pregnant Women Maternity Case Rate is a one-time payment made by the Agency to the MCO for the mother's component of a delivery/birth event.*

Rate Cells Subject to Blending

Institutional and Waiver populations' rate cells included in Table 1 will be combined to develop a blended rate as a basis for the capitation payment made by the Agency to each contracted MCO. In total there are four (4) blended rate cells, and the rate blending is performed by analyzing the following two elements:

- Historical and prospective contract enrollment, including increases in waiver slots, specific to each contracted MCO.
- The enrollment mix of institutional (nursing home) and HCBS populations.

Table 2 outlines the Institutional and Waiver rate cells from Table 1 that are blended together to develop the final capitation rate. The blended rate cells are not included in the rate estimate. This

information is provided to clarify which rate cells are blended and how the Agency will blend the individual rate cells for the final capitation rates. Following the award of the RFP, the Agency and their actuary will update the rate estimates provided for elements outlined in the section titled "SFY26 Rate Estimate Adjustment Considerations and Process" and calculate the appropriate enrollment mix proportions for the individual rate cells to develop the blended rate for SFY26.

Table 2 – Blended Rate Cells

Blended Rate Cell	Individual Rate Cells Subject Included in the Blended Rate Cell	1915(c) Waiver and CMS Waiver Number for HCBS Component
LTSS Elderly	☐ Custodial Care Nursing Facility 65+ ☐ Elderly HCBS Waiver	☐ IA HCBS Elderly Waiver (4155.R06.00)
LTSS Physically Disabled	☐ Custodial Care Nursing Facility <65 ☐ Non-Dual Skilled Nursing Facility ☐ Dual HCBS Waivers: PD; Health & Disability Waiver ☐ Non-Dual HCBS Waivers: Physical Disabilities Waiver; Health & Disability; AIDS Waiver ☐ Brain Injury HCBS Waiver	☐ IA HCBS AIDS/HIV (0213.R06.00) ☐ IA HCBS Waiver for Persons w/Physical Disabilities (0345.R04.00) ☐ IA HCBS - Brain Injury (BI) (0299.R05.00) ☐ Iowa HCBS Health and Disability Waiver (4111.R07.00)
LTSS Intellectually Disabled	☐ ICF/ID ☐ State Resource Center ☐ Intellectual Disability HCBS Waiver	☐ IA HCBS Intellectual Disabilities (ID) Waiver (0242.R06.00)
LTSS Children's Mental Health	☐ PMIC ☐ Children's Mental Health HCBS Waiver	☐ Children's Mental Health Waiver (0819.R02.00)

Table Notes:

1. *Included in the Rate Estimate Appendix is an example of the blended rate calculations.*

Rate Estimate Methodology

Overview

To develop the SFY26 rate estimate, the Agency's actuary utilized the SFY24 capitation rate development plus additional months of trend to the SFY26 contract period. Many of the current SFY24 adjustments (base data, trend, program changes, public health emergency unwind acuity, non-medical, and underwriting gain loads) are included in the rate estimate, with exception to those outlined in the rate estimate exclusions.

The following briefly describes key elements of the rate estimates, including the base data period and adjustments for the following:

- Historical base period data.
- Prospective adjustments, including non-medical (administrative) and underwriting gain load.
- Rate estimate exclusions.

Bidders are invited to view complete historical rate certification documents at https://dhs.iowa.gov/MCO_RFP_MED-26-001

The rate estimates will be updated following the contract award and prior to the go-live for the SFY26 contract period. These adjustments are described in the section of this document titled "SFY26 Rate Estimate Adjustment Considerations and Process."

Historical Base Data Overview

The adjusted SFY22 (July 1, 2021 to June 30, 2022) base period is the basis for the current SFY24 capitation rates and is also being used to develop the SFY26 rate estimates. The SFY22 data was aggregated by each rate cell and by incurred dates of service. The base data supplied in the Appendix reflects adjustments for the following:

- Incurred but not reported factors.
- Encounter data under-reporting, including MCO subcapitated expenditures.
- Allowable provider incentive and settlement payments.
- The collection of supplemental pharmacy rebates.
- Historical program changes not reflected (or not fully reflected) in the base period data.

The SFY22 base data includes the effect of the COVID-19 Public Health Emergency (PHE) where the Agency was required to maintain continuous eligibility for Medicaid enrollees and were prohibited from disenrolling many individuals at annual redetermination periods. The SFY24 capitation rates that serve as the basis for this rate estimate include adjustments to reflect the impact of the unwinding of the PHE which are described in the "Rate Estimate Prospective Adjustments" section.

Table 3 presents the categories of service (COS) that are within the base data included in the Appendix.

Table 3 – Rating Categories of Service

Included Categories of Service	
Behavioral Health – Inpatient	Laboratory (Lab)/Radiology (Rad)
Behavioral Health – Outpatient	Nursing Home and Hospice
Behavioral Health – Professional	Other Care
Day Services	Other HCBS Services
Durable Medical Equipment /Prosthetics	Outpatient – Emergency Room
Family Planning	Outpatient – Non-Emergency Room
Federally Qualified Health Center (FQHC)/Rural Health Center (RHC)	Outpatient – Professional
Home Health	Pharmacy
ICF/ID	Professional Office
Inpatient	Transportation
Inpatient – Professional	Waiver

Rate Estimate Prospective Adjustments

The adjusted base data and additional Appendices include the following adjustments:

- Trend factors (utilization and unit cost).
- Program changes (benefits and unit cost).
- Administration and non-claims expense.
- Underwriting gain.

Trend Factors

The trend factors illustrated in the rate estimate exhibit are consistent with actuarially sound capitation rates developed for the SFY24 contract period. Trend was developed based on quantitative analysis of historical Health Link utilization and unit cost data plus consideration for emerging trend factors and those observed in other similar Medicaid programs. For purposes of the SFY26 rate estimate, the trend factors are applied to the adjusted SFY22 base data and trended for 48 months, representing the period between the midpoint of the base period to the midpoint of the SFY26 contract period.

The adjustment process, as described later in this document, may include an update to the base data. Subsequent updates to the prospective trend factors will be necessary to develop the final capitation rates effective for SFY26.

Program Changes

The rate estimate reflects a series of prospective program changes (unit cost and benefit adjustments), effective in SFY24. These impacts were developed based on analysis of projected utilization and unit cost information for services and populations impacted by the program change. Note that reimbursement change impacts are consistent with SFY24 reimbursement, but there are certain services, such as FQHC/RHC, that that have historically had annual reimbursement updates. These reimbursement changes will be reflected within the final SFY26 capitation rates.

Similar to the trend factor re-evaluation that will occur following the RFP award, program changes will be re-evaluated for their inclusion in the final SFY26 capitation rates. Their treatment in the post award SFY26 capitation rate development will be dependent upon the updates and additional adjustments to the base data period discussed above. In a circumstance when the base data period is updated, the prospective program changes identified in the rate estimate may be inherent within the updated base data and therefore no longer require their inclusion as a separate adjustment. The Agency and its actuary will review these impacts as part of any base data period update, and will also incorporate any new program changes that become effective after the date of this RFP rate estimate.

Acuity Impacts

In response to the COVID-19 pandemic, the Agency implemented a disenrollment freeze for all Iowa Medicaid enrollees, with few exceptions in line with federal guidance, effective March 1, 2020, to comply with the Maintenance of Effort (MOE) requirements. The freeze on disenrollment resulted in

members who would normally lose eligibility for Iowa Medicaid remaining enrolled with an IA Health Link MCO since March 2020. With the MOE requirements no longer in place, the State began to disenroll Medicaid members impacted by the disenrollment freeze starting in April 2023. The member disenrollments are expected to continue throughout SFY24 into early calendar year 2024 and therefore are still in process at the time of this SFY26 RFP rate estimate. It is expected that this adjustment will be re-evaluated as part of the final SFY26 capitation rate development process.

The following populations have an acuity adjustment applied as the eligibility determination for these rate cells considers a member's Modified Adjusted Gross Income (MAGI) or there were significant disenrollments experienced by these cohorts through the November 2023 experience with material differences between the PMPMs for Leavers and Persisters:

- Children
- TANF Adult
- Wellness Plan
- Healthy Duals (Dual Eligible 0-64 M&F and Dual Eligible 65+ M&F rate cells)
- Breast and Cervical Cancer
- Pregnant Women rate cell

The remaining populations which reflect Disabled and LTSS rate cells do not have an acuity adjustment applied within the SFY24 rates. For all populations receiving an adjustment, with the exception of the Pregnant Women rate cell, a "Leaver/Persister" analysis was conducted to evaluate the impact of the disenrollments and corresponding shift in acuity for the IA Health Link program. Member-level Health Link enrollment files between April 2023 and November 2023 were utilized to classify members from the SFY22 base data into the following categories and evaluate the difference in average PMPMs for each type of member:

1. Persisters – Members who have remained in the IA Health Link managed care program after the monthly redeterminations through November 2023.
2. Actual Leavers – Members who have been disenrolled from IA Health Link between April 2023 through November 2023.

Some individuals left the IA Health Link program during the SFY22 base data prior to the unwinding of the MOE requirements. These members were classified as Persisters for the purposes of this analysis since they were disenrolled for allowable reasons prior to the reinstatement of the standard Medicaid redetermination evaluations.

The SFY22 member months and PMPM costs for the persisters and actual leavers were evaluated by rate cell. Optumas relied on a combination of actual disenrollments (through November 2023) and projected future disenrollments using information and guidance from Iowa Medicaid to estimate the remaining disenrollments and associated impact over the SFY24 contract period. The resulting differences in SFY22 base data PMPMs, after excluding the portion of enrollment classified as leavers

(actual and projected) is the basis for the acuity adjustment; overall, this results in an increase in PMPMs and varies by population.

During the SFY24 contract period, eligibility coverage for the Pregnant Women rate cell will once again reflect the enforcement of two months of postpartum coverage, which was not reinforced throughout the duration of the PHE. As such, a separate methodology was used in developing the acuity adjustment for the Pregnant Women rate cell to appropriately reflect the two months postpartum coverage policy.

Optumas reviewed the emerging disenrollment through October 2023 for the Pregnant Women cohort, as well as a projected reduction in 3+ months postpartum experience through the duration of SFY24, to estimate the impact of the removal of 3+ months postpartum throughout the SFY24 period. The PMPMs associated with 3+ months postpartum are on average lower than the combination of prenatal, month of delivery, and first 2 months of postpartum experience. Therefore, this resulted in a rating increase for the Pregnant Women cohort to reflect this change in enrollment coverage.

Administration and Non-Benefit Expense

The rate estimate provided includes administrative non-benefit costs reflected in the Health Link capitation rates for the SFY24 contract period. Historically, administrative costs have been developed using data and analysis from historical financial templates completed by each MCO and a review of non-benefit costs in Medicaid programs from states with similar populations and services. The non-benefit cost assumptions consider economies of scale of the Health Link program, the impact associated with the PHE-related moratorium on Medicaid disenrollment, and fixed and variable costs. This approach results in variation between final non-benefit cost projections across populations. The level of non-benefit costs necessary varies between populations to effectively manage care.

The adjustment process as described in this document will include an update to several rate development components, including the base data, prospective trend factors, and program changes; thus, the administrative and non-benefit expense loading will be re-evaluated to develop the final capitation rates effective for SFY26.

Rate Estimate Exclusions

The rate estimates presented in this document exclude certain components that may be reflected in the final SFY26 capitation rates. These exclusions are described in the RFP, including the managed care contract and attachments, and are briefly described below.

Leap Year Adjustment

An adjustment was made to the SFY24 capitation rates to account for an expected increase in utilization due to the leap year of 2024. This has been excluded from the SFY26 rate estimates since this contract period does not include a leap year.

Limited Pharmacy Carve-Out

The Agency has excluded Zolgensma and Mepsevii from the capitation rates, as outlined in the RFP Attachment F – Exhibit A. Note that Zolgensma and Mepsevii are excluded from the capitation rates; however, the Health Link MCOs provide coverage of these drugs to eligible Medicaid beneficiaries consistent with other pharmaceuticals and treatments. The Agency reimburses the MCOs for Zolgensma and Mepsevii via invoices billed to the Agency. Any Zolgensma and Mepsevii experience within the SFY22 base data has been carved out of the base data used for rate development. The SFY26 final capitation rate development will follow the same process in the event the base data period is updated, and all utilization and expenditures associated with these drugs will continue to be carved out.

Prospective Risk Adjustment

The final capitation rates paid by the Agency to each MCO, excluding the LTSS blended rate cells and certain other rate cells, are risk adjusted based on the relative risk in the health status of enrollees in each MCO. The risk adjustment recognizes variations in health risk that may occur between MCOs and better matches payment to risk for each applicable rate cell.

The Agency and its actuary uses a health-based risk score adjustment based on the University of California, San Diego CDPS+Rx Version 7.1 tool. The risk adjustment methodology process used in the SFY24 rates was based on CDPS+Rx Version 7.0 and included:

- Collect and evaluate appropriate enrollment and encounter data experience.
- Calculate and assign individual acuity factors for those enrollees with at least six months (6) of experience within the twelve-month (12) evaluation/study period. Individuals with less than 6 months of experience received member-specific demographic weights and the regional-average disease weight based on members with at least 6 months of enrollment.
- Adjust raw risk scores to be normalized between MCOs to ensure program-wide budget neutrality.
- Apply risk scores to the final capitation rates.

It is expected that a similar process will be implemented and applied to the final SFY26 capitation rates, once MCO member attribution information becomes known. The Agency reserves the right to modify this approach, including but not limited to the use of a more recent version of the risk adjustment tool, as part of the SFY26 rate finalization process.

Directed/Supplemental Payments

The current SFY24 Health Link program includes directed payments. A portion of the current directed payments are included in the capitation rate, while others are separate payment terms and reimbursed outside the capitation rates. Table 4 outlines the directed payments anticipated for SFY26 and their treatment in the SFY24 MCO capitation rates. These anticipated directed payments are not included in the rate estimate provided with this RFP but will be reflected appropriately in the SFY26 capitation rates.

Table 4 – Directed Payments

Directed Payment	Capitation Payment Term Excluded from Rate Estimate
Ground emergency transportation supplemental payment	Included in the final capitation rates
Physician teaching hospital average commercial rate (inpatient and physician services)	Separate payment term
Inpatient and outpatient hospital directed payment	Separate payment term

In addition to the directed payments noted above, the SFY24 capitation rates also include expenditures for the graduate medical expense (GME) supplemental payment. The GME payments have been excluded from the SFY26 rate estimate but will be included within the final SFY26 capitation rates.

SFY26 Rate Estimate Adjustment Considerations and Process

Throughout this document, references have been made to the adjustment process, following the RFP award, to update the SFY26 rate estimate into actuarially sound capitation rates for the SFY26 contract period. The Agency and its actuary will re-evaluate all elements of the rate estimates and will make updates, including but not limited to, the following:

- Base data period, including program demographics.
- Historical programmatic changes (including the PHE acuity adjustment).
- Trend projections.
- Programmatic changes (benefits or reimbursement changes) occurring after the procurement.
- Non-medical load and underwriting gain.
- Risk adjustment.
- LTSS rate blending.
- Directed payments.
- Pay for Performance Withholds (outlined in Attachment F: Exhibit A of the RFP).
- Impacts associated with, but not limited to, federal and/or state policy or court/judicial decisions.
- Other (as necessary).

These adjustments and the subsequent capitation rates will result in actuarially sound capitation rates that meet the CMS rate setting guidelines and will be in accordance with 42 CFR 438.4. During the capitation rate development, the Agency and its actuary will provide updated capitation rates, supporting information, and will engage in a rate development discussion with MCO contractors.