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State of Iowa Department of Health and Human Services, Iowa Medicaid Des Moines, Iowa

#### **Independent Accountant's Report**

We have examined the accompanying Adjusted Medical Loss Ratio of Iowa Total Care, Inc. (health plan) for the state fiscal year ended June 30, 2023. The health plan's management is responsible for presenting the Medical Loss Ratio in accordance with the criteria set forth in the Code of Federal Regulations (CFR) 42 § 438.8 and other applicable federal guidance (criteria). This criteria was used to prepare the Adjusted Medical Loss Ratio. Our responsibility is to express an opinion on the Adjusted Medical Loss Ratio based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the Adjusted Medical Loss Ratio is in accordance with the criteria, in all material respects. An examination involves performing procedures to obtain evidence about the Adjusted Medical Loss Ratio. The nature, timing, and extent of the procedures selected depend on our judgment, including an assessment of the risk of material misstatement of the Adjusted Medical Loss Ratio, whether due to fraud or error. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion.

We are required to be independent and to meet our other ethical responsibilities in accordance with relevant ethical requirements related to our engagement.

The accompanying Adjusted Medical Loss Ratio was prepared from information contained in the Medical Loss Ratio for the purpose of complying with the criteria, and is not intended to be a complete presentation in conformity with accounting principles generally accepted in the United States of America.

In our opinion, the Adjusted Medical Loss Ratio is presented in accordance with the criteria, in all material respects, and the Adjusted Medical Loss Ratio meets or exceeds the state requirement of 88 percent for the state fiscal year ended June 30, 2023.

This report is intended solely for the information and use of the Iowa Medicaid, CBIZ Optumas, and the health plan and is not intended to be and should not be used by anyone other than these specified parties.

Myers and Stauffer LC Kansas City, Missouri August 15, 2025

# Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2023 Paid Through December 31, 2023

	Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2023 Paid Through December 31, 2023				
Line #	Line Description	R	eported Amounts	Adjustment Amounts	Adjusted Amounts
1.	Medical Loss Ratio Numerator				
1.1	Incurred Claims	\$	2,810,907,736	\$ 38,399,525	\$ 2,849,307,263
1.2	Activities that Improve Health Care Quality	\$	46,980,104	\$ (11,305,703)	\$ 35,674,402
1.3	MLR Numerator	\$	2,857,887,840	\$ 27,093,822	\$ 2,884,981,662
1.4	Non-Claims Costs (Not Included in Numerator)	\$	151,475,064	\$ -	\$ 151,475,064
2.	Medical Loss Ratio Denominator				
2.1	Premium Revenue	\$	3,106,324,952	\$ 51,147,401	\$ 3,157,472,353
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	\$	16,956,972	\$ (2,553,912)	\$ 14,403,060
2.3	MLR Denominator	\$	3,089,367,980	\$ 53,701,313	\$ 3,143,069,293
3.	MLR Calculation				
3.1	Member Months		4,423,300	1,452	4,424,752
3.2	Unadjusted MLR		92.5%	-0.7%	91.89
3.3	Credibility Adjustment		0.0%	0.0%	0.0
3.4	Adjusted MLR		92.5%	-0.7%	91.89
4.	Remittance				
4.1	Contract Includes Remittance Requirement		No		No
4.2	State Minimum MLR Requirement		88.0%		88.0

<sup>\*</sup>The Non-Claims Costs line has not been subjected to the procedures applied in the examination, including testing for allowability of expenses or appropriate allocation to the Medicaid line of business. Adjustments identified during the course of the examination were not tested to determine any impact on Non-Claims Costs. Accordingly, we express no opinion on the Non-Claims Costs line.

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# **Schedule of Adjustments**

During the course of the engagement, the following adjustment(s) were identified.

#### Adjustment #1 - To remove non-qualifying VAS expense per health plan supporting documentation

The health plan reported value added services (VAS) expense that were not state approved programs. An adjustment was proposed to remove non-qualifying VAS per health plan supporting documentation. The incurred claims reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

	Proposed Adjustment	
Line # Line Description		Amount
1.1	Incurred Claims	(\$2,040,063)

#### Adjustment #2 - To adjust incurred claims expense to final net payments to pharmacies

The health plan reported pharmacy incurred claims expense for the third party pharmacy benefit manager (PBM), CVS Health, based on paid claims detail only reflecting ingredient cost and dispensing fees. It was determined the reported pharmacy incurred claims expense was overstated due to excluding the transmission fees assessed to the pharmacies by the PBM. An adjustment was proposed to reduce incurred claims expense by the amount related to the transmission fees in order to reflect the final amount paid to pharmacies. The incurred claims and third party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and Center for Medicaid & CHIP Services Informational Bulletin: MLR Requirements Related to Third Party Vendors dated May 15, 2019.

Proposed Adjustment				
Line #	Line Description	Amount		
1.1	Incurred Claims	(\$990,207)		

#### Adjustment #3 - To adjust pharmacy claims per PBM certification statement

The health plan reported services for third party PBM, CVS Health. A certification statement was submitted to support the vendor's actual claim payments incurred for services performed for the medical loss ratio (MLR) reporting period, which did not reconcile to the health plan reported amount. An adjustment was proposed to reduce incurred claims per the vendor certification statement. The incurred claims and third party reporting requirements are addressed in the Medicaid Managed Care

Final Rule 42 CFR § 438.8(e)(2) and Center for Medicaid & CHIP Services Informational Bulletin: MLR Requirements Related to Third Party Vendors dated May 15, 2019.

	Proposed Adjustment	
Line #	Line Description	Amount
1.1	Incurred Claims	(\$204,132)

# Adjustment #4 - To remove overstated and non-qualifying provider incentive payments per health plan supporting documentation

The health plan reported provider incentive payments for the MLR reporting period. It was determined the health plan amounts reported were overstated, attributed primarily to over capturing estimated payments that were ultimately not earned and paid to providers for the MLR reporting period. Additionally, it was determined other payments were non-qualifying, as the incentive arrangements were not tied to clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards. An adjustment was proposed to reduce provider incentive payments per health plan supporting documentation. The provider incentive reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

	Proposed Adjustment	
Line #	Line Description	Amount
1.1	Incurred Claims	(\$4,234,742)

# Adjustment #5 - To remove non-qualifying care coordination expenses per health plan supporting documentation

The health plan reported provider care coordination expenses within provider incentive payments. According to the provider contracts, the health plan pays a per-member per-month amount to specific providers for performing care coordination services. Since the services are considered health care quality improvement (HCQI) activities in nature and were not tied to clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards, the amounts did not qualify as provider incentive payments. An adjustment was proposed to remove the non-qualifying care coordination expenses per health plan supporting documentation. The provider incentive reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

	Proposed Adjustment	
Line #	Line Description	Amount
1.1	Incurred Claims	(\$7,043,880)



# Adjustment #6 – To remove the administrative component related to a capitated provider arrangement per health plan supporting documentation

The health plan reported an amount related to capitated primary care physician (PCP) services for third party provider, Exemplar, as provider incentive payments. According to the provider's contractual requirements, the provider was performing administrative services as well as PCP services. An adjustment was proposed to remove the administrative component of the capitation payments from incurred claims per health plan supporting documentation. The incurred claims reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and the Center for Medicaid & CHIP Services Informational Bulletin: MLR Requirements Related to Third Party Vendors dated May 15, 2019.

	Proposed Adjustment	
Line #	Line Description	Amount
1.1	Incurred Claims	(\$333,670)

## Adjustment #7 - To remove non-qualifying HCQI/HIT expenses per health plan supporting documentation

The health plan reported HCQI and health information technology (HIT) expenses based on salaries and benefits, vendor costs, and overhead costs. It was determined the health plan included non-qualifying expenses based on federal guidance. An adjustment was proposed to remove non-qualifying salaries, benefits, vendor costs, and overhead. The HCQI/HIT reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3) and 45 CFR § 158.150.

	Proposed Adjustment	
Line #	Line Description	Amount
1.2	Activities that Improve Health Care Quality	(\$12,546,720)

# Adjustment #8 - To reclassify qualifying HCQI expenses from provider incentive payments per provider supporting documentation

The health plan reported expenses related to provider care coordination services within provider incentive payments. Supporting documentation was requested for the providers' actual costs related to the care coordination services. Certain providers complied and submitted sufficient detail to determine the qualifying amount of HCQI expenses related to the care coordination services. Adjustment #5 removed the amount from provider incentive payments. An adjustment was proposed to reclassify the corresponding qualifying expenses to HCQI per provider supporting documentation. The HCQI/HIT

reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3) and 45 CFR § 158.150.

Proposed Adjustment			
Line #	Line Description	Amount	
1.2	Activities that Improve Health Care Quality	\$1,241,017	

### Adjustment #9 - To adjust revenues per state data

The health plan reported revenue amounts that did not reflect payments received for its members applicable to the covered dates of service for the MLR reporting period. An adjustment was proposed to report the revenues per state data for capitation, maternity, earned withhold, and graduate medical education (GME) payments. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2). The health plan completed the MLR based on the template instructions.

	Proposed Adjustment	
Line #	Line Description	Amount
2.1	Premium Revenue	\$6,256,338

#### Adjustment #10 – To adjust state directed payment revenue and associated expense per state data

The health plan reported state directed payments in the numerator and the denominator for the MLR reporting period. It was determined that both state directed expenses and revenues were understated in total based on comparison to state data for the University of Iowa Hospitals and Clinics Average Commercial Rate (UIHC ACR - Hospital), UIHC ACR Physician (UIHC ACR - Physician), and Ground Emergency Medical Transportation (GEMT). The American Rescue Plan Act (ARPA) program was not a state directed payment for the MLR reporting period and reported in error by the health plan. An adjustment was proposed to increase the state directed payments and associated expense per state data. See below for additional tables to break out the specific payments. The state directed payment reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR §§ 438.8(e)(2), 438.8(f)(2), and 438.6(c). The health plan completed the MLR based on the template instructions.

Proposed Adjustment				
Line #	Line Description	Amount		
2.1	Premium Revenue	\$53,247,586		
1.1	Incurred Claims	\$53,246,219		

UIHC ACR - Hospital		
Description	Amount	
Total Directed Payment Revenue	\$59,675,491	
Total Directed Payment Expense	\$59,675,491	

UIHC ACR - Physician		
Description	Amount	
Total Directed Payment Revenue	\$5,579,127	
Total Directed Payment Expense	\$5,579,127	

GEMT	
Description	Amount
Total Directed Payment Revenue	\$1,367
Total Directed Payment Expense	\$-

ARPA		
Description	Amount	
Total Directed Payment Revenue	(\$12,008,399)	
Total Directed Payment Expense	(\$12,008,399)	

#### Adjustment #11 – To adjust member months per state data

The health plan reported member month amounts did not reflect accurate amounts for the MLR reporting period. An adjustment was proposed to reflect member months per state data. The member month reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k).

Proposed Adjustment		
Line #	Line Description	Amount
3.1	Member Months	1,452



#### Adjustment #12 - To adjust income taxes per recalculation to audited financial statements

The health plan reported income taxes that did not reconcile to supporting documentation. It was determined the health plan did not appropriately remove taxes for investment income and factor in the change in deferred tax assets noted in the audited financial statements. A recalculation was performed based on the audited financial statements and was determined to be reasonable and appropriate. An adjustment was proposed to the recalculation utilizing the audited financial statements. The tax reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(3).

Proposed Adjustment		
Line #	Line Description	Amount
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	(\$2,553,912)

## Adjustment #13 - To adjust risk corridor settlement payments per state data

A risk corridor was contractually in effect for the MLR reporting period. The final risk corridor calculation occurred subsequent to the filing of the MLR. All applicable MLR examination adjustments are reflected within the final risk corridor calculation. An adjustment was proposed to report revenues based on the final risk corridor calculation per state data. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2).

Proposed Adjustment		
Line #	Line Description	Amount
2.1	Premium Revenue	(\$8,356,523)