IOWA TOTAL CARE, INC.
Iowa Health Link
Iowa Medicaid
Managed Care Programs

Adjusted Medical Loss Ratio

With Independent Accountant's Report Thereon

For the State Fiscal Year Ended June 30, 2024

Paid through December 31, 2024

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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, 2024. The health plan's management is responsible for presenting the Medical Loss Ratio in accordance with the criteria set forth in 42 Code of Federal Regulations (CFR) § 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, 2024.

This report is intended solely for the information and use of 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

Myers and Stauffer LC
Kansas City, Missouri
December 16, 2025

Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2024 Paid Through December 31, 2024

Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2024 Paid Through December 31, 2024				
Line #	**Line Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
1.	**Medical Loss Ratio Numerator**			
1.1	Incurred Claims	$ 2,993,802,630	$ (68,997,065)	$ 2,924,805,565
1.2	Activities that Improve Health Care Quality	$ 49,071,172	$ (11,244,154)	$ 37,827,018
1.3	MLR Numerator	$ 3,042,873,802	$ (80,241,219)	$ 2,962,632,583
1.4	Non-Claims Costs (Not Included in Numerator)	$ 148,694,845	$ -	$ 148,694,845
2.	**Medical Loss Ratio Denominator**			
2.1	Premium Revenue	$ 3,197,688,455	$ (49,023,137)	$ 3,148,665,318
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$ 10,900,011	$ 3,050,409	$ 13,950,420
2.3	MLR Denominator	$ 3,186,788,444	$ (52,073,546)	$ 3,134,714,898
3.	**MLR Calculation**			
3.1	Member Months	2,973,123	340	2,973,463
3.2	Unadjusted MLR	95.5%	-1.0%	94.5%
3.3	Credibility Adjustment	0.0%	0.0%	0.0%
3.4	Adjusted MLR	95.5%	-1.0%	94.5%
4.	**Remittance**			
4.1	Contract Includes Remittance Requirement	No		No
4.2	State Minimum MLR Requirement	88.0%		88.0%

**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.*

Schedule of Adjustments

During the course of the engagement, we identified the following adjustments.

Adjustment #1 – 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 medical loss ratio (MLR) reporting period. It was determined that both revenues and expenses were overstated in total based on comparison to state data for the following state directed payments: University of Iowa Hospitals and Clinics (UIHC) Hospital Average Commercial Rate (ACR), UIHC Physician ACR, Hospital Inpatient and Hospital Outpatient Services ACR, and Ground Emergency Medical Transportation Payment Program. An adjustment was proposed to reduce the state directed payments and associated expense per state data. 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**
1.1	Incurred Claims	($56,944,729)
2.1	Premium Revenue	($53,893,306)

Adjustment #2 – To adjust pharmacy rebates per PBM supporting documentation

The health plan reported prescription drug rebates received and accrued. It was determined the amount reported was understated based on supporting documentation submitted from the third party pharmacy benefit managers (PBM), Caremark PCS Health LLC (contract terminated December 2023) and Express Scripts (contract initiated January 2024). An adjustment was proposed to increase the prescription drug rebates based on PBM supporting documentation. Pharmacy rebates are a reduction to incurred claims, therefore the increase in rebates was shown as a negative adjustment. The prescription drug rebates received and accrued 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	($281,635)

Adjustment #3 – To adjust 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 overestimating final payments. 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 payments 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	($3,514,443)

Adjustment #4 – To remove non-qualifying provider incentive payments 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 provider incentive payments per health plan supporting documentation. The provider incentive payments 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	($968,870)

Adjustment #5 – 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 per health plan supporting documentation. The HCQI/HIT reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.2	Activities that Improve Health Care Quality	($11,586,381)

Adjustment #6 – To reclassify qualifying HCQI expenses per health plan supporting documentation

The health plan reported non-qualifying incurred claims. A portion of the amount was deemed qualifying HCQI expenses. An adjustment was proposed to remove the non-qualifying incurred claims and reclassify the qualifying HCQI expense per health plan supporting documentation. The incurred claims and HCQI reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR §§ 438.8(e)(2) and 438.8(e)(3).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($351,108)
1.2	Activities that Improve Health Care Quality	$342,227

Adjustment #7 – To remove carve-out services per health plan supporting documentation

The health plan reported high-cost drugs and COVID vaccines within incurred claims. Since the carve-out services are reimbursed outside of the capitation payment, these amounts should be excluded from the MLR. An adjustment was proposed to remove the carve-out services 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	($4,384,557)

Adjustment #8 – To adjust other incurred claims per health plan supporting documentation

The health plan reported other incurred claims for the MLR reporting period. It was determined the process to restate claims projects changed, resulting in a duplicative amount that was also captured in the incurred but not reported estimate. An adjustment was proposed to remove the duplicative 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).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($2,551,723)

Adjustment #9 – To adjust to revenues per state data

The health plan reported revenue amounts that understated payments received for its members applicable to the covered dates of service for the MLR reporting period. An adjustment was proposed to increase revenues per state data for capitation and maternity 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	$95,899

Adjustment #10 – To adjust earned withhold payments per state data

The health plan reported an estimated amount for the anticipated earned withholds related to achieved pay for performance metrics. An adjustment was proposed to report earned withhold payments per state data. 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	$4,774,270

Adjustment #11 – To adjust member months per state data

The health plan reported member months that 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	340

Adjustment #12 – To adjust premium taxes per adjusted state data

The health plan reported premium taxes for the MLR reporting period. Since the premium tax became effective on January 1, 2024, it applied only to revenues related to the first six-months of 2024. An adjustment was proposed to recalculate premium taxes per adjusted state data. 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	$3,050,409