MOLINA HEALTHCARE OF IOWA, 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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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 Molina Healthcare of Iowa, 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 15, 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	$ 1,463,195,561	$ 167,857,945	$ 1,631,053,506
1.2	Activities that Improve Health Care Quality	$ 21,350,969	$ 6,902,233	$ 28,253,202
1.3	MLR Numerator	$ 1,484,546,530	$ 174,760,178	$ 1,659,306,708
1.4	Non-Claims Costs (Not Included in Numerator)	$ 88,315,190	$ -	$ 88,315,190
2.	**Medical Loss Ratio Denominator**			
2.1	Premium Revenue	$ 1,612,901,979	$ 239,496,152	$ 1,852,398,131
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$ 7,166,590	$ 3,545,921	$ 10,712,511
2.3	MLR Denominator	$ 1,605,735,389	$ 235,950,231	$ 1,841,685,620
3.	**MLR Calculation**			
3.1	Member Months	2,328,004	235	2,328,239
3.2	Unadjusted MLR	92.5%	-2.4%	90.1%
3.3	Credibility Adjustment	0.0%	0.0%	0.0%
3.4	Adjusted MLR	92.5%	-2.4%	90.1%
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 VAS per health plan supporting documentation

The health plan reported state approved value-added service (VAS) expenses for the medical loss ratio (MLR) reporting period. It was determined the health plan overstated VAS expenses. An adjustment was proposed to reduce VAS expenses 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	($99,698)

Adjustment #2 – 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 revenues and expenses were overstated in total based on a 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	$178,995,488
2.1	Premium Revenue	$229,579,844

Adjustment #3 – To remove duplicated overpayment recoveries per health plan supporting documentation

The health plan reported duplicated recoveries for the MLR reporting period. It was determined the recoveries reported separately were also included within the incurred claims through the paid claims lag. An adjustment was proposed to remove duplicated recoveries 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).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	$390,274

Adjustment #4 – To adjust transportation and vision expenses per vendor certification statements

The health plan reported services for third party vendors, Access2Care and March Vision, based on fee-for-service and capitated arrangements, respectively. Certification statements were submitted to support the vendors' actual claim payments incurred for services performed for the MLR reporting period, which did not reconcile to the health plan reported amounts. An adjustment was proposed to reduce incurred claims per the vendor certification statements. 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	($551,040)

Adjustment #5 – 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 manager (PBM), Caremark PCS Health LLC. 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	($46,237)

Adjustment #6 – To adjust pharmacy rate guarantee calculation per PBM supporting documentation

The health plan reported pharmacy incurred claims expense for the third party PBM, Caremark PCS Health LLC, based on paid claims detail only reflecting ingredient cost and dispensing fees. It was determined that contracted rate guarantees were calculated annually for participating pharmacies based on contracts with the PBM. The calculation outlined, at the Medicaid line of business level, the effective rates paid to pharmacies compared to the contracted rate and dispensing fees. The overall impact for the Medicaid line of business was a reduction in reimbursement 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	($26,367)

Adjustment #7 – 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	($4,849,699)

Adjustment #8 – 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. 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	($3,331,706)

Adjustment #9 – To remove non-qualifying HCQI/HIT expenses and include qualifying corporate expenses per health plan supporting documentation, and include provider care coordination expenses per provider supporting documentation

The health plan reported HCQI and health information technology (HIT) expenses based on direct salaries and benefits, vendor costs, and overhead costs. It was determined the health plan included non-qualifying expenses based on federal guidance. Additionally, the health plan did not report corporate or provider care coordination expenses. An adjustment was proposed to remove non-qualifying salaries, benefits, vendor costs, and overhead and include qualifying corporate expenses per health plan supporting documentation, and include provider care coordination expenses per provider 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	$6,902,233

Adjustment #10 – To include pharmacy recoveries per health plan supporting documentation

The health plan did not report pharmacy recoveries as a reduction to incurred claims for the MLR reporting period. It was determined pharmacy recoveries were captured outside of the paid claims lag. An adjustment was proposed to reduce incurred claims related to pharmacy recoveries 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	($1,871,267)

Adjustment #11 – To adjust subrogation recoveries and remove non-qualifying vendor contingency fees per health plan supporting documentation

The health plan did not report an estimate for forthcoming subrogation recoveries for the MLR reporting period. Additionally, the health plan reported third party vendor, OptumInsight, contingency fees netted within the recoveries. Subrogation gross recoveries should be reported as a reduction to incurred claims, however, the associated third party vendor contingency fees should be reported as administrative expenses. An adjustment was proposed to reduce incurred claims related to additional subrogation recoveries and remove non-qualifying contingency fees 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	($751,803)

Adjustment #12 – To adjust premium 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	$8,719,245

Adjustment #13 – To adjust earned withhold payments per state data

The health plan reported an estimated amount for the anticipated pay for performance 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	$2,396,315

Adjustment #14 – To adjust risk corridor settlements 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	($1,199,252)

Adjustment #15 – 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	235

Adjustment #16 – To adjust federal income taxes and allocation methodology per health plan supporting documentation

The health plan reported income taxes that did not reconcile to supporting documentation. It was determined the health plan appropriately removed taxes for investment income and factored in the change in deferred tax assets noted in the audited financial statements. An adjustment was proposed to increase taxes to the appropriate amounts per health plan supporting documentation, including applying the appropriate Medicaid allocation methodology. 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	$207,233

Adjustment #17 – To remove non-qualifying CBE per health plan supporting documentation

The health plan inappropriately reported community benefit expenditures (CBE) for the MLR reporting period. As a for-profit entity, the health plan should report income taxes instead of CBE. An adjustment was proposed to remove CBE per health plan supporting documentation. The CBE 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	($71,868)

Adjustment #18 – 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, including the final risk corridor cost settlement. 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	$3,410,556