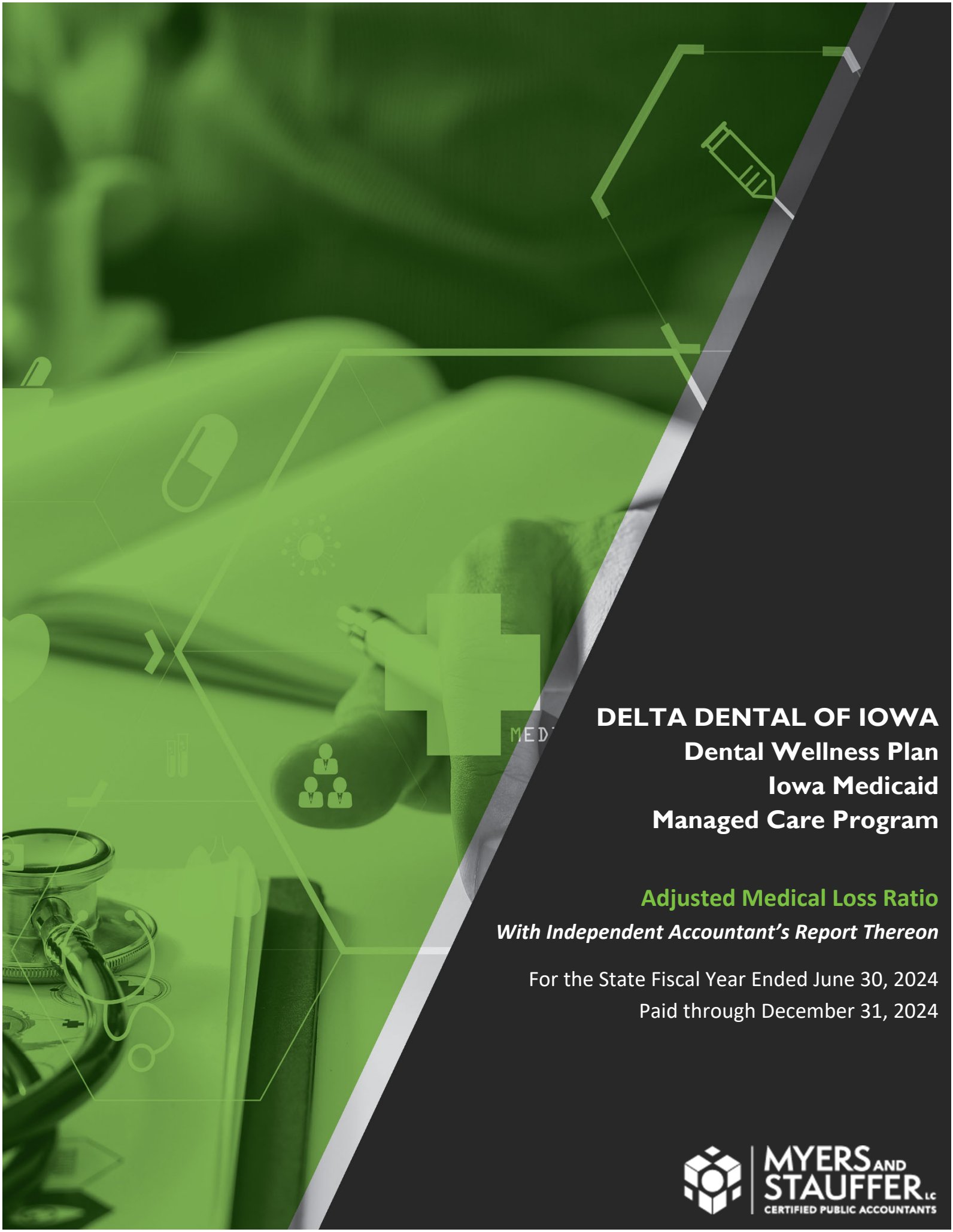

DELTA DENTAL OF IOWA
Dental Wellness Plan
Iowa Medicaid
Managed Care Program

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

Table of Contents

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 Delta Dental of Iowa (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 17, 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	$ 71,911,206	$ (32,446)	$ 71,878,760
1.2	Activities that Improve Health Care Quality	$ 386,545	$ (103,992)	$ 282,553
1.3	MLR Numerator	$ 72,297,751	$ (136,438)	$ 72,161,313
1.4	Non-Claims Costs (Not Included in Numerator)	$ 8,060,669	$ -	$ 8,060,669
2.	**Medical Loss Ratio Denominator**			
2.1	Premium Revenue	$ 71,579,251	$ 7,020,739	$ 78,599,990
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$ 823,012	$ (306,369)	$ 516,643
2.3	MLR Denominator	$ 70,756,240	$ 7,327,108	$ 78,083,348
3.	**MLR Calculation**			
3.1	Member Months	4,956,137	5,639	4,961,776
3.2	Unadjusted MLR	102.2%	-9.8%	92.4%
3.3	Credibility Adjustment	0.0%	0.0%	0.0%
3.4	Adjusted MLR	102.2%	-9.8%	92.4%
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.*

Note: The amounts reflected within the MLR calculation on line 2.3 contain a variance due to rounding.

Schedule of Adjustments

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

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

The health plan reported value-added services (VAS) expenses 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	($32,446)

Adjustment #2 – To remove non-qualifying HCQI/HIT expenses per health plan supporting documentation

The health plan reported health care quality improvement (HCQI) and health information technology (HIT) expenses based on salaries and benefits and vendor costs. It was determined the health plan included non-qualifying expenses based on federal guidance. An adjustment was proposed to remove non-qualifying vendor costs 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	($103,992)

Adjustment #3 – To adjust the risk corridor settlement to include state directed payments per health plan supporting documentation

A risk corridor was contractually in effect for the medical loss ratio (MLR) reporting period. The final risk corridor calculation occurred subsequent to the filing of the MLR. The MLR calculated an inappropriate risk corridor settlement by excluding state directed payments. The final risk corridor did not result in a settlement. An adjustment was proposed to correctly reflect the state directed payments in the calculated risk corridor settlement per health plan supporting documentation. 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	$7,020,739

Adjustment #4 – 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	5,639

Adjustment #5 – To reclassify qualifying CBE, remove non-qualifying CBE, and revise the allocation methodology utilized between lines of business per health plan supporting documentation

The health plan reported community benefit expenditures (CBE) for the MLR reporting period. The expenses were tested to determine qualifying CBE based on federal guidance. An adjustment was proposed to reclassify qualifying CBE within Adjustment #2, remove non-qualifying CBE, and reflect the appropriate allocation methodology 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	($306,369)