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June 13, 2025

Ms. Kelly Garcia
Iowa Department of Health and Human Services Director
Department of Health and Human Services
1305 East Walnut Street
Des Moines, IA 50319-0114

PROPRIETARY AND CONFIDENTIAL

Subject: **SFY26 IA Health Link Managed Care Rate Development**

Dear Ms. Garcia:

Thank you for the opportunity to assist the Department of Health and Human Services (HHS) and Iowa Medicaid with the development of the SFY26 IA Health Link capitation rates. The following report summarizes the methodology for the development of the capitation rates, effective July 1, 2025 – June 30, 2026 (SFY26). We have also provided our actuarial certification for these capitation rates, compliant with CMS guidelines and requirements. Please send me an email at barry.jordan@optumas.com or email Stephanie at stephanie.taylor@optumas.com if you have any questions.

Sincerely,

Barry Jordan, FSA, MAAA
Managing Director, CBIZ Optumas

Stephanie Taylor, ASA, MAAA
Senior Manager, CBIZ Optumas

CC: Joanne Bush, Iowa Medicaid
Jared Nason, CBIZ Optumas
Clifford Morrison, CBIZ Optumas
Michael Schmidt, CBIZ Optumas

CBIZ Optumas, LLC
7400 E. McDonald Dr., Suite 101
Scottsdale, AZ 85250
480-588-2499

Iowa Medicaid

IA Health Link Actuarial Certification

July 1, 2025 – June 30, 2026 Capitation Rates

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Executive Summary

Background

This report provides documentation and actuarial certification for the IA Health Link capitation rate development for rates effective July 1, 2025 – June 30, 2026 (SFY26).

The Iowa Department of Health and Human Services (HHS) implemented the IA Health Link program on April 1, 2016 as part of the Medicaid Modernization initiative. The majority of Iowa Medicaid members are enrolled in the IA Health Link program and receive physical health, behavioral health, pharmacy prescriptions, and long-term services and supports through the contracted managed care organizations (MCOs). A small portion of Medicaid members continue to be served through Medicaid fee-for-service (FFS). The Medicaid Modernization initiative aims to improve quality and access to care, promote accountability for patient outcomes, and create a more predictable and sustainable budget.

This document provides an explanation of the methodologies used in the development of the capitation rates for the IA Health Link program effective July 1, 2025 through June 30, 2026. Iowa Medicaid first contracted with CBIZ Optumas (Optumas) to develop actuarially sound capitation rates for the IA Health Link program beginning with the July 1, 2018 through June 30, 2019 (SFY19) rate development.

When the IA Health Link program began on April 1, 2016, three MCOs were contracted with Iowa Medicaid. Since then, the program has had two or three MCOs operating the program within each rating period. Within the SFY26 contract period the following health plans are contracted with Iowa Medicaid with the date they entered the Iowa Medicaid market noted:

- Wellpoint Iowa, Inc. (formerly known as Amerigroup Iowa, Inc. prior to January 1, 2024)
    - Operating since the program's inception on April 1, 2016.
- Iowa Total Care (ITC)
    - Entered the market on July 1, 2019.
- Molina Healthcare of Iowa
    - Entered the market on July 1, 2023.

As the consulting actuaries to HHS and Iowa Medicaid (State), Optumas worked with the State to create an appropriate rate setting methodology for the SFY26 IA Health Link capitation rates. Optumas ensured the methodology used to develop the SFY26 rates complies with the Centers for Medicare & Medicaid Services (CMS) guidance for the development of actuarially sound rates, 42 Code of Federal Regulations (CFR) §438.4, as well as 438.5, 438.6, and 438.7. Optumas worked with the State to identify the necessary rate development components for the SFY26 rating period, accounting for the covered services and populations as described in the IA Health Link contracts. The final rates were developed according to actuarially sound principles and reasonably reflect the experience projected for the SFY26 IA Health Link program.

This document is structured consistent with the CMS 2024-2025 Medicaid Managed Care Rate Development Guide, which is the most recent version of the guide at the time of rate development. Any sections that are not applicable are noted as such but have been included for completeness.

Summary of Capitation Rates

In developing the SFY26 capitation rates, Optumas adhered to guidance provided by CMS in accordance with 42 CFR §438.4, the CMS standards for developing actuarially sound capitation rates for Medicaid managed care programs. CMS defines actuarially sound rates as meeting the following criteria:

I. They have been developed in accordance with generally accepted actuarial principles and practices,
II. They are appropriate for the populations to be covered and the services to be furnished under the contract, and
III. They have been certified by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows practice standards established by the Actuarial Standards Board.

Optumas specifically considered the following Actuarial Standards of Practice (ASOPs) when developing the IA Health Link capitation rates:

- ASOP 1 – Introductory Actuarial Standard of Practice
- ASOP 5 – Incurred Health and Disability Claims
- ASOP 12 – Risk Classification (for All Practice Areas)
- ASOP 23 – Data Quality
- ASOP 25 – Credibility Procedures
- ASOP 41 – Actuarial Communications
- ASOP 45 – The Use of Health Status Based Risk Adjustment Methodologies
- ASOP 49 – Medicaid Managed Care Capitation Rate Development and Certification
- ASOP 56 – Modeling

Optumas worked in conjunction with Iowa Medicaid to develop an appropriate rate setting methodology which incorporated the necessary adjustments to ensure that the rates for the contract period were reasonable, appropriate, and attainable. The body of this document outlines the CMS 2024-2025 Medicaid Managed Care Rate Development Guide with compliance to each section discussed in detail.

The certified capitation rates for the IA Health Link managed care program gross of withholds and the additional graduate medical education (GME) and ground emergency medical transportation (GEMT) payments, effective July 1, 2025 - June 30, 2026, can be found in Appendix I.A. Note that estimates associated with directed payments that are operationalized as separate payment terms are not included within Appendix I.A but are shown later in Appendix I.C, as they are not explicitly built into the capitation rates.

Fiscal Impact Estimate

The estimated aggregate fiscal impact of the SFY26 IA Health Link rate changes, gross withhold and gross additional payments, is an annual increase of $392M based on SFY24 enrollment, which is the base data period used for rate development. The annual fiscal impact is shown in Appendix II.A and is based on a

comparison of the SFY26 certified capitation rates and the SFY25 Midyear Addendum rates, certified on February 24, 2025.

Rate Development Summary

A brief description of each component in the rate development process is shown in Appendix II.B. Each step of the SFY26 rate development will be discussed in further detail throughout the remainder of the document.

Section I. Medicaid Managed Care Rates

1. General Information

A. Rate Development Standards

i. Rate Range Standards

Optumas understands that unless otherwise stated, all standards and documentation expectations outlined in the CMS rate development guide for capitation rates also apply for the development of the upper and lower bounds of rate ranges, in accordance with 42 CFR §438.4(c). Optumas is certifying capitation rates and not capitation rate ranges. As such, any sections pertaining only to capitation rate ranges are not applicable but have been included for completeness.

ii. Contract Period

The rates contained in this certification are effective for the one-year period from July 1, 2025 through June 30, 2026 (SFY26).

iii. Required Components

Letter from Certifying Actuary

The rates contained in this document have been certified by Barry Jordan, Member of the American Academy of Actuaries (MAAA), and a Fellow of the Society of Actuaries (FSA) and Stephanie Taylor, Member of the American Academy of Actuaries (MAAA), and an Associate of the Society of Actuaries (ASA). Mr. Jordan and Ms. Taylor meet the requirements for an actuary in 42 CFR §438.2 and have certified that the final capitation rates meet the standards in 42 CFR §§ 438.3(c), 438.3(e), 438.4, 438.5, 438.6, and 438.7. The certification letter is included at the end of this document.

Final Certified Capitation Rates

The final and certified capitation rates for all rate cells are provided in Appendix I.A in accordance with 42 CFR §438.4(b)(4) and 42 CFR §438.3(c)(1)(i).

Description of Program

The Iowa Department of Health and Human Services (State) developed the IA Health Link program by contracting with three managed care organizations (MCOs) to begin service on April 1, 2016 as part of the Medicaid Modernization initiative. The majority of existing 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. A small portion of Medicaid members are served through Medicaid fee-for-service (FFS). The objectives of the Medicaid Modernization initiative are to improve quality and access to care, promote accountability for patient outcomes, and create a more predictable and sustainable budget.

When the IA Health Link program began on April 1, 2016, three MCOs were contracted with Iowa Medicaid. Since then, the program has had two or three MCOs operating the program within each rating

period. Within the SFY26 contract period the following health plans are contracted with Iowa Medicaid with the date they entered the Iowa Medicaid market noted:

- Wellpoint Iowa, Inc. (formerly known as Amerigroup Iowa, Inc. prior to January 1, 2024)
  - Operating since the program's inception on April 1, 2016.
- Iowa Total Care (ITC)
  - Entered the market on July 1, 2019.
- Molina Healthcare of Iowa
  - Entered the market on July 1, 2023.

MCOs participating in the IA Health Link program are required to provide benefits that include physical health, long-term services and supports, behavioral health, and pharmacy prescriptions. As outlined in the MCO contracts, Iowa Medicaid has carved out high-cost drugs with a per individual dose or treatment cost of $1.5M or greater from the services covered under the capitation rates. The MCOs will provide coverage of these drugs to eligible beneficiaries consistent with other pharmaceuticals and treatments; however, the State will reimburse the MCOs via invoices billed to Iowa Medicaid. Within the SFY24 base period, Zolgensma and Elevidys were the only high-cost drugs incurred and invoiced by the MCOs, and the experience has been carved out of the base data used for rate development.

Dental services and the Program of All-Inclusive Care for the Elderly are covered under separate managed care programs for the eligible populations. The base data was summarized into rating Categories of Service (COS) consistent with the SFY25 rate development, with the addition of Home Based Habilitation, shown in *Table 1* below:

Table 1. Rating Categories of Service

Categories of Service (COS)	
Behavioral Health – Inpatient	Inpatient – Professional
Behavioral Health – Outpatient	Laboratory (Lab)/Radiology (Rad)
Behavioral Health – Professional	Nursing Home and Hospice
Day Services	Other Care
Durable Medical Equipment (DME)/Prosthetics	Other Home- and Community-Based Services (HCBS)
Family Planning	Outpatient – Emergency Room
Federally Qualified Health Center (FQHC)/Rural Health Center (RHC)	Outpatient – Non-Emergency Room
Home Based Habilitation	Outpatient – Professional
Home Health	Pharmacy
Intermediate Care Facility for the Intellectually Disabled (ICF/ID)	Professional Office
Indian Health Services	Transportation
Inpatient	Waiver

MCOs participating in the IA Health Link program are required to provide benefits for all eligible populations. Populations have been grouped by similar risk patterns and specific rates have been set for each rate cell in accordance with 42 CFR §438.4(b)(4) and 438.7(c). The individual rate cells used for the SFY26 rate development are consistent with historical contract periods. For summary purposes, these

rate cells have been grouped into the following high-level Categories of Aid (COA) shown in *Table 2* below:

Table 2. IA Health Link Rate Cells and COA

Rate Cell	COA
Children 0-59 days old, Male and Female (M&F)	Children
Children 60-364 days M&F	Children
Children 1-4 M&F	Children
Children 5-14 M&F	Children
Children 15-20 F	Children
Children 15-20 M	Children
Children's Health Insurance Program (CHIP) - Hawki	Children
Non-Expansion Adults 21-34 F	Temporary Assistance for Needy Families (TANF) Adult
Non-Expansion Adults 21-34 M	TANF Adult
Non-Expansion Adults 35-49 F	TANF Adult
Non-Expansion Adults 35-49 M	TANF Adult
Non-Expansion Adults 50+ M&F	TANF Adult
Pregnant Women	Pregnant Women
Wellness Plan (WP) 19-24 F (Medically Exempt)	Wellness Plan
WP 19-24 M (Medically Exempt)	Wellness Plan
WP 25-34 F (Medically Exempt)	Wellness Plan
WP 25-34 M (Medically Exempt)	Wellness Plan
WP 35-49 F (Medically Exempt)	Wellness Plan
WP 35-49 M (Medically Exempt)	Wellness Plan
WP 50+ M&F (Medically Exempt)	Wellness Plan
WP 19-24 F (Non-Medically Exempt)	Wellness Plan
WP 19-24 M (Non-Medically Exempt)	Wellness Plan
WP 25-34 F (Non-Medically Exempt)	Wellness Plan
WP 25-34 M (Non-Medically Exempt)	Wellness Plan
WP 35-49 F (Non-Medically Exempt)	Wellness Plan
WP 35-49 M (Non-Medically Exempt)	Wellness Plan
WP 50+ M&F (Non-Medically Exempt)	Wellness Plan
Aged, Blind, and Disabled (ABD) Non-Dual <21 M&F	Disabled
ABD Non-Dual 21+ M&F	Disabled
Residential Care Facility	Disabled
Breast and Cervical Cancer	Disabled
Dual Eligible 0-64 M&F	Dual
Dual Eligible 65+ M&F	Dual
Custodial Care Nursing Facility <65	Institutional
Custodial Care Nursing Facility 65+	Institutional
Elderly HCBS Waiver	Waiver
Non-Dual Skilled Nursing Facility	Institutional
Dual HCBS Waivers: Physically Disabled (PD); Health and Disability (H&D)	Waiver

Rate Cell	COA
Non-Dual HCBS Waivers: PD; H&D; Acquired Immunodeficiency Syndrome (AIDS)	Waiver
Brain Injury HCBS Waiver	Waiver
Intermediate Care Facility for persons with an Intellectual Disabled (ICF/ID)	Institutional
State Resource Center (SRC)	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 M&F	Children
CHIP - Children 60-364 days M&F	Children
CHIP - Children 1-4 M&F	Children
CHIP - Children 5-14 M&F	Children
CHIP - Children 15-20 F	Children
CHIP - Children 15-20 M	Children
TANF Maternity Case Rate	Maternity Case Rate
Pregnant Women Maternity Case Rate	Maternity Case Rate

The certification letter includes documentation for the following special contract provisions related to payment underlying the capitation rates:

- Withhold arrangement,
- Minimum medical loss ratio requirement,
- Program-wide risk corridor arrangement, and
- State directed payments and alternative minimum fee schedule payments per 42 CFR §438.6(c).

The rates certified within this document are the original capitation rates for the SFY26 contract period. If the State and Optumas determine that a retroactive adjustment to the capitation rates is necessary, these retroactive adjustments will be certified by an actuary in a revised certification and submitted as a contract amendment in accordance with 42 CFR §438.7(c)(2). The revised rate certification will include a description of the rationale for the adjustment, the data, assumptions, and methodologies used to develop the magnitude of the adjustment, whether the state adjusted rates in the rating period by a *de minimis* amount in accordance with 42 CFR §438.7(c)(3) prior to the submission of the rate amendment, and will address and account for all differences from the most recently certified rates.

iv. Differences Among Capitation Rate Assumptions

Any differences in the assumptions, methodologies, and factors used to develop the SFY26 IA Health Link capitation rates for covered populations are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations. Any differences in the assumptions, methodologies, and factors used to develop the SFY26 IA Health Link capitation rates do not vary with the rate of Federal Financial Participation (FFP) associated with the covered populations in a manner that increases Federal costs.

v. Rate Cell Cross-Subsidization

There is no rate cell cross-subsidization within the SFY26 IA Health Link capitation rates.

vi. Program Change Effective Dates

The effective dates of changes to the IA Health Link Medicaid managed care program are consistent with the assumptions used to develop the capitation rates. The assumptions and adjustments are described in greater detail in Section I.2 in this document.

vii. Medical Loss Ratio (MLR)

The IA Health Link program capitation rates were developed using generally accepted actuarial practices and principles. The rates were developed in such a way that they provide reasonable, appropriate, and attainable non-benefit costs and that each MCO would reasonably achieve an MLR of at least 85% for the contract period. The State requires a minimum MLR of 88% for the MCOs operating within the IA Health Link program for SFY26. Further details on this arrangement are described within the Risk-Sharing Mechanisms section of this document.

viii. Rate Range Certification

This document certifies the specific SFY26 IA Health Link rates for each rate cell and does not certify a range of capitation rates for each rate cell.

ix. Rate Range Documentation

This document certifies the specific SFY26 IA Health Link rates for each rate cell and does not certify a range of capitation rates for each rate cell.

x. Generally Accepted Actuarial Practices

Reasonable, Appropriate, and Attainable Costs

All adjustments to the capitation rates, or to any portion of the capitation rates, reflect reasonable, appropriate, and attainable costs in the actuary's judgment and are included in the rate certification.

Adjustments Outside the Rate Setting Process

No adjustments are made outside of the rate setting process described in the rate certification. Adjustments to the rates that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 CFR §438.4.

Final Contracted Rates

Consistent with 42 CFR §438.7(c), the final contracted rates in each rate cell match the capitation rates in the rate certification.

xi. Rate Certification Periods

The rates in this document were developed for the SFY26 contract period and are certified for the SFY26 period, effective from July 1, 2025 through June 30, 2026.

xii. COVID-19 Public Health Emergency (PHE)

Optumas developed an acuity adjustment to model the impact of the changing per-member per-month (PMPM) costs associated with the disenrollments that have occurred due to the end of the PHE continuous eligibility requirement (disenrollment freeze). Additional details related to this adjustment are provided in Section I.7 of this document. Other COVID-19 PHE-related adjustments are described in Section I.2.

For the SFY26 contract period there will continue to be a two-sided risk mitigation strategy, which is partially in response to a continued shift in acuity associated with the completion of the COVID-19 PHE unwind.

Optumas has included narrative support describing the evaluation conducted, and the rationale for any applicable assumptions included or not included in rate development related to the COVID-19 PHE unwind within the applicable sections of this rate certification.

xiii. Amendments

Federal Financial Participation (FFP)

The State of Iowa intends to claim FFP for the IA Health Link capitation rates and will comply with the time limit for filing claims for FFP specified in section 1132 of the Social Security Act and implementing regulations at 45 CFR Part 95.

Changes to Rates

Any changes to the rates will result in the submission of a new rate certification, except for changes permitted as specified in 42 CFR §438.4(c) or 42 CFR §438.7(c)(3).

Contract Amendments

If contract amendments revise the covered populations, services furnished under the contract, or other changes that could reasonably change the rate development and rates, supporting documentation will be provided indicating the rationale as to why the rates continue to be actuarially sound in accordance with 42 CFR §438.4.

Limited Payment Changes

Supporting documentation rather than a new or revised certification will be provided to CMS if the actuarially sound capitation rates per rate cell outlined in this certification increase or decrease, as

required in 42 CFR §§ 438.7(c) and 438.4(b)(4), up to 1.5% during the rating period, in accordance with 42 CFR §438.7(c)(3).

Other Changes

A contract amendment will be submitted any time a rate changes for any reason other than application of an approved payment term included in the initial managed care contract.

Changes in Federal Statutes or Regulatory Authority

Optumas and Iowa Medicaid will submit a rate amendment if any IA Health Link program features are invalidated by courts of law, or by changes in federal statutes, regulations, or approvals. The rate amendment will adjust the capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law, taking into account the effective date of the loss of program authority.

B. Appropriate Documentation

i. Certification of Capitation Rates or Rate Ranges

This document certifies the specific SFY26 IA Health Link rates for each rate cell and does not certify a range of capitation rates for each rate cell.

ii. Documentation of Data, Assumptions, and Methodology

Data used, secondary data sources, justification for assumptions, and methods for analyzing data and developing adjustments are described in the relevant sections of this certification letter.

iii. Medical Loss Ratio (MLR)

The IA Health Link program capitation rates were developed using generally accepted actuarial practices and principles. The rates were developed in such a way that they provide reasonable, appropriate, and attainable non-benefit costs and that each MCO would reasonably achieve an MLR of at least 85% for the contract period. The State requires a minimum MLR of 88% for the MCOs operating within the IA Health Link program for SFY26. Further details on this arrangement are described within the Risk-Sharing Mechanisms section of this document.

iv. Rating Assumption Variations

This document provides rate certification for the IA Health Link program, and the actuaries certify to specific rates for each rate cell, not rate ranges, in accordance with 42 CFR §§ 438.4(b)(4) and 438.7(c). The certification discloses and supports the specific assumptions that underlie the certified rates for each rate cell, including the magnitude and narrative support for each specific assumption or adjustment. To the extent assumptions or adjustments underlying the capitation rates vary between managed care plans, the certification describes the basis for this variation.

v. Rate Range Requirements

This document certifies the specific SFY26 IA Health Link rates for each rate cell and does not certify a range of capitation rates for each rate cell.

vi. Index

This rate certification follows the structure of the CMS 2024-2025 Medicaid Managed Care Rate Development Guide. The table of contents at the beginning of this document serves as an index that documents the page number or the section number for the items described within the guidance. Inapplicable sections of the guidance are included for completeness and marked as "Not Applicable."

vii. FFP Assurance

Optumas confirms that any proposed differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations comply with 42 CFR §438.4(b)(1) and are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations. These differences do not vary with the rate of FFP associated with the populations in a manner that increases federal costs.

viii. FMAP

There are services, populations, or programs for which the state receives a different federal medical assistance percentage (FMAP) than the regular state FMAP. Appendix I.A contains final capitation rates by rate cell.

ix. Rate Change Comparison

A comparison of the statewide SFY26 capitation rates to the IA Health Link SFY25 Midyear Addendum rates is shown in Appendix II.A.

In aggregate across all rate cells, there is a 5.6% rate increase between the SFY25 Midyear Addendum rates and SFY26 capitation rates, gross withhold and gross additional payments. The SFY25 rate development relied on SFY23 base data experience while SFY26 relied on SFY24 base data experience. As a result, some rate cells have rate changes that are primarily driven by the changes in underlying base data.

The following rate cells have statewide rate changes greater than +/- 10% between the IA Health Link SFY25 Midyear Addendum rates and the SFY26 capitation rates:

- Children 0-59 days M&F and CHIP – Children 0-59 days M&F
- All WP Medically Exempt rate cells
- WP 25-34 M (Non-Medically Exempt)
- ABD Non-Dual <21 M&F
- ABD Non-Dual 21+ M&F
- Residential Care Facility
- Breast and Cervical Cancer

- PMIC
- Children's Mental Health HCBS Waiver

The driver of the large rate changes for most of these rate cells is a combination of the revised base data, which reflects a shift from SFY23 to SFY24, and higher projected benefit cost trends between the SFY24 base period and SFY26 contract period. The ABD Non-Dual <21 M&F and ABD Non-Dual 21+ M&F rate cells received an acuity adjustment within the SFY26 rates as a result of higher observed "Stayer" costs in emerging data, whereas these cohorts were not adjusted in the SFY25 acuity adjustment.

All components of the rate development and material changes to the capitation rates between the IA Health Link SFY25 and SFY26 rates are described in further detail within the remainder of the document. Each component of the rate development process is shown within Appendix I.B.

x. Known Amendments

The following rating adjustments are expected to be potentially made within a future rate amendment for the SFY26 contract period:

- Adjustments for legislatively approved policy changes that at the time of rate development were not yet signed by the Governor's office but are expected to have an effective date within SFY26.
- SFY26 provider fee updates which may include ICF/ID, Hospice, Nursing Facility, and GEMT. The rates reflect either the current SFY25 fee schedules, or draft SFY26 fee schedules pending finalization, for these services.
- Certified Community Behavioral Health Clinic (CCBHC) implementation.
- Implementation of Home Health acuity tiers.
- Inpatient hospital rate rebase.
- The impact of policy changes associated with maternity unbundling.
- The impact of changes in Emergency Room reimbursement associated with the Prudent Layperson policy change.
- Reimbursement increases for newborn screening services.
- The associated impacts on the non-medical load for additional staffing ratio requirements and assessor transitions associated with the population receiving Habilitation services.
- The associated impacts on the non-medical load related to care coordination shifts as they relate to Integrated Health Homes and the CCBHC implementation.
- Potentially revised Long-Term Services and Supports (LTSS) blend snapshot period based on more recent emerging experience.
- Potential changes to the Graduate Medical Education (GME) supplemental payment.
- A legislatively mandated premium tax change, reducing the tax from 0.950% to 0.925%, is expected to occur effective January 1, 2026.

An amendment is expected to be provided to CMS in September of 2025 documenting the impact of these rating adjustments. Additionally, a midyear amendment, submitted in January 2026, is expected to account for the premium tax change and any other applicable program changes that have an effective date after January 1, 2026.

The only other known amendments that will be provided to CMS in the future associated with the SFY26 capitation rates are the reconciliations associated with the separate payment term directed payments which are reimbursed outside of the capitation rates. Consistent with CMS requirements, Optumas has

included initial PMPM estimates by rate cell associated with these separate payment term arrangements in Appendix I.C. Once the contract period is over, Iowa Medicaid and Optumas will perform a reconciliation and revise the PMPMs based on actual directed payment utilization rendered within SFY26.

xi. COVID-19 Public Health Emergency Documentation

State Specific, National, or Regional Data and Information

Optumas used IA Health Link managed care encounter data in determining how to address the COVID-19 PHE unwind within the SFY26 rate development. In particular, Optumas reviewed emerging IA Health Link encounters and enrollment data through January 2025. Additional details on the specific data and assumptions used for each rating adjustment are included within the program change descriptions later in this document.

Description of Direct and Indirect Impacts

The SFY26 IA Health Link capitation rates directly account for the impacts of the COVID-19 PHE unwind through various rating adjustments described later in this document. The base data used for rate development is SFY24 data which includes impacts of COVID-19, including the significant member disenrollments associated with the PHE unwinding. The following rating adjustments were made to reflect expected changes in reimbursement between the SFY24 base data and SFY26 contract period as a result of policy changes associated with the ending of the PHE:

- Reinstatement of Copayments
- Carve-In and Repricing of COVID-19 Vaccine Administration and Ingredient Costs

An explicit acuity adjustment was made as a result of the COVID-19 PHE unwind and the significant member disenrollments that occurred throughout SFY24. More information on this adjustment is provided in Section I.7 of this document.

Non-Risk Basis Costs

Effective October 1, 2024, COVID-19 vaccine administration services were no longer carved out of the capitation rates. The COVID Vaccines Carve-In adjustment accounts for the MCOs' responsibility of providing COVID-19 vaccines and administration at the most recent reimbursement rates available. More information on this adjustment can be found in Section I.2.B.ii.

Risk Mitigation Strategies

Consistent with the SFY25 contract period, a two-sided risk corridor and minimum MLR requirement remain in place for the IA Health Link program for the SFY26 contract period as a result of the uncertainties in population acuity shifts associated with the ending of the COVID-19 pandemic and other IA Health Link program dynamics, such as the implementation of CCBHCs. The minimum MLR remains the same as the SFY25 contract period, but the risk corridor bands have been reduced from +/- 3.0% to +/- 2.0% to account for increased uncertainty surrounding upcoming HHS policy changes. More details can be found in Section I.4.

2. Data

A. Rate Development Standards

i. Base Data

Encounter Data, FFS Data, and Audited Financial Reports

Optumas received detailed Medicaid Management Information System (MMIS) encounter data, FFS data, State eligibility spans, and IA Health Link capitation payments from the program's inception (April 1, 2016) through March 31, 2025, with encounter submissions through March 2025. This data reflects actual experience for the Medicaid populations served by the IA Health Link MCOs. Optumas received member-level capitation files that were used to match up to the detailed encounters to ensure all claims used for rate development were for IA Health Link enrolled members.

Optumas summarized the data for comparison with financial templates that were submitted by each of the MCOs to help validate the MMIS encounter data. The detailed capitations and encounters for the emerging IA Health Link experience were also benchmarked to the base data used within the SFY25 rate development.

Appropriate Base Data

Optumas selected SFY24 (July 1, 2023 – June 30, 2024) encounter data as the base data for rate development. The SFY24 encounters represent the most recent complete year of IA Health Link program experience available at the time of rate development.

Medicaid Population

The base data used for rate setting represents detailed encounter data and enrollment for the Medicaid population in Iowa, as it consists of actual experience for the IA Health Link program.

Exceptions

The base data used for this rate setting falls within the most recent and complete three years prior to the rating period so no request for an exception is necessary.

B. Appropriate Documentation

i. Base Data

Data Requested by Actuary

Optumas requested all encounter data for the IA Health Link Program (April 2016 – March 2025), FFS claims, and all corresponding eligibility and capitation information from Iowa Medicaid. Additionally,

Optumas requested summarized financial data from each MCO reported in financial templates through the end of CY24.

Data Provided

Iowa Medicaid and the MCOs provided all information requested by Optumas.

Data Not Provided

All data requested was provided by Iowa Medicaid.

ii. Rate Development Data

Data Description

The base data used for the SFY26 rate setting consists of SFY24 encounters and capitation data from the IA Health Link program. Additional IA Health Link encounters outside of the SFY24 time period, as well as MCO financial summaries, and MCO detailed enrollment data were used to inform assumptions or adjustments to the base data. The data used to inform adjustments and program changes within the rate setting process is described for each adjustment throughout the document and a brief summary has been included in *Table 3* below:

Table 3. Data Source Summary

Data Type	Data Source	Level of Detail	Start Date	End Date
MMIS Encounters	Iowa Medicaid	Detailed	04/01/2016	3/31/2025
Capitation Payments	Iowa Medicaid	Detailed	04/01/2016	3/31/2025
FFS Claims	Iowa Medicaid	Detailed	01/01/2015	3/31/2025
Eligibility	Iowa Medicaid	Detailed	01/01/2015	3/31/2025
Financial Template (Encounters, other medical-related costs, admin, and enrollment)	All MCOs	Summarized	04/01/2016	12/31/2024

Optumas uses the paid amount submitted within the MMIS encounter data as the basis of rate development. The paid amount within the MMIS encounter data is net of third-party liability coverage (TPL), copays, and patient liability amounts and reflects the amount that the MCOs pay to providers for services rendered within the base data period. HHS and Iowa Medicaid do not dictate the payment structure for any of the MCO value-based purchasing (VBP) arrangements that are part of the general MCO contracts. Since the IA Health Link MMIS encounter experience is used as the basis of rate development the base data inherently reflects all provider reimbursement arrangements that the MCOs have in place, outside of additional payments provided by the MCOs as discussed within the completion factors section below. Thus, there are no additional adjustments necessary within the rate development process to account for the VBP arrangements that the MCOs are implementing to meet contractual requirements.

The base data reflects non-subcapitated claim payments from the MCOs to providers for services incurred during SFY24. The GEMT state directed payment program began on July 1, 2019. The enhanced

reimbursement for these services is billed under procedure code A0999, which has been excluded from the base data to avoid duplication. An estimate for the impact of this directed payment is reflected in the rates at the end of the rate development and is described in Section I.4.D of this document.

Per the MCO contracts, certain high-cost drugs costing $1.5M or more per dose or treatment are excluded from the capitation rates. One claim for Zolgensma and one claim for Elevidys were incurred during SFY24 and the utilization and cost for these claims were excluded from the base data compilation. Additionally, claims for value-added services that are not covered by the IA Health Link contract are reviewed and removed to the extent they are inherent in the MMIS encounters. Iowa Medicaid and the MCOs provided Optumas with the necessary logic to identify these services and exclude them from the encounters underlying the base data that was summarized and compared to the reported MCO financials.

Effective October 1, 2024, the MCOs are at risk for the cost of COVID-19 vaccine administration, and these costs are reflected in the SFY26 capitation rates; therefore, these costs were included within the SFY24 base data.

The IA Health Link MCOs have subcapitated arrangements for a small suite of services that varies by MCO. The underlying claims associated with MCO subcapitated services are inherent within the MMIS encounter data received from Iowa Medicaid. Additionally, the MCOs report the subcapitated services within the financial templates for Optumas to monitor and validate against the MMIS encounter data. Optumas excluded the MMIS subcapitated encounters from the initial base data used for rate development and reincorporated the MMIS subcapitated encounters after the application of the Reporting/IBNR adjustment. Further details on the subcapitated adjustment within the base data development are described below in Section I.2.B.iii.

Data Availability and Quality

Optumas validated the detailed MMIS encounter data through the use and review of control totals, financial templates, and monthly volume comparisons. Optumas has no concerns with the completeness or the accuracy of the IA Health Link MMIS encounter data used as the basis of rate development. As discussed in Section I.2.b.iii below, the MMIS encounters are consistent with the reported financials provided by the IA Health Link MCOs and very minimal reporting adjustments are necessary to align the MMIS encounter data with the MCO financial reports.

To ensure compliance with ASOP 23 – Data Quality, Optumas conducted the following data validation analyses as part of the initial steps of the rate development process:

1. **Referential Integrity Checks** – Optumas ensured that all encounters included in base data were incurred by a member with a valid Medicaid eligibility span that coincided with the incurred date associated with the specific encounter.

2. **Volume Checks** – Optumas checked both volume of encounters and service expenditures by looking at utilization, unit cost, and PMPM expenditures totals longitudinally by COA and COS. This ensured that any gaps or spikes in the data were identified and addressed before creating the base data. No additional adjustments to the base data were required.

3. **Benchmark Comparison** – Optumas compared summarized data to other base data summaries used in reference programs in other states for benchmarking purposes. Additionally, Optumas compared the MMIS encounter data to the reported financials from the MCOs to ensure consistency of the data across sources and that the base data used for rate development was complete.

Optumas relied upon the encounter, FFS, and capitation data provided by HHS and the contracted MCOs. Optumas determined that the data used was suitable for the purpose of developing actuarially sound rates for the SFY26 contract period since there were no concerns over the availability or quality of the data received from the State.

Appropriate Data

Optumas chose to limit the base period to SFY24 encounter data since SFY24 represents the most recent complete year of data available for the IA Health Link program at the time of rate development.

Reliance on a Databook

Optumas did not rely on an external databook in developing the IA Health Link capitation rates and instead relied on SFY24 program-specific detailed encounter and capitation data. Data sources used in rate development are described in the preceding sections.

iii. Adjustments

Data Credibility

Optumas worked with Iowa Medicaid and the MCOs to ensure the detailed encounter data and MCO financial templates were interpreted correctly and applied consistently within rate development. Through the financial comparisons Optumas determined that a combined Incurred But Not Reported (IBNR) and Reporting adjustment of 0.2% was necessary to fully capture the MCO medical encounter expenditures for the base data period.

Consistent with historical IA Health Link rate development cycles since the program's inception, certain CHIP rate cell populations were deemed to have insufficient enrollment volume to develop stand-alone rates. As a result, all non-Hawki CHIP enrollment, costs, and utilization were included with the more substantial corresponding Medicaid children rate cells to enhance credibility. The combined rate cells are shown within *Table 4* below.

Table 4. CHIP Children Rate Cells

Original Rate Cell	Combined Rate Cell
CHIP – Children 0-59 days M&F	Children 0-59 days M&F
CHIP – Children 60-364 days M&F	Children 60-364 days M&F
CHIP – Children 1-4 M&F	Children 1-4 M&F
CHIP – Children 5-14 M&F	Children 5-14 M&F
CHIP – Children 15-20 F	Children 15-20 F
CHIP – Children 15-20 M	Children 15-20 M

There are no differences in the underlying Medicaid benefit packages between Medicaid Children and CHIP Children. Separate rate cells are presented within the appendices for the Medicaid and CHIP cohorts only because certain supplemental payments are not applicable to the CHIP subset of the children population. If this were not the case, then these rates would otherwise be presented as combined rate cells. From an operational perspective, the only difference between these populations is the funding stream and FMAP associated with the CHIP children (Title XXI) compared to the non-CHIP Medicaid children (Title XIX) and the fact that the supplemental GME payment is not applicable to the CHIP population.

Completion Factors

Optumas summarized the detailed SFY24 base data and compared it to the financial data shared by the MCOs. The SFY24 base data reflects encounters paid and submitted through January 31, 2025. Optumas developed MCO-specific Reporting/IBNR adjustments by comparing the raw non-subcapitated SFY24 encounter data to the MCO reported financials inclusive of MCO-reported IBNR estimates through December 31, 2024. The combined Reporting/IBNR adjustment was applied in aggregate for each MCO's base data experience to reconcile these data sources and account for encounters not yet properly flowing through the MMIS system. As noted previously, the statewide, aggregate impact of the combined Reporting/IBNR adjustment was a 0.2% increase.

Optumas added the subcapitated costs reported in the MMIS encounter data, by cohort, to the Reporting/IBNR adjusted base data to ensure that all medical-related costs were considered in the development of the base data. The aggregate impact of this adjustment was a 0.3% increase to the statewide base data.

Additionally, other provider payments not inherent in the encounter data are detailed and identified within the MCO financials. Optumas worked collaboratively with the MCOs and Iowa Medicaid to interpret these payments and ensure they are reflected appropriately, by service and population, in the base data. The adjustments for MCO provider incentives and settlement payments resulted in an aggregate 0.7% increase to the statewide base data.

The IA Health Link MCOs are permitted to pursue supplemental drug rebates for the CHIP Hawki population. The encounter base data reflects pharmacy expenditures prior to accounting for the collection of drug rebates. Optumas used the amounts reported within the MCO financial templates to reduce the CHIP Hawki population's pharmacy expenditures to reflect the final cost of pharmacy services, net of rebates. The adjustments for MCO pharmacy rebates resulted in an aggregate reduction of 0.01% to the statewide base data.

Finally, the IA Health Link MCOs provided claim recovery amounts in SFY24 related to coordination of benefits and subrogation within their reported financials. These costs are not reflected in the MMIS encounter base data, so Optumas applied the reduction in claim costs evenly across all populations and categories of service, for each MCO. The adjustments for MCO subrogation and coordination of benefits resulted in an aggregate reduction of 0.1% to the statewide base data.

After applying these base data adjustments, the data sources consistently, accurately, and completely reflect the experience for the IA Health Link program in SFY24. The final adjusted base data is an

appropriate starting point from which to project to the SFY26 contract period. Each of these adjustments are shown in greater detail at the rate cell level within Appendix I.B.

Errors in Data

Optumas validated the encounter data, benchmarked to MCO-reported financials, and concluded that no errors existed within the data.

Program Changes

The following pre-trend adjustments were made to the base data to appropriately reflect the policies and reimbursement in effect during the SFY26 contract period. The impact of each of these program changes at the rate cell level is shown in Appendix I.B. A summary description of all program changes and each component of the rate development is shown in Appendix II.B.

COVID-19 Vaccines Carve-In

Effective October 1, 2024, COVID-19 vaccine administration services were no longer carved out of the capitation rates. Furthermore, the enhanced vaccine administration rate in effect during the SFY24 base period was replaced with a standard vaccine administration rate. During the SFY26 contract period non-Hawki children 18 years old and younger are expected to receive COVID-19 vaccines through the federal Vaccines for Children (VFC) program. Therefore, the MCOs will be responsible for the VFC administration rate of $19.68 with zero ingredient cost for all applicable children rate cells, which results in a reduction to the rates. For all other populations, the MCOs will be responsible for the vaccine administration rate of $5.09 and the full cost of the vaccine. Optumas repriced the SFY24 COVID-19 vaccines and administrative services to reflect the revised policy under the carve-in. The average COVID-19 vaccine cost from emerging October – December 2024 encounter data, submitted through March 2024, was used to estimate the cost of COVID-19 vaccines that will occur in SFY26 since there were periods of the SFY24 base (prior to September 2023) where the MCOs only paid for the vaccine administration costs.

Copay Adjustment

During the COVID-19 Public Health Emergency (PHE), the State suspended the collection of copays within the Health Link program. With the ending of the PHE, the State is expecting copays to resume for certain adult populations (non-pregnant Non-Expansion Adults and Wellness Plan Adults) and the CHIP – Hawki rate cell for non-emergent Emergency Room (ER) usage ($3 copay per visit for adults, $25 for Hawki) and Pharmacy ($1 copay per script for adults). Optumas identified the copay-applicable populations and services within the base data and adjusted the MCO paid amounts to reflect the collection of copays that should occur within the contract period per state policy. While the MCOs can choose whether to enforce the collection of copays, the State will reimburse capitation rates assuming copays are collected in full.

Pharmacy 90-Day Supply

During the COVID-19 PHE, the State allowed covered prescription and nonprescription medications to be dispensed in multiple month increments. Effective July 1, 2023, the policy reverted to the pre-COVID-19 policy, which allowed a maximum 30-day supply for all non-contraceptive pharmaceuticals. Effective October 1, 2024, some generic maintenance medications became eligible for 90-day supply scripts and the pharmacy dispensing fee was increased from $10.38 to $10.63. Optumas reviewed the base data

scripts, normalized on a 30-day basis, and compared the distribution to emerging SFY25 experience from October 2024 through February 2025 after the implementation of the revised policy. The percentage of scripts exceeding a 30-day supply increased monthly throughout this emerging period. To account for the revised policy, the base pharmacy script utilization was adjusted to align with the higher proportion of 90-day scripts reflected in the February 2025 emerging experience. The adjustment reduced the projected number of scripts and associated dispensing fees relative to the base experience. The incremental dispensing fee increase was then applied to the adjusted total script count, offsetting the total reduction applied for the SFY26 rates.

Dual Pharmacy Efficiency Adjustment

Optumas identified and removed Medicare Part D pharmacy claims for dual-eligible members where Medicaid was the primary payer instead of Medicare, consistent with SFY25 rate development.

FQHC/RHC Repricing

Optumas repriced Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) encounters to reflect the latest PPS rates, consistent with prior rate development cycles. The most recent known rates were effective January 1, 2025. An estimated annual increase of 4.1% was also applied for the rate changes that will occur midway through the contract period on January 1, 2026.

IHS Repricing

Optumas repriced Indian Health Service (IHS) encounters to reflect the latest payment rates, consistent with prior rate development cycles. The most recent known rates were effective January 1, 2025. An estimated annual increase of 10.7% was also applied for the rate changes that will occur midway through the contract period on January 1, 2026.

ICF/ID Repricing

Optumas repriced Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID) encounters to reflect the latest payment rates, consistent with prior rate development cycles. The most recent known rates were effective July 1, 2025. The ICF/ID population has been impacted by facility closures between the SFY24 base period and SFY26 contract period. Within the ICF/ID repricing program change, Optumas priced any SFY24 base data experience for facilities that have closed using the average per diem rates of the facilities that remain open to reflect the average cost of ICF/ID providers that are expected to exist in the SFY26 contract period.

SRC Repricing

Optumas repriced State Resource Center (SRC) encounters to reflect the latest payment rates, consistent with prior cycles of rate development. The most recent known rates were effective July 1, 2025. The SRC population was impacted by the Glenwood facility closure between the SFY24 base period and SFY26 contract period. Within the SRC repricing program change, Optumas repriced any SFY24 base data experience for Glenwood using the Woodward SFY26 per diem rate to reflect the cost of SRC services that will exist in the SFY26 contract period.

NF Repricing

Optumas repriced Nursing Facility (NF) encounters to reflect the latest payment rates, consistent with prior rate development cycles. The most recent known rates were effective July 1, 2024. While most NF providers did not receive a rate change with the latest rates, estimated cost-of-living increases throughout SFY26 increase the patient liability portion of NF services. Therefore, the NF repricing

adjustment resulted in an estimated reduction to the expected payment amounts for MCOs and corresponding reduction to the capitation rates.

Hospice Repricing

Optumas repriced hospice service encounters to reflect the latest payment rates, consistent with prior rate development cycles. The most recent rates, updated annually by CMS, were effective October 1, 2024. An estimated increase of 2.4% was also applied for the annual rates changes that are expected to occur on October 1, 2025.

SFY25 HH LUPA Appropriation

Effective July 1, 2024, Home Health Low Utilization Payment Amount (HH LUPA) providers received a 6.9% rate increase as a result of legislative appropriations. Iowa Medicaid provided Optumas with the list of all applicable providers and revenue codes that received the reimbursement increase. Optumas identified these providers and services within the base data and applied the increase to reflect the anticipated levels of reimbursement in the SFY26 contract period.

SFY25 ABA Appropriation

Effective July 1, 2024, Applied Behavior Analysis (ABA) services received a 5% rate increase as a result of legislative appropriations. Iowa Medicaid provided Optumas with the list of all applicable procedure codes and modifiers that received the reimbursement increase. Optumas identified these services within the base data and applied the increase to reflect the anticipated levels of reimbursement in the SFY26 contract period.

SFY25 Targeted Rate Increase Appropriations

Effective July 1, 2024, several provider types and services received targeted rate increases as a result of legislative appropriations. The table below outlines the services and their associated fee increases (rounded):

Table 5. Targeted Rate Increase Applicable Services and Rate Changes

Provider Types and Services	Fee Change
Medical Supplies	0.4%
Physician Assistants	2.1%
Physical Therapists	18.2%
Occupational Therapists	21.2%
Certified Nurse Midwife	11.7%
CMHCs	3.3%
Assertive Community Treatment	50.3%
Crisis Services	15.0%

Iowa Medicaid provided Optumas with the list of all applicable provider types, procedure codes, and modifiers that received the reimbursement increases. Optumas identified these providers and services within the base data and applied the increases to reflect the anticipated levels of reimbursement in the SFY26 contract period.

SFY25 HCBS Appropriations

Effective July 1, 2024, Home and Community Based Services (HCBS) received rate increases as a result of legislative appropriations. Residential-Based Supported Community Living (RBSCL) shifted from a single rate to a 3-tiered rate structure based on level of need. The estimated aggregate increase for RBSCL services is 137.1% when comparing the base reimbursement at the single rate structure to the emerging MCO reimbursement from July 2024 – October 2024 under the 3-tiered rate structure.

Additionally, Intermittent Supported Community Living received a 9% rate increase. All other HCBS services received a 4.1% increase. Iowa Medicaid provided Optumas with the list of all applicable procedure codes and modifiers that received each of these reimbursement increases. Optumas identified these services within the base data and applied the increases to reflect the anticipated levels of reimbursement in the SFY26 contract period.

SFY25 Air Ambulance Rate Increase Appropriations

Effective July 1, 2024, certain air ambulance services and providers received an 83.4% rate increase as a result of the legislative appropriations. Iowa Medicaid provided Optumas the list of applicable providers and procedure codes that received the reimbursement increase. Optumas identified these services within the base data and repriced the applicable service units to the revised fee schedule to reflect the anticipated levels of reimbursement in the SFY26 contract period.

SFY25 Biomarker Testing Expanded Coverage

Effective July 1, 2024, Iowa Medicaid expanded coverage for biomarker testing services when clinical utility has been demonstrated. Iowa Medicaid previously covered 86 biomarker tests and expanded coverage to include 50 new Medicare-covered codes. Optumas relied on information from Iowa Medicaid when evaluating the estimated rate impacts. The additional utilization and costs for these newly covered codes were estimated for each rate cell based on the distribution and average costs of the previously covered biomarker testing services inherent in the base data.

IHAWP Nursing Facility Utilization Adjustment

In 2022, HHS released policy clarification regarding nursing facility service utilization for members in Iowa Health and Wellness Plan (IHAWP) rate cells (WP rate cells). Optumas observed a shift in membership between the Custodial Care Nursing Facility <65 cohort and the WP rate cells throughout the base period, with a corresponding increase in utilization of Nursing Facility services for the WP populations. Under the current policy, the increased utilization of NF services is expected to continue in the SFY26 contract period. To develop a rating adjustment, Optumas reviewed the base data per-member per-month (PMPM) expenditures for the Nursing Home/Hospice category of service (COS), after adjusting for the Nursing Facility repricing, and compared the base experience to the emerging SFY25 experience for July 2024 – October 2024 for the WP populations. The percentage difference between the adjusted base PMPMs and the emerging SFY25 PMPMs represents the IHAWP Nursing Facility adjustment applied to the Nursing Home/Hospice COS for rate development.

The base membership for individuals who shifted from the Custodial Care Nursing Facility <65 rate cell to a WP rate cell was accounted for in the long-term services and supports (LTSS) blend section, described further below.

Program Changes Deemed Immaterial to Benefit Expenses in the Rate Period

All policy changes effective between the SFY24 base data and SFY26 contract period were provided by Iowa Medicaid and analyzed by Optumas to determine the cost impact on the IA Health Link managed care program. The adjustments described above were determined to have a material impact to the MCOs and warranted a rating adjustment. The COVID-19 Testing program change was determined to be immaterial and therefore does not have an adjustment within the SFY26 rate development, but is noted here for completeness.

Service and Payment Exclusions

The following services and payments have been excluded from the MMIS encounter data underlying the base data development. Each of these exclusions is described within the base data development description in the preceding sections:

- GEMT state directed payments (included in a separate rating adjustment)
- Drugs in excess of $1.5M since they are reimbursed outside of the capitation rates via invoicing
- Value Added Services (not funded via capitation payments per CMS guidance)

3. Projected Benefit Costs and Trends

A. Rate Development Standards

i. Services Allowed

Final capitation rates are based only upon the services allowed in 42 CFR §§ 438.3(c)(1)(ii) and 438.3(e). No state-only funded services are included within the capitation rates as these services are not allowed to be included in the Medicaid rate certification submitted for CMS review and approval.

ii. Trend Assumptions

In accordance with 42 CFR §438.5(d), each projected benefit cost trend assumption is reasonable and developed in accordance with generally accepted actuarial principles and practices. Trend assumptions are developed primarily from actual experience of the Iowa Medicaid population and include consideration of other factors that may affect projected benefit cost trends through the rating period.

Trend factors were applied to estimate the change in utilization rate (frequency of services) and unit cost (pure price change, technology, acuity/intensity, and mix of services) over time. These trend factors were used to project the costs from the base period to the contract period. Trends were developed on a statewide annualized basis, primarily using IA Health Link specific experience from SFY24 and emerging SFY25 through December 2024. Prospective trends were applied by major category of service (e.g., Inpatient, Professional, etc.) and broad population (e.g., TANF Adults, Children, etc.) from the midpoint of the SFY24 base data period (12/30/2023) to the midpoint of the SFY26 contract period (12/30/2025).

Prior to reviewing historical Iowa Medicaid experience, Optumas first normalized the base data for programmatic and reimbursement changes to ensure the impacts of these rating adjustments were not duplicated in trend projections. Next, the statewide IA Health Link data were arrayed by trend category of aid (COA), major COS, and month of service to review historical utilization per thousand, unit cost, and PMPMs. The data was arrayed so that 3-month moving averages (MMA), 6 MMA, and 12 MMA could be calculated. While MMAs were reviewed in developing prospective trends, there is not a pre-determined algorithm in place and trend assumptions vary based on nuances with a specific population or COS. Given that prospective trend is a projection of future experience, historical trends may differ from projected trends. For example, certain populations and services experienced reductions in spending but these negative trends were not necessarily projected into the contract period.

Note the following additional considerations in the development of the SFY26 prospective trends:

1. Normalize for PHE-Related Acuity Changes: Members flagged as “PHE Leavers” as part of the PHE unwind acuity adjustment were excluded from the monthly data used to develop trend projections. The methodology used to identify “PHE Leavers” is described in the acuity adjustment section.

2. Wellness Plan Trends: Historically, the Medically Exempt and Non-Medically Exempt Wellness Plan rate cells were aggregated to develop one set of prospective trend projections for the Wellness Plan cohorts. Due to significant growth differences throughout SFY24 and emerging

SFY25 experience, separate trends were developed for the Medically Exempt and Non-Medically Exempt cohorts for SFY26 rate development.

3. Pharmacy Trends: Medicaid programs nationally have experienced increased glucagon-like peptide-1 (GLP-1) drug utilization in recent years. When developing pharmacy trends, GLP-1 drugs were reviewed separately from specialty (defined as a script cost greater than $3,000), brand, and generic drugs. The pharmacy trend factors reflect the aggregate trend across all pharmacy services.

4. Increased Behavioral Health - Outpatient (BH – OP), Home Based Habilitation (HBH), and HCBS Trends: Optumas has observed large increases in both BH – OP, HBH, and HCBS experience for certain populations throughout the SFY24 and emerging SFY25 data which coincide with significant increases in provider reimbursement (which were already normalized for within the trend review) that have recently occurred for these services. Therefore, higher projected trends have been included for these services, as these observed increases are in addition to the impact of fee increases.

The annualized prospective utilization, unit cost, and PMPM trend assumptions by broad population and major category of service are included within Appendix II.C.

iii. In-Lieu-Of Services (ILOSs)

Iowa Medicaid policy has historically allowed for in-lieu-of services associated with beneficiaries residing in an institute for mental disease (IMD) up to fifteen days during a given month. Within the SFY26 contract period, additional in-lieu-of services may be provided in the IA Health Link program at the discretion of the MCOs and Medicaid enrollees. No explicit adjustment has been included within the SFY26 rate development for these ILOSs since the MCOs and beneficiaries are not mandated to use these services and there is a requirement that each ILOS is a medically appropriate and cost-effective substitute for covered services or settings under the state plan.

iv. State Medicaid Director Letter on ILOSs

No explicit adjustment has been included within the SFY26 rate development for these ILOSs since these ILOS have not been provided historically within the base data and minimal utilization exists within the emerging SFY25 experience; additionally, MCOs and beneficiaries are not mandated to use these services and there is a requirement that each ILOS is a medically appropriate and cost-effective substitute for covered services or settings under the state plan.

Projected ILOS Cost Percentage

The projected ILOS cost percentage, excluding short term stays in an IMD, within the SFY26 capitation rates is 0%. Minimal utilization experience exists for these services within emerging SFY25 encounters and MCO financial reporting. Additionally, the MCOs and beneficiaries are not mandated to use these services and there is a requirement that each ILOS is a medically appropriate and cost-effective substitute for covered services or settings under the state plan. Due to the minimal SFY25 emerging

utilization, uncertainty surrounding future utilization, and the requirements noted above, the projected ILOS percentage of capitation rates is 0%.

Final ILOS Cost Percentage

Optumas will submit documentation of the final ILOS Cost Percentage for the SFY26 contract period as part of a separate actuarial report that must be submitted to CMS no later than two years after the completion of the contract period.

v. IMDs as an ILOS

Iowa Medicaid policy allows for experience specific to beneficiaries aged 21 to 64 residing in an IMD for less than fifteen days to be included within the IA Health Link capitation rates. These services were included within the SFY24 base data. Iowa Medicaid policy reimburses IMDs at the statewide average per diem of the comparable non-IMD facilities. As a result of this policy, no repricing of the IMD utilization has been conducted within rate development.

B. Appropriate Documentation

i. Final Projected Benefit Costs

The rate certification documents the final projected benefit costs by rate cell in Appendix I.B.

ii. Development of Projected Benefit Costs

Description of Data, Assumptions, and Methodologies

Optumas relied on the MMIS encounter data provided by the State for the development of projected benefit cost trends. No material changes to the data, assumptions, and methodologies used outside of the program change adjustments and trend considerations previously described have occurred since the SFY25 rate certification.

The following adjustments were made after the application of trend to reflect the policies that will be in effect during the SFY26 contract period.

The impact of each of these post-trend program changes is shown in Appendix I.B for each rate cell. A summary description of all applicable program changes and components of the rate development is shown in Appendix II.B.

Leap Year Adjustment

The SFY24 base period contained an additional day compared to the SFY26 contract period due to CY24 being a leap year. Therefore, Optumas applied a reduction factor of 1/366 across all rate cells to services which are either reimbursed daily or would have increased utilization in a leap year. Consistent with the SFY24 rate development adjustment, which included an increase factor to account for the additional day in the contract period, these services include HCBS, nursing facility, inpatient, and emergency room expenditures.

CIOT Efficiency Adjustment

Consistent with prior rate development cycles, Optumas ran the base data encounters through the Care Improvement Opportunity Tool (CIOT), an industry-standard episode of care grouper developed by Optumas in collaboration with Signify Health. The CIOT uses detailed clinical algorithms to group encounter data into episodes of care and compares the services provided, outcomes, and associated costs against clinically determined best practices to identify any inefficiencies in the form of Adverse Actionable Events (AAE).

The results of the episodes of care and associated AAE costs identified from the CIOT were evaluated during rate development as part of Iowa Medicaid's cost containment initiatives.

The CIOT groups encounter data into episodes of care based on clinical definitions of look-back and look-forward time periods centered around typical trigger claims and services for each type of episode. Episodes include all clinically related services for a discrete condition or procedure for the entire continuum of care for a given period. Episodes were defined and refined with volunteer clinical experts assembled in Clinical Working Groups. Not all encounters or services are grouped into episodes of care, as not all services provided during an episode window are considered relevant to that episode. The CIOT tool identifies the following types of episodes:

- Chronic (17 conditions)
- Procedural (24 procedures)
- Other (Newborn and Pregnancy)

Optumas focused on the evaluation of Chronic episodes for this efficiency adjustment, since the MCOs should reasonably be able to impact costs within these episodes through proactive behavioral and care management and intervention. The table below lists the Chronic conditions evaluated:

Table 6. Chronic Episodes Evaluated by CIOT

Chronic Episodes	
Arrhythmia / Heart Block / Conduction Disorder	Heart Failure
Asthma	Hypertension
Bipolar Disorder	Low Back Pain
Chronic Obstructive Pulmonary Disease	Osteoarthritis
Coronary Artery Disease	Schizophrenia
Crohn's Disease	Substance Use Disorder
Depression & Anxiety	Trauma & Stressors Disorders
Diabetes	Ulcerative Colitis
Gastro-Esophageal Reflux Disease	

Once episodes are identified, services are split into Typical and AAE. Typical service costs are routine and expected for each episode, while AAEs are directly due to the condition/treatment and may be potentially avoidable with more active care management, member behavior changes, and care coordination efforts from the MCOs. The criteria described below outline the process for translating the CIOT results into the managed care efficiency rating adjustment, and identifying the AAE costs MCOs may be able to reasonably impact with targeted efforts:

1. Episode Limitations:
    a. Apply Episode Filters: Remove non-typical episodes from a clinical and cost perspective. Clinical filters include cases where a member has a condition that would make the episode clinically distinct and difficult to manage, such as the interaction with various cancers.
    b. Remove High-Cost Episodes: Remove the top 1% of episodes for each chronic episode type based on total costs.
2. Population Limitations:
    a. Duration Limit: Evaluate only members with at least six months of duration. The ability to impact costs associated with chronic conditions for members with shorter durations is limited compared to members with longer duration.
    b. Population Limit: Exclude long-term services and supports (LTSS) populations and non-risk adjusted populations. These populations have complicated conditions that may be more challenging for the MCOs to impact.
    c. Risk Score Limit: Exclude the top 10% of members with the highest concurrent risk scores in the SFY24 study period, using the University of California, San Diego (UCSD) Chronic Illness and Disability Payment System and Medicaid Rx model (CDPS+Rx) V7.2 tool for calculating risk scores. AAE costs for members with higher risk scores may be more challenging for the MCOs to reduce due to multiple comorbidities.
3. Service Limitations:
    a. Focus on Inpatient, Outpatient, and Emergency Room services (both physical health and behavioral health).
    b. Reduce AAE for targeted Inpatient categories (both Physical and Behavioral Health) by 25% and all other service categories by 50% to translate into potential savings. These have not been removed at 100%, as a mechanism to recognize that replacement costs for preventive services may be required to achieve savings for these AAE costs.
    c. This section also removes any experience for individuals classified as PHE Leavers within the acuity adjustment, described later within this section.

Postpartum Coverage Adjustment

During the base period, the Pregnant Women rate cell included members who exceeded the historical limit of two months of postpartum coverage due to the PHE disenrollment freeze. After member disenrollments were completed, HHS began enforcing the two months of postpartum coverage during the SFY25 contract period. Effective April 1, 2025, postpartum coverage for pregnant women was extended from two months to twelve months of continuous postpartum coverage, as directed by Senate File 2251 (SF 2251) legislation. Additionally, the income eligibility threshold for newly eligible pregnant women was lowered from 375% of the Federal Poverty Level (FPL) to 215% FPL, and the threshold for Medicaid newborns was lowered to 300% FPL. The revised policy also results in children ages 0-1 with FPLs between 300% to 302% being eligible through CHIP Hawki. Any individuals enrolled prior to April 1, 2025 will remain enrolled in their current rate cells throughout the entire twelve-month continuous coverage period even if their income exceeds the new FPL thresholds.

The revised postpartum coverage policy affects multiple rating cohorts outside of the Pregnant Women rate cell. Historically, members enrolled in the Pregnant Women rate cell were either disenrolled from Medicaid after two months of postpartum coverage or shifted aid categories, primarily to one of the Non-Expansion Adults or Wellness Plan rate cells. The methodology to estimate the impact of this policy change for each of the affected populations is described below.

Pregnant Women

Two primary components of the legislative change affect the Pregnant Women rate cell: the expansion of the postpartum coverage period and the reduction of the income eligibility threshold.

Optumas analyzed the base data to understand differences in cost profiles by FPL within the Pregnant Women cohort using monthly eligibility information provided by HHS. Members with incomes up to 215% FPL have higher PMPMs than those with incomes above 215% FPL. It is estimated that approximately 80% of women currently receiving coverage under the Pregnant Women rate cell will likely remain eligible under the updated FPL eligibility criteria. Optumas adjusted for the shifting cost profile and acuity of members within the Pregnant Women rate cell that are anticipated during the contract period. Since women enrolled as of April 1, 2025 are grandfathered into the program even if their income exceeds 215% FPL, acuity within the Pregnant Women rate cell will gradually increase over time as the aggregate membership shifts from up to 375% FPL to a maximum of 215% FPL.

The base data reflects a unique period when PHE member disenrollments were ongoing and some members had yet to be redetermined, which effectively created a pseudo-extended postpartum window, allowing Optumas to use actual Health Link experience to estimate the impact of this policy change. Optumas stratified the Pregnant Women cohort's base data into the following pregnancy-related time periods and compared the PMPMs for each subset:

- Prenatal Period
- Delivery Month
- Postpartum Months 1-2
- Postpartum Months 3-12

Postpartum months 3-12 have lower PMPMs than other time periods. Since the base data has excess enrollment due to the PHE disenrollment freeze, including experience past twelve months of postpartum coverage in some cases, the shift to twelve months of postpartum coverage results in an increase to the Pregnant Women rate cell. The stratification was evaluated two ways: all members with no FPL limitations, and only members with incomes up to 215% FPL. Optumas projected the SFY26 membership distribution for each pregnancy period within the Pregnant Women cohort, accounting for the gradual FPL limitation ramp-in and the April 1, 2025 effective date of the postpartum coverage extension. Optumas estimated the SFY26 costs for the Pregnant Women cohort by weighting the projected membership distribution for each subcategory with the corresponding base data PMPMs based on a combination of members who were grandfathered into the program and those with incomes up to 215% FPL that will be newly eligible after April 1, 2025.

Since the policy change was effective April 1, 2025, Optumas modeled a ramp-in of the additional postpartum months 3-12 because additional postpartum membership associated with deliveries after February 2025 will accumulate in the Pregnant Women rate cell within SFY26. HHS confirmed that any women who were redetermined after two months of postpartum coverage and shifted to another Medicaid rate cell prior to April 1, 2025 would not shift back to the Pregnant Women rate cell with the policy implementation. The combined impact of the postpartum coverage extension and eligibility income changes results in an increase to the Pregnant Women rate cell relative to the SFY24 base data.

Pregnant Women Maternity Case Rate

The FPL changes for the Pregnant Women cohort also impact the corresponding Pregnant Women Maternity Case Rate kick payments. Optumas observed higher per-member per-delivery (PMPD) costs

for members at or below 215% FPL than those above 215% FPL. The adjustment applied to the Pregnant Women Maternity Case Rate reflects the percentage difference in PMPD costs in the base data limited to members at or below 215% FPL relative to the total base data with no FPL limitations.

The new FPL eligibility requirement only applies to newly identified pregnant women, not individuals who were already enrolled in the Pregnant Women rate cell as of April 1, 2025. Therefore, the impact of the FPL threshold change will apply only to deliveries for Pregnant Women members enrolled on or after April 1, 2025. Given a five-month average prenatal period, the adjustment assumes only deliveries that occur in September 2025 or later will reflect the full impact of the acuity change. As a result, the SFY26 rates reflect 83.3% (10 out of 12 months) of the total FPL adjustment described above. The adjustment in future rate developments may reflect a larger increase in the Pregnant Women Maternity Case Rate once all deliveries are limited to members with incomes at or below 215% FPL.

CHIP – Hawki

State Plan Amendment (SPA) IA-24-0016 and Medicaid companion SPA IA-25-003 reduced the income eligibility threshold for Medicaid infants under one year old to 300% FPL which results in the CHIP Hawki program covering children ages 0-1 with FPLs up to 302%. Discussions with HHS indicated that a monthly average of approximately 24 infants between 300% and 302% FPL will shift from Medicaid to Hawki. Prior to April 1, 2025, newborns were exclusively covered by Medicaid. Under the revised policy, a small portion of the infants under one year will now be eligible for Hawki if their FPL is between 300% and 302%.

Additionally, SPA IA-24-0014 provides twelve months of continuous postpartum coverage to individuals enrolled in the Hawki program. Historically, Hawki members shifted to a Medicaid rate cell (generally the Pregnant Women rate cell) when identified as pregnant. Under the revised policy, pregnant Hawki members will remain in the Hawki rate cell throughout their pregnancy and twelve months of postpartum coverage. Furthermore, HHS has indicated these individuals will also have continuous eligibility beyond their twelve-month postpartum period until the next household review date, potentially extending coverage for an additional 1 to 11 months after their twelve-month postpartum period ends.

Optumas estimated the combined impact of the additional newborn individuals now covered within the Hawki rate cell, and individuals who become pregnant remaining in the Hawki rate cell through the twelve months of continuous postpartum coverage until their next renewal period.

Under the new policy, infants born on or after April 1, 2025 with FPLs between 300% and 302% that would historically have been covered under Medicaid within the Children – 0-59 days M&F and Children 60-364 days M&F cohorts will now be enrolled within the Hawki rate cell. Children who were already covered by Medicaid on April 1, 2025 will remain enrolled in their current rate cell. Using the monthly average of 24 infants, Optumas projected the membership distribution of the Hawki rate cell including infants under 364 days, accounting for the policy ramp-in, and compared it to the current Hawki emerging SFY25 enrollment from November 2024 – January 2025 with data submitted through March 2025. The PMPMs for children less than one year old have higher PMPMs than the average Hawki population without newborns, so the inclusion of infants within Hawki results in an increase to the average PMPM for the rate cell.

Similarly, Optumas estimated the impact of the additional membership and costs that will exist in SFY26 for Hawki individuals who become pregnant and remain in the rate cell. Optumas identified fewer than 50 pregnant women in the base data who shifted from Hawki to Medicaid due to becoming pregnant and used this to estimate the rating adjustment. Using the Pregnant Women rate cell's prenatal, delivery costs (including the case rate payment), and postpartum coverage PMPMs (with "PHE Leavers" removed and no FPL limitations), Optumas estimated the average cost of a pregnancy that would remain in the Hawki rate cell under the new policy. The assumption relies on an average of five months of prenatal experience and an additional six months of enrollment after the twelve months of postpartum coverage ends, due to the redetermination policy for the Hawki population. The additional pregnancy-related membership reflects higher PMPMs than the existing Hawki base data PMPMs, which results in an additional increase to the Hawki rates.

The delivery expenditures for the CHIP Hawki population remain within the individual rate cell and will not trigger a maternity case rate payment during the SFY26 contract period.

Non-Expansion Adults and Wellness Plan Populations

The postpartum coverage extension also impacts the Non-Expansion Adults and Wellness Plan (WP) Female rate cells. Members in the Pregnant Women cohort will now remain for 12 months rather than being disenrolled after 2 months of postpartum coverage or being redetermined for Medicaid eligibility and shifting to the Non-Expansion, Wellness Plan, or Children/CHIP cohorts. As a result, the base data for the TANF and Expansion cohorts includes excess membership and expenditures for postpartum months 3-12 that will now be covered under the Pregnant Women cohort. Optumas estimated the impact of the new postpartum coverage policy for the following rate cells and their high-level aggregate populations shown in the table below:

Table 7. Postpartum Coverage High-Level Population Crosswalk

Detailed Rate Cell	High-Level Population
CHIP – Children 15-20 F	TANF
Children 15-20 F	TANF
Non-Expansion Adults 21-34 F	TANF
Non-Expansion Adults 35-49 F	TANF
WP 19-24 F (Medically Exempt)	WP Med Exempt
WP 19-24 F (Non-Medically Exempt)	WP Non-Med Exempt
WP 25-34 F (Medically Exempt)	WP Med Exempt
WP 24-34 F (Non-Medically Exempt)	WP Non-Med Exempt
WP 35-49 F (Medically Exempt)	WP Med Exempt
WP 35-49 F (Non-Medically Exempt)	WP Non-Med Exempt

Optumas reviewed the base data and observed that approximately 55% of individuals in the Pregnant Women rate cell at the time of delivery transitioned to one of the above cohorts by their third postpartum month. Under the new policy, these members will remain in the Pregnant Women cohort throughout their twelve-month postpartum period. Consistent with the Pregnant Women adjustment, Optumas stratified the PMPMs for the Non-Expansion and WP cohorts by the following categories:

- Prenatal Period
- Delivery Month

- Postpartum Months 1-2
- Postpartum Months 3-12

Using the Pregnant Women deliveries for members with incomes up to 215% FPL as a proxy, Optumas estimated the reduction in member months for the Non-Expansion and WP cohorts. The adjustment accounts for the April 1, 2025 policy implementation date and gradually accumulates membership for individuals who will no longer shift cohorts in their third month of postpartum experience. The weighted average of these member months and their corresponding "Postpartum Months 3-12" costs were then removed from the SFY26 projection, which relies on an estimate of the monthly average of members within the three high-level groupings and the base data PMPMs, net of "PHE Leavers". The projected average monthly membership in SFY26 for these high-level populations, prior to the membership shifts associated with the policy change, is based on emerging SFY25 enrollment from November 2024 – January 2025, from capitations data submitted through March 2025.

Acuity Adjustment

Optumas developed an acuity adjustment to model the impact of the changing PMPM costs associated with the disenrollments that have occurred due to the end of the PHE continuous eligibility requirement (disenrollment freeze). Additional details related to this adjustment are provided in Section I.7 of this document.

Changes to Data, Assumptions, and Methodologies

Projected costs were developed in a manner consistent with the development of the SFY25 rates and generally accepted actuarial principles and practices.

Overpayments to Providers

Optumas is not aware of any specific overpayments to providers in the SFY24 base period that have not been accounted for within rate development.

iii. Projected Benefit Cost Trends

Data and Assumptions

Optumas used detailed IA Health Link encounter data, summarized by major category of aid and major category of service, to develop projected benefit cost trends. The encounter data reviewed spanned from July 2022 through December 2024, with encounters paid and submitted through January 31, 2025. Trends were benchmarked and compared against the reported MCO financial data and emerging experience for the ongoing SFY25 contract period.

Methodology

Trend factors were applied to estimate the change in service utilization (frequency of services) and unit cost (pure price change, technology, acuity/intensity, and mix) over time. These trend factors were used to project the costs from the base period to the future contract period. Trends were developed on a

statewide annualized basis and applied by major population and major service category from the midpoint of the base period to the midpoint of the contract period.

Trend factors were developed for both utilization and unit cost using historical encounter data and MCO financial data. The historical encounter data was analyzed by major population and major COS. The data was arrayed such that 3 MMA, 6 MMA, and 12 MMA could be reviewed and evaluated. There is not a pre-determined algorithm used in determining the prospective annual trends. Each data summary is reviewed independently, and prospective trend projections may vary depending on particular nuances within each COS or population. Trend was applied from the midpoint of the SFY24 base data (12/30/2023) to the midpoint of the SFY26 contract period (12/30/2025), for a total of 24 trend months.

Trend factors were developed consistent with generally accepted actuarial principles and practices. The methodology used is consistent with that of the annualized trends developed for the SFY19 through SFY25 IA Health Link rates.

Comparison to Historical Trends

The annual aggregate trend underlying the SFY26 IA Health Link rates is 4.6%, compared to the annual aggregate trend of 3.6% underlying the SFY25 Midyear capitation rates. In general, utilization increases were observed for most populations and services. The following services are key drivers of increased trend projections for the SYF26 rates relative to SFY25:

- Behavioral Health – Outpatient and Behavioral Health – Professional: both utilization and unit cost trends
- Home Based Habilitation: utilization and unit cost increases, particularly for the Wellness Plan Medically Exempt population
- Pharmacy: in particular, increases in both utilization and unit cost for Specialty drugs and GLP-1s

Outlier and Negative Trends

No negative or outlier trends were used for projection within the SFY26 rate development.

Components

The annualized prospective utilization and unit cost trend assumptions by major population and category of service are included within Appendix II.C.

Variations

Projected benefit cost trends were developed at the level of service and population categories shown within Appendix II.C. Trend assumptions were developed on a statewide basis for the entire IA Health Link program and do not vary by MCO. Similar rate cells were combined for trend development in order to increase credibility when developing trend projections and are shown within *Table 8* below.

Table 8. Trend Cohorts

Trend Cohort	Rate Cells Incorporated
Children	Children 0-59 Days M&F, Children 60-364 days M&F, Children 1-4 M&F, Children 5-14 M&F, Children 15-20F, Children 15-20M, CHIP - Children 0-59 Days M&F, CHIP - Children 60-364 days M&F, CHIP - Children 1-4 M&F, CHIP - Children 5-14 M&F, CHIP - Children 15-20F, CHIP - Children 15-20M, CHIP – Hawki
Disabled	ABD Non-Dual <21 M&F, ABD Non-Dual 21+ M&F, Residential Care Facility, Breast and Cervical Cancer
Dual	Dual Eligible 0-64 M&F, Dual Eligible 65+ M&F
Institutional	Custodial Care Nursing Facility <65, Custodial Care Nursing Facility 65+, Non-Dual Skilled Nursing Facility, ICF/ID, State Resource Center, PMIC
Maternity Case Rate	TANF Maternity Case Rate, Pregnant Women Maternity Case Rate
Pregnant Women	Pregnant Women
TANF Adult	Non-Expansion Adults 21-34 F, Non-Expansion Adults 21-34 M, Non-Expansion Adults 35-49 F, Non-Expansion Adults 35-49 M, Non-Expansion Adults 50+ M&F
Intellectual Disability (ID) Waiver	ID HCBS Waiver
Non-ID Waiver	Elderly HCBS Waiver, Dual HCBS Waivers: PD; H&D, Non-Dual HCBS Waivers: PD; H&D; AIDS, Brain Injury HCBS Waiver; Children's Mental Health HCBS Waiver
Wellness Plan (WP) Medically Exempt	WP 19-24 F (Medically Exempt), WP 19-24 M (Medically Exempt), WP 25-34 F (Medically Exempt), WP 25-34 M (Medically Exempt), WP 35-49 F (Medically Exempt), WP 35-49 M (Medically Exempt), WP 50+ M&F (Medically Exempt)
WP Non-Medically Exempt	WP 19-24 F (Non-Medically Exempt), WP 19-24 M (Non-Medically Exempt), WP 25-34 F (Non-Medically Exempt), WP 25-34 M (Non-Medically Exempt), WP 35-49 F (Non-Medically Exempt), WP 35-49 M (Non-Medically Exempt), WP 50+ M&F (Non-Medically Exempt)

The aggregate annual PMPM trend used to project from the SFY24 base data to the SFY26 contract period is 4.6% using the SFY24 statewide base membership mix.

Other Material Adjustments

No other adjustments to projected benefit cost trends, either material or non-material, were made during the SFY26 rate development.

Other Non-Material Adjustments

No other adjustments to projected benefit cost trends, either material or non-material, were made during the SFY26 rate development.

iv. Mental Health Parity and Addiction Equity Act

Optumas is unaware of any material program changes that would require an adjustment for compliance with the Mental Health Parity and Addiction Equity Act as required by 42 CFR §438.3(c)(1)(ii). The projected benefit costs reflect payment amounts that are adequate to allow the MCOs to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements.

v. In-Lieu-Of Services

Description of Each ILOS

No ILOSs outside of short term stays in an IMD existed within the SFY24 base data used for rate development. Appendix III contains the list of allowable ILOSs provided by Iowa Medicaid that are included within the SFY26 MCO contracts with service definitions, exclusions and limitations, as well as specific coding requirements for encounter data identification.

Projected ILOS Cost Percentage

The projected ILOS cost percentage in aggregate, excluding short term stays in an IMD, within the SFY26 capitation rates is 0% since there is no experience for these services within the SFY24 base data, and minimal experience within the emerging SFY25 data. Additionally, the MCOs and beneficiaries are not mandated to use these services and there is a requirement that each ILOS is a medically appropriate and cost-effective substitute for covered services or settings under the state plan. Each individual ILOS for the SFY26 contract period is projected to have an immaterial impact on the SFY26 rates, with projected ILOS cost percentage of 0%. The projection is 0% since within the SFY25 emerging experience through December 2024, actual ILOS utilization is immaterial and these voluntary services are not required to be provided by the MCOs.

Consideration of ILOSs in Projected Benefit Cost Development

There is no ILOS experience within the encounters underlying the SFY24 base data or experience reviewed for trend development. As such, no explicit consideration for ILOSs has been made within the projected benefit cost development for the SFY26 rate since no explicit rating adjustment has been made.

IMD as an ILOS

Iowa Medicaid policy allows for experience specific to beneficiaries aged 21 to 64 residing in an IMD for less than fifteen days to be included within the IA Health Link capitation rates. These services were included within the IA Health Link contract during the SFY24 base data. Iowa Medicaid policy reimburses IMDs at the statewide average per diem of the comparable non-IMD facilities. As a result of this policy, no repricing of the IMD utilization has been conducted within rate development and the rates comply with the requirements of 42 CFR § 438.6(e).

vi. Retrospective Eligibility

Retroactive eligibility periods have been excluded from the IA Health Link program since initial implementation and continue to remain in FFS for the SFY26 contract period. Therefore, no adjustment has been made for retrospective eligibility in the development of the SFY26 capitation rates.

vii. Changes in Covered Benefits

Any changes to covered benefits in the IA Health Link program in SFY26 have been accounted for and are described in detail above in Section I.2.B.iii.

viii. Impact of Changes

The impact on IA Health Link projected benefit costs from changes to covered benefits between the SFY24 base and the SFY26 contract period are shown in Appendix I.B. A description of the data, assumptions, and methodologies used to develop each adjustment is included in Section I.2.B.iii. above.

4. Special Contract Provisions Related to Payment

A. Incentive Arrangements

No incentive arrangements are included in the contract between the State and the MCOs in the IA Health Link program.

B. Withhold Arrangements

i. Rate Development Standards

Per the SFY26 IA Health Link contracts, 2.0% of premium is withheld by the State of Iowa and the MCOs can earn back the withhold to the extent that specific quality and performance measures are met as stated in the contract. These quality and performance measures are distinct from general operational requirements under the contract. The 2.0% withhold is not a component of the non-medical load since it is removed from the final capitation rate, net of the amounts itemized for the GME and GEMT additional payments. The withhold for SFY26 is consistent with the withhold percentages inherent in the SFY25 rates.

Per CMS guidance, contracts that provide for a withhold arrangement must ensure that the capitation payment minus any portion of the withhold that is not reasonably achievable is actuarially sound as determined by an actuary. The total amount of the withhold, achievable or not, must be reasonable and take into consideration the MCO's, prepaid inpatient health plan's (PIHP's) or prepaid ambulatory health plan's (PAHP's) financial operating needs accounting for the size and characteristics of the populations covered under the contract, as well as the MCO's, PIHP's or PAHP's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves.

The estimated percentage of the withhold that is expected to be earned back is between 60% and 100% based on a review of the earned withholds for the SFY23-SFY24 contract periods. To the extent that the IA Health Link MCOs do not earn back the withhold, the payment rate would still be reasonable and appropriate for the covered services and populations and the resulting rates would be actuarially sound and consistent with the CMS guidance mentioned above.

ii. Appropriate Documentation

Time Period of Withhold Arrangement

The time period of the withhold arrangement is consistent with the SFY26 rating period from July 1, 2025 through June 30, 2026.

Enrollees, Services, and Providers Covered

The 2.0% withhold applies to the aggregate capitation rate, net GME and GEMT, for all rate cells within the IA Health Link program for each MCO.

Purpose of the Withhold Arrangement

The purpose of the arrangement primarily relates to specified activities, targets, performance measures, and/or quality-based outcomes regarding metabolic monitoring, blood glucose testing, and cholesterol testing for children, timeliness of prenatal care, National Committee for Quality Assurance health plan ratings, and reporting on LTSS measures.

Description of the Total Percentage Withheld

The 2.0% withhold is based on total capitation rate revenue, net of the GME and GEMT additional payments, which is consistent with historical contract periods. Each MCO has the ability to earn back the withhold to the extent that specific quality and performance measures are met as stated in the contract. The capitation rates gross and net of the 2.0% withhold are shown in Appendix I.A.

Estimate of Percentage to be Returned

Based on emerging experience of the IA Health Link MCOs associated with the withhold earnings for prior rating periods and discussions with Iowa Medicaid, Optumas estimates that the MCOs will earn between 60% to 100% of the 2.0% withhold. This range aligns with expectations noted in prior rate cycles and continues to be substantiated by quarterly MCO financial reporting.

Reasonableness of Withhold Arrangement

Optumas' review of the total withhold percentage of 2.0% of capitation revenue is reasonable within the context of the IA Health Link capitation rate development.

Effect on capitation rate development

The withhold arrangements had no effect on the development of the capitation rates. The capitation payments, minus any portion of the withhold that is not reasonably achievable, are actuarially sound.

To the extent that the IA Health Link MCOs do not earn back the full withhold, the payment rate would still be reasonable and appropriate for the covered services and populations and the resulting rates would be actuarially sound.

C. Risk-Sharing Mechanisms

i. Rate Development Standards

There will be a program-wide risk corridor for SFY26 due to the acuity shifts that have occurred since the SFY24 base period as well as the uncertainties associated with the CCBHC implementation that is expected to occur July 1, 2025. Consistent with prior cycles, the program-wide risk corridor is based on the aggregate medical loss ratio (MLR) percent experience across all populations and services for the MCOs. The profit and loss shares for the MCOs and the State for the different risk corridor bands are shown in the table below. The bands have shifted from +/- 3.0% in SFY25 to +/- 2.0% in SFY26 due to

increased uncertainty surrounding the CCBHC implementation and various other program changes such as the maternity unbundling that are expected within the contract period.

The profit and loss shares for the MCOs and the State for the different risk corridor bands are shown in *Table **9*** below. To the extent any policy changes, such as modifications to care coordination or assessor requirements, results in an adjustment to the non-medical load component of the rates, the risk corridor bands will remain +/- 2.0%, but the target will be updated based on the revised non-medical load amount built into the amended rates.

Table 9. SFY26 Risk Corridor Arrangement

SFY26 Risk Corridor Bands		Profit/Loss Share	
Min. Threshold %	Max Threshold %	MCO	State
0.0%	88.9%	0%	100%
88.9%	90.9%*	100%	0%
90.9%*	92.9%	100%	0%
92.9%	92.9%+	0%	100%

**The target MLR of 90.9% is based on the weighted average of total non-medical load amounts built into the SFY26 rates using the SFY24 enrollment distribution. The actual target used for the final reconciliation will vary slightly based on the actual population distribution for the MCO during the SFY26 contract period. To the extent the target MLR varies from 90.9% using the actual MCO contract period enrollment mix, the risk corridor bands will still be +/- 2.0% from the revised target MLR.*

In accordance with 42 CFR §438.6(b), the risk-sharing mechanism outlined above in the rate certification is consistent with that documented in the MCO contracts and was determined prior to the start of the rating period. The risk corridor was developed in accordance with §438.4, the rate development standards in §438.5, and generally accepted actuarial principles and practices. Iowa Medicaid and Optumas acknowledge that risk-sharing mechanisms may not be added or modified after the start of the rating period.

The risk corridor reconciliation will be applied prior to the calculation of the minimum MLR and any recoupments necessary between the MCO and State will be incorporated as an adjustment to revenue prior to the minimum MLR calculation.

The SFY26 IA Health Link capitation rates have been developed as full risk rates. The only other risk-sharing arrangements between the MCOs and the State for the SFY26 contract period are associated with the state directed payments described in Section I.4.D below. Specifically, for the SFY26 contract period, the University of Iowa Hospitals and Clinics (UIHC) Physician Average Commercial Rate (ACR) and both UIHC and non-UIHC Hospital ACR directed payments are structured as separate payment term arrangements that are reimbursed outside of the capitation rates. These arrangements will have a retrospective reconciliation performed after the end of the SFY26 contract period based on actual utilization incurred by eligible providers through the directed payment arrangement. Further details on these specific arrangements are outlined in Section I.4.D. No other risk-sharing arrangements apply within the IA Health Link program outside of those previously mentioned.

ii. Appropriate Documentation

Description of Risk-Sharing Arrangements

The program-wide risk corridor settlement is the calculated gain or loss determined when comparing the actual MLR developed from the SFY26 experience to the risk sharing corridor percentages in *Table 9* above. The actual MLR is calculated as the total adjusted medical expenditures divided by the total capitation rate for all populations. The total capitation rate excludes any taxes and fees built into the rates, as well as amounts related to GME or any directed payments implemented as a separate payment term for which the MCO is not at risk (e.g., UIHC Physician ACR, and both UIHC and non-UIHC Hospital ACR payments).

Adjusted medical expenditures shall be determined by the State and Optumas based on encounter data and plan financial data submitted by each MCO. Adjusted medical expenditures only include services covered by the IA Health Link program and will exclude all expenditures associated with carve-out services such as high-cost drugs with costs above $1.5M per dose or treatment. The MCOs may provide services to enrollees that are in addition to those covered under the State Plan (i.e., value-add services); however, per the MCO contracts, the cost of these services will not be included within the risk corridor calculation for the SFY26 contract period and were not included within the development of the SFY26 capitation rates. Additionally, administrative expenditures included in the pharmacy claims will be removed from the expenditures for purposes of the risk corridor calculation as applicable. The final adjusted medical expenditures will not include quality improvement expenses, case management expenses, or other administrative expenses. Adjusted medical expenditures will not include amounts related to GME or any directed payments implemented as a separate payment term for which the MCO is not at risk (e.g., UIHC Physician ACR payment as well as the UIHC and non-UIHC Hospital ACR payments). Items such as fraud, waste, and abuse will not be considered in the numerator of the MLR risk corridor calculation.

The implementation of the risk corridor and MLR requirement did not impact the development of the actuarially sound capitation rates or influence any of the adjustments made within rate development. The risk-sharing mechanism has been developed in accordance with generally accepted actuarial principles and practices and is consistent with pricing assumptions used in capitation rate development, as shown in *Table 9.* No remittance/payment will be made if an MCO's actual MLR experience is within +/- 2.0% of the pricing assumptions used in capitation rate development.

MLR Arrangement

The program-wide risk corridor settlement is the calculated gain or loss determined when comparing the actual MLR developed from the emerging experience to the risk sharing corridor percentages in *Table 9*. Any MLR experience outside of the +/- 2.0% risk corridor bands will result in a transfer of funds between the MCO and Iowa Medicaid. The target MLR of 90.9% noted in *Table 9* is based on the weighted average of total non-medical load amounts built into the SFY26 rates using the SFY24 enrollment distribution. The actual target used for the final reconciliation may vary slightly based on the actual population distribution for the MCO during the SFY26 contract period. To the extent the target MLR varies from 90.9% using the actual MCO enrollment mix during the contract period, the risk corridor bands will still be +/- 2.0% from the revised target MLR.

In addition to the risk corridor arrangement, the State requires all health plans to maintain a minimum MLR of 88%. If an MCO's MLR is less than 88%, after adjusting revenue for the risk corridor reconciliation, the health plans must refund the State the difference. Plan submitted MMIS encounters and reported financials will be reconciled to the assumed experience included in the SFY26 rates to evaluate any MLR payments necessary after the risk corridor reconciliation. The methodology for the minimum MLR calculation differs from the MLR-based risk corridor, as a result of allowable differences including but not limited to the inclusion of Health Care Quality Improvement, Health Information Technology, and External Quality Review expenditures in the numerator for the minimum MLR calculation that are not allowable in the risk corridor calculation.

Reinsurance

The contracts between HHS and the MCOs require that the MCOs comply with reinsurance requirements of 191 Iowa Administrative Code 40.17 and shall file with the Agency all contracts of reinsurance or a summary of the plan of self-insurance. The contractor shall provide to the Agency the risk analysis, assumptions, cost estimates, and rationale supporting its proposed reinsurance arrangement.

D. State Directed Payments

i. Rate Development Standards

There are four state directed payment initiatives associated with the IA Health Link managed care program for the SFY26 contract period that are in accordance with 42 CFR §438.6(c). Three of these arrangements (UIHC Physician ACR payments, as well as the separate UIHC and non-UIHC Hospital ACR payments) will be implemented as separate payment term structures that are reimbursed outside of the SFY26 capitation rates. Optumas has received and reviewed each state directed payment preprint and confirms that each state directed payment documented below is consistent with the applicable preprints. At this time, the preprints for the UIHC Physician and UIHC Hospital ACR provider payment arrangements have been submitted to CMS, but not yet approved, for the SFY26 contract period. The Non-UIHC Hospital ACR provider payment arrangement and GEMT directed payments are expected to be submitted prior to the July 1, 2025 contract start date.

Iowa Medicaid and Optumas understand that in accordance with 42 CFR §438.6(c)(2), all state directed payments, except for minimum fee schedules using Medicaid State plan approved rates as defined in 42 CFR §438.6(a), must receive written prior approval from CMS and that the review of the rate certification and related contract actions that incorporate these state directed payments cannot be finalized until all necessary written prior approvals are obtained. The state directed payments included in the rate certification are consistent with the information in the applicable preprints that have been, or will be, submitted to CMS for review.

All contract arrangements that direct the IA Health Link MCOs' expenditures were developed in accordance with 42 CFR §438.4, the standards specified in §438.5, and generally accepted actuarial principles and practices.

There are no requirements regarding the reimbursement rates the plans must pay to any providers unless specified in this certification as a directed payment or authorized under applicable law, regulation, or waiver. No additional directed payments exist within the IA Health Link managed care program for SFY26 outside of the four arrangements described below. Each of the payment arrangements is accounted for in the rate development in a manner consistent with the applicable preprints. The sections below describe how each state directed payment arrangement under §438.6(c) is either incorporated into the base capitation rates as an adjustment as defined in §438.5(f) or addressed through a separate payment term.

UIHC Physician ACR Payments

Description of Arrangement

The UIHC Physician ACR state directed payment was originally approved by CMS for the SFY19 IA Health Link contract period and the arrangement has been renewed annually through SFY25. The UIHC Physician ACR directed payment is a uniform percentage increase in reimbursement for physician and professional services at qualifying Iowa State-Owned or Operated Professional Services Practices. The State plans to continue the arrangement in SFY26 and has submitted the necessary preprint to CMS for review for the July 1, 2025 through June 30, 2026 contract period, although it has not yet been approved.

The additional payment made to these qualifying physicians under the uniform percent increase provides support for contracting and maintaining access for Medicaid beneficiaries to the applicable physicians. Under this arrangement, in accordance with 42 CFR §438.6(c)(2)(ii)(B), a supplemental payment for covered physician services will be made for the services provided by a faculty or staff member of a qualifying Iowa State-Owned or Operated Professional Services Practice to reflect the uniform percent increase in reimbursement. Currently, only physicians affiliated with the University of Iowa meet this definition. Base reimbursement for these services is Iowa Medicaid reimbursement and the supplemental (directed) payment brings the final reimbursement to an Average Commercial Rate level.

Consistent with the SFY25 contract period, Iowa Medicaid is seeking approval for the arrangement to be operated as a separate payment term and reimbursed outside of the capitation rates. Thus, there will be a retrospective reconciliation of payments after the contract period ends and the UIHC Physician ACR PMPMs within Appendix I.C reflect initial estimates for this separate payment term arrangement. Once actual utilization for SFY26 is available, Optumas and Iowa Medicaid will calculate revised PMPMs using the actual claims incurred for each rate cell under the arrangement and actual membership for the contract period. Any differences between the original Physician ACR estimate (calculated as the rate cell specific PMPMs x SFY26 membership) and actual claims incurred under the arrangement will be paid out as a lump sum payment/recoupment from Iowa Medicaid to the MCOs. After the rating period is complete and the State makes any necessary reconciliation payment/recoupment, Optumas will submit a rate certification addendum outlining the distribution methodology and revised PMPMs that reflect the final payments made under this arrangement for SFY26.

Rating Adjustment

The methodology used to calculate the initial estimate for this arrangement is described below and is consistent with the information submitted by the State in the §438.6(c) preprint currently under review by CMS for the SFY26 rating period.

Optumas received a list of University of Iowa providers from the State, which was used to identify claims and services attributed to providers who are eligible to receive the enhanced ACR fee schedule reimbursement. The SFY24 data reflects the Medicaid reimbursement for all claims under this arrangement and the basis for the supplemental payment is the difference between the customary Medicaid rate and the average commercial rate for specific physician service procedure codes. Optumas relied on the total amount of the directed payment estimated by HHS within the directed payment preprint and allocated the directed payment expenditures based on the distribution of applicable services across rate cells within the SFY24 base data to calculate estimated PMPMs shown within Appendix I.C. The MCOs are responsible for paying the calculated differential payments to qualifying practices based on actual utilization within the contract period.

This supplemental PMPM, which does not contain any applied non-medical load, is the estimated amount of the impact of implementing the uniform percent increase to commercial reimbursement for physician and professional services at qualifying Iowa State-Owned or Operated Professional Services Practices.

The estimated PMPMs by rate cell for the UIHC Physician ACR directed payment are shown in Appendix I.C. The estimate is based on historical utilization of services by qualifying physicians and practitioners. The actuaries are certifying the amount of the initially estimated separate payment term arrangement within this certification. Once actual experience for SFY26 is available, the retrospective reconciliation will be performed and the initial PMPM estimates, shown in Appendix I.C, will be revised to reflect the actual experience incurred for each rate cell with an addendum submitted to CMS outlining the final payments made under the arrangement.

UIHC Hospital ACR Payments

Description of Arrangement

Effective July 1, 2021, the UIHC Hospital ACR payment was a new state directed payment for inpatient and outpatient hospital services at qualifying Iowa State-Owned teaching hospitals with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education. The uniform percent increase directed payment is structured in accordance with 42 CFR §438.6(c). The State plans to continue the arrangement in SFY26 and has submitted the necessary preprint to CMS for review for the July 1, 2025 through June 30, 2026 contract period, although it has not yet been approved.

The additional payment made to these qualifying hospitals under the uniform percent increase provides support for contracting to maintain/expand access to services essential for Medicaid beneficiaries. Under this arrangement, in accordance with 42 CFR §438.6(c)(2)(ii)(B), a supplemental payment for qualifying Inpatient and Outpatient hospital services will be made to reflect the reimbursement of the

uniform percent increase. Currently, only the University of Iowa Hospitals and Clinics meets the eligibility criteria for the directed payment arrangement. Base reimbursement for these services is Iowa Medicaid reimbursement and the supplemental (directed) payment brings the final reimbursement to an average commercial rate level.

For the SFY26 contract period the UIHC Hospital ACR directed payment will be reimbursed outside of the Health Link capitation rates via a separate payment term structure. Optumas has developed an estimate for the separate payment term arrangement consistent with the preprint that has been submitted to CMS, noted above. The methodology used to estimate the payments associated with the hospital directed payment is similar to the physician arrangement described previously. The basis for the supplemental payment is the difference between the provider's negotiated Medicaid managed care reimbursement and the average commercial rate (uniform percent increase) calculated using an ACR payment-to-charge ratio for inpatient and outpatient (both acute and behavioral health) hospital services. The MCOs are responsible for paying the calculated differential payments to qualifying providers based on actual utilization on a per claim basis within the contract period.

Once actual utilization for SFY26 is available, Optumas and Iowa Medicaid will calculate revised PMPMs using the actual claims incurred for each rate cell under the arrangement and actual membership for the contract period. Any differences between the original UIHC Hospital ACR estimate (calculated as the rate cell specific PMPMs x SFY26 membership) and actual claims incurred under the arrangement will be paid out as a lump sum payment/recoupment from Iowa Medicaid to the MCOs. After the rating period is complete and the State makes any necessary reconciliation payment/recoupment, Optumas will submit a rate certification addendum outlining the distribution methodology and revised PMPMs that reflect the final payments made under this arrangement for SFY26.

Rating Adjustment

The methodology used to calculate the initial estimate for this arrangement is described below and is consistent with the information submitted by the State in the §438.6(c) preprint currently under review by CMS for the SFY26 rating period.

Optumas received a list of hospitals eligible for this directed payment, which was used to identify inpatient and outpatient services in the SFY24 data that will receive the enhanced ACR reimbursement during the contract period. The State also provided the most recent average ratio of payment to charges for the top five commercial payors split between inpatient and outpatient services, as well as the SFY26 preprint containing the total estimate for the directed payment arrangement. Optumas relied on the total amount of the directed payment estimated by HHS within the required preprint and allocated the estimated directed payments based on the distribution of UIHC inpatient and outpatient services across rate cells within the SFY24 base data to develop the estimated PMPMs shown in Appendix I.C. The differential between the commercial reimbursement calculated and the customary Medicaid reimbursement represents the supplemental directed payment that will be paid on a per claim basis for eligible services. These supplemental PMPMs are an estimate of the directed payment arrangement but are not included within the capitation rates paid monthly to the MCOs. Once actual utilization for the contract period is available, Optumas will submit an addendum with the final PMPM costs associated with the hospital directed payment by rate cell to CMS.

The estimated PMPMs for each rate cell associated with the UIHC Hospital ACR Payment are shown in Appendix I.C. The estimated payments were developed based on historical utilization of Inpatient and Outpatient services by qualifying hospitals. The actuaries are certifying the amount of the initially estimated separate payment term arrangement within this certification. Once actual experience for SFY26 is available, the retrospective reconciliation will be performed and the initial PMPM estimates, shown in Appendix I.C, will be revised to reflect the actual experience incurred for each rate cell with an addendum submitted to CMS outlining the final payments made under the arrangement.

Non-UIHC Hospital ACR Payments

Description of Arrangement

Effective July 1, 2023, the Non-UIHC Hospital ACR payment was a new state directed payment for all non-state owned or operated hospitals eligible to receive inpatient and/or outpatient payments consistent with the State Plan Attachments 4.19A and 4.19B. All hospitals except for the UIHC hospitals are eligible to participate in this directed payment. The uniform percent increase directed payment is structured in accordance with 42 CFR §438.6(c). The State plans to continue the arrangement in SFY26 and intends to submit the necessary preprint to CMS for review for the July 1, 2025 through June 30, 2026 contract period, prior to July 1, 2025.

The additional payment made to these qualifying hospitals under the uniform percent increase provides additional funding for rate increases to hospitals that will help ensure continued access to hospital care and improve quality of care received by Medicaid enrollees. Under this arrangement, in accordance with 42 CFR §438.6(c)(2)(ii)(B), a supplemental payment for qualifying inpatient and outpatient hospital services will be made to reflect the reimbursement of the uniform percent increase. Base reimbursement for these services is Iowa Medicaid reimbursement, and the supplemental (directed) payment brings the final reimbursement to 91% of the average commercial rate level.

For the SFY26 contract period the Non-UIHC Hospital ACR directed payment will be reimbursed outside of the Health Link capitation rates via a separate payment term structure. Optumas has developed an estimate for the separate payment term arrangement consistent with the draft SFY26 preprint that the state plans to submit prior to July 1, 2025. The methodology used to estimate the payments associated with the hospital directed payment is similar to the UIHC Physician and Hospital ACR arrangements described previously. The basis for the supplemental payment is the difference between the provider's negotiated Medicaid managed care reimbursement and 91% of the average commercial rate (uniform percent increase). The MCOs are responsible for paying the calculated differential payments to qualifying providers based on actual utilization on a per claim basis within the contract period.

Once actual utilization for SFY26 is available, Optumas and Iowa Medicaid will calculate revised PMPMs using the actual claims incurred for each rate cell under the arrangement and actual membership for the contract period. Optumas will submit a rate certification addendum outlining the distribution methodology and revised PMPMs that reflect the final payments made under this arrangement for SFY26.

Rating Adjustment

The methodology used to calculate the initial estimate for this arrangement is described below and is consistent with the information in the draft §438.6(c) preprint that the State plans to submit to CMS prior to July 1, 2025. Once the final preprint is submitted to CMS, Optumas will review to confirm that the initial amounts estimated for the directed payment remain consistent with the final version. While it is not anticipated, if a material change to the preprint between the draft and final version occurs, an amendment to the rates would be provided to ensure consistency with the final preprint and the certification letter.

Optumas identified all non-UIHC hospital inpatient and outpatient services within the SFY24 base data that will be eligible to receive the enhanced ACR reimbursement during the contract period. The State provided Optumas with the preprint that is expected to be submitted to CMS for approval, containing the total estimate for the non-UIHC Hospital ACR directed payment arrangement. Optumas relied on the total amount of the directed payment estimated by HHS within the required preprint and allocated the estimated directed payments based on the distribution of non-UIHC inpatient and outpatient services across rate cells within the SFY24 base data to develop the estimated PMPMs shown in Appendix I.C. The differential between the commercial reimbursement calculated and the customary Medicaid reimbursement represents the supplemental directed payment that will be paid on a per claim basis for eligible inpatient and outpatient services. These supplemental PMPMs are an estimate of the directed payment arrangement but are not included within the capitation rates paid monthly to the MCOs. Once actual utilization for the contract period is available, Optumas will submit an addendum with the final PMPM costs associated with the hospital directed payment by rate cell to CMS.

The estimated PMPMs for each rate cell associated with the Non-UIHC Hospital ACR Payment are shown in Appendix I.C. The estimated payments were developed based on historical utilization of inpatient and outpatient services for qualifying hospitals. The actuaries are certifying the amount of the initially estimated separate payment term arrangement within this certification. Once actual experience for SFY26 is available, a retrospective reconciliation will be performed and the initial PMPM estimates, shown in Appendix I.C, will be revised to reflect the actual experience incurred for each rate cell with an addendum submitted to CMS outlining the final payments made under the arrangement.

GEMT Payment Program

Description of Arrangement

Effective July 1, 2019, the State implemented the GEMT Payment Program in accordance with 42 CFR §438.6(c) and incorporated the approved supplemental GEMT payment program into the Iowa State Plan via SPA transmittal #19-0002. The GEMT Payment Program is made to qualifying Emergency Medical Service (EMS) providers within Iowa for Emergency Medical Transportation services. Iowa Medicaid provided Optumas with the list of applicable providers and procedure codes that will receive the prospective provider-specific payment rates during the SFY26 contract period. The provider-specific rates are based on CMS-approved GEMT cost reports submitted by the EMS providers. The EMS additional payments will provide support for contracting and maintain access for Medicaid beneficiaries to receive GEMT services. Under this arrangement, in accordance with 42 CFR §438.6(c)(2)(ii)(B), the supplemental payment for covered emergency transportation services will be billed under procedure

code A0999 for the services provided by an approved EMS provider. The A0999 procedure codes associated with the GEMT directed payment arrangement were excluded from the base data underlying rate development to avoid duplication with this supplemental payment calculation. The GEMT state directed payment was incorporated into the rate certification in the base capitation rates as a rate adjustment consistent with the preprint that is expected to be submitted to CMS on or before June 30, 2025. The State provided Optumas with the draft preprint that is expected to be submitted to CMS, and the arrangement built into the rates is consistent with the draft preprint as well as the approved SPA GEMT supplemental payment program. Once the final preprint is submitted to CMS, Optumas will review to confirm that the amount built into the rates remains consistent with the final version. While it is not anticipated, if a material change to the preprint between the draft and final version occurs, an amendment to the rates would be provided to ensure consistency with the final preprint and the capitation rates.

The payment arrangement for the SFY26 contract period will be based on actual emergency transportation service utilization within the contract period and is structured such that the MCOs pay both the customary Medicaid rate and the supplemental provider-specific prospective rate when adjudicating claims. The provider-specific prospective payment rate, billed under procedure code A0999, represents the additional uncompensated actual costs necessary to perform EMS transports based on submitted cost reports. Base reimbursement for the eligible emergency transportation services is Iowa Medicaid reimbursement. The supplemental payment (state directed uniform dollar increase) reflects the provider-specific Medicaid uncompensated care cost per transport to fully reimburse eligible EMS providers for the applicable services.

Rating Adjustment

The providers receiving the supplemental payment associated with the GEMT program are eligible EMS providers who will continue submitting CMS-approved cost reports that will be used to calculate their supplemental prospective payment in future fiscal years. The State provided the list of eligible EMS providers who will be participating in the program for the SFY26 contract period and accompanying provider-specific rates, which were used to calculate the supplemental PMPM amounts noted below.

The supplemental payment for GEMT is calculated based on emergency transport service utilization for qualifying EMS providers within the SFY24 base data, at the rate cell level, projected to the SFY26 contract period. The GEMT PMPMs by rate cell are shown in Appendix I.B and the amounts are included within the base capitation rates.

ii. Appropriate Documentation

To comply with 42 CFR §§ 438.7(b)(6) and 438.6(c), the rate certification and supporting documentation includes a description of each state directed payment utilized by the state within the IA Health Link manage managed care program. *Table 10* below contains a brief summary of each applicable state directed payment for the SFY26 contract period.

Table 10. IA Health Link State Directed Payments

State Directed Payment Control Name	Type of Payment	Brief Description (Reference preceding section for more information.)	Rate Adjustment or Separate Payment Term?
UIHC Physician ACR Payment Control Name: IA_Fee_AMC_Renewal_20250701-20260630	Uniform Percentage Increase	Reimbursement increase to Average Commercial Rate for applicable services.	Separate Payment Term
UIHC Hospital ACR Payment Control Name: IA_Fee_IPH.OPH_Renewal_20250701-20260630	Uniform Percentage Increase	Reimbursement increase to Average Commercial Rate for applicable services.	Separate Payment Term
Non-UIHC Hospital ACR Payment Control Name: Information not yet available	Uniform Percentage Increase	Reimbursement increase to 91% of the Average Commercial Rate for applicable services.	Separate Payment Term
GEMT Payment Control Name: Information not yet available	Uniform Dollar Increase	Provider specific supplemental payments set based on CMS-approved cost reports.	Rate Adjustment

In compliance with 42 CFR §§ 438.7(b)(6) and 438.6(d), further details are included in *Table 11* below for the GEMT state directed payment that is included within the base capitation rates.

Table 11. Directed Payments Included Within the Capitations Rates

State Directed Payment Control Name	Rate Cells Affected	Impact	Description of the Adjustment	Confirmation that the Rates are Consistent with the Preprint
GEMT Payment Control Name: Information not yet available	All Except Maternity Case Rate Payments	Please see column BO of Appendix I.B labelled "GEMT".	Please see the GEMT Rating Adjustment in Section I.D.i above.	Optumas has not yet received the final directed payment preprint. The rating adjustment is accounted for in a manner consistent with the approved SPA and draft version of the preprint that will be submitted to CMS for review.

Further details are included in *Table 12* below for the ACR directed payments that will be operated as separate payment terms with reimbursement outside of the IA Health Link capitation rates for the SFY26 contract period.

Table 12. Directed Payments Operated as Separate Payment Terms

State Directed Payment Control Names	Aggregate Amount of Payment*	Certifying Statement	Magnitude on a PMPM Basis	Confirmation of Consistency	Confirmation of End of Rating Period Documentation
UIHC Physician ACR Payment Control Name: IA_Fee_AMC_Renewal_20250701-20260630	Please see column E of Appendix I.C. labelled "Total UIHC Physician ACR Estimate".	The actuaries are certifying the estimated PMPMs shown within Appendix I.C.	Please see column D of Appendix I.C. labelled "UIHC Physician ACR PMPM".	This state directed payment is accounted for in a manner consistent with the preprint submitted to CMS.	After the rating period is complete, documentation that incorporates the total amount of the state directed payment into each rate cell will be submitted consistent with the distribution methodology included in the preprint.
UIHC Hospital ACR Payment Control Name: IA_Fee_IPH.OPH_Renewal_20250701-20260630	Please see column G of Appendix I.C. labelled "Total UIHC Hospital ACR Estimate".	The actuaries are certifying the estimated PMPMs shown within Appendix I.C.	Please see column F of Appendix I.C. labelled "UIHC Hospital ACR PMPM".	This state directed payment is accounted for in a manner consistent with the preprint submitted to CMS.	After the rating period is complete, documentation that incorporates the total amount of the state directed payment into each rate cell will be submitted consistent with the distribution methodology included in the preprint.
Non-UIHC Hospital ACR Payment Control Name: Information not yet available	Please see column I of Appendix I.C. labelled "Total Non-UIHC Hospital ACR Estimate".	The actuaries are certifying the estimated PMPMs shown within Appendix I.C.	Please see column H of Appendix I.C. labelled "Non-UIHC Hospital ACR PMPM".	This state directed payment is accounted for in a manner consistent with the preprint that the State intends to submit to CMS.	After the rating period is complete, documentation that incorporates the total amount of the state directed payment into each rate cell will be submitted consistent with the distribution methodology included in the preprint.

** The estimated aggregate amount of the directed payment is shown based on the SFY24 base data membership multiplied by the estimated SFY26 PMPMs and will vary within the SFY26 contract period based on actual service utilization experience and actual membership.*

There are no additional directed payments in the program that are not addressed in this certification documentation including minimum fee schedules using Medicaid State plan approved rates as defined in 42 CFR §438.6(a).

There are no requirements regarding the reimbursement rates the managed care plans must pay to any providers unless specifically specified above as a state directed payment or authorized under applicable law, regulation, or waiver.

E. Pass-Through Payments

GME payments are incorporated within the capitation rates and reflect payments to hospitals for graduate medical education programs. However, the GME payment is outside of the standard definition of pass-through payments per 42 CFR 438.6(a); therefore, there are no pass-through payments in the IA Health Link SFY26 contract period.

Although the GME payment is outside the standard definition of pass-through payments per 42 CFR 438.6(a), Optumas has included the description and amount of the GME payment in this section of the certification letter. The GME payments are made to teaching hospitals for the purpose of funding GME within the state. These payments are received by teaching hospitals with an accredited medical education program and are funded with direct State appropriations to the Medicaid agency. These amounts are paid to the teaching hospitals by the MCOs but are not included in the contracted rates between the plans and the hospitals.

The amount of GME payments included in the SFY26 capitation rates is $5.04 PMPM for applicable rate cells and is consistent with the amounts included within the SFY25 capitation rates. The PMPMs by rate cell are shown in Appendix I.B.

5. Projected Non-Benefit Costs

A. Rate Development Standards

i. Required Components

In accordance with 42 CFR §438.5(e), the development of the non-benefit component of the rate includes reasonable, appropriate, and attainable expenses related to MCO administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, and cost of capital. In addition, the non-benefit component includes other operational costs associated with the provision of services under the contract, including those administrative costs for compliance with the mental health parity standards in 42 CFR §438.3, subpart K.

ii. PMPM and Percentage of Capitation Rates

Non-benefit costs were developed as a percentage of the capitation rates, net additional payments (UIHC Hospital and Physician ACR payments, Non-UIHC Hospital ACR payments, GEMT, and GME) described in Section I.4.D and Section I.4.E above with a separate Waiver Care Coordination PMPM development for updated care coordination staffing ratio requirements and assessor transitions that have been ongoing since January 1, 2025.

B. Appropriate Documentation

i. Development

Description of Data

Non-benefit costs were developed using financial data reported by each MCO for SFY24 through SFY25 Q2 (July 2023 – December 2024) along with a review of non-benefit costs in Medicaid programs from states with similar covered populations and services. In developing the non-benefit cost assumptions, Optumas relied primarily on the MCO financial templates and supplemental Care Manager and Assessor cost information provided by the MCOs in March 2025. The projected level of non-benefit costs necessary varies between populations to effectively manage care and are shown by rate cell in Appendix I.B.

Material Changes/Adjustments

Due to the updated care coordination ratio contractual requirements and assessor transitions, Optumas requested supplemental information regarding staffing and expenditures associated with Care Managers and Assessors for each MCO for consideration within the non-medical load development. Otherwise, there were no material changes or adjustments in the development of the non-medical load for the SFY26 capitation rates from that of the SFY20 through SFY25 capitation rates.

Effective January 1, 2025, HHS implemented revised care coordination staffing ratio requirements that resulted in the MCOs hiring additional staff to meet the contractual obligations of a 1:45 ratio and began

transitioning ID Waiver assessments from the MCOs to a third-party vendor. Additionally, effective July 1, 2025, HHS is shifting the responsibility of all comprehensive assessments, HCBS level of care assessments, and needs-based assessments for all HCBS and Habilitation populations from the MCOs to the third-party. The additional care coordination requirements are expected to increase the administrative load, while the assessor responsibility shifts will likely decrease the total administrative expenditures within the contract period relative to the SFY24 and CY24 baseline prior to the policy implementation.

The supplemental Care Manager and Assessor cost information provided by the MCOs was used to evaluate the administrative expenditures reported in the SFY24 financial templates, itemize care coordination and assessor-related expenditures for the Waiver populations, and determine the associated impact of the care coordination and assessor policy changes that will be in effect during the contract period. The supplemental information included details on the number of open care manager positions as of February 2025, as well as assessor transitions that are anticipated to occur, including the expected number of full-time employees (FTEs) that will be required to fulfill any remaining MCO assessment obligations. Optumas evaluated the financial and supplemental information to calculate statewide administrative expense PMPMs, with and without the Waiver Care Management and Assessor costs. This information was used to develop a baseline administrative PMPM for all administrative functions that will not be impacted by the new policies. The Waiver Care Manager and Assessor supplemental information was used to estimate the anticipated costs associated with the revised MCO obligations and develop a separate estimated care coordination and assessor PMPM for the Waiver rate cells. Please note that the Children's Mental Health HCBS Waiver is estimated to have a lower PMPM due to the majority of members receiving care coordination through an Integrated Health Home.

The statewide non-medical load includes projected costs and profit, risk, contingency margin for all administrative expenditures outside of the Waiver care coordination/assessor (Waiver CC) PMPMs; this varies by rate cell and is applied consistently to all MCOs for all rate cells. The total SFY26 non-Waiver CC load is approximately 8.3% in aggregate, using the SFY24 base membership mix. The profit, risk, continency margin remains at 1.75% of premium for all rate cells. The total non-medical load (including care manager/assessor PMPMs) is 9.1% in aggregate for the SFY26 rates compared to 9.5% for the SFY25 Midyear rates. While the total non-medical load (including care manager/assessor PMPMs) on a percent of premium basis has decreased relative to the SFY25 Midyear rates, the administrative load on a PMPM basis has increased.

Note, HHS is determining final policy related to further changes to MCO care coordination requirements in conjunction with the Certified Community Behavioral Health Clinic (CCBHC) implementation and additional staffing ratio requirements associated with the population receiving Home Based Habilitation services. No explicit adjustments have been made to the non-medical load for these policies at this time. Optumas expects to provide an amendment to the rates to incorporate any additional care coordination requirement shifts along with the additional appropriations and adjustments noted within this document once the policies are finalized. Additionally, Optumas has adjusted the non-medical load to reflect a reduction in assessor costs, based on information reported by the MCOs. However, this assumption may be revised within the upcoming addendum pending updated supplemental data from the MCOs regarding the anticipated assessor costs that will remain as the transitions continue to evolve and additional cost information is available for the responsibilities remaining with the MCOs rather than the third-party vendor.

ii. Cost Categories

The non-medical load includes administrative costs and an allocation for profit, risk, and contingency which is 1.75% of premium for all rate cells. This amount is consistent with that of the SFY20 through SFY25 capitation rates.

Effective January 1, 2024, a 0.975% premium tax was implemented for each Medicaid MCO on gross premium revenues, including directed payments. The premium tax decreased to 0.95% effective January 1, 2025. The premium tax is applied to the rates net of the 2.0% withhold as a percent of total premium, and any earned withhold will be adjusted for the 0.95% premium tax after evaluation of the withhold amount earned by each MCO. The premium tax adjustment is separate from the non-medical load assumption built into the rates.

Effective January 1, 2026, the premium tax is expected to be reduced to 0.925%. To the extent that this or any other changes to the premium tax amount materialize, Optumas will submit a revised midyear rate addendum, for the effective date of the change, to account for the change in premium tax.

iii. Historical Non-Benefit Cost Data

As described in the sections above, the historical non-benefit cost data provided by the IA Health Link MCOs was relied upon when developing the non-medical load assumptions within the capitation rates. The MCOs provided financial information for the SFY24 base period and emerging SFY25 non-benefit experience. Optumas reviewed all quarterly data for consistency but relied primarily on the SFY24 and CY24 annual periods in conjunction with the supplemental Care Manager and Assessor cost and staffing information provided by the MCOs. Optumas and Iowa Medicaid will continue to monitor the non-benefit cost data provided by the IA Health Link MCOs in future rate development cycles as the program and MCO contractual responsibilities continue to evolve.

6. Risk Adjustment

A. Rate Development Standards

i. Risk Adjustment

Optumas accounted for the relative risk in the health status of enrollees in each MCO through a combination of health-based risk scores based on UCSD's CDPS+Rx tool and cost-based relativity factors for certain Dual and LTSS populations for the SFY26 rate development. The methodology is largely consistent with that of the SFY25 rate development.

Optumas developed and applied risk scores or relativity factors for most populations within the IA Health Link program. The populations that are adjusted for within the SFY26 rates are consistent with those adjusted for within SFY25 rate development. Risk score calculations and cost-based relativity factor development were largely consistent with prior rate development cycles, with updated study periods and snapshot periods. This cycle also included methodological updates to account for durational differences between MCOs and observed differences in utilization patterns for Integrated Health Home (IHH) and Home Based Habilitation (HBH) services, which are not adequately captured by typical Medicaid risk adjustment models. Similarly, the cost-based relativity factors also include an explicit duration adjustment due to the preferential auto-assignment policy that was in place from December 2023 through June 2024, which resulted in Molina having a larger proportion of lower duration members within the study periods evaluated for risk/relativity adjustment. The final risk and relativity adjustment factors were applied in a budget neutral manner and a description of the methodology is included in the following sections.

ii. Methodology

Consistent with 42 CFR §438.5(g), Optumas worked with Iowa Medicaid to select a prospective risk adjustment and relativity adjustment methodology that uses generally accepted models. The adjustment factors are applied in a budget neutral manner, consistent with generally accepted actuarial principles and practices.

B. Appropriate Documentation

i. Risk Adjustment

In accordance with 42 CFR §438.7(b)(5)(i), the rate certification describes all prospective risk adjustment methodologies below.

Data

Optumas relied on January 1, 2024 – December 31, 2024 (CY24) enrollment and encounter data as the study period for capturing the relevant diagnoses and pharmacy information used to calculate member risk scores and develop the relativity factors at the rate cell level. Iowa Medicaid provided Optumas with member-level MCO capitations paid through March 2025 that were used to attribute the members

within the CY24 base data period to Wellpoint, Iowa Total Care, and Molina. The capitation data contains detailed member-level demographic information for members enrolled within the three MCOs each month. The final MCO risk/relativity adjustment factors used in SFY26 rate development reflect an aggregation of actual experience for CY24. Optumas relied on the December 2024 snapshot month to assign members and their associated risk scores to each MCO and to assign members and their associated cost-based relativity factors to each MCO, for purposes of prospective risk adjustment in the SFY26 capitation rate development. December 2024 was used as it represents the most complete month of enrollment experience due to the inherent lag in capitation payments that has been historically observed for the LTSS populations within the IA Health Link program.

Model

The populations that are risk/relativity adjusted for SFY26 are consistent with those adjusted for SFY25 rate development.

Consistent with prior cycles of rate development, Optumas applied health-status based risk scores to most non-LTSS populations. Baseline risk scores were developed using UCSD's CDPS+Rx V7.2 tool, with national prospective weights and a December 2024 enrollment snapshot. Optumas identified significant differences in the membership distribution by duration (number of months enrolled) across MCOs as a result of the preferential auto-assignment policy. This difference in duration is not expected to continue in the contract period as enrollment stabilizes, so Optumas shifted the durational criteria this cycle so that scored members must have at least 9 months of enrollment within the CY24 study period. Unscored members received the statewide average disease weight of scored members for each rate cell, along with their member-specific demographic weight.

The specific rate cells attributed to each MCO that have fewer than 300 unique members were adjusted for credibility using the classical credibility formula:

$$\sqrt{\frac{Member\ Count}{300}}$$ = weight given to the MCO-specific risk score, with a maximum of 100%

The complement percentage was given to the statewide average risk score for each rate cell. The result is a credibility-adjusted risk score that mitigates bias due to rate cell sample size.

The following standard Medicaid populations are risk adjusted using CDPS+Rx risk scores:

- Children (over the age of one)
- Non-Expansion Adults
- Wellness Plan Adults
- ABD Non-Duals

After prospective risk scores were developed, Optumas blended the MCO-specific normalized risk scores with a normalized MCO-specific IHH/HBH relativity factor for risk adjusted rate cells with material experience for IHH/HBH services. The IHH/HBH relativity factor was developed by comparing each MCO's specific IHH/HBH CY24 PMPMs by rate cell to the CY24 statewide average PMPM. The December 2024 enrollment snapshot was used to normalize the risk adjustment factors. The blend percentage was based on the portion of the total statewide CY24 experience that the IHH/HBH services represent for each rate cell. The final blended risk score gives the IHH/HBH percentage weight to the IHH/HBH

relativity factor and the complement to the CDPS+Rx normalized risk scores. The blended risk adjustment factors were developed to recognize that an MCO with a disproportionate share of IHH/HBH experience will likely have artificially understated risk scores relative to expected cost differences, when relying only on CDPS+Rx since these services are not generally captured through the standard Medicaid risk adjustment tools.

Dual populations and cohorts with significant LTSS utilization and expenditures were adjusted via a relativity factor rather than CDPS+Rx risk adjustment. CDPS+Rx risk adjustment does not adequately capture the differences in risk profiles for these populations since typical Medicaid risk adjustment tools rely mainly on acute care services, while the majority of costs for these populations are either covered by Medicare or are LTSS. Instead, relativity factors were developed by comparing the total PMPM of each rate cell, by MCO, to the statewide PMPM. The December 2024 capitation data was used to identify member months and costs associated with members enrolled with each MCO. By comparing the relative PMPMs, initial MCO-specific relativity factors were developed for each rate cell. Members who were present throughout CY24, but not present in the December 2024 capitation data, were excluded from the initial relativity factor calculation.

Optumas reviewed the prevalence of members with high-cost claims to ensure that the cost-based relativity factors would not be skewed by outlier claims. After reviewing, Optumas determined no explicit adjustment was needed for members with high-cost claims.

Optumas reviewed the average CY24 enrollment duration for members assigned to each MCO to determine whether durational differences affected relativity factor development. Optumas observed durational differences between MCOs due to the preferential auto-assignment policy and determined that an explicit adjustment to the relativity factor development was necessary. The duration adjustment was developed by grouping members into the following classifications based on total months enrolled within CY24 at both the statewide and MCO level for each rate cell:

- Durations 1-3
- Durations 4-6
- Durations 7-9
- Durations 10+

Statewide relativity factors were developed based on each duration group's PMPM relative to the total CY24 PMPM for each rate cell. The statewide relativity factors were then applied to the MCO-specific distribution of duration groups to develop an aggregate durational adjustment factor for each rate cell. These factors were used to adjust the initial relativity factor calculation described above and were renormalized to be budget neutral.

The CY24 experience reflects encounters submitted through March 2025. Optumas reviewed monthly relativity factors between the MCOs from July 2023 through December 2024 to determine whether any differences in the timing of claims payments and encounter submissions were impacting the original CY24 relativity factors. Optumas reviewed rolling averages of the monthly relativity factors and monthly PMPMs for each MCO and determined that no smoothing adjustment was necessary.

Molina entered the Health Link program in SFY24, resulting in a shifting of members between MCOs during the open enrollment period. Additionally, Iowa Medicaid temporarily assigned Molina 100% of new auto-enrollees from December 2023 through June 2024. Therefore, the December 2024 snapshot

was selected to capture a period of greater enrollment stability between MCOs. Furthermore, the inclusion of a durational adjustment mitigates the influence of differences in duration between the MCOs that occurred because of the auto-assignment policy. Due to the expectation of greater population stability between MCOs throughout the contract period, Optumas has not applied any blend of the cost-based relativity factors with the statewide average of 1.0 for the relativity-adjusted populations for SFY26 rate development as was done in the SFY25 rate development.

Relativity factors were used for the following Dual and LTSS populations:

- Residential Care Facility
- Dual Eligible Members
- Custodial Care Nursing Facility
- HCBS Waiver Members
- ICF/ID
- PMIC

Populations that are neither risk adjusted, nor relativity-factor adjusted, receive statewide rates. These rate cells either have insufficient membership levels for risk adjustment to be credibly applied, or are typically comprised of entirely new members in subsequent years:

- Newborns
- Pregnant Women
- Maternity Case Rates
- Breast and Cervical Cancer
- Non-Dual Skilled Nursing Facility
- State Resource Center

A table detailing the risk adjustment model used for each rate cell, along with the resulting factors, is shown in Appendix II.D.

Methodology

The risk adjustment and relativity factors were applied to the statewide rates in a budget neutral manner consistent with historical rate developments. The risk and relativity adjustment methodologies follow the use of generally accepted actuarial principles and practices that surround standard risk adjustment. Appendix II.E demonstrates the budget neutrality of the risk adjustments made to split the statewide rates into MCO-specific risk adjusted rates for each applicable rate cell. Consistent with the statewide rate development, same-demographic Children and CHIP rate cells were combined for credibility in developing the risk adjustment factors.

Magnitude

A proxy SFY26 membership mix for each MCO was developed using the distribution of members between Wellpoint, Iowa Total Care, and Molina for each rate cell within the capitation file paid through March 2025. This proxy SFY26 MCO enrollment is based on annualized membership in the first quarter of SFY25 and is used when aggregating the totals within Appendix II.E and Appendix II.F. The magnitude of the risk/relativity adjustment is an increase of 2.4% for Wellpoint, an increase of 1.8% for Iowa Total

Care, and a decrease of 6.4% for Molina, based on each MCO's respective SFY26 proxy membership. The impact by rate cell and in total for each MCO is shown in Appendix II.F.

Assessment of Predictive Value

Optumas reviewed the raw risk scores by rate cell developed for the SFY26 IA Health Link rates to the raw risk scores within the SFY25 rate development and compared the MCO-specific normalized risk scores to the relativity factors used within the SFY25 rate development. In general, the normalized risk scores for most populations were directionally consistent with the SFY25 rate development. As more recent experience becomes available for the IA Health Link program, Optumas and Iowa Medicaid will continue to monitor and review the correlation between the relativity factors and relative costs by MCO and rate cell to determine if there are further shifts in relative acuity of the population between MCOs.

Concerns

At this time, Optumas does not have concerns with the predictive value of the risk and relativity adjustment methodology used within SFY26 for predicting the relative risk differences between MCOs.

ii. Retrospective Risk Adjustment

No retrospective risk adjustment has been made in the development of the SFY26 rates.

iii. Changes to Risk Adjustment Model and Budget Neutrality

The risk adjustment model remained largely consistent between the SFY25 and SFY26 rate development cycles. Within the SFY25 rate development, Optumas used UCSD's CDPS+Rx V7.1 health-status based risk adjustment tool, which has been updated to V7.2 for the SFY26 rates. The SFY24 base period contained several unique enrollment circumstances that caused significant membership differences between MCOs: allocation of members to a third MCO entering the market, shifting of members between MCOs during the open enrollment period, and Iowa Medicaid's decision to temporarily assign 100% of new auto-enrollees to Molina from December 2023 – June 2024. As a result, the SFY24 base exhibited significant durational differences between MCOs that warranted an explicit durational adjustment. Additionally, consideration was given to emerging costs surrounding the utilization of Integrated Health Home and Home Based Habilitation services in the development of risk scores. This is because these services are not adequately captured by typical Medicaid risk adjustment models. For rate cells with material IHH/HBH experience, the CDPS+Rx risk scores were blended with each MCOs' respective cost-based relativity factor using the statewide proportion of the total PMPM that is made up by IHH/HBH services.

Dual eligible and certain LTSS populations continue to be risk adjusted using cost-based relativity factors by plan compared to statewide PMPMs. For SFY25 rate development, cost-based relativity factors were blended with the statewide average of 1.0 using a 90% weighting on MCO-specific relativity factors and a 10% weighting on the statewide average, to reflect that Molina was expected to continue to receive a higher proportion of new individuals who would more closely resemble the statewide average. The CY24 study period displayed more stabilization of enrollment within the Health Link program between the three MCOs compared to the CY23 study period used in SFY25 rate development. Therefore, Optumas

has not applied a blend to the MCO-specific cost-based relativity factors in SFY26 rate development. However, Optumas observed a lower average duration for members enrolled in Molina in the CY24 study period due to the preferential auto-assignment policy in place throughout SFY24. To account for this, an explicit durational adjustment was incorporated to reflect that the duration of members enrolled in Molina will presumably more closely resemble the duration of members enrolled in other MCOs in SFY26.

All risk/relativity adjustments are applied in a budget neutral fashion in accordance with 42 CFR §438.5(g). Appendix II.E demonstrates the budget neutrality of the risk adjustments made to split the statewide rates into MCO-specific rates for each applicable rate cell.

7. Acuity Adjustment

A. Rate Development Standards

i. Risk Adjustment

An adjustment applied to the total payments across all managed care plans to account for significant uncertainty about the health status or risk of a population is considered an acuity adjustment, which is a permissible adjustment under 42 CFR § 438.5(f) (81 FR 27595).

Optumas has applied a prospective acuity adjustment within the SFY26 IA Health Link rates to account for the significant member disenrollments and subsequent changing population as a result of the COVID-19 PHE unwinding.

B. Appropriate Documentation

i. Acuity Adjustment Description

Reason for Health Status Uncertainty

In response to the COVID-19 pandemic, HHS implemented a disenrollment freeze for all IA Medicaid populations, resulting in members who would otherwise lose eligibility remaining enrolled with an IA Health Link MCO. The acuity adjustment accounts for an expected increase in per capita costs due to the expiration of the PHE. Beginning in April 2023, HHS began disenrolling members due to the expiration of the Maintenance of Effort requirement. This disenrollment process continued through April 2024 and is only partially reflected in the base data used for rate development.

Model

Optumas reviewed enrollment data to identify members in the base data who were disenrolled due to the end of the PHE disenrollment freeze (“PHE Leavers”) and who are expected to no longer be enrolled during the contract period. Optumas observed that the “PHE Leavers” have lower costs relative to members who remained in the program. The “PHE Leavers” were identified as members who enrolled in the Health Link program during or prior to SFY22, subsequently disenrolled prior to May 2024, and remained disenrolled as of October 2024. Individuals who died in the SFY24 base period were not considered “PHE Leavers”. Individuals who joined the program after SFY22 but have since been disenrolled from Health Link were not considered “PHE Leavers” since these individuals were not enrolled in the program for a prolonged period and are more indicative of "typical churn" populations.

Removing these lower cost “PHE Leavers” results in an increase to the base PMPMs. The acuity adjustment is an upward adjustment in aggregate, with the magnitude of the adjustment varying by rate cell and category of service. The rate cells adjusted for SFY26 are consistent with SFY25 rate development, with two exceptions. First, the ABD Non-Dual <21 M&F and ABD Non-Dual 21+ M&F rate cells were included in the SFY26 adjustment as a result of observed higher costs for remaining members in the emerging data. Second, no adjustment was made for the Breast and Cervical Cancer rate cell, as

the "PHE Leavers" were more costly on average than the remaining population and therefore would have resulted in a negative acuity adjustment.

Additionally, Optumas observed an increase in the PMIC rate cell's PMPM throughout the base period due to a decrease in members who were low- or non-utilizers. The acuity adjustment also includes an adjustment to the PMIC rate cell that accounts for this increase. The PMIC acuity adjustment was developed by adjusting the statewide base data PMPMs to reflect the aggregate level of PMPMs observed in the second half of SFY24 (January – June 2024), which was consistent with emerging SFY25 experience.

Data Used

Optumas relied on enrollment data from July 2021 through October 2024 to classify members as "PHE Leavers" within the acuity adjustment. The SFY24 encounter data and corresponding enrollment was reaggregated based on the member classification to develop the acuity adjustment impact.

Potential Interactions

When evaluating trend, Optumas removed the experience for members classified as "PHE Leavers" for the July 2022 through December 2024 data to estimate secular trends without the interaction of the increasing acuity as members gradually disenrolled throughout SFY24.

Frequency of Calculation

The IA Health Link enrollment volume stabilized within the emerging SFY25 experience. Further significant member disenrollment is not expected. As such, the prospective acuity adjustment that has been applied to the current SFY26 rates is not expected to be recalculated, since the data used reflected actual disenrollments through the completion of the PHE unwinding.

Adjustment to Rates

The acuity adjustment results in an aggregate increase to the rates with the magnitude of the adjustment varying by rate cell based on the volume of disenrollments and PMPM cost-differentials of "PHE Leavers" and population remaining enrolled within the program.

Documentation

The acuity adjustment applied within the SFY26 IA Health Link rates has been developed in accordance with generally accepted actuarial principles and practices.

Section II. Medicaid Managed Care Rates with Long-Term Services and Supports

1. Managed Long-Term Services and Supports

A. Applicability of Section I for MLTSS

Optumas confirms the development of the SFY26 rates for the managed long-term services and supports (MLTSS) populations is consistent with the guidance and documentation noted above in Section I of the required standards for rate development and CMS' expectations for appropriate documentation.

The IA Health Link program covers individuals receiving LTSS services across several rate cells. Beneficiaries in these rate cells include elderly and disabled individuals, including all home and community-based waiver enrollees. A significant portion of services provided to these members are LTSS benefits including nursing facility, home care, and HCBS waiver services. The IA Health Link program includes individuals receiving the following services:

- Intermediate care facility or nursing home care
- ICF/ID facilities
- State resource centers
- Hospice
- Psychiatric mental institutions for children
- HCBS Waiver Services, including:
    - Physical Disability Waiver
    - Health and Disability Waiver
    - AIDS Waiver
    - Brain Injury Waiver
    - Elderly Waiver
    - Children's Mental Health Waiver
    - Intellectually Disability Waiver

The SFY26 rates were developed for all services incurred by LTSS members, with the exception of dental services, which are covered by a separate Iowa Medicaid dental managed care program.

B. Rate Development Standards

i. Rate Blending

Optumas developed the LTSS capitation rates by blending the individual rate cells for each LTSS rating group. The rating groups are consistent with those used in the SFY25 rate development and include the following:

- LTSS Elderly
- LTSS Physically Disabled
- LTSS Intellectually Disabled
- LTSS Children's Mental Health.

Optumas developed MCO-specific LTSS blend assumptions for the LTSS capitation rates. Optumas used the October 2024 enrollment as the basis for the LTSS blend for each MCO, which represents the most complete month of enrollment available at the time of rate development that reflects the following key enrollment shifts that have occurred for the LTSS populations throughout SFY24:

- Transitions associated with the Glenwood SRC closure on June 30, 2024.
- Transitions associated with various ICF/ID closures.
- Transitions between the Custodial Care NF and Wellness Plan rate cells.

The capitation data provides the actual mix of Institutional and Waiver members enrolled with each MCO as of October 2024, after enrollment shifts stabilized and the auto-assignment policy ended. For certain blended rate cells, these membership shifts resulted in a reduction to the blended rate cells relative to the SFY24 mix on a statewide basis, as the Institutional populations represent a smaller portion of the total for the blended rate cells.

As part of the SFY26 addendum, Optumas anticipates reviewing additional SFY25 emerging enrollment for continued stability as it relates to the LTSS blend and may revise the snapshot period to a more recent month or quarter, if appropriate.

C. Appropriate Documentation

i. Payment Structures

Capitation payments for LTSS benefits are paid as a single capitation rate to the MCOs for each LTSS rating group outlined above. The total MCO payments vary based on actual MCO enrollment.

The individual LTSS rate cells are blended using the rating groups mentioned in Section II.1.B. above. A summary of the rate blending methodology is shown in Appendix II.G. The development of the individual LTSS rate cells including the base data, assumptions, and general methodologies for program changes and overall rate setting are consistent with the traditional Medicaid populations and are described within Section I.

The capitation payments made to the MCOs are reflective of the rates (net withhold) shown within Appendix I.A based on the members enrolled within the Health Link MCO for each month of the contract period.

The rates within Appendix I.A are the rates paid to the MCOs. Appendix I.A rates reflect the blended LTSS rates shown within Appendix II.G, with the additional payments included for each rate cell. A summary of the additional payments that are added after the LTSS rate blending (GME and GEMT) are shown in Appendix I.B. The GME and GEMT additional payments vary by individual rate cell based on service utilization differences and because providers are not eligible to receive enhanced payments for all populations (e.g., dual eligible members). The UIHC Physician as well as UIHC and Non-UIHC Hospital ACR directed payments are operationalized via separate payment term arrangements that are reimbursed outside of the capitation rates, but initial PMPM estimates for these arrangements for the LTSS rate cells have been included in Appendix I.C.

ii. Non-Benefit Costs

The non-medical load for the LTSS population was developed in a manner consistent with the approach for all IA Health Link populations with additional considerations for care coordination and assessor contractual requirement changes in SFY26. Further details can be found in Section I.5 of this certification letter.

iii. Sources

The LTSS capitation rates were developed using SFY24 encounter data as the basis for the rates with program change adjustments, trends, and non-medical load assumptions developed in a manner consistent with the approach for all IA Health Link rate cells described throughout Section I.

Section III. New Adult Group Capitation Rates

1. Data

A. New Adult Group Data

The same data sources used to set the SFY26 rates for the traditional Medicaid populations were used to develop rates for the new adult group. IA Health Link encounter data for the WP new adult group, as described in Section I.2, was primarily used to develop SFY26 rates.

B. Previous Rating Periods

i. New Data

Optumas used IA Health Link experience from SFY24 as the basis for SFY26 rate development since this was the most recent complete year of data for the IA Health Link program. Additionally, encounter and enrollment data paid and submitted through March 2024 was used to inform trend projections, risk-adjustment, and the PHE unwind acuity adjustment.

ii. Monitor Costs

Iowa Medicaid and Optumas will continue to review emerging experience for the WP population and will consider the necessity of rebasing or any additional adjustments in future rate developments should emerging experience vary materially from cost projections.

iii. Actual Experience Compared with Expectations

Optumas believes that the use of SFY24 IA Health Link experience as the basis for rate development should better align payment to risk for the SFY26 contract period as compared with the pre-IA Health Link data used in the early years of IA Health Link rate development, or the more recent but now dated IA Health Link encounter data used in prior cycles, as experience continues to evolve.

iv. Adjustment for Differences

Optumas has used SFY24 encounter data as the base data for the SFY26 rates, which incorporates the most recent WP population's actual experience under the IA Health Link program. Therefore, no adjustment has been made for any differences between actual experience compared with expectations. It is expected that the use of SFY24 IA Health Link experience, along with the acuity-based adjustment noted in Section III.2.A.iii below, will better align payment to risk for the SFY26 contract period as compared to prior rate development cycles.

2. Projected Benefit Costs

A. New Adult Group Required Documentation

i. New Adult Groups Covered in Previous Rating Periods

Optumas worked with Iowa Medicaid to utilize SFY24 IA Health Link encounter data as the base for the SFY26 capitation rates. Emerging data through March 2025 was used to inform a variety of rating adjustments described within Section I of this certification.

No adjustments were made for the following items as a result of using actual IA Health Link program experience:

- Pent-up demand
- Adverse selection
- Demographic changes
- Differences in provider reimbursement rates, as these differences do not exist between the WP and non-WP populations

All benefit plan changes have been documented in Section I of this certification letter. No additional benefit plan changes specific to the WP population have been made.

ii. New Adult Groups Not Covered in Previous Rating Periods

Not applicable. The IA Health Link program has covered the new adult group population since the program's inception in April 2016.

iii. Key Assumptions

Acuity Adjustments

Optumas made an acuity adjustment related to the ending of the disenrollment freeze as part of the COVID-19 PHE unwind for the WP population in the same manner as the other populations that were adjusted for acuity changes. The methodology for this adjustment is outlined in Section I.7.

Pent-up Demand

The WP population has had several years of experience within the Iowa Medicaid program at the time of the SFY24 base data period, so no adjustment for pent-up demand was deemed necessary.

Adverse Selection

The WP population has had multiple years of experience with the Iowa Medicaid program, and no significant changes in the population are expected, so no adjustment for adverse selection was deemed necessary.

Demographics

The WP population has had multiple years of experience with the Iowa Medicaid program, and no significant changes in the population are expected, so no adjustment for demographic changes was deemed necessary.

Provider Reimbursement and Networks

Any reimbursement or network adjustments made as part of the program change adjustments were applied to all populations and are described in Section I. Any variations in the assumptions used to develop the projected benefit costs for IA Health Link covered populations were based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.

Other Adjustments

No other adjustments were made to the WP projected benefit costs outside of those previously described in Section I.

B. Other Material Changes or Adjustments to Projected Benefit Costs

Within the SFY26 rate development, Optumas developed prospective trends separately for the WP Medically Exempt and WP Non-Medically Exempt populations due to significant differences in growth within the underlying SFY24 base data and emerging SFY25 experience evaluated within trend development. No other material changes or adjustments were made to the WP projected benefit costs outside of those previously described in Section I.

3. Projected Non-Benefit Costs

A. Required Components

i. Changes in Methodology

Projected non-benefit costs for the WP populations were developed using the same data, methodology, and assumptions as the traditional Medicaid populations, described in Section I.5. No other methodology changes have been made to the projected non-benefit costs between the SFY25 and SFY26 IA Health Link rate developments for the WP population.

ii. Changes in Assumptions

Projected non-benefit costs for the WP population were developed using the same data, methodology, and assumptions as the traditional Medicaid populations, described in Section I.5. No other changes in assumptions for the following items have been made to the projected non-benefit costs between SFY25 and SFY26 outside of what has already been described in Section I.5:

- Administrative costs
- Care coordination and care management
- Provision for operating or profit margin
- Taxes, fees, and assessments
- Other material non-benefit costs

B. Key Assumptions

Optumas used the same assumptions in developing the statewide non-benefit costs for the WP and traditional Medicaid populations. The development of non-benefit costs for all populations is described in Section I.5 and non-benefit costs are shown by rate cell and MCO in Appendix I.B.

4. Final Certified Rates

A. Required Components

i. Comparison to Previous Rates

Consistent with CMS' request under 42 CFR §438.7(d), Appendix II.A contains a comparison of the final certified SFY26 statewide rates to the final rates from the previous SFY25 Midyear rate certification. This appendix contains the comparison for all rate cells, including the Wellness Plan populations.

ii. Other Material Changes

No other material changes outside of what has previously been described in this document were made to the rate development for either the standard Medicaid populations or the new adult Wellness Plan populations.

5. Risk Mitigation Strategies

A. Description of Strategy

As discussed in Section I.4, the SFY26 IA Health Link capitation rates have been developed as full risk rates. There is a program-wide risk corridor in place for the SFY26 contract period, but there are no risk mitigation strategies that are specific to only the Wellness Plan population. Both the risk corridor and minimum MLR requirement apply to the overall IA Health Link program, across all populations.

B. Comparison to Previous Period

i. Changes in Strategy

There have been no changes in risk mitigation strategy for IA Health Link in SFY26 compared to SFY25 that are specific to the Wellness Plan population.

ii. Rationale for Change

There has been no change from the previous rates in use of a risk corridor specific to the WP population.

iii. Experience and Results

No risk mitigation strategy has been in place specific to the WP population. Therefore, there is no relevant information available for prior rate cycles.

Actuarial Certification Letter

We, Barry Jordan, Managing Director at Optumas and Member of the American Academy of Actuaries (MAAA) and a Fellow of the Society of Actuaries (FSA), and Stephanie Taylor, Senior Manager at Optumas and Member of the American Academy of Actuaries (MAAA) and an Associate of the Society of Actuaries (ASA), are certifying the calculation of the capitation rates described in this certification letter. Appendix I contains the Rate Development Summaries and final capitation rates (Appendix I.A) for all cohorts for each MCO. We meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time to time by the Actuarial Standards Board.

The capitation rates provided with this certification are considered actuarially sound for purposes of 42 CFR § 438.4, according to the following criteria:

- The capitation rates have been developed in accordance with generally accepted actuarial principles and practices,
- The capitation rates are appropriate for the populations to be covered, and the services to be furnished under the contract; and
- The capitation rates meet the requirements of 42 CFR § 438.4.

The actuarially sound rates that are associated with this certification are effective July 1, 2025 through June 30, 2026 for the IA Health Link Managed Care program.

The actuarially sound capitation rates are based on a projection of future events. Actual experience may vary from the experience assumed within the rate projection. The capitation rates offered may not be appropriate for any specific Managed Care Organization (MCO). An individual MCO should review the rates in relation to the benefits that it is obligated to provide the covered population and to its specific business model. The MCO should evaluate the rates in the context of its own experience, expenses, capital, surplus, and profit requirements prior to agreeing to contract with Iowa Medicaid. As a result of this evaluation, the MCO may require rates above or below the actuarially sound rates associated with this certification.

Please feel free to contact Barry at barry.jordan@optumas.com or Stephanie at stephanie.taylor@optumas.com for any additional information.

Sincerely,

Barry Jordan, FSA, MAAA
Managing Director, CBIZ Optumas

Stephanie Taylor, ASA, MAAA
Senior Manager, CBIZ Optumas

Appendices

Detailed tables containing data summaries, analyses, and assumptions used within the rate development are shown within the accompanying Microsoft Excel appendices:

- IA Health Link SFY26 Rate Certification Appendix I 2025.06.13.xlsx
- IA Health Link SFY26 Rate Certification Appendix II 2025.06.13.xlsx

The list of allowable ILOSs provided by Iowa Medicaid that are included within the MCO contracts is contained within the following PDF that accompanies this document:

- IA Health Link SFY26 Rate Certification Appendix III 2025.06.13.xlsx