July 13, 2018
Mr. Michael Randol
Iowa Medicaid Director
Iowa Medicaid Enterprise
100 Army Post Rd.
Des Moines, IA 50315

**Subject:** **SFY19 IA Health Link Managed Care Rate Development**

Dear Mr. Randol:

Thank you for the opportunity to assist the Iowa Medicaid Enterprise (IME) with the development of the SFY19 IA Health Link capitation rates. The following report summarizes the methodology used for the development of the capitation rates, effective July 1, 2018 – June 30, 2019. We have also provided our actuarial certification for these capitation rates, compliant with CMS guidelines and requirements. Please send me an e-mail at zachary.aters@optumas.com or call me at 480.588.2495, or e-mail Barry at barry.jordan@optumas.com or call at 480.588.2492 if you have any questions.

Sincerely,

Zachary Aters, ASA, MAAA
Senior Actuary, **Optumas**

Barry Jordan, ASA, MAAA
Consulting Actuary, **Optumas**

CC: Elizabeth Matney, Medicaid Managed Care Bureau Chief
Steve Schramm, **Optumas**

# Iowa Medicaid Enterprise

# IA Health Link Rate Development Actuarial Certification

July 1, 2018 – June 30, 2019 Capitation Rates

# Table of Contents

# Executive Summary

## Background

The Iowa Department of Human Services 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. Most existing Medicaid members were enrolled on April 1, 2016 and most new members will also be enrolled in IA Health Link. Some Medicaid members will continue to be served through Medicaid Fee-For-Service. The objectives of this initiative are to improve quality and access to care, promote accountability for patient outcomes, and create a more predictable and sustainable budget.

This document offers an explanation of the methodologies used in the development of the capitation rates for the program effective SFY19 (July 1, 2018 through June 30, 2019). Iowa Medicaid Enterprise (IME) had used another vendor to develop capitation rates prior to SFY19 and has contracted with **Optumas** to develop actuarially sound capitation rates for the IA Health Link program effective SFY19.

Through a collaborative approach, IME, the participating MCOs, and **Optumas** worked to develop additional cost-saving interventions that could be implemented throughout SFY19. These interventions are expected to take effect on different dates throughout the SFY19 contract period. **Optumas** has developed the rates for IME to be operationalized in three "tiers" throughout the year. These tiers take into account the interventions that are expected to be in place during each respective time period and are grouped as follows:

- Tier 1: July 1, 2018 – September 30, 2018
- Tier 2: October 1, 2018 – December 31, 2018
- Tier 3: January 1, 2019 – June 30, 2019

For purposes of this rate certification, the blended annual rates (25% Tier 1, 25% Tier 2, and 50% Tier 3) and figures will be shown, unless otherwise described. If the interventions do not go into effect on the dates currently expected an update to this rate certification may be required, and in this scenario will be submitted to account for necessary changes to the rates.

AmeriHealth Caritas Iowa Inc. withdrew from IA Health Link effective November 30, 2017. The majority of members previously enrolled with AmeriHealth were transitioned to UnitedHealthcare Plan of the River Valley, Inc. with coverage beginning December 1, 2017; approximately 10,000 members were temporarily enrolled in Fee-For-Service (FFS) but have since been enrolled in Amerigroup as of March 1, 2018. The rates in this document were developed with the expectation that members enrolled in the IA Health Link program will be covered by the two MCOs currently operating in SFY19.

As consulting actuaries to IME, **Optumas** worked with the State to create a rate setting methodology determined to be most appropriate for the SFY19 IA Health Link capitation rates. **Optumas** worked to ensure the methodology used to develop these rates complies with the Centers for Medicare & Medicaid Services (CMS) guidance for the development of actuarially sound rates. This document is structured consistent with the CMS "2018-2019 Medicaid Managed Care Rate Development Guide". The final rates were developed according to actuarially sound principles and reasonably reflect the experience projected for the SFY19 IA Health Link program.

## Summary of Capitation Rates

In developing the SFY19 capitation rates, **Optumas** developed a methodology that adheres 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:

1. They have been developed in accordance with generally accepted actuarial principles and practices,
2. They are appropriate for the populations to be covered and the services to be furnished under the contract, and
3. 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 5 – Incurred Health and Disability Claim
- ASOP 23 – Data Quality
- 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

As the consulting actuaries to the State of Iowa for the IA Health Link capitation rates, **Optumas** worked in conjunction with the State to develop an appropriate rate setting methodology. The State and **Optumas** worked in partnership to ensure that the necessary adjustments were made resulting in reasonable, appropriate and attainable rates for the expected experience in the contract period. **Optumas** applied the above criteria within the development of the methodology for calculating capitation rates for the SFY19 contract period. The body of this document outlines the 2018-2019 CMS Consultation 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 pass-throughs, effective July 1, 2018 - June 30, 2019, can be found in Appendix I.A.

## Fiscal Impact Estimate

The estimated aggregate fiscal impact of the SFY19 IA Health Link rate changes is an increase of $344.2M based on SFY17 enrollment, which is the base data time period used for rate development. The fiscal impact of the SFY19 certified capitation rates, gross withhold, net pass-throughs, compared to the SFY18 capitation rates, gross withhold, net pass-throughs are shown in Appendix II.A.

## Rate Development Summary

A brief description of each component in the rate development process is shown in Appendix II.B., including which components are relevant to each rate Tier. Each step of the SFY19 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. Contract Period

The rates contained in this certification are effective for the 12-month fiscal year period of July 1, 2018 through June 30, 2019 (SFY19) and are broken into three tiers as described in the Executive Summary of this report.

### ii. Required Components

#### *Letter from Certifying Actuary*

The rates contained in this document have been certified by Zach Aters, Member of the American Academy of Actuaries (MAAA), and an Associate of the Society of Actuaries (ASA) and Barry Jordan, Member of the American Academy of Actuaries (MAAA), and an Associate of the Society of Actuaries (ASA). Mr. Aters and Mr. Jordan 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 (excluding paragraph (b)(9)), 438.5, 438.6, and 438.7. A letter from Mr. Aters and Mr. Jordan 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 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. Most existing Medicaid members were enrolled on April 1, 2016 and most new members will also be enrolled in IA Health Link. Some Medicaid members will continue to be served through Medicaid Fee-For-Service. The objectives of this initiative are to improve quality and access to care, promote accountability for patient outcomes, and create a more predictable and sustainable budget.

Amerigroup Iowa, Inc. (Amerigroup), AmeriHealth Caritas Iowa Inc. (AmeriHealth) and UnitedHealthcare Plan of the River Valley, Inc. (United) enrolled members statewide effective April 1, 2016. AmeriHealth withdrew from IA Health Link effective November 30, 2017. The majority of members previously enrolled with AmeriHealth were transitioned to United with coverage beginning December 1, 2017; approximately 10,000 members were temporarily enrolled in FFS but have since been enrolled in Amerigroup as of March 1, 2018. The rates detailed in this certification letter are effective SFY19 and have been developed with the expectation that members enrolled in IA Health Link will be covered by Amerigroup and United.

MCOs participating in the IA Health Link program are required to provide benefits that include physical health, long-term supports and services, behavioral health, and pharmacy prescriptions. These MCOs are not at-risk for certain high-cost drugs which are reimbursed outside of the capitation rates and reimbursed via invoice by IME. The list of drugs excluded from the capitation rates is included in Appendix II.C. Dental services and the Program of All-Inclusive Care for the Elderly (PACE) are covered under separate managed care programs. The base data was summarized into similar service categories that included those required to be provided by the MCOs, referred to as the following Categories of Service (COS):

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

MCOs participating in the IA Health Link program are required to provide benefits for all populations eligible for the IA Health Link program. 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). For summary purposes, these rate cells have been grouped into the following Categories of Aid (COA):

| Rate Cell | Category of Aid (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) - Hawk-i** | Children |
| **Non-Expansion Adults 21-34 F** | 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 |

| Rate Cell | Category of Aid (COA) |
|---|---|
| **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 |
| **Non-Dual HCBS Waivers: PD; H&D; AIDS** | Waiver |
| **Brain Injury HCBS Waiver** | Waiver |
| **ICF/ID** | Institutional |
| **State Resource Center** | 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, and
- Pass-through payments

No retroactive adjustments to the capitation rates are being made at this time for the SFY19 contract period.

### iii. Differences Among Capitation Rates

All proposed differences among the SFY19 IA Health Link capitation rates according to covered populations are based on valid rate development standards, not based on the rate of federal financial participation associated with the covered populations.

### iv. Rate Cell Cross-Subsidization

Payments from any rate cell within the SFY19 IA Health Link capitation rates do not cross-subsidize and are not cross-subsidized by payments from any other rate cell.

### v. Program Change Dates

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

### vi. 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*

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. Therefore, no adjustments are made outside of the rate setting process described in the rate certification.

#### *Final Contracted Rates*

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

### vii. Rate Certification Periods

The rates in this document are certified for the period in which they are effective, SFY19.

### viii. Amendments

#### *Changes to Rates*

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

### *Contract Amendments*

If the contract amendment revises 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.

### *Risk Adjustment*

The state applies risk scores to the capitation rates paid to the plans under a risk adjustment methodology described in the rate certification for that rating period and contract, in accordance with 42 CFR §438.7(b)(5)(iii).

### *Other Changes*

A contract amendment will be submitted any time a rate changes for any reason other than application of an approved payment term (e.g., risk adjustment methodology), which was included in the initial managed care contract.

## B. Appropriate Documentation

### i. Documentation of Data, Assumptions, and Methodology

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

### ii. Index

This rate certification follows the structure of the 2018-2019 Medicaid Managed Care Rate Development Guide. As a result, 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. In cases where sections of the guidance are not relevant for this particular rate certification (e.g., an amended certification that adds a new benefit for part of the year), inapplicable sections of the guidance are included and marked as “Not Applicable”.

### iii. 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.

### iv. Rate Change Comparison

The rates contained in this document represent the first IA Health Link capitation rates developed by **Optumas**. A comparison to rates for SFY18, developed by the previous vendor, is shown in Appendix II.A.

Any other material changes to the capitation rates or the rate development is addressed in other sections of this document.

# 2. Data

## A. Rate Development Standards

### i. Base Data

#### *Encounter data, FFS data, and Audited Financial Reports*

As part of the SFY19 rate setting process, **Optumas** received detailed IA Health Link encounter data from the program's inception through the end of CY17 (04/01/16-12/31/2017). This data reflects experience for the populations to be served by the IA Health Link MCOs. **Optumas** summarized this data for comparison with financial templates that were submitted by each of the three MCOs. **Optumas** also benchmarked the IA Health Link encounter data to the detailed FFS data received for CY15, as well as the base data used by the previous vendor in the SFY18 rate development. In addition to claim data, **Optumas** requested detailed enrollment files from each MCO for comparison with the MMIS eligibility from IME.

#### *Appropriate Base Data*

**Optumas** selected SFY17 (07/01/2016-06/30/2017) as the most appropriate base data for the SFY19 rate development, as it provided the most recent complete year of experience available under managed care in the IA Health Link program.

#### *Medicaid population*

The base data used for this rate setting represents the Medicaid population in Iowa, as it consists of 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 – December 2017), FFS claims for the last three years (January 2015 – December 2017), and all corresponding enrollment information from IME. Additionally, **Optumas** requested summarized financial data from each MCO through data templates, and detailed enrollment files from each MCO.

### *Data Provided by IME*

IME and the health plans provided all of the information requested by **Optumas**, as noted above.

### *Data Not Provided*

All data requested for this rate setting was provided.

## ii. Rate Development Data

### *Data Description*

The base data used for this rate setting is the SFY17 encounter data from the IA Health Link program. Additional data from the IA Health Link program outside SFY17, as well as FFS claims data, MCO financial summaries, and MCO-submitted detailed enrollment data was used to inform assumptions or adjustments to the base data. The data used to inform adjustments to the base data is described for each adjustment in this document. Below is a summary of the data used:

| Data Type | Data Source | Level of Detail | Start Date | End Date |
|---|---|---|---|---|
| **Encounters** | IME MMIS | Detailed | 04/01/2016 | 12/31/2017 |
| **FFS Claims** | IME | Detailed | 01/01/2015 | 12/31/2017 |
| **Enrollment** | IME | Detailed | 01/01/2015 | 12/31/2017 |
| **Financial Template (Encounters, other medical-related costs, admin, and enrollment)** | All MCOs | Summarized | 04/01/2016 | 12/31/2017 |
| **Enrollment** | All MCOs | Detailed | 04/01/2016 | 12/31/2017 |
| **Pharmacy Claims** | One MCO | Detailed | 04/01/2016 | 12/31/2017 |

In addition to encounter data for non-subcapitated arrangements, **Optumas** added the sub capitated costs reported in the MCO financials, by cohort, to the base data to ensure that all medical-related costs were considered in the development of the base data. The impact of this adjustment was 0.5% and is shown in detail in Appendix I.B.

### *Data Availability and Quality*

**Optumas** validated the detailed encounter data through control total, financial template, and monthly volume comparisons. **Optumas** identified a significant discrepancy in Amerigroup's detailed pharmacy data focused in the fourth quarter of CY16 and some surrounding months. IME identified that this was due to an issue with the processing of Amerigroup's pharmacy claims and replacements through Point of Sale and the MMIS systems. Therefore, **Optumas** requested detailed pharmacy data from Amerigroup to use in lieu of the MMIS data. The replacement data matched closely to Amerigroup's financial template and was incorporated into the base data.

**Optumas** summarized the updated detailed data and compared it to the financial data shared by the MCOs. A reporting adjustment was applied, by cohort, to the base data to reconcile these data sources

and account for encounters not yet properly flowing through the MMIS system. The impact of this adjustment was -1.4% and is shown in detail in Appendix I.B.

Additionally, other payment systems not present in the encounter data are detailed in the MCO financial templates and validated against the MCO financials. **Optumas** worked with the MCOs and IME to interpret these payments and ensure they are reflected appropriately, by service and population, in the base data. Adjustments for provider incentives and other miscellaneous payments by the MCOs resulted in a 0.1% increase to the base data. These adjustments are shown in greater detail in Appendix I.B. After applying these adjustment, **Optumas** believes the data sources consistently, accurately, and completely reflect the experience for the IA Health Link program in SFY17.

### *Appropriate Data*

**Optumas** chose to limit the base data to SFY17 completed encounter data. Less than two years of encounter data existed at the beginning of this rate setting process, and the selection of SFY17 as the base allows for sufficient run-out, limiting the impact of Incurred-But-Not-Reported (IBNR) adjustments. This period represents the most recent complete fiscal year of data available for the IA Health Link program.

The IA Health Link program operated with three MCOs during the SFY17 base data period, but one MCO left the program between SFY17 and the SFY19 contract period. The remaining MCOs and IME expressed concerns that contracting and other inefficiencies that may have existed for the plan that departed should not influence plan relativities and expected reimbursement. Effective December 2017, the vast majority of the members previously enrolled with AmeriHealth transitioned to enrollment with United. **Optumas** compared average unit costs by procedure code and modifier, plan, and rate cell. **Optumas** found that many reimbursement rates for a given code tended to be similar between the two remaining plans but inflated for the departing plan. **Optumas** applied an adjustment factor to the total service costs for each rate cell and relevant service category for AmeriHealth enrollees to match the expected reimbursement from their new plan, United. These factors resulted in a $1.1 million reduction to professional costs and $20.3 million reduction to waiver costs in the base data.

### *Reliance on a Databook*

**Optumas** did not rely on the use of a databook in developing the SFY19 IA Health Link capitation rates. Data sources used in rate development are described in the preceding sections.

## iii. Adjustments

### *Data Credibility*

**Optumas** worked with IME and the MCOs to ensure the detailed encounter data and MCO financial templates were interpreted consistently. As a result of these discussions, **Optumas** replaced Amerigroup pharmacy MMIS detailed data with MCO-submitted detailed data and applied a -1.4% reporting adjustment to incorporate non-encounterable expenditures, as discussed in Section I.2.B.II, to enhance the credibility of the base data.

For rate development purposes, the CHIP rate cell populations were deemed by **Optumas** to have insufficient enrollment volume to develop stand-alone rates. As a result, all non-hawk-I CHIP enrollment, costs, and utilization were included with the more substantial corresponding children rate cells as shown below, to enhance credibility:

| 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 |

### *Completion Factors*

**Optumas** developed completion factors by comparing month of incurral and month of payment of encounters for each COS and MCO. **Optumas** compared these factors to those submitted by the MCOs for reasonableness. The overall impact of the Incurred-But-Not-Reported (IBNR) analysis resulted in a 0.991 completion factor.

### *Errors in Data*

**Optumas** identified a discrepancy between the detailed data and financials for Amerigroup's pharmacy claims and replaced it with detailed data from Amerigroup, as discussed above in Section I.2.B.II.

### *Program Changes*

***Anesthesia CF***
The anesthesia conversion factor was changed from $1.76 to $1.40 per minute, effective 7/1/2017. Claims with the anesthesia conversion factor were repriced in the base data to reflect this update, with a net impact resulting in a $3.7 million reduction to the base.

***FQHC, RHC, and IHS Repricing***
New FQHC and RHC PPS rates, as well as IHS encounter rates went into effect 1/1/2018. Encounters were repriced to reflect the new payment schedule for FQHCs, RHCs, and IHS facilities. These adjustments resulted in a $3.3 million increase to the base.

***HH LUPA Rates***
Home Health Low Utilization Payment Adjustment (LUPA) rates were updated effective 7/1/2017. HH LUPA claims were repriced in the base data to reflect this update, with a net impact resulting in a $0.2 million increase to the base.

***ICF-ID Repricing***
Rates for ICF-IDs are periodically updated. The most recent changes to the rate schedule at the time of rate development, include rates that became effective 10/1/2017. ICF-ID claims were repriced in the

base data to reflect the most recent rates available, with a net impact resulting in an $8.9 million increase to the base.

***SRC Repricing***
Rates for SRCs are periodically updated. The most recent changes to the rate schedule at the time of rate development, include rates that became effective 10/1/2017. SRC claims were repriced in the base data to reflect the most recent rates available, with a net impact resulting in a $7.8 million increase to the base.

***CAH Repricing***
New CAH rates went into effect 7/1/2015. Encounters were repriced to reflect the new payment schedule, which resulted in a $3.1 million reduction to the base.

***NF Repricing***
Rates for NFs are periodically updated, and adjustments are made based on the acuity of the members present. The most recent changes to the rate schedule became effective 4/1/2018. NF claims were repriced in the base data to reflect the most recent rates available, with a net impact resulting in a $6.4 million increase to the base.

***Outpatient APC Rates***
Outpatient APC rates were updated effective 1/1/2018. Outpatient claims were repriced in the base data to reflect this update, with a net impact resulting in a $7.5 million reduction to the base.

***Crossover Coordination of Benefits***
Effective 7/1/2017, Medicaid reimbursement on Medicare Part A and Part B was limited to the lesser of the Medicare cost sharing amount, and the difference between the Medicaid fee schedule and the sum of payment from Medicare and all other third parties. Previously, Medicaid had paid the full Medicare cost sharing amount. Crossover claims were repriced to reflect this logic change, resulting in a $21.6 million reduction to the base.

***DRG Outliers***
Effective 7/1/2017, the cost outlier threshold for DRG payments was increased. The new threshold is the greater of two times the statewide average DRG payment for the claim- and hospital-specific DRG payment, plus $75,000. Inpatient claims were repriced in the base data to reflect this update, with a net impact resulting in a $27.7 million reduction to the base.

***Consultation Codes***
Effective 7/1/2017, consultation procedure codes are no longer payable through Medicaid. Services previously billed through consultation codes may be billed through a different visit code, which may have a different reimbursement. Consultation codes in the base data were modified to reflect this update, with a net impact resulting in a $5.4 million reduction to the base.

***Site-of-Service Differential***
Effective 7/1/2017, Medicaid reimbursement rates apply a differential to reflect the difference between the cost of services when provided in a health care facility setting and the cost of services when provided in an office setting. Professional claims were repriced in the base data to reflect this update, with a net impact resulting in a $10.2 million reduction to the base.

***ACA Enhanced PCP***
Enhanced payments to qualifying PCPs for certain services ended 06/30/2017. PCP claims were repriced in the base data to reflect this update, with a net impact resulting in a $20.6 million reduction to the base.

***Fluoride Service***
Effective 7/1/2017, topical fluoride varnish is required to be covered during well child visits. Additional costs were added to the Child 1-4 rate cell for Professional Office visits representing an expected $0.6 million increase.

***Pharmacy Rebates for hawk-i***
Effective 7/1/2017, MCOs are permitted to pursue supplemental drug rebates for the hawk-i population. Using MCO annualized estimates based on experience since the change went into effect, Pharmacy claims for the hawk-i population have been reduced by $1.1 million.

***Medicare Part B/Part D Duals***
Effective 1/1/2018, a logic enhancement for Amerigroup prevents pharmacies from billing dual members with primary coverage the whole amount of the claim, for Part B and Part D claims. Using MCO annualized estimates based on experience since the change, Pharmacy claims for the dual population have been reduced by $0.9 million.

***Habilitation Criteria***
Effective 7/1/2017, an update to the Iowa Medicaid Habilitation Guideline revised criteria to better identify the appropriate level of care for members using home-based habilitation services. Using MCO annualized estimates based on experience since the change, Waiver services for Waiver populations have been reduced by $2.7 million.

***Out of Network***
Effective 7/1/2017, rates for out-of-network providers have been reduced to 80% of the Medicaid Allowed amount. Using MCO annualized estimates based on experience since the change, claims have been reduced by $1.1 million.

***Re-contracting***
Contracts with some hospitals have come up for renewal, allowing MCOs to negotiate better terms. Using MCO annualized estimates based on experience since the change, hospital claims have been reduced by $4.2 million.

***ASC Misuse***
Physicians choosing to perform certain services, such as dermatological biopsies, gynecological biopsies, and orthopedic joint aspirations at an Ambulatory Surgical Center (ASC), rather than a more appropriate office setting, have billed claims for professional and facility fees. A policy change effective 4/1/18 reimburses these claims for the professional component only. Using MCO annualized estimates based on experience since the change, Outpatient claims have been reduced by $0.1 million.

***NOC Overlap***
A review of incorrect coding regarding Not Otherwise Classified (NOC) codes used for drugs, beginning 9/1/2017, has allowed an MCO to identify savings in the IA Health Link program. This intervention was

shared with all plans in the program and the MCO annualized estimate based on experience since this change, as a percentage of plan costs, was used to develop a reduction of $0.4 million to Pharmacy costs to the total program.

***Sick Baby DRG***

Newborns with minor conditions, typically seen during the newborn period of an inpatient observation stay, are being billed with diagnosis codes that are driving payments up to a "sick baby DRG". When newborn claims are submitted with only newborn revenue codes (170 and 171), and there is no authorization for a sick baby stay, the claims will be paid down to the normal newborn rate, effective 4/1/2018. Using MCO annualized estimates based on experience since the change, Inpatient claims for Children age 0-59 days have been reduced by $0.1 million.

***Modifier Audit***

The Office of the Inspector General (OIG) released a report titled "Use of Modifier 59 to Bypass Medicare's National Correct Coding Initiative Edits". The OIG found 40% of code pairs billed with modifier '59' and recommended that carriers perform pre- and post-payment review of modifier '59'. This intervention was shared with all plans in the program and the MCO annualized estimate based on experience since this change, as a percentage of plan costs, was used to develop a reduction of $0.5 million to costs to the Dual populations in the total program.

***Sleep DME***

One MCO identified an intervention to allow for pre-service management of sleep Durable Medical Equipment (DME), including CPAP, APAP, and related supplies, effective for 2018. Using MCO annualized estimates based on experience since the change, Inpatient claims for Children age 0-59 days have been reduced by $0.2 million.

***Late Notification***

The Iowa Medicaid provider manual instructions require that all hospitals notify the plan when a patient is admitted for an IP stay, so the plan can accurately monitor the case, and assume case management for the ongoing case and potential discharge. This intervention was shared with all plans in the program and the MCO annualized estimate based on experience since this change, as a percentage of plan costs, was used to develop a reduction of $0.7 million to costs to IP services across the total program.

***Short Stay Management***

An MCO initiative beginning 7/1/2017 focuses on reviewing short stays and recommending observations instead, with some initial claims for admission being denied. This intervention was shared with all plans in the program and the MCO annualized estimate based on experience since this change, as a percentage of plan costs, was used to develop a reduction of $1.0 million to costs to Nursing Home services across the total program.

***PCP Assignment Optimization***

An MCO initiative for 2018 expands a PCP assignment program incorporating provider cost, quality, and performance metrics. Using MCO annualized estimates based on experience since the change, Professional Office claims have been reduced by $0.2 million.

***Program Integrity***

IME has reported identifying approximately $12 million annually in fraud, waste, and abuse through the FFS program. As the IA Health Link program accounts for the vast majority of medical claim costs in Iowa's Medicaid program, and these erroneous costs are typically generated through providers or members, **Optumas** reduced estimated costs to reflect denials and recoupments related to program integrity. After discussions with IME and the MCOs, plan systems and efforts may already be reducing some of this waste. Using a conservative estimate with guidance from IME, claim costs have been reduced by 0.2%, or $8.2 million, to reflect expected program integrity savings.

***Exception Reduction***

Within the IA Health Link program, Amerigroup identified Single Case Agreements within the first year of experience which required an Exception to Policy (ETP), the IME method of choice in addressing complex cases. Most of these ETPs relate to LTSS or Behavioral Health related services and it is expected that number of ETPs will significantly be reduced in the SFY19 contract period. In working with Amerigroup to identify an estimated impact of ETP reductions, an overall reduction of $0.7 million has been made to the base data for this item.

***PMIC LOS***

Pediatric Medical Institutions for Children (PMIC) stays have historically been higher in Iowa than national norms for other Medicaid plans. The Iowa plan is working to reverse this trend and shorten the average Length of Stay (LOS) for these children by implementing new medical management processes, effective 7/1/2017. Using MCO annualized estimates based on experience since the change Behavioral Health – Inpatient costs for the PMIC population have been reduced $1.1 million.

The impact of each of these program changes on each rate cell is shown in Appendix I.B. A table showing which program changes are applicable in each rate period is shown in Appendix II.B.

### *Service and Payment Exclusions*

Certain high-cost pharmacy drugs are excluded from the managed care capitation rates; IME reimburses the MCOs directly for the costs of these prescriptions rather than being included in the monthly capitation rate. **Optumas** identified NDCs that meet the criteria for being carved out of the capitation rates and removed them from the base data, resulting in a -0.4% adjustment. This adjustment is shown in detail in Appendix I.B. A list of the drugs that meet this criteria is included in Appendix II.C.

# 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).

### ii. Variation of Assumptions

Variations in the assumptions used to develop the projected benefit costs for covered populations are based on valid rate development standards, not the rate of federal financial participation associated with the covered populations.

### iii. 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 Medicaid population and include consideration of other factors that may affect projected benefit cost trends through the rating period.

### iv. In-lieu-of Services

IME policy has historically allowed for in-lieu-of services associated with beneficiaries residing in an IMD up to fifteen days during a given month.

### v. IMD Benefits

IME policy has historically allowed for experience specific to beneficiaries age 21 to 64 residing in an IMD for less than fifteen days to be included within the IA Health Link capitation rates. Upon reviewing the historical experience for IMD utilization within Iowa's Medicaid program, **Optumas** determined that this volume was immaterial to the overall experience within IA Health Link, and therefore no explicit adjustment has been made to reflect additional IMD utilization.

### vi. IMD as In-lieu-of Service

Please see subsections iv. and v. above.

## B. Appropriate Documentation

### i. Final Projected Benefit Costs

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

## ii. Development of Projected Costs

### *Description*

***Complex Needs***
Iowa has 14 Mental Health and Disability Service Regions that have been required, by the legislature, to make certain services available for Iowans in a consistent matter across the state. To meet the requirements, regions are developing Access Centers and Asserted Community Treatment Teams to provide additional access and expanding the network for Subacute and Intensive Residential Home Services. The expansion of these services is expected to mature over the next few years and the Access Centers are not limited to the Medicaid population. IME provided a Fiscal Impact Summary, using the most up-to-date information about the development of these Centers and expansion of services, to project cost estimates by Fiscal Year. Using these cost estimates, Behavioral Health services have been increased by $2.1 million in SFY19 to account for increased utilization.

***APC***
IME periodically rebases Ambulatory Payment Classifications (APCs) using emerging data. The current APC structure was created prior to data for the Wellness Plan (WP) having coverage. IME is expected to rebase the APC structure in July 2018, which will be retroactively effective beginning 1/1/2018. Using estimates from the MCOs and IME, Outpatient – Emergency Room and Outpatient – Non-Emergency Room services have been reduced by $3.1 million in SFY19 to account for the estimated change in costs resulting from this rebase.

***CC and IHH Adjustment***
Iowa had established a program of Chronic Condition and Integrated Health Homes prior to the IA Health Link program and overlapping case management may now be occurring. IME plans to review IHH performance and eliminate Health Homes that are underperforming, effective January 1, 2019. Case management procedure codes *99490* and *S0280* account for $37.0 million paid to IHHs in SFY17. Using estimates from IME, costs have been reduced by $2.3 million in SFY19, by COA and COS relative to their share of these costs, to account for the change in case management payments.

***DRG Rebase***
IME periodically rebases Diagnosis Related Groups (DRGs) using emerging data. The current DRG structure was created prior to data for the Wellness Plan (WP) having coverage. IME is expected to rebase the DRG structure effective October 1, 2018. Using estimates from the MCOs and IME, Inpatient services have been reduced by $23.1 million in SFY19 to account for the change in costs.

***Exclusive DME Provider***
IME has instructed the MCOs to develop DME contracts with a national provider to leverage national pricing and reduce DME costs through a preferred vendor. This change in contracting is expected to go into effect no later than January 1, 2019. Using estimates from the MCOs and IME, DME/Prosthetics services have been reduced by $1.5 million in SFY19 to account for the change in costs.

***Non-Emergent ED***
IME will require an emergent diagnosis code in the primary diagnosis code position and update the list of allowable emergent diagnosis codes for Emergency Room utilization. The list update is effective

7/1/2018 and the requirement for an emergent code in the primary position is expected to be implemented 8/1/2018. Using estimates from the MCOs and IME, Outpatient – Emergency Room services have been reduced by $8.5 million in SFY19 to account for the change in costs.

***Oxygen Adjustment***
Providers see discounts when buying in bulk for oxygen services. **Optumas** reviewed billing patterns for procedure codes of oxygen services and identified instances of oxygen billed at daily rates, consecutively for 30 or more days, when it should have been billed at discounted monthly rates. MCOs are expected to require monthly billing when oxygen is used consistently for a month, rather than daily billing. Based on this analysis, oxygen services have been reduced by $0.8 million in SFY19 by COA and COS relative to their share of these costs, to account for this change.

***Swing Bed Payments***
Swing bed reimbursement in Critical Access Hospitals (CAH) is significantly higher than reimbursement for similar services available at Nursing Facilities (NF). Members are required to use a NF bed rather than a CAH swing bed if one is available within 30 miles. IME plans to change this policy immediately to require NF priority if a bed is available within 50 miles instead. Using estimates from the MCOs and IME, Inpatient services have been reduced by $1.0 million in SFY19 to account for the change in costs.

***ID Waiver Addition***
IME is committed to providing better care for the Intellectually Disabled population and has worked with the State to identify an additional $7.5 million in funding streams to be allocated to enhancement of the ID tiered service rates. In addition, $1.8 million dollars has been set aside for funding for individuals with complex needs. These dollars have been added to the capitation rates based on distribution of costs within each service category and MCO.

The impact of each of these program changes on each rate cell is shown in Appendix I.B. A table showing which program changes are applicable in each rate period is shown in Appendix II.B.

### *Changes to Data, Assumptions, and Methodology*

Projected costs were developed consistent with generally accepted actuarial principles and practices. The last rate certification was developed by a previous vendor, and some differences in assumptions and methodology for the development of projected costs are likely but cannot be explicitly described.

## iii. Projected Benefit Cost Trends

### *Data and Assumptions*

**Optumas** used detailed IA Health Link encounter data, by COA and COS, to develop projected benefit cost trends. The encounter data available spanned from April 2016 through December 2017, which incorporates the entirety of the SFY17 base data. The use of this data allowed **Optumas** to use Managed Care data for trends while circumventing potential skewed trends from including FFS data, which is assumed to have potentially different trends. These trends were developed primarily using actual experience from the Medicaid population, and were informed using MCO financial data and experience with similar Medicaid programs in other states.

### *Methodology*

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) of services over time. These trend factors were used to project the costs from the base period to the future contract period. Trends were developed on an annualized basis and applied by 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, MCO financial data, and experience with similar Medicaid programs in other states. The historical encounter data was analyzed by population and COS. The data was arrayed such that 3 month moving averages (MMA), 6 MMA, and 12 MMA could be calculated. These resulting averages were evaluated and weighted to best reflect the expected prospective annual trend. There was not a pre-determined algorithm related to the weighting; it was based on each data extracts' results and varied depending on particular nuances within each COS or population.

Trend was applied from the midpoint of the base data (1/1/2017) to the midpoint of each of the respective three rate 'tiers' described earlier in this document:

- Tier 1 (7/1/2018 – 9/30/2018) – Midpoint of 8/15/2018, trended 19.5 months
- Tier 2 (10/1/2018 – 12/31/2018) – Midpoint of 11/15/2018, trended 22.5 months
- Tier 3 (1/1/2019 – 6/30/2019) – Midpoint of 4/1/2018, trended 27 months

Trend factors were developed consistent with generally accepted actuarial principles and practices. The last rate certification was developed by a previous vendor, and some differences in assumptions and methodology for the development of trends are likely but cannot be explicitly described.

### *Components*

The annualized prospective utilization and unit cost trend assumptions by cohort and category of service are included within Appendix II.D.

### *Variations*

Projected benefit cost trends were developed at the service category level by cohort for each MCO. Similar rate cells were combined for trend development in order to increase credibility. Trends were combined based on the distribution of enrollment and costs between the MCOs to achieve statewide trends. Because United now covers members previously enrolled with AmeriHealth, figures for AmeriHealth were trended using the United trends. The following table describes the rate cells incorporated into 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 – Hawk-i |

| Trend Cohort | Rate Cells Incorporated |
|---|---|
| **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 |
| **Waiver** | Elderly HCBS Waiver, Dual HCBS Waivers: PD; H&D, Non-Dual HCBS Waivers: PD; H&D; AIDS, Brain Injury HCBS Waiver; Intellectual Disability HCBS Waiver; Children's Mental Health HCBS Waiver |
| **Wellness Plan** | 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 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) |

### *Other Material Adjustments*

No other adjustments to projected benefit cost trends were made.

## iv. Mental Health Parity and Addiction Equity Act

We are unaware of any material program changes at this time, 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).

## v. In-lieu-of Services

Please see Section I.3.A.iv and I.3.A.v for information surrounding IMD services.

## vi. Retrospective Eligibility

**Optumas** has relied on IA Health Link experience for SFY17 as the base data used to develop the SFY19 capitation rates. Retroactive eligibility periods have historically been excluded from the IA Health Link program. Therefore, no explicit adjustment has been made for this in the development of the SFY19 IA Health Link capitation rates.

### vii. Changes in Covered Benefits

Any changes to covered benefits in the IA Health Link program in SFY19 have been accounted for within the rate development and are described in detail above in Section I, Subsection 2.B.iii.

### viii. Impact of Changes

The impact of changes to covered benefits in the IA Health Link program in SFY19 are shown in Appendix I.B. Each change to covered benefits includes an estimated impact of the change on the amount of projected benefit costs and a description of the data, assumptions, and methodologies used to develop the adjustment in Section I, Subsection 2.B.iii. above.

# 4. Special Contract Provisions Related to Payment

## A. Incentive Arrangements

There are no incentives included in the contract between the State and the MCOs in the IA Health Link program.

## B. Withhold Arrangements

### i. Rate Development Standards

This section provides supporting documentation and describes the withhold arrangement in the contract between the State and the IA Health Link MCOs.

### ii. Appropriate Documentation

#### *Time Period and Purpose*

The time period of the withhold arrangement is consistent with the SFY19 rating period. The purpose of the arrangement primarily relates to value-based purchasing, access to care, network distance standards, and the appeal process.

#### *Description of the Total Percentage Withheld*

In SFY19, there is a withhold in place of 2% of the total capitation rate revenue. 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% withhold are shown in Appendix I.A.

#### *Estimate of Percentage to be Returned*

Based on emerging experience of the IA Health Link MCOs and discussion with IME, we estimate that the MCOs will earn between 50% to 75% of the 2% withhold.

#### *Reasonableness of Withhold Arrangement*

Our review of the total withhold percentage of 2% of capitation revenue is reasonable within the context of the 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 the portion that is not reasonably achievable are actuarially sound.

## C. Risk-Sharing Mechanisms

### i. Rate Development Standards

This section provides supporting documentation and describes the risk-sharing arrangements between the State and the health plans.

### ii. Appropriate Documentation

#### *Other Risk-Sharing Arrangements*

The SFY19 IA Health Link capitation rates have been developed as full risk rates. The State has decided, as a policy decision, to discontinue the use of the non-waiver habilitation services risk pool. As a result of the departure of AmeriHealth from the IA Health Link program and the majority of their prior members enrolling in United, the disparity in service utilization between MCOs is expected to be significantly reduced.

#### *Medical Loss Ratio Arrangement*

The State requires all health plans to maintain a medical loss ratio (MLR) of 88%. If the MLR is less than 88%, the health plans must refund the State the difference.

#### *Reinsurance*

The contracts between DHS and the MCOs require that the MCOs shall 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. Delivery System and Provider Payment Initiatives

Not applicable.

## E. Pass-Through Payments

### i. Rate Development Standards

This section provides supporting documentation and describes all existing pass-through payments incorporated into the rates for this rating period.

## ii. Appropriate Documentation

### *Pass-Through Payments*

Graduate Medical Education (GME) and University of Iowa Physician ACR payments are the pass-through payments incorporated into the rates for this rating period.

The GME payments are made to teaching hospitals for purpose of funding graduate medical education 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. Although we interpret this GME payment to be outside the standard definition of pass-through payments per 42 CFR 438.6(a), we have included the description and amount of the GME payment in this section of the certification letter.

The University of Iowa Physician ACR payments are made to qualifying physicians with the University of Iowa. The additional payments made to the physicians provide support for contracting and maintain access for Medicaid beneficiaries to the University of Iowa physicians and the MCOs.

### *Amount*

The amount of GME payments included in the SFY19 rates is approximately $22.2 million at an aggregate PMPM of $3.07. The PMPM amount included for the rate cells that receive this payment ($5.28 PMPM) is consistent with the amount included in the SFY18 rates. The estimated amount for the University of Iowa ACR payments is approximately $63.7 million at an aggregate PMPM of $8.81. The total amount for the ACR payments is allocated across the rate cells based on utilization of services by qualifying physicians and practitioners.

### *Providers receiving the payment*

The providers receiving the GME payments are teaching hospitals. The providers receiving the adjusted UPL payments are University of Iowa qualifying physicians and practitioners.

### *Financing mechanism*

GME payments are funded with direct State appropriations to the Medicaid agency. The University of Iowa UPL payments are funded through intergovernmental transfers (IGT).

### *Pass-through payments in the previous rating period*

The GME payment amount in the SFY18 rates was approximately $22.7 million. The university of Iowa ACR payment amount was estimated to be $49.6 million in the SFY18 rates.

### *Pass-through payments for the rating period in effect on July 5, 2016*

The GME payment amount in the rate effective July 5, 2016 (SFY17 rates) was approximately $22.3 million. The University of Iowa ACR payment amount was estimated to be $57.0 million in the SFY17 rates.

### *Hospital pass-through payments*

GME payments are incorporated within the SFY19 capitation rates and reflect payments to hospitals. However, we interpret the GME payment to be outside the standard definition of pass-through payments per 42 CFR 438.6(a). Therefore, there are no hospital pass-through payments in the SFY19 rates per the definition of pass-through payments per 42 CFR 438.6(a).

# 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, as required by 42 CFR §438.3(c)(1)(ii).

### ii. PMPM and Percentage of Capitation Rates

Non-benefit costs were developed as a percentage of capitation rates.

### iii. Variations

Variations in the assumptions used to develop the projected non-benefit costs for covered populations are based on valid rate development standards. Variations in non-benefit costs exist between rate cells and between MCOs. Variations are not based on the rate of federal financial participation associated with the covered populations

### iv. Health Insurance Providers Fee

The ACA Health Insurance Providers Fee (HIPF) has a moratorium for the CY19 time period. Since these capitation rates are for SFY19, they include six months of CY19 and six months of CY18. **Optumas** will work with IME to determine the funding mechanism that will make MCOs whole for their CY18 liability. If IME decides to reimburse the MCOs for the HIPF via capitation rates, **Optumas** plans to provide an updated certification with an informed estimate of the HIPF once that information becomes available in early Fall 2018.

## B. Appropriate Documentation

### i. Development

#### *Description*

Non-benefit costs were developed using data from financial templates completed by each MCO and a review of non-benefit costs in Medicaid programs from states with similar populations and services. Although three MCOs completed these templates, AmeriHealth members transferred service to United in December 2017. In developing non-benefit cost assumptions, consideration was given to economies of scale resulting in variation between final MCO non-benefit cost projections. The level of non-benefit costs necessary can vary between population to effectively manage care. Non-benefit costs are shown by rate cell and MCO in Appendix I.B.

### *Material Changes*

In the development of the non-medical load for the SFY19 capitation rates, **Optumas** reviewed MCO financial templates summarizing costs quarterly for CY16 and CY17, which included the SFY17 base data period as well as more recent data. Assumptions and methodologies may vary between the SFY18 certification and this document but cannot be explicitly described as the SFY19 capitation rates reflect the first year in which **Optumas** has developed capitation rates for the IA Health Link program.

## ii. Cost Categories

The non-medical cost load includes administrative costs and allocation for profit, risk, and contingency (P/R/C). Non-medical load, itemizing administrative and P/R/C loads, is shown in Appendix I.B.

## iii. Health Insurance Providers Fee

As noted in Section 5.A.iv, no allowance has been made at this time for the HIPF.

# 6. Risk Adjustment and Acuity Adjustments

## A. Risk Development Standards

### i. Risk Adjustment

**Optumas** accounted for the relative risk in the health status of enrollees in each MCO through various methods designed to best match payment to risk for each cohort.

### ii. Methodology

Consistent with 42 CFR §438.5(g), for the prospective risk adjustment, **Optumas** worked with IME to select a risk adjustment methodology that uses generally accepted models and applied it in a budget neutral manner, consistent with generally accepted actuarial principles and practices, across all MCOs in the program to calculate adjustments to the payments as necessary.

### iii. Acuity Adjustment

No acuity adjustments have been made in the development of the SFY19 IA Health Link capitation rates.

## B. Appropriate Documentation

### i. Prospective 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 enrollment and encounter data from SFY17 (July 2016 – June 2017) as the experience period for capturing the relevant diagnosis and pharmacy information for calculating member risk scores. The transition plan for AmeriHealth's departure from IA Health Link enrolled the vast majority of AmeriHealth's members with United, beginning December 2017. Due to this shift in enrollment, **Optumas** relied on a December 2017 snapshot month to assign members and their associated risk scores, for purposes of prospective application to the SFY19 capitation rates.

#### *Model*

**Optumas** incorporated developed risk scores and relativities to apply to most populations in the IA Health Link program. For the remaining populations, **Optumas** made no risk adjustment and defaulted to the statewide rate.

**Optumas** applied risk scores to most non-LTSS populations, including Children (over the age of one), Non-Expansion Adults, Wellness Plan, and ABD Non-Duals. Risk scores were developed using UCSD's CDPS+RX V.6.2.2 tool, with national prospective weights and a December 2017 enrollment snapshot.

This modeling was developed with a three-month eligibility duration requirement, such that members had to have at least three months of enrollment within SFY17 to be scored. Members who were unscored through this process received the MCO-specific average disease weight of scored members for each COA, along with their specific demographic weight.

For the LTSS populations, **Optumas** developed relativity factors to be applied instead of risk scores. The majority of costs for these members is derived from LTSS services which would not be adequately identified using the CDPS+RX analysis. These factors were developed by comparing the total PMPM of each rate cell within an MCO to the statewide PMPM for the rate cell in the SFY17 base data period; experience for the previous AmeriHealth-enrolled population was aggregated with United's SFY17 experience to ensure the relativities accurately captured the impact of this transition in enrollment.

The remaining populations used a statewide rate. Some of these populations, like BCCP and Non-Dual Skilled Nursing Facility had populations insufficient for a risk adjustment to be credibly applied. A table detailing the risk adjustment model used for each rate cell, along with the resulting factors, is shown in Appendix II.E.

### *Methodology*

The risk adjustment factors were applied in a statewide budget neutral manner for the MCOs. The risk adjustment methodology uses generally accepted actuarial principles and practices. Appendix II.F demonstrates the budget neutrality of the risk adjustments made for each rate cell. Consistent with how rates were developed, same-demographic Children and CHIP rate cells were combined for credibility in developing risk adjustment factors. This budget neutrality summary is shown using the blend of the three Tier contract period rates (25% Tier 1, 25% Tier 2, 50% Tier 3).

### *Magnitude*

The magnitude of the adjustment is an increase of 0.02% for UHC and a decrease of 0.04% for AGP. The impact by rate cell and in total for each MCO is shown in Appendix II.G.

### *Assessment of Predictive Value*

**Optumas** reviewed the normalized risk scores as developed for the SFY19 IA Health Link rates to the normalized risk scores used by the previous vendor in the development of the SFY18 rates. In general, the relative risk scores by COA and MCO showed consistency in direction and magnitude. As more recent experience becomes available for the IA Health Link program, **Optumas** will continue to monitor and review the correlation between prospective risk scores and relative costs by MCO and COA.

### *Concerns*

At this time, **Optumas** has no concerns with the risk adjustment process.

### ii. Retrospective Risk Adjustment

No retrospective risk adjustment has been made in the development of the SFY19 rates.

### iii. Changes to Risk Adjustment Model and Budget Neutrality

In the SFY19 rates, the LTSS service components, along with the non-LTSS service component of the capitation rates for the LTSS populations, were risk adjusted using relativity factors by plan compared to statewide PMPMs. Additionally, certain populations (notably dual eligible populations) that had been risk adjusted using CDPS+Rx in SFY18 now rely on a cost-based relativity factor. All other components of the risk adjusted model are consistent with the SFY18 rates and all risk adjustment are applied in a budget neutral fashion.

### iv. Acuity Adjustment

No acuity adjustments were made for the SFY19 rates.

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

# 1. Managed Long-Term Services and Supports

## A. Required Content

The development of the SFY19 rates for the LTSS populations is consistent with the guidance 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 rating cells. Beneficiaries in these rate cells include elderly and disabled individuals age 19 and older who do not qualify for Medicare coverage and are receiving Medicaid assistance, 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 home and community based (HCBS) waiver services. The IA Health Link 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
- Home and Community Based 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 SFY19 rates were developed for all services incurred by LTSS members, with the exception of dental services and certain prescription drugs that are carved out of the capitation rates.

## B. Rate Development Standards

### i. Rate Blending

**Optumas** developed the LTSS capitation rates by blending the rates for each LTSS rating group. The rating groups include: Elderly, Physically Disabled, Intellectually Disabled, and Children's Mental Health.

## C. Appropriate Documentation

### i. Payment Structures

Capitation payments for LTSS benefits are paid as a single capitation rate for each LTSS rating group, by MCO. MCO payments vary based on actual MCO enrollment. **Optumas** used December 2017 enrollment as the basis for the LTSS blend. The rate cells are blended using the rating groups mentioned in B. above.

A summary of the rate blending methodology is shown in Appendix II.H. This summary is shown using the blend of the three Tier contract period rates (25% Tier 1, 25% Tier 2, 50% Tier 3).

### ii. Non-Benefit Costs

Non-medical load for the LTSS population has been developed consistent with the approach for all IA Health Link populations. This is described further in Section I.5 of this certification letter.

### iii. Sources

The LTSS capitation rates were developed using SFY17 encounter data. After accounting for program change adjustments, trend, applying risk adjustment, and adjusting for non-medical load, the rates were blended according to broad rating groups. A summary of the rate blending methodology is shown in Appendix II.H.

# Section III. New Adult Group Capitation Rates

# 1. Data

## A. New Adult Group Data

The same data used to set rates for SFY19 for the traditional Medicaid populations was used to develop rates for the new adult group. IA Health Link encounter data for the Wellness Plan (WP) new adult group, as described in Section I.2., was used to develop SFY19 rates.

## B. Previous Rating Periods

### i. New Data

Previous rate setting for the WP population in SFY18 used a combination of FFS and MCO experience to develop rates. For the SFY19 rate setting, **Optumas** utilized IA Health Link experience from SFY17, the most recent complete year of the IA Health Link program, as the base data to develop rates.

### ii. Monitor Costs

IME and **Optumas** will continue to review emerging experience for the WP population, and will consider the necessity of any adjustments resulting from emerging experience varying materially from cost projections.

### iii. Actual Experience Compared with Expectations

Projected costs fell below emerging experience for each MCO during program year 1 of the IA Health Link program, SFY17. **Optumas** believes that the use of SFY17 experience as the base should better align payment to risk for the SFY19 contract period as compared with the pre-IA Health Link data used in the development of the SFY18 rates.

### iv. Adjustment for Differences

**Optumas** has used SFY17 encounter data as the base for the SFY19 rates, which incorporates a full year of WP encounter experience under the IA Health Link program. While there is not an explicit adjustment calculated based on the relative experience between the SFY17 rates and the SFY17 actual experience, **Optumas** believes that the use of SFY17 data takes into account this difference as it reflects actual experience under the IA Health Link program.

# 2. Projected Benefit Costs

## A. New Adult Group Projection Issues

### i. New Adult Groups Covered in Previous Rating Periods

**Optumas** worked with IME to utilize SFY17 IA Health Link encounter data as the base for the SFY19 capitation rates. This reflects a change in base data as compared with the SFY18 rate development process, which relied on pre-IA Health Link FFS data for this population.

As a result of using actual experience from the IA Health Link program, no adjustments were made for:

- Acuity adjustments
- 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

## B. Key Assumptions

### i. Acuity Adjustments

No acuity adjustment was made for the WP population.

### ii. Pent-up Demand

The WP population has had several years of experience within the Iowa Medicaid program at the time of the SFY17 base data period, so no adjustment for pent-up demand was deemed necessary.

### iii. 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.

### iv. 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.

### v. Reimbursement and Networks

Any reimbursement or network adjustments made applied to all populations, and are described in Section I.

### vi. Other Adjustments

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

## C. Benefit Plan Changes

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

## D. Other Material Changes

No other material changes were made to the WP population rate setting.

# 3. Projected Non-Benefit Costs

## A. Required Components

### i. Changes in Methodology

Projected non-benefit costs for the WP were developed using the same data, methodology, and assumptions as the traditional populations, described in Section I.5. Consistent with the description in Section I.5, methodology may vary between the SFY18 certification and this document but cannot be explicitly described as SFY19 reflects the first year in which **Optumas** has developed IA Health Link capitation rates.

### ii. Changes in Assumptions

Projected non-benefit costs for the WP were developed using the same data, methodology, and assumptions as the traditional populations, described in Section I.5. Consistent with the description in Section I.5, methodology may vary between the SFY18 certification and this document but cannot be explicitly described as SFY19 reflects the first year in which **Optumas** has developed IA Health Link capitation rates.

## B. Key Assumptions

**Optumas** used the same assumptions in developing non-benefit costs for the WP and other 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

A comparison to the final certified in the previous rate certification, for the WP population, consistent with 42 CFR §438.7(d), is shown in Appendix II.A.

### ii. Other Material Changes

No other material changes were made to the WP rate development outside of what has been described in this document.

# 5. Risk Mitigation Strategies

## A. Description of Strategy

As discussed in Section I. 4., the SFY19 IA Health Link capitation rates have been developed as full risk rates. The State has decided, as a policy decision, to discontinue the use of the non-waiver habilitation services risk pool.

## B. Comparison to Previous Period

### i. Changes in Strategy

A risk corridor was in place for Amerigroup's total population for SFY18. No risk corridor is currently in place for any population in SFY19.

### ii. Rationale for Change

There has been no change from the SFY18 rates in use of a risk corridor for the WP population.

### iii. Experience and Results

As a result of using SFY17 experience from the IA Health Link program for the WP population, which reflects experience after multiple years of enrollment for the WP population in Iowa's Medicaid program, experience is not anticipated to fluctuate drastically between the base period and the contract period, with the exception of the impact of program changes already incorporated within the SFY19 capitation rate development. As a result of using the newer base data, no additional risk mitigation strategy is deemed necessary.

## Actuarial Certification Letter

We, Zach Aters, Senior Actuary at **Optumas** and Member of the American Academy of Actuaries (MAAA) and an Associate of the Society of Actuaries (ASA), and Barry Jordan, Consulting Actuary 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 for all cohorts. 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 the 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, 2018 through June 30, 2019 for the IA Health Link Managed Care program, and developed as three separate contract period tiers:

- Tier 1: July 1, 2018 – September 30, 2018
- Tier 2: October 1, 2018 – December 31, 2018
- Tier 3: January 1, 2019 – June 30, 2019

The actuarially sound capitation rates are based on a projection of future events. Actual experience may vary from the experience assumed within their 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 to 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 IME. 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 Zach at 480.588.2495 or Barry at 480.588.2492 for any additional information.

Sincerely,

Zachary Aters, ASA, MAAA
Senior Actuary, **Optumas**

Barry Jordan, ASA, MAAA
Consulting Actuary, **Optumas**

# Appendices

The appendices are contained in the following accompanying Excel workbooks:

IA Health Link SFY19 Rate Certification Appendix I 2018.07.13.xlsx
IA Health Link SFY19 Rate Certification Appendix II 2018.07.13.xlsx