July 10, 2019

Mr. Michael Randol
Medicaid Director
Iowa Medicaid Enterprise
611 5th Ave.
Des Moines, IA 50309

Subject: **SFY20 IA Health Link Managed Care Rate Development**

Dear Mr. Randol:

Thank you for the opportunity to assist the Department of Human Services (DHS) and Iowa Medicaid Enterprise (IME) with the development of the SFY20 IA Health Link capitation rates. The following report summarizes the methodology used for the development of the capitation rates, effective July 1, 2019 – June 30, 2020 (SFY20). 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, **IME**
Steve Schramm, **Optumas**
Jessica Grado, **Optumas**
Stephanie Taylor, **Optumas**
Elrycc Berkman**, Optumas**

Iowa Medicaid Enterprise

IA Health Link Actuarial Certification

July 1, 2019 – June 30, 2020 Capitation Rates

Table of Contents

Executive Summary

Background

The Iowa Department of Human Services (DHS) 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 will also be enrolled in IA Health Link in subsequent years. A small portion of Medicaid members will continue to be 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.

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, 2019 through June 30, 2020 (SFY20). Iowa Medicaid Enterprise (IME) first contracted with **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.

During the SFY19 rate development process, IME, the participating MCOs, and **Optumas** worked collaboratively to develop additional cost-saving interventions that could be implemented within SFY19. These interventions were expected to take effect on different dates throughout the SFY19 contract period so **Optumas** developed the SFY19 rates for IME to operationalize in three "tiers" throughout the SFY19 contract year. These tiers took into account the interventions that were expected to be in place during each respective time period and were 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

When the IA Health Link program began in April 1, 2016, three MCOs were contracted with IME: Amerigroup, AmeriHealth Caritas Iowa Inc., and UnitedHealthcare Plan of the River Valley, Inc. During the SFY18 contract period, AmeriHealth Caritas Iowa Inc. 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 Fee-For-Service (FFS) but have since been enrolled in Amerigroup as of March 1, 2018. At the end of the SFY19 contract period (June 30, 2019), United will also be withdrawing from the IA Health Link program.

Beginning July 1, 2019, Iowa Total Care, will begin to provide care to the IA Health Link enrollees. Amerigroup and Iowa Total Care will be the only two MCOs contracted with IME for the SFY20 contract period of the IA Health Link program. Members previously enrolled with United will be allocated between Amerigroup and Iowa Total Care, targeting an even distribution of members between the MCOs, prior to any shifts due to member selection. The SFY20 rates in this document were developed consistent with the expectation that members enrolled in the IA Health Link program will be covered by either Amerigroup or Iowa Total Care.

As the consulting actuaries to IME, **Optumas** worked with the State to create a rate setting methodology determined to be most appropriate for the SFY20 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 "2019-2020 Medicaid Managed Care Rate Development Guide". The final rates were developed according to actuarially sound principles and reasonably reflect the experience projected for the SFY20 IA Health Link program.

As the consulting actuaries to the Iowa Department of Human Services (DHS) and Iowa Medicaid Enterprises (IME), **Optumas** ensured that the methodology used to develop the SFY20 IA Health Link capitation rates complied with the Centers for Medicare & Medicaid Services (CMS) guidance for the development of actuarially sound rates, 42 CFR 438.4, as well as 438.5, 438.6, and 438.7.

Optumas worked with DHS and IME to identify the necessary rate development components for the July 1, 2019 – June 30, 2020 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 SFY20 IA Health Link program.

This document is organized in the same order as the 2019-2020 CMS Medicaid Managed Care Rate Development Guide. Any sections that are not applicable are noted as such, but have been included for completeness.

Summary of Capitation Rates

In developing the SFY20 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 Claims
- 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 SFY20 contract period. The body of this document outlines the 2019-2020 CMS 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 additional GME, ACR, and GEMT payments, effective July 1, 2019 - June 30, 2020, can be found in Appendix I.A.

Fiscal Impact Estimate

The estimated aggregate fiscal impact of the SFY20 IA Health Link rate changes is an annual increase of $385.7M based on SFY18 enrollment, which is the base data time period used for rate development. The fiscal impact of the SFY20 certified capitation rates, gross withhold, net additional payments, compared to the annualized Tier 3 SFY19 capitation rates, gross withhold, net additional payment 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. Each step of the SFY20 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 July 1, 2019 through June 30, 2020 (SFY20).

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. The majority of existing Medicaid members were enrolled on April 1, 2016 and most newly eligible Medicaid members will also be enrolled in IA Health Link though a small portion of Medicaid members will continue to be 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.

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. At the end of the SFY19 contract period (June 30, 2019), United is withdrawing from the IA Health Link program. Beginning July 1, 2019, Iowa Total Care will begin to provide care to the IA Health Link enrollees. Members previously enrolled with United will be allocated between Amerigroup and Iowa Total Care. The rates in this document were developed with the

expectation that members enrolled in the IA Health Link program will be covered by Amerigroup and Iowa Total Care for the entire contract period.

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. Historically, the MCOs were not at-risk for certain high-cost drugs which were reimbursed outside of the capitation rates via invoice by IME. Effective July 1, 2019, these high-cost drugs will be covered via the capitation rates and the MCOs will be reimbursed for these services within the monthly capitation payments for each rate cell. As such, these high-cost drugs are inherent within the SFY18 base data used for the SFY20 rate development. The list of drugs historically excluded from the capitation rates and inherent within the SFY18 base data, 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) shown in Table 1 below:

Table 1: Rating Categories of Service

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) shown in Table 2 below:

Table 2: IA Health Link Rate Cells and Categories of Aid

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

Rate Cell	Category of Aid (COA)
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
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

Rate Cell	Category of Aid (COA)
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 and alternative minimum fee schedule payments per 42 CFR §438.6(c)

No retroactive adjustments to the capitation rates are being made at this time for the SFY20 contract period.

iii. Differences Among Capitation Rates

All proposed differences among the SFY20 IA Health Link capitation rates for the 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 SFY20 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. Medical Loss Ratio

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 a medical loss ratio of at least 85% for the contract period. As part of the IA Health Link contract, the State will use a minimum Medical Loss Ratio (MLR) of 88% for the MCOs operating within the program. Further details on this arrangement are described within the Risk-Sharing Mechanisms portion of this document.

vii. 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.

viii. Rate Certification Periods

The rates in this document are certified for the period in which they are effective, July 1, 2019 through June 30, 2020.

ix. 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.

Other Changes

A contract amendment will be submitted any time a rate changes for any reason other than application of an approved payment term, 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 2019-2020 CMS 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. Inapplicable sections of the guidance for this particular rate development are included for completeness 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

A comparison to rates developed by **Optumas** for the SFY19 contract period is shown in Appendix II.A. The SFY19 Tier 3 rates which were in effect for the January 1, 2019 – June 30, 2019 time period are shown within the rate comparison included within Appendix II.A since these are the most recent rates in effect for the Health Link program.

There are a few components of rate development driving the large differences between the SFY19 Tier 3 rates and the SFY20 rates. Differences between the base data underlying rate development, the inclusion of high cost drug coverage within the capitation rates, and the removal of certain SFY19 program changes and cost-saving interventions that did not materialize are the primary drivers of the aggregate statewide rates increase; these components having varying impacts to each of the COAs. In particular, the following SFY19 cost-interventions described within the SFY19 certification were removed from the SFY20 rate development either because the intervention was delayed or the estimated savings did not materialize within the emerging SFY19 experience.

- Outpatient APC Rates
- DRG Rebase
- Non-Emergent ED Adjustment
- CC and IHH Adjustment

The inclusion of the high cost pharmacy drug carve-in accounts for 0.3% of the aggregate increase, with variation at the cohort level while the removal of the SFY19 cost interventions accounts for about 1.1% of the aggregate statewide rate increase. New policy changes, effective within the SFY20 contract period account for about 2.4% of the overall rate increase, of which 2.0% is attributed to the Nursing Facility rates increase passed by the Iowa legislature. The remainder of the aggregate rate increase is primarily

comprised of changes in the trend and administrative load assumptions used within rate development and are described within the remainder of the certification letter. Any other material changes to the capitation rates or the rate development are described within the remaining 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 SFY20 rate setting process, **Optumas** received detailed IA Health Link MMIS encounter data, FFS data, and State eligibility and Health Link capitation payments from the program's inception through the end of CY18 (April 1, 2016 – December 31, 2018). This data reflects experience for the populations 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 historically operating within the IA Health Link program. **Optumas** also benchmarked the IA Health Link encounter data to the detailed pre-Health Link FFS data received for CY15, as well as the SFY17 Health Link base data used in the SFY19 rate development. In addition to claims data, **Optumas** received member-level capitation files for the Health Link program to use for enrollment within rate development.

Appropriate Base Data

Optumas selected SFY18 (July 1, 2017 – June 30, 2018) encounter data as the base data for the SFY20 rate development. The SFY18 encounters represent the most recent complete year of IA Health Link program experience available at the time of rate development. Additionally, key program changes implemented in prior years such as the Crossover Coordination of Benefits, Consultation Codes, Site-of-Service Differential, and ACA Enhanced PCP are inherent within the SFY18 experience and no longer required estimated impacts of these initiatives on the program's experience.

During the transition of members from AmeriHealth to Amerigroup, approximately 10,000 members were temporarily enrolled in FFS before being attributed to Amerigroup on March 1, 2018. As such, **Optumas** included the FFS experience (both claims and enrollment information) within the base data during the transition period from December 1, 2017 through February 28, 2018.

Medicaid population

The SFY18 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. Additionally, FFS claims and eligibility data for the members who transitioned from AmeriHealth to Amerigroup were also included to get a complete representation of IA Health Link member experience for the entire SFY18 time period.

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 2018), FFS claims for the last four years (January 2015 – December 2018), and all corresponding enrollment and capitation information from IME. Additionally, **Optumas** requested summarized financial data from each MCO through financial templates.

As previously discussed, United is withdrawing from the IA Health Link program effective July 1, 2019; therefore, Amerigroup and Iowa Total Care will be the two MCOs providing managed care within the program during the SFY20 contract period. As part of the development of the plan relativity factors for the SFY20 rates, which is described in further detail within the risk adjustment section of the document, **Optumas** relied on the use of a member-level attribution file provided by IME. The MCO Attribution file contained all IA Health Link members as of June 20, 2019, and an indication as to which MCO the member would be attributed to effective July 1, 2019.

Data Provided by IME

IME and the MCOs 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 the SFY20 rate setting consists of SFY18 encounter data from the IA Health Link program, as well as FFS data for members who were temporarily enrolled in FFS December 1, 2017 – February 28, 2018. Additional data from the IA Health Link program outside of the SFY18 time period, 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 throughout the document, but 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	IME	Detailed	04/01/2016	12/31/2018
Capitation Payments	IME	Detailed	04/01/2016	12/31/2018
FFS Claims	IME	Detailed	01/01/2015	12/31/2018
Eligibility	IME	Detailed	01/01/2015	12/31/2018

Financial Template (Encounters, other medical-related costs, admin, and enrollment)	All MCOs	Summarized	04/01/2016	12/31/2018
Pharmacy Claims	One MCO	Detailed	04/01/2016	12/31/2017
MCO Attribution File	IME	Detailed	6/20/2019	6/20/2019

Data Availability and Quality

Optumas validated the detailed encounter data through control totals, financial template, and monthly volume comparisons. During the SFY19 rate development, **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. During the SFY19 rate development, **Optumas** requested detailed pharmacy data from Amerigroup to use in lieu of the MMIS data. As part of the SFY20 rate development **Optumas** reviewed the Amerigroup MMIS pharmacy encounters data and determined that the replacement data should still be used for the time period prior to December 2017. Detailed MMIS data from December 2017 through December 2018 was used within the rate development. The combination of the replacement data prior to December 2017 and MMIS encounter data post December 2017 matched closely to Amerigroup's financial template and was incorporated into the SFY18 base data used for rate setting.

Appropriate Data

Optumas chose to limit the base data to SFY18 completed encounter data due to the transitions that have occurred within the IA Health Link program. Additionally, this period represents the most recent complete fiscal year of data available for the IA Health Link program at the time of rate development. As it becomes available, additional years of IA Health Link encounter data are expected to be used for future rate cycles.

Reliance on a Databook

Optumas did not rely on the use of a databook in developing the SFY20 IA Health Link capitation rates and instead relied on detailed encounter and capitation data for the Health Link program for the SFY18 time period. 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 correctly and applied consistently within rate development. As a result of these discussions, **Optumas** replaced Amerigroup pharmacy MMIS detailed data with the MCO-submitted detailed data for the July 2017 – November 2017 time period that was received as part of the SFY19 rate development. The Amerigroup MMIS encounter data for pharmacy services was consistent with the financial template for dates of service incurred after December 2017, so the encounter submission issues appear to have been resolved. It is expected that future cycles of rate development

will not rely on the use of detailed supplemental pharmacy data from the MCO. Additionally, through the financial comparison analyses it was determined that an underreporting adjustment of 0.4% was necessary to fully capture the MCO medical encounter expenditures for the SFY18 base data time period.

Consistent with historical rate development cycles for the IA Health Link program, the CHIP rate cell populations were deemed 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 in Table 4, to enhance credibility:

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

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 0.9964 completion factor across all populations and services. This adjustment was made prior to the reporting adjustment described below.

Optumas summarized the IBNR-adjusted SFY18 detailed data and compared it to the financial data shared by the MCOs. A reporting adjustment was applied, in aggregate, to the SFY18 base data to reconcile these data sources and account for encounters not yet properly flowing through the MMIS system. The statewide aggregate impact of this adjustment was a 0.4% increase and is shown within Appendix I.B.

In addition to encounter data for non-subcapitated arrangements, Optumas added the subcapitated costs reported in the MCO financials, by cohort, to the IBNR and Underreporting 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 0.4% increase to the statewide base data and is shown in detail in Appendix I.B.

Additionally, other payment systems not present in the encounter data are detailed and validated against the MCO financials. **Optumas** worked collaboratively 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 settlement payments by the MCOs resulted in an aggregate 0.3% increase to the statewide base data. These adjustments are shown in greater detail in Appendix I.B. After applying these base data adjustments, the data sources consistently, accurately, and

completely reflect the experience for the IA Health Link program in SFY18 and **Optumas** believes the data is an appropriate starting point from which to project to the SFY20 contract period.

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 for the July 2017 – November 2017 portion of the base data, as discussed above in Section I.2.B.II.

Program Changes

This section outlines all of the program changes and adjustments made to the SFY18 base data, prior to trend, within rate development in order to appropriately reflect the policies in effect during the SFY20 contract period.

FQHC, RHC, and IHS Repricing
New Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) PPS rates, as well as Indian Health Service (IHS) encounter rates go into effect 1/1/2019. Encounters were repriced to reflect the new payment schedule for FQHCs, RHCs, and IHS facilities. These adjustments resulted in a $2.40M increase to the base.

HH LUPA Repricing
Home Health Low Utilization Payment Adjustment (HH LUPA) rates were updated effective 7/1/2018. HH LUPA claims were repriced in the base data to reflect this update, with a net impact resulting in a $1.26M increase to the base.

ICF/ID Repricing
Rates for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID) are periodically updated. The most recent changes to the rate schedule at the time of rate development, include rates that are effective 7/1/2019. ICF/ID claims were repriced in the SFY18 base data to reflect the most recent rates available, with a net impact resulting in an $3.65M increase to the base.

SRC Repricing
Rates for State Resource Centers (SRCs) are periodically updated. The most recent changes to the rate schedule at the time of rate development, include rates that become effective 7/1/2019. SRC claims were repriced in the base data to reflect the most recent rates available, with a net impact resulting in a $7.73M decrease to the base.

CAH CAF Repricing
The Iowa legislature added $3.83M in additional funding to CAH services as part of the transition to the Cost Adjustment Factor (CAF); the implementation of the CAF allows for the removal of the retrospective cost settlement approach and allows for a prospective method of reimbursing CAHs effective 7/1/2019. The additional funding was evenly distributed based on service utilization within the SFY18 base data, which resulted in a net $3.83M increase to the base.

NF Repricing

Rates for Nursing Facilities (NFs) are periodically updated, and adjustments are made based on the acuity of the members present. The most recent changes to the rate schedule are effective 7/1/2019 and the Iowa legislature approved a significant increase in funding to NF services in terms of a rate rebase and an increase to the Quality Assurance Assessment Fee (QAAF) the facilities receive. The NF claims within the SFY18 base data were repriced to reflect the most recent rates and QAAF payment available, with a net impact resulting in a $89.2M increase to the base.

Hospice Repricing

Hospice rates are updated annually. **Optumas** used the most recent hospice rates, effective 10/1/2018, and repriced the hospice service utilization within the SFY18 base data to reflect the most recent reimbursement levels. The net impact of this adjustment results in an increase of $0.07M to the base.

Pharmacy Rebates for hawk-i

Effective 7/1/2017, the IA Health Link MCOs are permitted to pursue supplemental drug rebates for the hawk-i population. Since the SFY18 base data reflects pharmacy expenditures prior to accounting for rebates, **Optumas** used the amounts reported within the MCO financial templates to reduce the hawk-i population's pharmacy service expenditures within the SFY18 base data to reflect the net cost of pharmacy services for the MCOs. The pharmacy dollars for the hawk-i population have been reduced by $1.40M to reflect the cost of the services, net of rebates.

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 estimates based on experience since the change, Inpatient claims for Children age 0-59 days have been reduced by $0.48M.

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 2/1/2019. Using MCO annualized estimates, DME/Prosthetic services across all populations have been reduced by $0.40M.

PCP Assignment Optimization

An MCO initiative that began 1/1/2018 expands a PCP assignment program incorporating provider cost, quality, and performance metrics. Using MCO estimates based on actual savings experience since the initiative began, Professional Office claims have been reduced by $0.21M.

Program Integrity (Fraud Detection)

IME has reported identifying approximately $12M annually in fraud, waste, and abuse through the historical 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 and the MCOs, claim costs have been reduced by 0.2%, or $8.43M, to reflect expected program integrity savings.

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, effective 1/1/2019, was used to develop a reduction of $0.48M to costs to the Dual populations within the IA Health Link program.

Re-contracting
Contracts with some hospitals have come up for renewal, effective 1/1/2018 and 1/1/2019, allowing MCOs to negotiate better terms. Using MCO-specific estimates based on experience since the changes, hospital services for across all populations have been reduced by $3.10M.

Pharmacy Dispensing Fee Adjustment
Effective 11/1/2018, a new policy increased the pharmacy dispensing fee from $10.02 to $10.07. **Optumas** used the pharmacy claims utilization within the SFY18 and applied the incremental change in dispensing fees necessary to reflect a final dispensing fee of $10.07 for the pharmacy encounters within the base data. The aggregate impact of this adjustment results in an increase of $0.38M to the rates.

PDN Rate Change
Private Duty Nursing (PDN) and Personal Care service rates are periodically updated based on provider cost reports. **Optumas** received the most recent rates by provider for these services, most of which are effective 1/1/2018, and repriced the service utilization within the SFY18 base data to reflect these rates. The aggregate impact of this repricing is a $1.26M increase to the SFY18 base data.

The impact of each of these program changes at the rate cell level is shown in Appendix I.B, and a summary of all program changes and each step of the rate development is shown in Appendix II.B.

Service and Payment Exclusions

Certain high-cost pharmacy drugs have historically been excluded from the IA Health Link managed care capitation rates. IME reimbursed the MCOs directly for the costs of these drugs via invoices rather than including the service costs and utilization within the monthly capitation rate. Effective July 1, 2019, these high-cost pharmacy drugs will no longer be carved out of the capitation rates and the MCOs will be reimbursed for these services via the monthly capitation payments. Therefore, these services have been included within the SFY18 base data used for rate development rather than carved out as done within prior rate development cycles. The carve-in of these high-cost pharmacy drugs results in an aggregate 0.3% increase to the rates.

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 IA Health Link 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) 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 and applied by major category of service (e.g., Inpatient, Professional, etc.) and broad population (e.g., TANF, Wellness Plan, etc.). Prospective trends were applied from the midpoint of the SFY18 base data (12/30/2017) to the midpoint of the SFY20 contract period (12/30/2019).

Prior to reviewing historical Iowa Medicaid experience, **Optumas** first normalized the SFY18 base data for programmatic and reimbursement changes described above, to ensure that the impact of these changes was not duplicated as both a rating adjustment and as trend. Once this was done, the historical FFS and encounter data was arrayed by rate cell, COS, and month of service, so that historical utilization/1,000, unit cost, and PMPMs could be reviewed. The data was arrayed so that 3-month moving averages (MMA), 6 MMA, and 12 MMA could be calculated. In general, a combination of these three metrics was used to determine prospective trend. However, 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, it is necessary to make adjustments considering that historical trend experience may differ from what will materialize in the future. For example, certain populations and services experienced reductions in spend, but these negative trends were not projected into the contract period.

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

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 as In-lieu-of Service

IME policy allows 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, and these services were included within the IA Health Link contract during SFY18, which is the base data used for the SFY20 rates. IME policy reimburses IMD's 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.

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

As described in the Base Data section and Trend Assumptions section above **Optumas** relied on the MMIS encounter data and FFS data provided by the State for the development of projected benefit cost trends and therefore projected costs of the IA Health Link SFY20 contract period. No material changes to the data, assumptions, and methodologies used outside of the program change adjustments and carve-in of high costs drugs previously described have occurred since the SFY19 rate certification.

Prior to summarizing the SFY18 base data used for rate development, the detailed FFS claims and MMIS encounter data were adjusted to include only last-in-chain versions of IA Health Link covered services so no overpayments to providers needed to be accounted for within rate development.

The following adjustments were made after the SFY18 base data had been adjusted for the program and policy changes that occurred between the SFY18 base data time period and the SFY20 contract period. These program changes are effective after the base data period and the estimates have been applied within rate setting after the adjusted base data has been trended forward to the SFY20 contract period.

Description

Complex Needs Service Addition
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 $14.8M within SFY20 to account for increased utilization associated with these new services.

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 went into effect January 1, 2019. Using estimates from the MCOs and IME, DME/Prosthetics services have been reduced by $3.0M in SFY20 to account for the change in costs associated with these services.

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. Effective August 1, 2018 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 $0.8M in SFY20 and attributed 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 changed this policy during the SFY19 contract period and required NF priority if a bed is available within 50 miles. Using estimates from the MCOs and IME, Inpatient services have been reduced by $1.0M in SFY20 to account for the change in costs associated with this policy change.

Inpatient Readmission Adjustment

Effective 12/1/2018, IME is updating their Inpatient (IP) readmission policy for planned procedures that result in multiple admissions under the same DRG to the same hospital within 30 days of each other. Previously, these types of readmissions were denied coverage under historical IME readmission policy. Hospital readmissions that are reimbursed through the same DRGs at acute hospitals, Behavioral Health psychiatric hospitals, and Critical Access Hospitals will be covered under the new 30 day readmission policy. Using estimates from the MCOs and IME, Inpatient services have been increased by $1.5M in SFY20 to account for the costs of new services associated with the updated readmission policy.

ID Waiver Addition

IME is committed to providing better care for the Intellectually Disabled (ID) population and has worked with the State to identify an additional $7.5M in funding streams to be allocated to enhancement of the ID tiered service rates. In addition, $1.8M has been set aside for funding for individuals with complex needs. An additional $2.6M has also been allocated to these services, effective July 1, 2019. The total $11.9M for these additional funds have been added to the capitation rates for Intellectually Disability HCBS Waiver rate cell.

Hepatitis C Adjustment

Effective January 1, 2019, IME changed the requirements to receive Hepatitis C drugs from Fibrosis Scores 3-4 to F2 for the IA Health Link population. This loosening of the requirement for treatment is

expected to increase the service utilization associated with these drugs. An increase of $3.6M for the SFY20 contract period has been added to the rates to account for this policy change.

The impact of each of these program changes on each rate cell is shown in Appendix I.B and a summary of all applicable program changes and steps of the rate development is shown in Appendix II.B.

Changes to Data, Assumptions, and Methodology

Projected costs were developed consistent with the development of SFY19 rates and generally accepted actuarial principles and practices.

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 2018, with paid dates through December 2018. As described in the base data section, FFS data for the AmeriHealth to Amerigroup transitional members was included for the December 2017 – February 2018 time period. Additionally, to the extent possible, **Optumas** reviewed more recent SFY19 emerging Health Link encounter data through May 2019 to help inform the trend projections used within the SFY20 rate development. These trends were developed primarily using actual experience from the IA Health Link 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 (12/30/2017) to the midpoint of the SFY20 contract period (12/30/2019), for a total of 24 trend months.

Trend factors were developed consistent with generally accepted actuarial principles and practices and are consistent with annualized trends developed for the SFY19 rates.

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 the statewide IA Health Link program. Similar rate cells were combined for trend development in order to increase credibility when developing trend projections and are shown within Table 5 below.

Table 5: 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
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)

The aggregate average annual PMPM trend used within the SFY19 rate development was 0.9% on a statewide basis. For the SFY20 rates, the aggregate average annual PMPM trend used to project from the SFY18 base data to the SFY20 contract period is 2.35% using the SFY18 statewide base membership mix. This difference in trend accounts for about 2.8% of the overall rate increase between the SFY19 Tier 3 rates and the SFY20 rates.

Other Material Adjustments

No other adjustments to projected benefit cost trends were made during rate development.

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 SFY18 as the base data used to develop the SFY20 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 SFY20 IA Health Link capitation rates.

vii. Changes in Covered Benefits

Any changes to covered benefits in the IA Health Link program in SFY20 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 SFY20 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. Per the SFY20 IA Health Link MCO contracts, 2.0% of premium is withheld by the State of Iowa and the MCOs have the ability to earn back the withhold to the extent that specific quality and performance measures are met. 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. 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.

ii. Appropriate Documentation

Time Period and Purpose

The time period of the withhold arrangement is consistent with the SFY20 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 SFY20, 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.

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.

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 SFY20 IA Health Link capitation rates have been developed as full risk rates. Consistent with the SFY19 rate development, 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 and now United from the IA Health Link program and the members being allocated to Amerigroup and Iowa Total Care 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

There are two provider payment initiatives included within the SFY20 capitation rates, which are in accordance with 42 CFR 438.6(c). These payments are described below:

Physician ACR Payments

Description of Arrangement

University of Iowa Physician ACR payments were the pass-through payments incorporated into the historical capitation rates. After the originally developed SFY19 rates were certified, the State began working with CMS to develop an approvable alternative minimum fee schedule for physician and professional services at qualifying Iowa State-Owned or Operated Professional Services Practices, in accordance with 42 CFR 438.6(c), effective July 1, 2018. As of December 27, 2018, CMS has approved this arrangement for SFY19. The State plans to continue this arrangement for SFY20.

The methodology used to incorporate the payments associated with the approved minimum fee schedule is described below and is consistent with the information submitted by the State in the 438.6(c) preprint approved by CMS for SFY19.

The additional payment made to these qualifying physicians under the minimum fee schedule provide support for contracting and maintain access for Medicaid beneficiaries to the applicable physicians and the MCOs. Under this arrangement, in accordance with CFR 438.6(c)(2)(i)(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 reimbursement of the approved minimum fee schedule. Currently, only physicians affiliated with the University of Iowa meet this definition.

The payment arrangement is based on actual utilization within the contract period structured such that the MCOs pay the customary Medicaid rate when adjudicating claims and the basis for the supplemental payment is the difference between the average commercial rate (minimum fee schedule) for specific physician service procedure codes. The MCOs are responsible for paying the calculated differential payments to qualifying practices based on actual utilization within the contract period.

Rating Adjustment

The methodology for calculating the value of the minimum fee schedule arrangement amounts built into the rates is noted below.

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 minimum fee schedule reimbursement, as these are the providers eligible. The State also provided the most recent commercial-level fee schedules and **Optumas** calculated the differential between the Medicaid payment within the underlying SFY18 base data and the University of Iowa minimum fee schedule as specified in the state plan and trended to the SFY20 contract period. This difference was calculated to arrive at a supplemental PMPM amount by rate cell, which is the amount in excess of what would be paid at the standard Medicaid fee schedule. This supplemental PMPM, which does not contain any applied non-medical load, is the amount built into the capitation rates to reflect the impact of implementing the alternative minimum fee schedule physician and professional services at qualifying Iowa State-Owned or Operated Professional Services Practices.

The estimated amount for the approved minimum fee schedule is approximately $78.4 million at an aggregate PMPM of $10.78 based on the SFY18 statewide base membership. The increase over the amount built into the SFY19 rates (approximately $63.7M, or $8.81 PMPM) is primarily due to an increase in service utilization because the amount of qualifying providers participating in the program increased by about 12%. The total amount for the payments is allocated across the rate cells based on utilization of services by qualifying physicians and practitioners.

Ground Emergency Transportation (GEMT) Payment Program

Description of Arrangement

The State is in the process of seeking approval for the Ground Emergency Medical Transportation (GEMT) Payment Program in accordance with 42 CFR 438.6(c), effective July 1, 2019. The GEMT Payment Program will be made to qualifying Emergency Medical Service (EMS) providers within Iowa for Emergency Medical Transportation services. IME provided **Optumas** with the list of applicable providers and procedure codes that will be receiving the supplemental payment needed to bring them up to the approved minimum fee schedule for the initial year of the program. Future years will have provider-specific prospective payment rates based on CMS-approved GEMT cost reports submitted by providers. The additional payments made to the EMS providers 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)(i)(B), a supplemental payment for covered emergency transportation services will be billed under procedure code A0999 for the services provided by an approved EMS provider participating in the GEMT Payment Program. The payment arrangement for the SFY20 contract period will be based on actual emergency transportation service utilization within the contract period and is structured such that the MCOs pay the customary Medicaid rate when adjudicating claims. The supplemental payment is the difference between the standard Medicaid fee schedule for the emergency transport procedure codes and the additional provider-specific uncompensated actual costs to perform EMS transports. For the SFY20 contract period the initial statewide prospective payment rate is $1,183.97 per transport. The provider-specific prospective payment rates based on submitted cost reports will be calculated during the SFY20 contract period and implemented within SFY21 with an adjustment to the rates to account for prior year overpayment or underpayment that may have occurred from using the statewide supplemental payment. This adjustment will only be required for the first year of implementation, because provider-specific rates will be developed annually once the program begins implementation.

Rating Adjustment

The providers receiving the supplemental payment associated with the GEMT program are eligible EMS providers who will be going through the process of submitting CMS-approved cost reports that will be used to calculate their supplemental prospective payment in future fiscal years. The State provided **Optumas** the list of eligible EMS providers who will be participating in the program for the SFY20 contract period, which was used to calculate the supplemental PMPM amount noted below.

The additional payment associated with the GEMT Payment Program is calculated to be $3.41 PMPM in aggregate using the SFY18 statewide base membership, and utilization projected to SFY20, which represents approximately $24.8M. The supplemental payment for GEMT payments is calculated based

on emergency transport service utilization by qualifying EMS providers at the rate cell level, trended to the contract period.

E. Pass-Through Payments

Graduate Medical Education (GME) payments are incorporated within the SFY20 capitation rates and reflect payments to hospitals. 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 SFY20 rates per the definition of pass-through payments per 42 CFR 438.6(a).

Although the GME payment is 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 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.

The amount of GME payments included in the SFY20 rates is approximately $22.0M at an aggregate PMPM of $3.02 based on the statewide SFY18 membership. The $5.28 PMPM amount included for the rate cells that receive this payment is consistent with the amount included in the SFY19 rates.

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 the capitation rates, net additional payments (GME, ACR, and GEMT).

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 SFY20 time period so no adjustment has been made to the rates to reflect the HIPF payment.

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 all three IA Health Link MCOs completed the financial templates, AmeriHealth and United have both withdrawn from the IA Health Link program and will not be providing care to Iowa Medicaid beneficiaries during the SFY20 contract period. The MCO transitions led **Optumas** to rely primarily on the non-benefit costs incurred by Amerigroup when developing the SFY20 non-medical load assumptions for rate development. In developing non-benefit cost assumptions, consideration was given to economies of scale, as well as fixed and variable costs, 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 SFY20 capitation rates, **Optumas** reviewed MCO financial templates summarizing costs quarterly for CY17 and CY18, which included the SFY18 base data period as well as more recent data. The statewide non-medical load within the SFY20 rates is approximately 7.8% in aggregate.

ii. Cost Categories

The non-medical cost load includes administrative costs and allocation for profit, risk, and contingency which is 1.75% of premium for all rate cells.

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

Within the SFY19 rate development process, **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. **Optumas** reviewed the risk adjustment methodology, assumptions, and risk scores used within the SFY19 rates which relied on a combination of risk scores based on UCSD's CDPS+Rx tool and cost-based relativity factors for certain LTSS populations. After thorough review and detailed discussions with IME and the participating MCOs, it was determined that the use of cost-based relativity factors, rather than risk scores, was most appropriate to use within the SFY20 rate development. This is primarily due to the MCO transitions that have occurred and the concern that a disproportionate share of more acute, high-cost members would be attributed to one of the remaining MCOs and that risk scores would not be adequate to cover the differentials in costs, as further described below. As such, it was decided that a one-time use of cost-based relativity factors would be used to split the statewide rates into risk adjusted SFY20 rates. Once the program stabilizes over the SFY20 contract period, it is anticipated that CDPS+Rx will be used again in future rate development cycles.

ii. Methodology

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

Optumas conducted an initial analysis in April 2019 using SFY18 experience, which compared the relative risk scores (using CDPS+Rx concurrent risk scores) to the relative PMPMs, between the chronic populations who were initially planned to be excluded from the MCO attribution process and those who would be subject to the attribution. The finding was that when using an MCO's overall enrollment (those excluded chronic members and not excluded members), the relative risk scores between MCOs matched well to the relative PMPM differences. However, when focusing on the relative risk scores and PMPM differences between the excluded and non-excluded populations, the cost differential was much higher for the excluded population than the risk score gave credit. **Optumas**, IME, and the MCOs had multiple discussions surrounding this analysis, and decided that since there was an expectation that a disproportionate share of the excluded population would potentially remain with one MCO, an alternative approach to CDPS+Rx was warranted for the SFY20 rate cycle. Ultimately, it was agreed upon that a cost-based relativity adjustment similar to that used for the LTSS populations within the SFY19 rate development would be used to develop plan-specific SFY20 rates.

iii. Acuity Adjustment

No acuity adjustments have been made in the development of the SFY20 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 the SFY18 enrollment and claims base data as the experience period for developing the relativity factors at the rate cell level. IME provided **Optumas** with a member-level MCO attribution file that was used to attribute the members within the SFY18 base data period to Amerigroup and Iowa Total Care in order to develop the plan-specific relativity factors on a PMPM basis. The MCO attribution file was provided on June 20, 2019 and contained the member attributions that would be in effect as of July 1, 2019 for the start of the contract period. The IA Health Link program offers a 3-month period of open-enrollment within the SFY20 contract period where members can choose to switch MCOs. As such, **Optumas** and IME will be monitoring member-choice MCO transitions and will review the relativity adjustment as part of the mid-year rate review, and will prospectively make updates if material changes are experienced.

Model

Optumas developed and applied relativity factors to most populations in the IA Health Link program, namely Children, Non-Expansion Adults, Wellness Plan, ABD Non-Duals, and the LTSS populations similar to the relativity factors that were used for the LTSS population within the SFY19 rate development. The remaining populations reflect a statewide rate. Some of these populations, like BCCP and Non-Dual Skilled Nursing Facility had populations insufficient for a relativity adjustment to be credibly applied. A table detailing the use of relativity adjustment or statewide rate for each rate cell, along with the resulting factors, is shown in Appendix II.E.

Optumas identified the member months and costs associated with each of the members within the MCO attribution file provided by IME within the SFY18 base data, to the extent that these members had experience in SFY18. This was then used to develop a PMPM, by MCO and rate cell, based on SFY18 base data for attributed members. By comparing the relative PMPM, by rate cell for each MCO, an initial MCO relativity factor was developed for each rate cell.

Consideration was given for members who were present in SFY18, but not included within the attribution file; these members were classified as the 'leavers' of the program. It was assumed that the 'joiners' (those not enrolled in SFY18, but who will be enrolled in SFY20) will have comparable experience to the 'leavers' noted above. **Optumas** assumed that the 'joiners' would be distributed evenly between the two MCOs. By splitting these members 50/50 between the two MCOs, this results in a slight adjustment to the MCO relativity factors noted above.

During the development of the relativity factors, **Optumas** reviewed the prevalence of members with $100k+ claims in the SFY18 base data, by rate cell, for members assigned to both Iowa Total Care and Amerigroup. This review was conducted to ensure that the use of a cost-based relativity factor was not

resulting in skewed results as a result of one or two high outlier claims. Upon review of both the total dollars in excess of $100k claims as a percent of the base data, as well as the distribution of members with $100k+ claims between the two MCOs, **Optumas** determined that there was no compelling reason to make an adjustment for members with $100k+ claims as part of the relativity factor development.

Similarly, **Optumas** reviewed the average SFY18 enrollment duration for members assigned to Amerigroup and Iowa Total Care to understand the differences in duration and consider whether significant differences in duration played a role in the relativity factor development. Upon this review, **Optumas** observed that the average duration was consistent between the two MCOs. Therefore, no explicit adjustment has been made in the relativity factor development for duration, outside of the 'leavers' and 'joiners' consideration described above.

Methodology

The relativity factors were applied to the statewide rates in a budget neutral manner for the MCOs in the same fashion that standard health status-based risk adjustment factors were applied within the SFY19 rate development. The SFY20 relativity adjustment methodology follows the use of generally accepted actuarial principles and practices that surround standard risk adjustment. Appendix II.F demonstrates the budget neutrality of the relativity adjustment made for each rate cell. Consistent with how rates were developed, same-demographic Children and CHIP rate cells were combined for credibility in developing the relativity adjustment factors.

Magnitude

A proxy SFY18 membership mix for each MCO was developed using the distribution of members between Amerigroup and Iowa Total Care for each rate cell within the June MCO Attribution file. The SFY18 base data membership was distributed between the MCOs using the enrollment for each rate cell within the MCO Attribution file. This proxy SFY18 MCO enrollment is used when aggregating the totals within the certification appendices. The magnitude of the relativity adjustment is an increase of 0.95% for Amerigroup and a decrease of 1.41% for Iowa Total Care, based on each MCO's respective SFY18 proxy membership. The impact by rate cell and in total for each MCO is shown in Appendix II.G.

Assessment of Predictive Value

The MCO relativity factors were developed using MCO-attribution as of June 20, 2019, and these relativities will be used as prospective relativity factors for capitation rate purposes within the SFY20 contract period. The relativity factors will be re-opened as part of the review for a mid-year rate update for January 1, 2020, and at that point, the MCO relativities may change, as a result of differences in attribution between MCOs since the June attribution file. As more recent experience becomes available for the IA Health Link program, **Optumas** and IME will continue to monitor and review the correlation between the relativity factors and relative costs by MCO and rate cell.

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 SFY20 rates.

iii. Changes to Risk Adjustment Model and Budget Neutrality

Consistent with the SFY19 rates, certain LTSS populations were risk adjusted using relativity factors by plan compared to statewide PMPMs. However, as described in prior sections, this relativity adjustment methodology was also extended to the other standard Medicaid populations for the SFY20 rate development rather than the use of CDPS+Rx risk scores. This is as a result of the concerns surrounding MCO attribution and the potential for a disproportionate share of chronic members remaining within one MCO as a result of member choice. All other considerations of the relativity adjustment model are consistent with the SFY19 rates and the relativity adjustments are applied in a budget neutral fashion.

iv. Acuity Adjustment

No acuity adjustments were made for the SFY20 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 SFY20 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 SFY20 rates were developed for all services incurred by LTSS members, with the exception of dental services 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 are consistent with those used within the SFY19 rate development and 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 the MCO-attribution file as

the basis for the LTSS blend. This file provides the actual mix of Institutional and Waiver members that each MCO will have enrolled with their organization as of July 1, 2019, the first day of the SFY20 contract period. The individual LTSS 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.

ii. Non-Benefit Costs

Non-medical load for the LTSS population has been developed consistent with the approach for all IA Health Link populations and further details can be found in Section I.5 of this certification letter.

iii. Sources

The LTSS capitation rates were developed using SFY18 encounter data as well as the FFS data for the December 2017 through February 2018 time period for the members who transitioned from AmeriHealth to FFS prior to being enrolled in Managed Care again with Amerigroup. After accounting for program change adjustments, trend, applying risk adjustment, and adjusting for non-medical load, the LTSS 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 SFY20 for the traditional Medicaid populations was used to develop rates for the new adult group. IA Health Link encounter data and FFS data for the Wellness Plan (WP) new adult group, as described in Section I.2., was primarily used to develop SFY20 rates.

B. Previous Rating Periods

i. New Data

Optumas utilized IA Health Link experience from SFY17 for the SFY19 rate development. Underlying the SFY20 rates, **Optumas** used IA Health Link experience from SFY18 as the basis for rate development since this was the most recent complete year of data available for the IA Health Link program.

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 and 2 of the IA Health Link program, SFY17 and SFY18. **Optumas** believes that the use of SFY18 experience as the basis for rate development should better align payment to risk for the SFY20 contract period as compared with the pre-IA Health Link data used in prior rate development cycles.

iv. Adjustment for Differences

Optumas has used SFY18 encounter and AmeriHealth transitional member FFS data as the base data for the SFY20 rates, which incorporates the second full year of WP actual encounter experience under the IA Health Link program. Therefore, no adjustment has been made for any differences as it is expected that the use of SFY18 IA Health Link experience will better align payment to risk for the SFY20 contract period as compared to prior rate development cycles.

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 SFY18 IA Health Link encounter data as the base for the SFY20 capitation rates, which is consistent with the source of base data used within the SFY19 rate development, but represents a more recent time period.

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 SFY18 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. No other methodology changes have been made to the projected non-benefit costs between the SFY19 and SFY20 Health Link rate development for the WP population.

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. No other methodology changes have been made to the projected non-benefit costs between the SFY19 and SFY20 Health Link rate development for the WP population.

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 previously been described in this document.

5. Risk Mitigation Strategies

A. Description of Strategy

As discussed in Section I.4., the SFY20 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 beginning with the SFY19 capitation rates.

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 SFY20.

ii. Rationale for Change

There has been no change from the SFY19 rates in use of a risk corridor for the WP population.

iii. Experience and Results

As a result of using SFY18 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 SFY20 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, 2019 through June 30, 2020 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 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 SFY20 Rate Certification Appendix I 2019.07.10.xlsx
IA Health Link SFY20 Rate Certification Appendix II 2019.07.10.xlsx