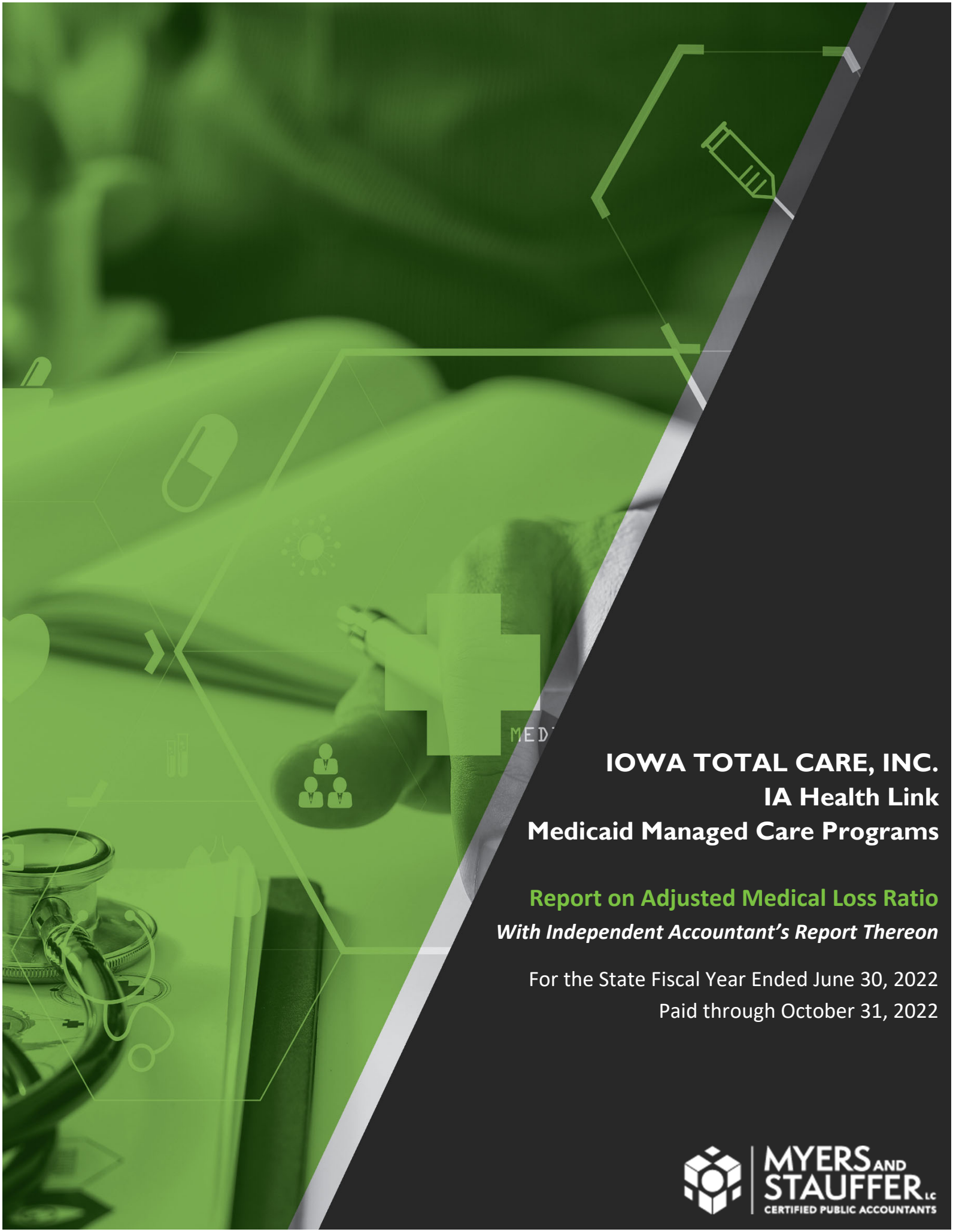

IOWA TOTAL CARE, INC.
IA Health Link
Medicaid Managed Care Programs

Report on Adjusted Medical Loss Ratio

With Independent Accountant's Report Thereon

For the State Fiscal Year Ended June 30, 2022

Paid through October 31, 2022

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

State of Iowa
Department of Health and Human Services, Iowa Medicaid
Des Moines, Iowa

Independent Accountant's Report

We have examined the Medical Loss Ratio Calculation of Iowa Total Care, Inc. (health plan) for the state fiscal year ended June 30, 2022. The health plan's management is responsible for presenting information contained in the Medical Loss Ratio Calculation in accordance with the criteria set forth in the Code of Federal Regulations (CFR) 42 § 438.8 and other applicable federal guidance (criteria). This criteria was used to prepare the Adjusted Medical Loss Ratio. Our responsibility is to express an opinion on the Adjusted Medical Loss Ratio based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the Adjusted Medical Loss Ratio is in accordance with the criteria, in all material respects. An examination involves performing procedures to obtain evidence about the Adjusted Medical Loss Ratio. The nature, timing, and extent of the procedures selected depend on our judgment, including an assessment of the risk of material misstatement of the Adjusted Medical Loss Ratio, whether due to fraud or error. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion.

We are required to be independent and to meet our other ethical responsibilities in accordance with relevant ethical requirements relating to our engagement.

The accompanying Adjusted Medical Loss Ratio was prepared from information contained in the Medical Loss Ratio Calculation for the purpose of complying with the criteria, and is not intended to be a complete presentation in conformity with accounting principles generally accepted in the United States of America.

In our opinion, the Adjusted Medical Loss Ratio is presented in accordance with the criteria, in all material respects, and the Adjusted Medical Loss Ratio exceeds the state requirement of 88 percent for the state fiscal year ended June 30, 2022.

This report is intended solely for the information and use of the Iowa Medicaid, CBIZ Optumas, and the health plan and is not intended to be and should not be used by anyone other than these specified parties.

Myers and Stauffer LC

Myers and Stauffer LC
Kansas City, Missouri
January 30, 2024

Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2022 Paid Through October 31, 2022

Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2022 Paid Through October 31, 2022				
Line #	**Line Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
1.	**Medical Loss Ratio Numerator**			
1.1	Incurred Claims	$ 2,451,871,807	$ 114,336,791	$ 2,566,208,598
1.2	Activities that Improve Health Care Quality	$ 46,525,363	$ (10,604,430)	$ 35,920,933
1.3	**MLR Numerator**	$ 2,498,397,171	$ 103,732,361	$ 2,602,129,532
1.4	Non-Claims Costs (Not Included in Numerator)	$ 123,841,547	$ -	$ 123,841,547
2.	**Medical Loss Ratio Denominator**			
2.1	Premium Revenue	$ 2,648,973,772	$ 168,255,520	$ 2,817,229,292
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$ 18,261,576	$ (5,322,924)	$ 12,938,652
2.3	**MLR Denominator**	$ 2,630,712,196	$ 173,578,444	$ 2,804,290,640
3.	**MLR Calculation**			
3.1	Member Months	3,973,514	790	3,974,304
3.2	Unadjusted MLR	95.0%	-2.2%	92.8%
3.3	Credibility Adjustment	0.0%	0.0%	0.0%
3.4	Adjusted MLR	95.0%	-2.2%	92.8%
4.	**Remittance**			
4.1	Contract Includes Remittance Requirement	No		No
4.2	State Minimum MLR Requirement	88.0%		88.0%

**The Non-Claims Costs line has not been subjected to the procedures applied in the examination, including testing for allowability of expenses or appropriate allocation to the Medicaid line of business. Adjustments identified during the course of the examination were not tested to determine any impact on Non-Claims Costs. Accordingly, we express no opinion on the Non-Claims Costs line.*

Schedule of Adjustments and Comments for the State Fiscal Year Ended June 30, 2022

During our examination, we identified the following adjustments.

Adjustment #1 – To adjust vision vendor expenses

The health plan reported services for related party vendor, Envolve Vision based on a per-member per-month (PMPM) arrangement. A certification statement was submitted to support the vendor's actual claim payments incurred for services performed for the medical loss ratio (MLR) reporting period. An adjustment was proposed to remove the administrative and profit components of the PMPM amount from incurred claims. The incurred claims and third party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2), Center for Medicaid & CHIP Services Informational Bulletin: MLR Requirements Related to Third Party Vendors dated May 15, 2019.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($675,829)

Adjustment #2 – To remove IBNR margin per health plan supporting documentation

The health plan reported incurred but not reported (IBNR) expenses that included an amount in excess of the incurred claims contained within the health plan's paid claims lag tables. It was determined the reported amount included a non-allowable reserve margin percentage. An adjustment was proposed to remove the calculated IBNR margin. The incurred claims and IBNR reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($3,137,715)

Adjustment #3 – To remove interest expense per health plan supporting documentation

The health plan included interest paid on untimely processed claims as an incurred claims expense. Interest on paid claims is not an allowable expense within incurred claims. An adjustment was proposed to remove the interest expense. The incurred claims reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($66,276)

Adjustment #4 – To adjust transportation vendor expenses

The health plan reported services for third party vendor, Access2Care, based on a fee-for-service (FFS) arrangement. A certification statement was submitted to support the vendor's actual claim payments incurred for services performed for the MLR reporting period, which did not reconcile to the health plan reported amount. An adjustment was proposed to increase incurred claims per the vendor certification statement. The incurred claims and third party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and Center for Medicaid & CHIP Services Informational Bulletin: MLR Requirements Related to Third Party Vendors dated May 15, 2019.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	$77,701

Adjustment #5 – To adjust incurred claims expense to final net payments to pharmacies

The health plan reported pharmacy incurred claims expense for the third party pharmacy benefit manager (PBM), CVS Health, based on paid claims detail only reflecting ingredient cost and dispensing fees. It was determined the reported pharmacy incurred claims expense was overstated due to excluding the transaction fees assessed to the pharmacies by the PBM. An adjustment was proposed to reduce incurred claims expense by the amount related to the transaction fees in order to reflect the final amount paid to pharmacies. The incurred claims and third party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and Center for Medicaid & CHIP Services Informational Bulletin: MLR Requirements Related to Third Party Vendors dated May 15, 2019.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($965,324)

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

The health plan reported pharmacy incurred claims for the third party vendor PBM. It was determined contracted rate guarantee calculations were calculated annually for participating pharmacies based on contracts with the PBM. The calculation outlined, at the Medicaid line of business level, the effective rates paid to pharmacies compared to the contracted rate and dispensing fees. The overall impact for the Medicaid line of business was a reduction in reimbursement to pharmacies. An adjustment was proposed to remove the Medicaid calculated amount for the MLR reporting period from incurred claims. The incurred claims and third party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and Center for Medicaid & CHIP Services Informational Bulletin: MLR Requirements Related to Third Party Vendors dated May 15, 2019.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($20,294)

Adjustment #7 – To remove non-qualifying administrative expenses reported as provider incentive payments

The health plan reported provider incentive payments for the MLR reporting period that included various types of expenses. Supporting documentation demonstrated non-qualifying amounts related to translation services, prior authorization, and medical records expense were reported within provider incentive payments. An adjustment was proposed to remove the non-qualifying amounts from provider incentive payments. Within Adjustment #7, the allowable translation services expenses were reclassified to HCQI. The provider incentive reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and 45 CFR § 158.140(b)(2)(iii).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($677,459)

Adjustment #8 – To remove non-qualifying provider incentive payments

The health plan reported provider incentive payments for the MLR reporting period that included various types of expenses related to claims processing issues. Supporting documentation demonstrated these amounts were also reported within the health plan's paid claims lag tables once the claims were processed. An adjustment was proposed to remove the duplicated amounts from provider incentive

payments. The incurred claims and provider incentive reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and 45 CFR § 158.140(b)(2)(iii).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($12,973,010)

Adjustment #9 – To remove unsupported provider care coordination expenses

The health plan reported provider care coordination expenses within provider incentive payments. Based on the provider contracts, the health plan pays a PMPM payment to specific providers for performing care coordination services. Since the health plan could not obtain actual cost details from the providers related to these services, the amounts could not be reported as HCQI expenses. An adjustment was proposed to remove the unsupported care coordination payments. The HCQI reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($7,793,216)

Adjustment #10 – To adjust provider incentive payments per health plan supporting documentation

The health plan reported provider incentive payments for the MLR reporting period. It was determined based on health plan supporting documentation, amounts reported were understated, attributed primarily from capturing estimated payments rather than actual amounts paid to providers for the MLR reporting period. An adjustment was proposed to increase provider incentive payments per health plan supporting documentation. The provider incentive reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	$757,999

Adjustment #11 – To reclassify allowable HCQI expenses from provider incentive payments

The health plan reported provider incentive payments for the MLR reporting period that included varying types of expenses. Health plan supporting documentation demonstrated amounts related to translation services were reported within provider incentive payments. An adjustment was proposed to

remove the amount from provider incentive payments within Adjustment #7 and reclassify the allowable expense to HCQI per health plan supporting documentation. The HCQI reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.2	Activities that Improve Health Care Quality	$107,301

Adjustment #12 – To adjust COB recovery amounts and claims settlements outside claims system per health plan supporting documentation

The health plan did not report third party liability vendor coordination of benefit (COB) recovery amounts and provider claims settlements captured outside of the paid claims lag tables for the MLR reporting period. An adjustment was proposed to reflect COB recoveries and provider settlements as a reduction to incurred claims. The incurred claims reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($19,740,426)

Adjustment #13 – To remove non-qualifying HCQI/ HIT expenses

The health plan reported HCQI and health information technology (HIT) expenses based on salaries and benefits, vendor costs, and overhead costs. It was determined the health plan included non-qualifying expenses based on federal guidance. An adjustment was proposed to remove non-qualifying salaries, benefits, vendor costs, and overhead. The HCQI/ HIT reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.2	Activities that improve health care quality	($10,886,054)

Adjustment #14 – To reclassify qualifying HCQI vendor expenses from VAS reporting

The health plan reported HCQI expenses for related party vendor, Envolve PeopleCare as value added services (VAS). It was determined the salary and benefit portion of these expenses were allowable as HCQI based on federal guidance rather than VAS. Per vendor supporting documentation, salaries and

benefits were submitted to appropriately capture the cost of the vendor providing the HCQI services. An adjustment was proposed to remove the PMPM reported as VAS and include the qualifying HCQI salaries and benefits. The incurred claims, HCQI, and related party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR §§ 438.8(e)(2), 438.8(e)(3), and CMS Publication 15-1, Chapter 10.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($930,626)
1.2	Activities that improve health care quality	$174,322

Adjustment #15 – To adjust VAS expenses per health plan supporting documentation

The health plan reported state approved VAS expenses for the MLR reporting period. Based on supporting documentation, the health plan overstated the VAS expenses. An adjustment was proposed to reduce the VAS expenses per health plan supporting documentation. The incurred claims reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($188,952)

Adjustment #16 – To adjust premium revenues and incurred claims to incorporate approved directed payment programs

The health plan reported state directed payments in the numerator and the denominator for the MLR reporting period. It was determined that both state directed expenses and revenues were understated based on comparison to state data for the University of Iowa Hospitals and Clinics Average Commercial Rate (UIHC ACR), American Rescue Plan Act (ARPA), Nursing Facility Covid Relief Rate (NF CRR), and Ground Emergency Medical Transportation (GEMT). An adjustment was proposed to increase the state directed payments and associated expense per state data. See below for additional tables to break out the specific payments. The state directed payment reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR §§ 438.8(e)(2), 438.8(f)(2), and 438.6(c). The health plan completed the MLR Calculation based on the template instructions.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	$160,670,217
2.1	Premium Revenue	$161,487,933

UIHC ACR - Hospital	
Description	**Amount**
Total Directed Payment Revenue	$121,181,728
Total Directed Payment Expense	$121,181,728

UIHC ACR - Physician	
Description	**Amount**
Total Directed Payment Revenue	$26,879,259
Total Directed Payment Expense	$26,879,259

ARPA	
Description	**Amount**
Total Directed Payment Revenue	$12,609,230
Total Directed Payment Expense	$12,609,230

NF CRR	
Description	**Amount**
Revenue - State Data	$336,443
Risk Corridor Settlement	$492,393
Total Directed Payment Revenue	$828,836
Total Directed Payment Expense	$832,200
Expense Claimed by Health Plan	$851,100
Reclassification to Claims Expense	($18,900)
Incurred Claims Adjustment	$0

GEMT	
Description	**Amount**
Total Directed Payment Revenue	($11,119)
Total Directed Payment Expense	$0

Adjustment #17 – To adjust revenues per state data

The health plan reported revenue amounts that did not reflect payments received for its members applicable to the covered dates of service for the MLR reporting period. An adjustment was proposed to report the revenues per state data for capitation payments. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2). The health plan completed the MLR Calculation based on the template instructions.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
2.1	Premium Revenue	$2,305,470

Adjustment #18 – To adjust withhold payments per state data

The health plan reported an estimated amount for the anticipated earned withholds related to achieved pay for performance metrics. An adjustment was proposed to report earned withhold payments per state data. The withhold payments reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2). The health plan completed the MLR Calculation based on the template instructions.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
2.1	Premium Revenue	$4,462,117

Adjustment #19 – To adjust member months per state data

The health plan reported member month amounts did not reflect accurate amounts for the MLR reporting period. An adjustment was proposed to reflect member months per state data. The member month reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
3.1	Member Months	790

Adjustment #20 – To adjust income taxes per recalculation to audited financial statements

The health plan reported income taxes that did not reconcile to the supporting documentation. It was determined the health plan did not appropriately remove taxes for investment income and factor in the change in deferred tax assets noted in the audited financial statements. A recalculation was performed based on the audited financial statements and was determined to be reasonable and appropriate. An adjustment was proposed to the recalculation utilizing the audited financial statements. The tax reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(3) and Centers for Medicare & Medicaid Services Medical Loss Ratio Annual Reporting Form Filing Instructions.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
2.2	Federal, State, and local taxes and licensing and regulatory fees	($5,322,924)