April 29, 2021

Ms. Julie Lovelady
Interim Medicaid Director
Iowa Medicaid Enterprise
Department of Human Services
1305 East Walnut Street
Des Moines, IA 50319-0114

Subject: SFY22 IA Health Link Managed Care Rate Development

Dear Ms. Lovelady:

Thank you for the opportunity to assist the Department of Human Services (DHS) and Iowa Medicaid Enterprise (IME) with the development of the SFY22 IA Health Link capitation rates. The following report summarizes the methodology used for the development of the capitation rates, effective July 1, 2021 – June 30, 2022 (SFY22). We have also provided our actuarial certification for these capitation rates, compliant with CMS guidelines and requirements. Please send me an e-mail at barry.jordan@optumas.com or call at 480.588.2492, or e-mail Elrycc at elrycc.berkman@optumas.com or call at 480.247.2890 if you have any questions.

Sincerely,

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

Elrycc Berkman, ASA, MAAA
Consulting Actuary, **Optumas**

CC: Mary Stewart, **IME**
Steve Schramm, **Optumas**
Jared Nason, **Optumas**
Stephanie Taylor, **Optumas**

Iowa Medicaid Enterprise

IA Health Link Actuarial Certification

July 1, 2021 – June 30, 2022 Capitation Rates

Table of Contents

TABLE OF CONTENTS I

EXECUTIVE SUMMARY 4

BACKGROUND 4
SUMMARY OF CAPITATION RATES 5
FISCAL IMPACT ESTIMATE 5
RATE DEVELOPMENT SUMMARY 6

SECTION I. MEDICAID MANAGED CARE RATES 7

1. GENERAL INFORMATION 8

A. RATE DEVELOPMENT STANDARDS 8
I. CONTRACT PERIOD 8
II. REQUIRED COMPONENTS 8
III. DIFFERENCES AMONG CAPITATION RATES 11
IV. RATE CELL CROSS-SUBSIDIZATION 11
V. PROGRAM CHANGE DATES 11
VI. MEDICAL LOSS RATIO 11
VII. GENERALLY ACCEPTED ACTUARIAL PRACTICES 12
VIII. RATE CERTIFICATION PERIODS 12
IX. AMENDMENTS 12
B. APPROPRIATE DOCUMENTATION 13
I. DOCUMENTATION OF DATA, ASSUMPTIONS, AND METHODOLOGY 13
II. RATING ASSUMPTION VARIATIONS 13
III. INDEX 13
IV. FMAP 13
V. RATE CHANGE COMPARISON 13
VI. KNOWN AMENDMENTS 14

2. DATA 15

A. RATE DEVELOPMENT STANDARDS 15
I. BASE DATA 15
B. APPROPRIATE DOCUMENTATION 16
I. BASE DATA 16
II. RATE DEVELOPMENT DATA 16
III. ADJUSTMENTS 18

3. PROJECTED BENEFIT COSTS AND TRENDS 23

A. RATE DEVELOPMENT STANDARDS 23
I. SERVICES ALLOWED 23
II. VARIATION OF ASSUMPTIONS 23
III. TREND ASSUMPTIONS 23
IV. IN-LIEU-OF SERVICES 24
V. IMD AS IN-LIEU-OF SERVICE 24
B. APPROPRIATE DOCUMENTATION 24
I. FINAL PROJECTED BENEFIT COSTS 24
II. DEVELOPMENT OF PROJECTED COSTS 24
III. PROJECTED BENEFIT COST TRENDS 26
IV. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT 30
V. IN-LIEU-OF SERVICES 30
VI. RETROSPECTIVE ELIGIBILITY 30

VII. Changes in Covered Benefits 30
VIII. Impact of Changes 31

4. SPECIAL CONTRACT PROVISIONS RELATED TO PAYMENT 32

A. Incentive Arrangements 32
B. Withhold Arrangements 32
I. Rate Development Standards 32
II. Appropriate Documentation 32
C. Risk-Sharing Mechanisms 33
I. Rate Development Standards 33
II. Appropriate Documentation 34
D. Delivery System and Provider Payment Initiatives 35
UIHC Physician ACR Payments 35
UIHC Hospital ACR Payments 37
Ground Emergency Transportation (GEMT) Payment Program 39
Nursing Facility COVID-19 Relief Rate (NF CRR) Directed Payment 40
E. Pass-Through Payments 42

5. PROJECTED NON-BENEFIT COSTS 44

A. Rate Development Standards 44
I. Required Components 44
II. PMPM and Percentage of Capitation Rates 44
III. Variations 44
IV. Health Insurance Providers Fee 44
B. Appropriate Documentation 44
I. Development 44
II. Cost Categories 45
III. Historical Non-Benefit Cost Data 45
IV. Health Insurance Providers Fee 45

6. RISK ADJUSTMENT AND ACUITY ADJUSTMENTS 46

A. Risk Development Standards 46
I. Risk Adjustment 46
II. Methodology 47
III. Acuity Adjustment 47
B. Appropriate Documentation 47
I. Prospective Risk Adjustment 47
II. Retrospective Risk Adjustment 50
III. Changes to Risk Adjustment Model and Budget Neutrality 50
IV. Acuity Adjustment 50

SECTION II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS 51

1. MANAGED LONG-TERM SERVICES AND SUPPORTS 52

A. Required Content 52
B. Rate Development Standards 52
I. Rate Blending 52
C. Appropriate Documentation 53
I. Payment Structures 53
II. Non-Benefit Costs 53
III. Sources 53

SECTION III. NEW ADULT GROUP CAPITATION RATES 54

1. DATA 55

A. NEW ADULT GROUP DATA 55
B. PREVIOUS RATING PERIODS 55
I. NEW DATA 55
II. MONITOR COSTS 55
III. ACTUAL EXPERIENCE COMPARED WITH EXPECTATIONS 55
IV. ADJUSTMENT FOR DIFFERENCES 55

2. PROJECTED BENEFIT COSTS 56

A. NEW ADULT GROUP PROJECTION ISSUES 56
I. NEW ADULT GROUPS COVERED IN PREVIOUS RATING PERIODS 56
II. NEW ADULT GROUPS NOT COVERED IN PREVIOUS RATING PERIODS 56
III. KEY ASSUMPTIONS 56

3. PROJECTED NON-BENEFIT COSTS 58

A. REQUIRED COMPONENTS 58
I. CHANGES IN METHODOLOGY 58
II. CHANGES IN ASSUMPTIONS 58
B. KEY ASSUMPTIONS 58

4. FINAL CERTIFIED RATES 59

A. REQUIRED COMPONENTS 59
I. COMPARISON TO PREVIOUS RATES 59
II. OTHER MATERIAL CHANGES 59

5. RISK MITIGATION STRATEGIES 60

A. DESCRIPTION OF STRATEGY 60
B. COMPARISON TO PREVIOUS PERIOD 60
I. CHANGES IN STRATEGY 60
II. RATIONALE FOR CHANGE 60
III. EXPERIENCE AND RESULTS 60

ACTUARIAL CERTIFICATION LETTER 61

APPENDICES 62

Executive Summary

Background

The Iowa Department of Human Services (DHS) implemented the IA Health Link program on April 1, 2016 as part of the Medicaid Modernization initiative. The majority of Iowa Medicaid members are enrolled in the IA Health Link program and receive physical health, behavioral health, pharmacy prescriptions, and long-term supports and services through the contracted Managed Care Organizations (MCOs). A small portion of Medicaid members 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, 2021 through June 30, 2022 (SFY22). 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.

When the IA Health Link program began on April 1, 2016, three MCOs were contracted with IME: Amerigroup, AmeriHealth Caritas Iowa Inc., and UnitedHealthcare Plan of the River Valley, Inc. Since then, AmeriHealth and United have withdrawn from the program, effective November 30, 2017 and June 30, 2019, respectively. A new MCO, Iowa Total Care, entered the market on July 1, 2019. Amerigroup and Iowa Total Care have been the only two MCOs providing care to IA Health Link enrollees since SFY20 and will continue to be the only MCOs operating in SFY22.

The State and MCOs have implemented a variety of COVID-19 provider/member relief related measures in response to the pandemic that will be in effect for the duration of the Public Health Emergency (PHE) declaration. At the time of the SFY22 rate development, the PHE is expected to continue through the end of calendar year 2021. IME, **Optumas**, and the IA Health Link MCOs have been monitoring emerging data associated with the COVID-19 provider/member relief measures since the start of the PHE in March 2020. The SFY22 capitation rates, effective July 1, 2021 – June 30, 2022, have been developed using all available information at the time of rate development, including emerging IA Health Link experience associated with COVID-19.

As the consulting actuaries to DHS and IME, **Optumas** worked with the State to create an appropriate rate setting methodology for the SFY22 IA Health Link capitation rates. **Optumas** ensured the methodology used to develop the SFY22 rates complies 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 the State to identify the necessary rate development components for the July 1, 2021 – June 30, 2022 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 SFY22 IA Health Link program.

This document is structured consistent with the CMS "2020-2021 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

The certified capitation rates for the IA Health Link managed care program gross of withholds and the additional GME, GEMT, and NF CRR payments, effective July 1, 2021 - June 30, 2022, can be found in Appendix I.A. Note that estimates associated with the Hospital and Physician ACR payments, which are addressed through separate payment terms, are not included within Appendix I.A but are shown later in Appendix I.C, as they are not explicitly built into the capitation rates.

In developing the SFY22 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

Optumas worked in conjunction with IME to develop an appropriate rate setting methodology and applied necessary rating adjustments resulting in reasonable, appropriate, and attainable capitation rates for the SFY22 contract period. The body of this document outlines the 2020-2021 CMS Medicaid Managed Care Rate Development Guide with compliance to each section discussed in detail.

Fiscal Impact Estimate

The estimated aggregate fiscal impact of the SFY22 IA Health Link rate changes, net additional payments, is an annual increase of $50.0M based on CY19 enrollment, which is the base data period used for rate development. The annual fiscal impact of the SFY22 certified capitation rates, gross withhold, net additional payments, compared to the SFY21b capitation rates, gross withhold, net additional payments is 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 SFY22 rate development will be discussed in further detail throughout the remainder of the document.

Section I. Medicaid Managed Care Rates

1. General Information

A. Rate Development Standards

i. Contract Period

The rates contained in this certification are effective for the one-year period from July 1, 2021 through June 30, 2022 (SFY22).

ii. Required Components

Letter from Certifying Actuary

The rates contained in this document have been certified by Barry Jordan, Member of the American Academy of Actuaries (MAAA) and Fellow of the Society of Actuaries (FSA), and Elrycc Berkman, Member of the American Academy of Actuaries (MAAA) and Associate of the Society of Actuaries (ASA). Mr. Jordan and Mr. Berkman 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. The certification letter from Mr. Jordan and Mr. Berkman 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)(if).

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 continue to be enrolled in IA Health Link in subsequent years. A small portion of Medicaid members are served through Medicaid Fee-For-Service (FFS). The objectives of the Medicaid Modernization initiative are to improve quality and access to care, promote accountability for patient outcomes, and create a more predictable and sustainable budget.

When the IA Health Link program began on April 1, 2016, three MCOs were contracted with IME: Amerigroup, AmeriHealth Caritas Iowa Inc., and UnitedHealthcare Plan of the River Valley, Inc. Since then, AmeriHealth and United have withdrawn from the program effective November 30, 2017 and June 30, 2019, respectively. Effective July 1, 2019, Iowa Total Care entered the market and began serving IA Health Link managed care enrollees. Amerigroup and Iowa Total Care will be the only two IA Health Link MCOs providing care to Iowa Medicaid beneficiaries during the SFY22 contract period. Each of the MCOs cover the entire state of Iowa and the capitation rates reflect statewide rates.

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 are now covered via the capitation rates and the MCOs are reimbursed for these services within the monthly capitation payments for each rate cell. Consistent with the SFY20 and SFY21 rate developments, these high-cost drugs are inherent within the base data used for rate development as the capitation rates will continue to cover these high-cost drugs during the SFY22 contract period. As outlined in Section 4 of the MCO Contracts, IME has excluded Zolgensma from being reimbursed via the capitation rates, consistent with the SFY21 contract period. The MCOs will provide coverage of Zolgensma to eligible beneficiaries consistent with other pharmaceuticals and treatments; however, IME will reimburse the MCOs via invoices billed to IME. Any Zolgensma experience within the CY19 base data time period has been carved out of the base data used for rate development.

Dental services and the Program of All-Inclusive Care for the Elderly (PACE) are covered under separate managed care programs for the eligible populations. The base data was summarized into rating Categories of Service (COS) consistent with the SFY21 rate development, 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 eligible populations. Populations have been grouped by similar risk patterns and specific rates have been set for each rate cell in accordance with 42 CFR §438.4(b)(4) and 438.7(c). The individual rate cells used for the SFY22 rate development are consistent with historical contract periods. For summary purposes, these rate cells have been grouped into the following high-level Categories of Aid (COA) shown in Table 2 below:

Table 2: IA Health Link Rate Cells and 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

Rate Cell	Category of Aid (COA)
Children 1-4 M&F	Children
Children 5-14 M&F	Children
Children 15-20 F	Children
Children 15-20 M	Children
Children’s Health Insurance Program (CHIP) - Hawk-a	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

Rate Cell	Category of Aid (COA)
CHIP - Children 60-364 days M&F	Children
CHIP - Children 1-4 M&F	Children
CHIP - Children 5-14 M&F	Children
CHIP - Children 15-20 F	Children
CHIP - Children 15-20 M	Children
TANF Maternity Case Rate	Maternity Case Rate
Pregnant Women Maternity Case Rate	Maternity Case Rate

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

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

No retroactive adjustments to the capitation rates were made for the SFY22 contract period.

iii. Differences Among Capitation Rates

All proposed rate changes within the SFY22 IA Health Link capitation rates are based on valid rate development standards. No consideration was made to rating adjustments based on the rate of federal financial participation associated with the covered populations.

iv. Rate Cell Cross-Subsidization

There is no rate cell cross-subsidization within the SFY22 IA Health Link capitation payment rates.

v. Program Change Dates

The effective dates of changes to the IA Health Link Medicaid managed care program are consistent with the assumptions used to develop the capitation rates. The adjustments 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. The State requires a minimum Medical Loss Ratio (MLR) of 88% for the MCOs operating within the IA Health Link program for SFY22. 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

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

Final Contracted Rates

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

viii. Rate Certification Periods

The rates in this document were developed for the SFY22 contract period and are certified for the SFY22 time period, effective from July 1, 2021 through June 30, 2022.

ix. Amendments

Federal Financial Participation

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

Changes to Rates

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

Contract Amendments

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

Other Changes

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

Changes in Federal Statutes or Regulatory Authority

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

B. Appropriate Documentation

i. Documentation of Data, Assumptions, and Methodology

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

ii. Rating Assumption Variations

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

iii. Index

This rate certification follows the structure of the 2020-2021 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”.

iv. 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.

v. Rate Change Comparison

A comparison of the SFY22 capitation rates to the SFY21b rates is shown in Appendix II.A.

In aggregate across all rate cells, there is an approximate 1.0% rate increase between the SFY21b and SFY22 capitation rates. The SFY21b and SFY22 rate development relied on the same CY19 base data experience and the same rating adjustments are applicable for both contract periods and have a similar impact to the capitation rates. As a result, most of the rate cells have a modest rate change, within +/- 2.0%, that is primarily driven by the additional trend months to project from the base data time period to the SFY22 contract period.

All components of the rate development are described in further detail within the remainder of the document and are shown within Appendix I.B.

vi. Known Amendments

The only known amendments that will be provided to CMS in the future associated with the SFY22 capitation rates are the reconciliations associated with the UIHC Physician and Hospital ACR directed payments. During the SFY22 contract period these directed payments are being operationalized as separate payment term arrangements and are reimbursed outside of the capitation rates. Consistent with CMS requirements, **Optumas** has included initial PMPM estimates by rate cell associated with these payment arrangements in Appendix I.C. Once the contract period is over, IME and **Optumas** will perform a reconciliation and revise the PMPMs based on actual UIHC Physician and Hospital ACR directed payment utilization rendered within the July 1, 2021 – June 30, 2022 contract period.

Other potential amendments that may be implemented within the SFY22 IA Health Link contract period are associated with the COVID-19 Public Health Emergency (PHE) proclamation. Underlying the COVID-19 related rating adjustments described later in this document is the assumption that the PHE is expiring on December 31, 2021. To the extent that the PHE does not expire on December 31, 2021, **Optumas** and IME will review the impact on the proposed rates and submit contract amendments and rate certification addendums if a rating adjustment is warranted.

2. Data

A. Rate Development Standards

i. Base Data

Encounter data, FFS data, and Audited Financial Reports

As part of the SFY22 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 (April 1, 2016) through December 31, 2020. This data reflects actual experience for the Medicaid populations served by the IA Health Link MCOs. **Optumas** received member-level capitation files that were used to match up to the detailed encounters to ensure all claims were for Health Link enrolled members.

Optumas summarized this data for comparison with financial templates that were submitted by each of the MCOs historically operating within the IA Health Link program. The detailed capitations and encounters for the emerging IA Health Link experience were also benchmarked to the base data used within the SFY19 through SFY21 rate developments.

Appropriate Base Data

Optumas selected CY19 (January 1, 2019 – December 31, 2019) encounter data as the base data for the SFY22 rate development. The raw, unadjusted CY19 base data is consistent with the base data used within the SFY21b rate development. The CY19 encounters represent the most recent complete year of IA Health Link program experience available at the time of rate development that does not reflect the suppressed utilization associated with the early months of the COVID-19 pandemic following office closures and stay at home orders during March-May 2020. The CY19 time period was deemed the most appropriate year to use as the base data for SFY22 rate setting since it is the most recent year of IA Health Link experience prior to the COVID-19 pandemic and includes actual experience from Iowa Total Care who joined the market July 1, 2019.

IA Health Link experience pre- and post-CY19 was reviewed as part of the trend evaluation and emerging experience associated with the COVID-19 pandemic was used to inform other rating adjustments described within the remainder of this document.

Medicaid population

The CY19 base data used for rate setting represents detailed encounter data and enrollment for the Medicaid population in Iowa, as it consists of actual experience for the IA Health Link program.

Exceptions

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

B. Appropriate Documentation

i. Base Data

Data Requested by Actuary

Optumas requested all encounter data for the IA Health Link Program (April 2016 – December 2020), FFS claims, and all corresponding eligibility and capitation information from IME. Additionally, **Optumas** requested summarized financial data from each MCO reported in financial templates through the end of CY20.

United withdrew from the IA Health Link program effective June 30, 2019, leaving Amerigroup and Iowa Total Care as the only two MCOs providing managed care within the program during SFY20 and subsequent contract periods. The CY19 base data represents encounter experience for IA Health Link across Amerigroup (entire CY19 time period), United (first 6 months), and Iowa Total Care (last 6 months). As part of the development of the risk adjustment and relativity factors for the SFY22 rates, **Optumas** relied on the use of a snapshot month of July 2020 for member attribution between MCOs, by using the capitation file that includes actual July 2020 capitation payments for Amerigroup and Iowa Total Care. **Optumas** used the July 2020 member-level information to attribute the CY19 base data membership and encounters to the current MCOs when developing the risk and relativity factors used to adjust the statewide rate build-up to MCO-specific rates. Additionally, **Optumas** used the July 2020 member-level information snapshot for development of blended Long Term Supports and Service (LTSS) rates.

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 was provided by IME.

ii. Rate Development Data

Data Description

The base data used for the SFY22 rate setting consists of CY19 encounters and capitation data from the IA Health Link program. Additional data from the IA Health Link program outside of the CY19 time period, as well as FFS claims data, MCO financial summaries, and MCO detailed enrollment data was used to inform assumptions or adjustments to the base data. The data used to inform adjustments within the rate setting process is described for each adjustment throughout the document and a brief summary has been included in Table 3 below:

Table 3: Data Source Summary

Data Type	Data Source	Level of Detail	Start Date	End Date
MMIS Encounters	IME	Detailed	04/01/2016	12/31/2020
Capitation Payments	IME	Detailed	04/01/2016	12/31/2020
FFS Claims	IME	Detailed	01/01/2015	12/31/2020
Eligibility	IME	Detailed	01/01/2015	12/31/2020
Financial Template (Encounters, other medical-related costs, admin, and enrollment)	All MCOs	Summarized	04/01/2016	12/31/2020

Optumas uses the paid amount submitted within the MMIS encounter data as the basis of rate development. The paid amount within the MMIS encounter data is net of third-party liability coverage (TPL), copays, and patient liability amounts and reflects the amount that the MCOs pay to providers for services rendered within the CY19 base data period. DHS and IME do not dictate the payment structure for any of the MCO Value-Based Purchasing (VBP) arrangements that are part of the general MCO contracts. Since the IA Health Link MMIS encounter experience is used as the basis of rate development the base data inherently reflects all provider reimbursement arrangements that the MCOs have in place. Thus, there are no additional adjustments necessary within the rate development process to account for the VBP arrangements that the MCOs are implementing in order to meet any contract requirements.

The base data reflects non-subcapitated claim payments from the MCOs to providers for services incurred during the CY19 time period. The State-directed Ground Emergency Medical Transportation (GEMT) payment program began on July 1, 2019. The enhanced reimbursement for these services is billed under procedure code A0999, which has been excluded from the base data to avoid duplication. An estimate for these payments will be added in as a supplemental payment at the end of the rate development and is described in Section I.4.D of this document.

Per the MCO contracts, Zolgensma is excluded from the capitation rates. Only one claim for Zolgensma was incurred during the CY19 contract period and the utilization and cost for this claim was excluded from the base data compilation. Additionally, claims for value-added services that are not covered by the IA Health Link contract are inherent in the MMIS encounters. IME and the MCOs provided **Optumas** the necessary logic to identify these services and exclude them from the encounters underlying the CY19 base data that was summarized and compared to the reported MCO financials.

No adjustment for the administration of COVID-19 vaccines has been made within the SFY22 rate development. IME will be reimbursing the MCOs for the cost of administering the vaccine outside of the capitation rates as a non-risk payment via direct invoicing in a manner similar to Zolgensma and consistent with the SFY21b rates. All COVID-19 vaccine administration invoices must be submitted no later than 12 months from the date of service and must be backed by claim level detail sufficient to support the invoice. No adjustment was necessary to the underlying CY19 base data since the COVID-19 vaccines first became available in December 2020, which is outside of the base data time period used for rate development.

The IA Health Link MCOs have subcapitated arrangements for a small suite of services that varies by MCO. The underlying claims associated with MCO subcapitated services are inherent within the MMIS encounter data received from IME. Additionally, the MCOs report the subcapitated services within the

financial templates for **Optumas** to monitor and validate against the MMIS encounter data. Further details on the subcapitated adjustment within the base data development are described below in Section I.2.B.iii.

Data Availability and Quality

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

Appropriate Data

Optumas chose to limit the base data to CY19 encounter data due to the MCO transitions that have occurred historically within the IA Health Link program and the COVID-19 public health emergency that began in the second half of SFY20. The CY19 time period represents the most recent complete calendar year of data available for the IA Health Link program at the time of rate development and includes Iowa Total Care experience prior to the COVID-19 pandemic. As more experience becomes available for Iowa Total Care and the overall Health Link program during the COVID-19 pandemic, **Optumas** and IME will evaluate the appropriateness of shifting to more recent IA Health Link encounter data as the base data for future rate cycles.

Reliance on a Databook

Optumas did not rely on an external databook in developing the SFY22 IA Health Link capitation rates and instead relied on detailed encounter and capitation data for the Health Link program for the CY19 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. Through the financial comparison analyses **Optumas** determined that a combined Incurred But Not Reported (IBNR) and Reporting adjustment of -0.3% was necessary to fully capture the MCO medical encounter expenditures for the CY19 base data time period. This decrease relative to the CY19 base data used for the SFY21b rate development is mainly driven by revised MCO reported financials, paid through December 2020, which show expectations for additional claims recoupments in the CY19 base data 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 to enhance credibility. The combined rate cells are shown within Table 4 below.

Table 4: CHIP Children Rate Cells

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

Completion Factors

Optumas summarized the detailed CY19 base data and compared it to the financial data shared by the MCOs. The CY19 base data reflects encounters paid and submitted through September 30, 2020. **Optumas** developed completion factors by comparing the encounters' month of incurral and month of payment for each service category and MCO. **Optumas** developed MCO-specific Reporting/IBNR adjustments by comparing the raw non-subcapitated CY19 encounter data to the MCO reported financials inclusive of MCO-reported IBNR estimates through December 31, 2020. The combined Reporting/IBNR adjustment was applied in aggregate for each MCO's CY19 base data experience to reconcile these data sources and account for encounters not yet properly flowing through the MMIS system. As noted above, the statewide, aggregate impact of the combined Reporting/IBNR adjustment was a 0.3% decrease.

In addition to encounter data for non-subcapitated arrangements, **Optumas** added the subcapitated costs reported in the MCO financials, by cohort, to the Reporting/IBNR adjusted base data to ensure that all medical-related costs were considered in the development of the base data. The aggregate impact of this adjustment was a 0.4% increase to the statewide base data.

Additionally, other provider payments not inherent in the encounter data are detailed and identified within the MCO financials. **Optumas** worked collaboratively with the MCOs and IME to interpret these payments and ensure they are reflected appropriately, by service and population, in the CY19 base data. The adjustments for MCO provider incentives and settlement payments resulted in an aggregate 0.5% increase to the statewide base data.

After applying these base data adjustments, the data sources consistently, accurately, and completely reflect the experience for the IA Health Link program in CY19 and **Optumas** believes the data is an appropriate starting point from which to project to the SFY22 contract period. Each of these adjustments are shown in greater detail at the rate cell level within Appendix I.B.

Errors in Data

Within the development of the SFY19 and SFY20 rates, **Optumas** identified a discrepancy between the detailed data and financials for Amerigroup's pharmacy claims and replaced it with detailed data from Amerigroup for July 2017 – November 2017. This data is outside of the CY19 base data used for rate

development and since then the MMIS encounters for the July 2017 – November 2017 time period have been reprocessed and are considered complete after performing updated financial comparisons. No other errors in the data were identified during the rate development process.

Program Changes

This section outlines all of the program changes and adjustments made to the CY19 base data within rate development, prior to trend, in order to appropriately reflect the policies in effect during the SFY22 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 went into effect January 1, 2021. Consistent with prior cycles of rate development, the CY19 base data encounters were repriced to reflect the new payment rates for FQHCs, RHCs, and IHS facilities. An estimate was also applied for the rate changes that will occur midway through the contract period on January 1, 2022. These adjustments resulted in a $11.0M increase to the CY19 base.

ICF/ID Repricing

Rates for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID) are updated annually. The most recent changes to the rate schedule at the time of rate development includes rates that are effective July 1, 2020, so an additional increase was applied to estimate the rate change that will occur effective July 1, 2021. The CY19 base data ICF/ID encounters were repriced to reflect the projected SFY22 rates that will be paid during the contract period, with a net impact resulting in a $5.2M increase to the base.

SRC Repricing

Rates for State Resource Centers (SRCs) are periodically updated. At the time of rate development, the most recent SRC rates were effective July 1, 2020, so an additional increase was applied to estimate the rate change that will occur effective July 1, 2021. The SRC repricing resulted in a $7.8M increase to the base.

CAH CAF Repricing

The Iowa legislature added $3.8M in additional funding to Critical Access Hospital (CAH) services as part of the transition to the Cost Adjustment Factor (CAF) which was accounted for within the SFY20 rate development. 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 July 1, 2019. The July – December 2019 portion of the CY19 base data reflects the additional funding approved by the legislature. To reflect the rates that will be in effect during the contract period, **Optumas** allocated the remaining $1.9M of the additional funding based on CAH service utilization across rate cells within the January – June 2019 portion of the base data.

NF Repricing

Rates for Nursing Facilities (NFs) are periodically updated with quarterly adjustments made based on the acuity of the members present. The most recent changes to the rate schedule are effective January 1, 2021. Effective July 1, 2019, the NF rates were rebased and the Iowa legislature approved a significant increase to the Quality Assurance Assessment Fee (QAAF) the facilities receive as part of their

reimbursement. This significant increase is already inherent in the second half of the CY19 base data used for rate development. All NF claims within the CY19 base data were repriced to reflect the most recent rates with an estimate for the additional rate increase that will occur effective July 1, 2021. The net impact of the NF repricing results in a $44.7M increase to the base.

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 July 1, 2019, and repriced the CY19 base data service utilization to reflect these rates. The aggregate impact of this repricing is a $1.4M increase to the CY19 base data.

Pharmacy Rebates for hawk-i

Effective July 1, 2017, the IA Health Link MCOs are permitted to pursue supplemental drug rebates for the CHIP hawk-i population. The CY19 base data reflects pharmacy expenditures prior to accounting for drug rebates. **Optumas** used the amounts reported within the MCO financial templates to reduce the hawk-i population's pharmacy expenditures to reflect the net cost of pharmacy services for the MCOs. The hawk-i pharmacy expenditures have been reduced by $0.9M to reflect the cost of the services, net of rebates.

Program Integrity (Fraud Detection)

The MCOs provide financial reporting templates to IME/**Optumas** as part of the rate development process. Within these templates, the MCOs reported TPL recoveries and overpayments to providers for the CY19 base data time period. These settlements are outside of the MMIS encounter data that is used as the basis for rate development. **Optumas** reduced the base data based on the MCO reported financials to reflect the program integrity effort recoupments that the MCOs have been performing within the Health Link program. The resulting impact of this adjustment is a $3.2M reduction to the CY19 base data.

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 Assertive Community Treatment teams to provide additional access and expanding the network for Subacute and Intensive Residential Home Services. The expansion of these services is expected to mature over the next few years and the Access Centers are not limited to the Medicaid population. IME provided a Fiscal Impact Summary, using the most up-to-date information about the development of these Centers and expansion of services, to project cost estimates by Fiscal Year. Using these cost estimates, Behavioral Health services have been increased by $2.1M to account for increased utilization associated with these new services.

ID Waiver Repricing

IME is committed to providing better care for the Intellectually Disabled (ID) population and the State legislature approved additional funding for services, effective July 1, 2019. The additional funding was used to enhance the payment rates for certain procedure codes, effective July 1, 2019. The enhanced rates are inherent within the July – December portion of the CY19 base data. **Optumas** repriced the January – June 2019 service utilization for the applicable ID Waiver procedure codes to reflect the enhanced rates that were approved by the State legislature. A total of $5.5M in additional funds have

been added to the CY19 base data used for rate development for the Intellectual Disability HCBS Waiver rate cell.

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

Program Changes Deemed Immaterial to Benefit Expenses in the Rate Period

All policy changes effective between the CY19 base data and SFY22 contract period were provided by IME and analyzed by **Optumas** to determine the cost impact on the IA Health Link managed care program. The adjustments described above were determined to have a material impact to the MCOs and warranted a rating adjustment. The following program changes were determined to be immaterial and therefore do not have an adjustment within the SFY22 rate development, but are noted here for completeness:

- Passive Enrollment
- Home Health LUPA Repricing
- Hospice Repricing
- Home Maker COVID-19 Service Expansion
- Companion COVID-19 Service Expansion

Service and Payment Exclusions

Historically, certain high-cost pharmacy drugs were excluded from the rates and MCOs submitted invoices to IME for reimbursement; however, these pharmaceuticals began being covered by the monthly MCO capitation payments effective July 1, 2019. During the SFY22 contract period, the MCOs will continue to be reimbursed for these services via the monthly capitation payments and the costs of these services have been included within the CY19 base data used for rate development.

Consistent with the SFY20 and SFY21 contracts, IME has excluded Zolgensma from being reimbursed via the capitation rates within the SFY22 contract period. The MCOs will provide coverage of Zolgensma to eligible beneficiaries consistent with other pharmaceuticals and treatments, but IME will reimburse the MCOs via invoices billed to IME rather than through the capitation rates. Within the CY19 base data period, only one Zolgensma claim was incurred by the IA Health Link MCOs and this claim was excluded from the base data used for rate development.

Consistent with the SFY21b contract period, the administration of COVID-19 vaccines will continue to be reimbursed outside of the capitation rates for the SFY22 contract period as a non-risk payment. IME will reimburse the MCOs through the same invoicing process that is being used for Zolgensma reimbursement. Since the vaccines first became available in December 2020, no adjustment was necessary to the CY19 base data to account for this policy decision.

Claims for value-added services that are not covered by the IA Health Link contract are inherent in the MMIS encounters. IME and the MCOs provided **Optumas** the necessary logic to identify these services and exclude them from the encounters underlying the CY19 base data used for rate development. No other service and payment exclusions have been applied to the CY19 base data outside of those previously described within this certification.

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 CY19 base data (7/2/2019) to the midpoint of the SFY22 contract period (12/30/2021).

Prior to reviewing historical Iowa Medicaid experience, **Optumas** first normalized the CY19 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 IA Health Link 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 necessarily 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.C.

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. These services were included within the IA Health Link contract during CY19, which is the base data used for the SFY22 rates. IME policy reimburses IMDs at the statewide average per diem of the comparable non-IMD facilities. As a result of this policy, no repricing of the IMD utilization has been conducted.

B. Appropriate Documentation

i. Final Projected Benefit Costs

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

ii. Development of Projected Costs

Description of Data, Assumptions, and Methodologies

As described in the Base Data section and Trend Assumptions section above, **Optumas** relied on the MMIS encounter data provided by the State for the development of projected benefit cost trends and therefore projected costs of the IA Health Link SFY22 contract period. No material changes to the data, assumptions, and methodologies used outside of the program change adjustments previously described have occurred since the SFY21b rate certification.

The following adjustments were made after trend was applied to reflect the policies that will be in effect during the SFY22 contract period.

Hepatitis C Adjustment
Effective July 1, 2020, IME completely removed the Fibrosis Score requirements to receive Hepatitis C drugs for all Iowa Medicaid members. This loosening of the requirement for treatment is expected to increase the service utilization associated with these drugs relative to the CY19 base data Health Link experience. **Optumas** reviewed the emerging Hepatitis C drug utilization for July – December 2020 Health Link experience, in conjunction with estimated expenditures for this expansion provided by IME and revised the estimate that was included in the SFY21b capitation rates based on lower-than-expected utilization. The revised estimate results in an annual increase of $8.4M to account for this policy change.

COVID-19 Home Meals Expansion
Effective March 13, 2020, IME and the MCOs began authorizing and paying claims for service expansions of home delivered meals, homemaker services, and companion services for members who meet certain eligibility criteria for populations that are more susceptible to COVID-19 such as the HCBS Waiver members, members receiving Habilitation Services, and Medicaid members who are home bound. The

COVID-19 service expansions are effective, at a minimum, through the duration of the Public Health Emergency (PHE) proclamation. **Optumas** reviewed the level of service utilization for each of these services within the CY19 base data and compared to the emerging experience for the months of April – December 2020, after the policy was in place. Of the services expanded, only the home delivered meals showed an increase in utilization within the April – December 2020 time period, as compared to that of the CY19 base data. As such, no adjustment was applied for the homemaker and companion service expansion within rate development.

The rating adjustment for COVID-19 Home Meal Expansion was developed by reviewing the rate-cell level PMPMs associated with procedure code S5170, home meals, within the CY19 base data and comparing to the PMPMs within the emerging April – December 2020 experience. Inherent within the CY19 base data, there is a concentration of service utilization for only the Elderly HCBS Waiver, Dual HCBS Waivers: PD; H&D, and Non-Dual HCBS Waivers: PD; H&D; AIDS rate cells, consistent with the policy in place prior to the COVID-19 public health emergency. Within the April – December 2020 emerging experience, the S5170 procedure code is prevalent across other adult and children rate cells as the service was expanded to be eligible for certain home bound and high-risk populations receiving habilitation services. At the time of rate development, the PHE declaration is expected to continue through the end of CY21, so half of the SFY22 contract period would have the home meal service expansion. As such, **Optumas** calculated half of the difference between the COVID-impacted home meal PMPMs and the home meal PMPMs inherent in the pre-COVID CY19 base data, for each rate cell, to develop the adjustment.

The resulting impact of the temporary home meal service expansion varies by rate cell and reflects an increase of $1.7M annualized to the overall IA Health Link capitation rates.

<u>COVID-19 Testing Service Addition</u>

Over the course of the COVID-19 pandemic, CMS and the American Medical Association (AMA) have issued coding guidance for documenting COVID-19 diagnoses and billing HCPCS/CPT codes for laboratory tests detecting COVID-19. IME and the MCOs have monitored the prevalence of COVID-19 diagnoses and testing since March 2020 for the IA Health Link Medicaid population. The base data used for rate development is CY19, which does not contain any utilization/costs associated with COVID-19. The PHE proclamation is expected to expire after the end of calendar year 2021 and COVID vaccines are expected to become more widely available before and over the course of the SFY22 contract period, with an increase in fully vaccinated individuals expected to continue. As such, **Optumas** believes that the IA Health Link MCOs will continue to provide COVID-19 testing throughout the SFY22 contract period and has estimated the additional costs the MCOs will incur to provide these services.

The IA Health Link MCOs have been reporting weekly service costs and utilization for various COVID-19 related services to IME since March 13, 2020. **Optumas** relied on the MCO weekly reported information for the months of September through November 2020 along with emerging statewide testing information through February 2021 to help inform the COVID-19 testing rating adjustment for SFY22. Using enrollment information and the MCO reported costs for September - November 2020, an aggregate PMPM across all non-dual, non-under 1 rate cells was calculated. Statewide testing information for the same time period was reviewed and compared to testing volumes in February 2021. The average number of statewide tests per day in February 2021 was approximately 40% lower in February 2021 than the September – November 2020 period. With the COVID-19 vaccines becoming more widely available, **Optumas** believes that Medicaid testing volume within the SFY22 contract period

will be lower than the September – November 2020 period so adjusted the aggregate Health Link COVID-19 testing PMPM to reflect an estimate consistent with the February 2021 testing volumes by applying the 40% decrease in utilization. Note that, while the testing rate is trending downward and would likely continue to do so with more members becoming fully vaccinated, **Optumas** has not reduced the estimate any further than what has been observed statewide through February 2021; as a result of recent federal guidance loosening requirements for individuals who could have tests covered, it is reasonable to expect that this could result in an offset to downward trends that otherwise may occur.

Optumas estimated that COVID-19 testing will cost an additional $1.78 PMPM across the non-dual rate cells with members greater than 1 year old during the SFY22 contract period, and has applied a consistent PMPM across all applicable cohorts. This equates to approximately $12.2M on an annualized basis using the CY19 base data membership.

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

Changes to Data, Assumptions, and Methodology

Projected costs were developed in a manner consistent with the development of the SFY21b rates and generally accepted actuarial principles and practices. Additional prospective adjustments associated with the COVID-19 pandemic have been incorporated into the SFY22 rate development as actual emerging experience impacted by COVID-19 for the IA Health Link program has become available.

Overpayments to Providers

Prior to summarizing the CY19 base data used for rate development, the detailed MMIS encounter data was adjusted to include only last-in-chain, or final, versions of claims for IA Health Link covered services. Additional overpayment to providers and TPL recoveries are reported by the MCOs within the financial templates used within rate development. An adjustment has been made for these recoveries that are outside the MMIS encounter data via the Program Integrity adjustment that is described in Section I.2.B.iii above. The resulting impact of this adjustment is a $3.2M reduction to the CY19 base data.

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 2020, with encounters paid and submitted through December 2020. FFS data for the historical AmeriHealth to Amerigroup transitional members was included for the December 2017 – February 2018 time period consistent with prior rate development cycles. The projected trends were developed using actual IA Health Link program experience prior to March 2020. Emerging data associated with the COVID-19 pandemic (experience after March 2020) was reviewed and considered within rate development, but the projected trends were developed using pre-COVID IA Medicaid experience. Additionally, trends were

benchmarked and compared against the reported MCO financial data and emerging experience for the ongoing SFY21 contract period.

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 population and major service category from the midpoint of the base period to the midpoint of the contract period.

Trend factors were developed for both utilization and unit cost using historical encounter data and MCO financial data. The historical encounter data was analyzed by major population and major COS. The data was arrayed such that 3 month moving averages (MMA), 6 MMA, and 12 MMA could be reviewed and evaluated. There is not a pre-determined algorithm related determining the prospective annual trends. Each data summary is reviewed independently and results vary depending on particular nuances within each COS or population.

Trend was applied from the midpoint of the CY19 base data (7/2/2019) to the midpoint of the SFY22 contract period (12/30/2021), for a total of 30 trend months.

Trend factors were developed consistent with generally accepted actuarial principles and practices and the methodology used is consistent with that of the annualized trends developed for the IA Health Link program's SFY19 through SFY21 rates.

Comparison to Historical Trends

The annual aggregate trend underlying the SFY21b IA Health Link rates was 2.7%, which is similar to the annual aggregate trend of 2.5% that is inherent within the SFY22 capitation rates. The same CY19 pre-COVID IA Health Link program experience was used as the basis for rate development and supports the consistency in the overall aggregate trends between the rating periods. In general, the utilization of most categories of service shows either negative or relatively flat annual trends, but **Optumas** has not projected these negative utilization trends into the SFY22 contract period with the exception of pharmacy for the Non-Expansion Adult (TANF) and Wellness Plan populations. A very modest -0.5% annual utilization trend is applied for these populations for the pharmacy service category, but the overall annual PMPM trend for pharmacy for these populations is approximately 6.5% within the SFY22 rate development.

Components

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

Variations

Projected benefit cost trends were developed at the level of service and population categories shown within Appendix II.C. Trend assumptions were developed on a statewide basis for the entire IA Health Link program and do not vary by MCO. Similar rate cells were combined for trend development in order to increase credibility when developing trend projections and are shown within Table 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 annual PMPM trend used to project from the CY19 base data to the SFY22 contract period is 2.5% using the CY19 statewide base membership mix. Within the SFY21b rates, the aggregate annual PMPM trend was about 2.7%.

Other Material Adjustments

In response to the COVID-19 pandemic, DHS and IME implemented a disenrollment freeze for all IA Medicaid populations, with few exceptions in line with federal guidance, effective March 1, 2020 through the duration of the PHE proclamation. The freeze on disenrollment results in members who would normally lose eligibility for IA Medicaid remaining enrolled with an IA Health Link MCO

throughout the COVID-19 PHE declaration. At this time, the PHE declaration is expected to run through the end of calendar year 2021.

It is generally known that Medicaid members who disenroll from Medicaid during normal times have lower acuity (lower PMPM costs) than members who remain eligible for the Medicaid program. This differential has been observed through nationwide Medicaid redetermination efforts over the past few years. When reviewing the emerging experience for the IA Health Link program longitudinally over time through December 2020, **Optumas** has seen the overall IA Health Link managed care enrollment increase by about 1.1% each month since March 2020. This steady increase in enrollment is a direct result of the freeze in disenrollment due to the COVID-19 pandemic and likely results in downward pressure on the average PMPM of the overall IA Health Link program. This phenomenon is conceptually the reverse of the upward pressure that is seen with Medicaid redetermination efforts. **Optumas** performed an analysis to quantify the acuity of members who under normal circumstances would disenroll from the IA Health Link managed care program and estimated the impact that the disenrollment freeze has on the aggregate population acuity within the SFY22 capitation rates. The analysis focused on the Children (excluding the CHIP – hawk-i population), Non-Expansion (TANF) Adults, and the Wellness Plan populations, excluding the Wellness Plan 50+ rate cells, since these cohorts typically have higher levels of enrollment churn during normal times than the Dual, Disabled, LTSS, and Pregnant Women populations and are therefore expected to be more significantly impacted by the disenrollment freeze.

To develop the acuity adjustment for rate development, **Optumas** conducted a "Leaver, Joiner, Persister" analysis to quantify the estimated impact of the disenrollment freeze. Using the CY19 base data, **Optumas** classified members into three categories both on a monthly basis to determine typical levels of churn within the IA Health Link program and on an annual basis to evaluate the difference in average PMPMs for each type of member:

1. Leavers – Members who left the IA Health Link program within CY19.
2. Joiners – Members who joined the IA Health Link program within CY19.
3. Persisters – Members who remained enrolled within IA Health Link throughout CY19.

After classifying members into the above categories on a monthly basis, **Optumas** quantified the percent of members who were considered Leavers for each major population (Children, TANF Adults, and Wellness Plan). The percent of members who were Leavers for an average month, absent the COVID-19 disenrollment freeze, is shown in the "Acuity Adjustment Impact" table below. **Optumas** then quantified the aggregate CY19 PMPMs associated with each category to evaluate the differences in costs for each group of members. The combined Joiner and Persister PMPM experience was compared to the Leaver PMPM for each major population and shows that Leavers were on average 33% less costly than the combined Joiners/Persisters. **Optumas** recognizes that some of the members who would normally disenroll from the IA Health Link program absent the COVID-19 pandemic would actually remain eligible for Medicaid due to the economic impacts that the pandemic has caused. Thus, instead of taking the data-driven 33% cost differential, it was assumed that the difference between the Joiner/Persisters and Leaver PMPMs would be 25% within the SFY22 contract period. In other words, if the Joiner/Persister population has a PMPM of $100, the Leaver population is expected to have a $75 PMPM on average.

Optumas used the monthly Leaver percentages shown in the table below, with progressively reduced percentages over time to recognize that some Leavers could have re-joined Medicaid after months of

being disenrolled absent the PHE, to estimate the percent of the population that has been accumulating as Leavers on a monthly basis from March 2020 through the SFY22 contract period. Discussions with IME have indicated that if the PHE declaration expires at the end of December 2021, it will likely take approximately two months to notify and begin disenrolling members from Iowa Medicaid. As such, **Optumas** assumed the earliest members would leave the program was March 2022. Using the distribution of Persisters/Joiners and Leavers that is expected to continue to accumulate until March 2022 and the 25% cost differential between the member categories, **Optumas** estimated the PMPM impact that the disenrollment freeze will have during the SFY22 contract period. The estimated PMPM impact for each population is shown in Table 6 below and can be seen at the rate cell level within Appendix I.B.

Table 6: Acuity Adjustment Impact

Population	Monthly Leavers	PMPM Impact
Children	1.3%	-3.2%
TANF Adult	2.1%	-4.7%
Wellness Plan	2.9%	-2.9%

Other Non-Material Adjustments

No other adjustments to projected benefit cost trends, either material or non-material, were made during the SFY22 rate development.

iv. Mental Health Parity and Addiction Equity Act

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

v. In-lieu-of Services

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

vi. Retrospective Eligibility

Optumas has relied on the CY19 IA Health Link experience as the base data used to develop the SFY22 capitation rates. Retroactive eligibility periods have historically been excluded from the IA Health Link program and continue to remain in FFS for the SFY22 contract period. Therefore, no adjustment has been made for retrospective eligibility in the development of the SFY22 capitation rates.

vii. Changes in Covered Benefits

Any changes to covered benefits in the IA Health Link program in SFY22 have been accounted for within the rate development and are described in detail above in Section I.2.B.iii.

viii. Impact of Changes

The impact of changes to covered benefits in the IA Health Link program in SFY22 are shown in Appendix I.B. Each change to covered benefits includes an estimated impact to the projected benefit costs and a description of the data, assumptions, and methodologies used to develop the adjustment in Section I.2.B.iii. above.

4. Special Contract Provisions Related to Payment

A. Incentive Arrangements

There are no incentive arrangements 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 SFY22 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, net of the amounts itemized for the GME, GEMT, and NF CRR directed payments. The withhold for SFY22 is consistent with the withhold percentages inherent in the SFY19, SFY20, and SFY21 rates. 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 SFY22 rating period from July 1, 2021 through June 30, 2022. The 2.0% withhold applied to all rate cells within the IA Health Link program for all MCOs. The purpose of the arrangement primarily relates to encounter data submissions, timely claims processing, follow-up hospitalizations for mental illness, follow-up after emergency department visits for mental health, and health equity.

Description of the Total Percentage Withheld

In SFY22, there is a withhold in place of 2.0% of the total capitation rate revenue, net of GME, GEMT, and NF CRR payments. This withhold is consistent with the withhold percentages for the SFY19, SFY20, and SFY21 contract periods. Each MCO has the ability to earn back the withhold to the extent that specific quality and performance measures are met as stated in the contract. The capitation rates gross and net of the 2.0% withhold are shown in Appendix I.A.

Estimate of Percentage to be Returned

Based on emerging experience of the IA Health Link MCOs associated with the withhold earnings for prior rating periods and discussions with IME, **Optumas** estimates that the MCOs will earn between 50%

to 75% of the 2.0% withhold. This range is consistent with expectations noted in prior rate cycles, and continues to be substantiated by monthly MCO reporting through October 2020.

Reasonableness of Withhold Arrangement

Our review of the total withhold percentage of 2.0% 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 any portion of the withhold that is not reasonably achievable are actuarially sound.

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

C. Risk-Sharing Mechanisms

i. Rate Development Standards

This section provides supporting documentation and describes the risk-sharing arrangements between the State and the health plans. During the SFY22 contract period there will be a program-wide risk corridor due to the ongoing uncertainties associated with the COVID-19 public health emergency. **Optumas** worked with the State to develop a program-wide risk corridor based on the aggregate MLR percent experience across all populations and services for the MCOs. The profit and loss shares for the MCOs and the State for the different risk corridor bands are shown in Table 7 below.

Table 7: SFY22 Risk Corridor Arrangement

SFY22 Risk Corridor Bands		Profit/Loss Share	
Min. Threshold %	Max Threshold %	MCO	State
0.0%	89.2%	0%	100%
89.2%	92.2%*	100%	0%
92.2%*	95.2%	100%	0%
95.2%	95.2%+	0%	100%

**The target MLR of 92.2% is based on the weighted average of total non-medical load amounts built into the SFY22 rates using the CY19 enrollment distribution. The actual target used for the final reconciliation may vary slightly based on the actual population distribution for the MCO during the SFY22 contract period. To the extent the target MLR varies from 92.2% using the actual MCO enrollment mix during the contract period, the risk corridor bands will still be +/- 3.0% from the revised target MLR.*

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

The only other risk-sharing arrangement between the MCOs and the State for the SFY22 contract period are associated with the state-directed payments described in Section I.4.D below. Specifically, for the SFY22 contract period, the UIHC Physician and Hospital ACR directed payments are structured as separate payment term arrangements that are reimbursed outside of the capitation rates. These arrangements will have a retrospective reconciliation performed after the end of the SFY22 contract period based on actual utilization incurred by eligible providers through the directed payment arrangement. Consistent with the SFY20 and SFY21 rates, NF CRR directed payments have a +/- 1.0% risk corridor for these specific payments. These arrangements are described in the MCO contracts and were developed in accordance with §438.4, the rate development standards in §438.5, and generally accepted actuarial principles and practices. Further details on these specific arrangements are outlined in Section I.4.D.

ii. Appropriate Documentation

The program-wide risk corridor settlement is the calculated gain or loss determined when comparing the actual MLR developed from the emerging experience to the risk sharing corridor percentages in Table 7 above. The actual MLR is calculated as the total adjusted medical expenditures divided by the total capitation rate for all populations. The total capitation rate excludes any taxes and fees built into the rates, as well as amounts related to the UIHC Physician and Hospital ACR payments, GEMT payment, GME, and NF CRR payments.

Adjusted medical expenditures shall be determined by the State and **Optumas** based on encounter data and plan financial data submitted by each MCO. Adjusted medical expenditures only include services covered by the IA Health Link program and will exclude all expenditures associated with carve-out services such as Zolgensma and claims that were invoiced to IME as part of the COVID-19 vaccine administration. The MCOs may provide value-add services to enrollees that are in addition to those covered under the State Plan. However, the cost of these value-add services will not be included within the medical expenditures portion of the risk corridor calculation for the SFY22 contract period and were not included within the development of the SFY22 capitation rates. Additionally, administrative expenditures included in the pharmacy claims will be removed from the expenditures for purposes of the risk corridor calculation as applicable. The final adjusted medical expenditures will not include quality improvement expenses, case management expenses, or other administrative expenses, or costs related to the UIHC Physician and Hospital ACR payments, GEMT payment, GME, and NF CRR directed payments. Items such as fraud, waste, and abuse, will not be considered in the numerator of the MLR risk corridor calculation.

The implementation of the risk corridor and MLR requirement did not impact the development of the actuarially sound capitation rates or influence any of the adjustments made within rate development.

Other Risk-Sharing Arrangements

The SFY22 IA Health Link capitation rates have been developed as full risk rates. There is a program-wide risk corridor outlined in Table 7 above. The only other risk-sharing arrangements are associated with the state-directed payments described in Section I.4.D below. No other risk-sharing arrangements apply within the IA Health Link program outside of those previously mentioned.

Medical Loss Ratio Arrangement

The State requires all health plans to maintain a medical loss ratio (MLR) of 88%. If an MCO's MLR is less than 88%, after adjusting revenue if applicable for the risk corridor reconciliation, the health plans must refund the State the difference. Plan submitted MMIS encounters and reported financials will be reconciled to the assumed experience included in the SFY22 rates to evaluate any MLR payments necessary after the risk corridor reconciliation. The methodology for the minimum MLR calculation differs from the MLR-based risk corridor, as a result of allowable differences including but not limited to the inclusion of Health Care Quality Improvement (HCQI), Health Information Technology (HIT), and External Quality Review (EQR) expenditures in the numerator for the minimum MLR calculation that are not allowable in the risk corridor calculation.

Reinsurance

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

D. Delivery System and Provider Payment Initiatives

There are four provider payment initiatives associated with the IA Health Link managed care program for the SFY22 contract period that are in accordance with 42 CFR 438.6(c). Two of these arrangements (UIHC Physician and Hospital ACR payments) will be implemented as separate payment term structures that are reimbursed outside of the SFY22 capitation rates. At this time, the pre-prints for each of these payment arrangements have not been approved by CMS for the SFY22 contract period and are still under review. Each of the payment arrangements is accounted for in the rate development in a manner consistent with the pre-print that has been, or will be, submitted to CMS for review. No additional directed payments exist within the IA Health Link managed care program outside of those described below. There are no requirements regarding the reimbursement rates the plans must pay to any providers unless specifically specified in this certification as a directed payment.

UIHC Physician ACR Payments

Description of Arrangement

University of Iowa Physician Average Commercial Rate (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. CMS approved the pre-print for this arrangement for SFY19 in December 2018. The State continued this arrangement for the SFY20 and SFY21 contract periods and plans to submit a pre-print to continue the arrangement in SFY22.

A structural change within the SFY22 contract period is that IME is seeking approval for the arrangement to be operated as a separate payment term and reimbursed outside of the capitation rates. Thus, there will be a retrospective reconciliation of payments after the contract period ends and the PMPMs reflected within the certification appendices are initial estimates for this arrangement. IME's decision to alter the structure of this arrangement and include a retrospective reconciliation for the SFY22 contract period stems from continued uncertainties surrounding the COVID-19 pandemic and overall service utilization for this arrangement. The UIHC ACR PMPMs for each rate cell within Appendix I.C reflect the initial estimate for this separate payment term arrangement.

Once actual utilization for SFY22 is available, **Optumas** and IME will calculate revised PMPMs using the actual claims incurred for each rate cell under the arrangement and actual membership for the contract period. Any differences between the original Physician ACR estimate (calculated as the rate cell specific PMPMs x SFY22 membership) and actual claims incurred under the arrangement will be paid out as a lump sum payment/recoupment from IME to the MCOs. After the rating period is complete and the State makes any necessary reconciliation payment/recoupment, **Optumas** will submit a rate certification addendum outlining the distribution methodology and revised PMPMs that reflect the final payments made under this arrangement for SFY22.

The methodology used to calculate the initial estimate for this arrangement is described below and is consistent with the information submitted by the State in the 438.6(c) pre-print approved by CMS for SFY19 through SFY21 as well as the pre-print that IME plans to submit to CMS for SFY22.

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 42 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. Base reimbursement for these services is Iowa Medicaid reimbursement, which based on the historical mix of services for the applicable providers, is approximately 74% of Medicare. The supplemental (directed) payment brings the final reimbursement to an Average Commercial Rate level, which is approximately 377% of Medicaid, or around 279% of Medicare.

Historically, this payment arrangement has been based on actual utilization within the contract period and was structured such that the MCOs paid the customary Medicaid rate when adjudicating claims. Effective March 2020, the MCOs began paying the enhanced ACR amount when adjudicating claims. The CY19 data reflects the Medicaid reimbursement for all claims under this arrangement. Consistent with prior cycles, the basis for the supplemental payment is the difference between the customary Medicaid rate and 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 initial PMPM estimates is noted below. The methodology is consistent with the SFY20 and SFY21 rate developments.

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. The State also provided the most recent commercial-level fee schedules and **Optumas** calculated the differential between the Medicaid payment within the underlying CY19 base data and the University of Iowa minimum fee schedule as specified in the state plan and projected to the SFY22 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 ACR directed payment is approximately $90.7M, on an annualized basis, at an aggregate PMPM of $11.72 based on the CY19 statewide base membership. The decrease over the annualized amount built into the SFY21b rates (approximately $94.7M, or $12.23 PMPM based on CY19 membership) is primarily due to a decrease in service utilization because the number of qualifying providers participating in the program decreased by about 4%. The total amount for the payments is allocated across the rate cells based on historical utilization of services by qualifying physicians and practitioners. The actuaries are certifying the amount of the initially estimated separate payment term within this certification. Once actual experience for SFY22 is available, the retrospective reconciliation will be performed and the initial PMPM estimates, shown in Appendix I.C, will be revised to reflect the actual experience incurred for each rate cell with an addendum submitted to CMS outlining the final payments made under the arrangement.

UIHC Hospital ACR Payments

Description of Arrangement

The University of Iowa Hospital Average Commercial Rate (ACR) payments is a new state-directed alternative minimum fee schedule payment for inpatient and outpatient hospital services at qualifying Iowa State-Owned teaching hospitals with more than 500 beds and either or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education. The directed payment is effective July 1, 2021 and is structured in accordance with 42 CFR 438.6(c). The University of Iowa Hospitals and Clinics (UIHC) is the only eligible hospital for this qualified directed payment at this time.

For the SFY22 contract period the Hospital ACR directed payment will be reimbursed outside of the Health Link capitation rates via a separate payment term structure. **Optumas** is required to develop estimates for the separate payment term and include a description of the arrangement when certifying the Health Link capitation rates. The methodology used to estimate the payments associated with the hospital directed payment is similar to the physician arrangement described previously. The basis for the

supplemental payment is the difference between the provider's negotiated Medicaid managed care reimbursement and the average commercial rate (minimum alternative fee schedule) calculated using an ACR payment-to-charge ratio for inpatient and outpatient (both acute and behavioral health) hospital services. The MCOs are responsible for paying the calculated differential payments to qualifying providers based on actual utilization on a per claim basis within the contract period.

Once actual utilization for SFY22 is available, **Optumas** and IME will calculate revised PMPMs using the actual claims incurred for each rate cell under the arrangement and actual membership for the contract period. Any differences between the original Hospital ACR estimate (calculated as the rate cell specific PMPMs x SFY22 membership) and actual claims incurred under the arrangement will be paid out as a lump sum payment/recoupment from IME to the MCOs. After the rating period is complete and the State makes any necessary reconciliation payment/recoupment, **Optumas** will submit a rate certification addendum outlining the distribution methodology and revised PMPMs that reflect the final payments made under this arrangement for SFY22.

The methodology used to calculate the initial estimate for this arrangement is described below and is consistent with the information submitted by the State in the 438.6(c) pre-print that is pending CMS approval for the SFY22 contract period.

The additional payment made to these qualifying hospitals under the minimum fee schedule provide support for contracting and maintain/expand access to services essential for Medicaid beneficiaries. Under this arrangement, in accordance with 42 CFR 438.6(c)(2)(i)(B), a supplemental payment for qualifying Inpatient and Outpatient hospital services will be made to reflect the reimbursement of the approved minimum fee schedule. Currently, only the University of Iowa Hospitals and Clinics meets the eligibility criteria for the directed payment arrangement. Base reimbursement for these services is Iowa Medicaid reimbursement, which based on the historical mix of services for the applicable providers, is approximately 75% of Medicare for Inpatient services and 89% of Medicare for Outpatient services. The supplemental (directed) payment brings the final reimbursement to an Average Commercial Rate level, which is approximately 238% of Medicare for Inpatient services and 302% for Outpatient services.

Rating Adjustment

Optumas received a list of hospitals eligible for this directed payment from the State, which was used to identify claims and inpatient and outpatient services in the CY19 data that will be eligible to receive the enhanced ACR reimbursement during the contract period. The State also provided the most recent average ratio of payment to charges (RPC) for the top five commercial payors split between inpatient and outpatient services. **Optumas** applied the inpatient and outpatient commercial RPCs to the charged amounts from the eligible CY19 claims to determine the average commercial reimbursement for the UIHC hospital services. The differential between the commercial reimbursement calculated and the customary Medicaid reimbursement represents the supplemental directed payment that will be paid on a per claim basis for the eligible inpatient and outpatient services. 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, and utilization was then projected to the SFY22 contract period to develop the final estimated cost of the directed payment arrangement. These supplemental PMPMs, shown in Appendix I.C, are an estimate of the directed payment arrangement, but are not included within the capitation rates paid monthly to the MCOs. Once actual utilization for the contract

period is available, **Optumas** will submit an addendum with the final PMPM costs associated with the hospital directed payment by rate cell to CMS.

The estimated PMPM associated with the UIHC Hospital ACR Payment is $45.90 in aggregate based on CY19 statewide membership and translates to approximately $355.3M annually. The total amount for the payments is allocated across the rate cells based on historical utilization of Inpatient and Outpatient services by qualifying hospitals. The actuaries are certifying the amount of the initially estimated separate payment term within this certification. Once actual experience for SFY22 is available, the retrospective reconciliation will be performed and the initial PMPM estimates, shown in Appendix I.C, will be revised to reflect the actual experience incurred for each rate cell with an addendum submitted to CMS outlining the final payments made under the arrangement.

Ground Emergency Transportation (GEMT) Payment Program

Description of Arrangement

Effective July 1, 2019, the State has implemented the Ground Emergency Medical Transportation (GEMT) Payment Program in accordance with 42 CFR 438.6(c). The GEMT Payment Program is 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 prospective provider-specific payment rates during the SFY22 contract period. The provider-specific rates reflect an approved minimum fee schedule and are based on CMS-approved GEMT cost reports submitted by the EMS providers. The EMS additional payments will provide support for contracting and maintain access for Medicaid beneficiaries to receive GEMT services. Under this arrangement, in accordance with 42 CFR 438.6(c)(2)(i)(B), the supplemental payment for covered emergency transportation services will be billed under procedure code A0999 for the services provided by an approved EMS provider participating in the GEMT Payment Program. The A0999 procedure codes associated with the GEMT directed payment arrangement were excluded from the CY19 base data underlying rate development to avoid duplication with this supplemental payment calculation.

The payment arrangement for the SFY22 contract period will be based on actual emergency transportation service utilization within the contract period and is structured such that the MCOs pay both the customary Medicaid rate and the supplemental provider-specific prospective rate when adjudicating claims. The provider-specific prospective payment rate, billed under procedure code A0999, represents the additional uncompensated actual costs necessary to perform EMS transports based on submitted cost reports. Base reimbursement for the eligible emergency transportation services is Iowa Medicaid reimbursement. The supplemental (directed) payment brings the final reimbursement to approximately 10 times the standard Medicaid reimbursement.

Rating Adjustment

The providers receiving the supplemental payment associated with the GEMT program are eligible EMS providers who will continue submitting CMS-approved cost reports that will be used to calculate their supplemental prospective payment in future fiscal years. The State provided **Optumas** the list of eligible EMS providers who will be participating in the program for the SFY22 contract period, which was used to calculate the supplemental PMPM amount noted below.

The additional payment associated with the GEMT Payment Program with utilization projected to SFY22 is calculated to be $3.51 PMPM in aggregate using the CY19 statewide base membership. This translates to approximately $27.1M on an annualized basis, using the CY19 base membership. The supplemental payment for GEMT is calculated based on emergency transport service utilization for qualifying EMS providers within the CY19 base data, at the rate cell level, projected to the contract period. The GEMT PMPMs by rate cell are shown in Appendix I.B.

Nursing Facility COVID-19 Relief Rate (NF CRR) Directed Payment

Description of Arrangement

Effective March 13, 2020, COVID-19 Relief Rate (CRR) payments are available to Medicaid certified skilled nursing facilities (SNF) and nursing facilities (NF) during the period of the federal public health emergency who meet one of the following requirements:

1. The facility has a designated isolation unit for the treatment of COVID-19; or
2. The facility, in its entirety, is designated for the treatment of COVID-19.

CRR payments are $300 per day made to eligible facilities for each enrollee residing in a designated isolation unit or COVID-19 designated facility who:

1. Is discharging from a hospital to the nursing facility; or
2. Is pending test results for COVID-19; or
3. Has a positive COVID-19 diagnosis.

The purpose of these payments is to provide financial assistance to facilities that incur unexpected costs when caring for Medicaid members who are diagnosed with or quarantined for potential COVID-19. These additional expenses can be burdensome to facilities and the current rate methodology does not capture these expenses in a timely manner. The designated isolation area would allow for a higher infection control protocol, higher staff ratios, and dedicated staff to avoid cross contamination.

The effective date a facility could qualify to receive CRR payments starts March 13th, 2020 and extends through the end of the federal public health emergency which is expected to end December 31, 2021. The $300 daily CRR payment is in addition to the already established per diem rates. Providers will submit claims with the “disaster related” condition code added to the claim form in order to receive the CRR payment. Base reimbursement for these services is Iowa Medicaid Nursing Facility per diems, which is approximately $201 per day using the CY19 utilization across all Nursing Facility providers. The $300 daily add-on therefore reflects an approximately 150% increase in reimbursement when the NF CRR payment is made. Thus, a total of approximately $501 per day, or 250% of the standard Medicaid Nursing Facility Reimbursement depending upon the facility and specific per diem, is paid when a facility meets the CRR payment criteria. The directed payment is specific to the COVID-19 pandemic and is not made to all Nursing Facilities for all services rendered.

CRR payments are a temporary measure available to provide financial assistance to facilities due to unexpected higher costs when caring for Medicaid members who are impacted by COVID-19. IME will develop a separate schedule to report the cost and additional funds related to COVID-19 during the

emergency declaration. Increased and new costs will not be allowed for the normal room and board that are rebased biannually.

Rating Adjustment

Optumas reviewed the emerging March 2020 – December 2020 encounter data to calculate the prevalence of COVID-19 cases within the IA Health Link program, identified by diagnosis code U07.1 and B34.2. The statewide COVID-19 prevalence during the March – December 2020 time period for the nursing facility populations is 14.9%. Since March 2020, the IA Health Link MCOs have been submitting summaries to IME of the NF CRR payments that have been paid thus far. **Optumas** used the MCO reported information through February 2021 to determine the average length of time that the $300 NF CRR payments have been made to facilities for a member who tested positive for COVID-19. **Optumas** used the prevalence of COVID-19 cases for the nursing facility cohorts combined with the assumption that the CRR payments would be made for 9 days to estimate total NF CRR payments of $45.60 PMPM.

The PHE declaration is expected to expire at the end of calendar year 2021 and the NF CRR payments are only applicable through the emergency declaration. Thus, **Optumas** adjusted the final NF CRR estimate by dividing the $45.60 PMPM by 2 to reflect the fact that the payments are only expected to be in place for half of the fiscal year contract period. Additionally, the nursing facility population was given priority access to COVID-19 vaccines and studies have estimated that about 90% of nursing facility residents in Iowa have already received the COVID-19 vaccine, but facility staff members have a lower vaccine take-up rate. As such, **Optumas** is assuming that approximately 25% of the Medicaid nursing facility population is at risk of being impacted by COVID-19 during the SFY22 contract period. This additional adjustment results in a final estimate of $5.70 PMPM for the Nursing Facility cohorts during the SFY22 contract period.

Consistent with prior contract periods and CMS guidance, there will be a risk corridor associated with the NF CRR payments. To the extent that the experience for the NF CRR payments is materially different than originally estimated, the risk corridor described below will provide protection to the MCOs/IME for materially higher or lower costs, respectively.

NF CRR Risk Mitigation

Per CMS guidance, a risk mitigation strategy will accompany the implementation of the NF CRR directed payments. There will be a risk corridor of +/- 1.0% around the amounts estimated and the actual NF CRR payments made by the MCOs during the SFY22 contract period. The structure of the risk corridor is consistent with that of the SFY20 and SFY21 contract periods. The risk corridor calculation will be based on the aggregate experience for the NF CRR payments for the populations noted below:

- Custodial Care Nursing Facility <65
- Custodial Care Nursing Facility 65+
- Non-Dual Skilled Nursing Facility

The risk corridor settlement is derived from the difference determined when comparing (A) the actual experience for the NF CRR payments during the SFY22 time period to (B) the actual SFY22 member months for all of the three cohorts noted above multiplied by the estimated $5.70 PMPM. An illustrative

example of the calculation for (B) is shown below, within Table 8. The "Hypothetical SFY22 MMs" reflected within the example are based on the statewide CY19 member months for the applicable cohorts:

Table 8: NF CRR Risk Corridor (B) Example Calculation

Rate Cell	Hypothetical SFY22 MMs	NF CRR PMPM	Total Estimated Expenditures
Custodial Care Nursing Facility <65	21,451	$5.70	$122,271
Custodial Care Nursing Facility 65+	123,079	$5.70	$701,550
Non-Dual Skilled Nursing Facility	1,780	$5.70	$10,146
Total	**146,310**	**$5.70**	**$833,967**

In this example, (B) would be $833,967; this total dollar amount will vary depending upon the actual SFY22 MMs for these cohorts for each of the MCOs.

The State will calculate a value (C) = (A) – (B), which represents how much more or less was paid for the NF CRR payments than originally estimated. If the amount (C) is within a +/- 1.0% band of the original estimate (B) then no risk corridor payment will be made. In this example, the band for which (C) must fall in order for no risk corridor payment to take place is a value between -$8,340 and $8,340. Any difference (C) in costs between actual utilization (A) and the original estimate (B) outside the 1.0% band would result in a payment to or from the State of the amount by which (C) exceeds 1.0% of (B) or falls below -1.0% of (B).

The reconciliation will consist of the State paying the MCO a risk corridor settlement in the case of actual utilization (A) exceeding the original estimates (B) by more than 1.0% of (B). The State will receive a risk corridor settlement from the MCO in the case that actual utilization (A) is below the original estimates (B) by more than 1.0% of (B).

For example, if an MCO paid out $1,000,000 in NF CRR payments during SFY22, and had the SFY22 NF membership shown above, the risk corridor settlement would be a payment of $157,693 or $1.08 PMPM from the State to the MCO.

If instead, the MCO had the same enrollment but paid $700,000 in NF CRR payments during SFY22, the risk corridor settlement would be a payment of $125,627 or $0.86 PMPM from the MCO to the State.

Given the potential for over-classification of members identified as having COVID-19 per this policy, IME is considering program integrity policies and practices to mitigate any inappropriate payments under this arrangement.

E. Pass-Through Payments

Graduate Medical Education (GME) payments are incorporated within the SFY22 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 SFY22 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 SFY22 capitation rates is $5.28 PMPM for applicable rate cells, consistent with the SFY20 and SFY21 rates. This represents approximately $22.6M, on an annualized basis for the overall IA Health Link program using the CY19 base data membership.

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 described in Section I.4.D and Section I.4.E above (GME, Physician/Hospital ACR, GEMT, and NF CRR).

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. Variations are not based on the rate of federal financial participation associated with the covered populations.

iv. Health Insurance Providers Fee

No adjustment has been made to the rates to reflect the HIPF payment as a result of the repeal of this annual fee for calendar years beginning after December 31, 2020.

B. Appropriate Documentation

i. Development

Description

Non-benefit costs were developed using data from CY19 and CY20 financial templates completed by each MCO and a review of non-benefit costs in Medicaid programs from states with similar populations and services. In developing non-benefit cost assumptions, consideration was given to economies of scale associated with the disenrollment freeze, as well as fixed and variable costs, resulting in variation between final non-benefit cost projections across populations. The level of non-benefit costs necessary varies between populations to effectively manage care. Non-benefit costs are shown by rate cell in Appendix I.B.

Material Changes

There were no material changes or adjustments in the development of the non-medical load for the SFY22 capitation rates from that of the SFY20 and SFY21 capitation rates. **Optumas** reviewed MCO financial templates summarizing costs quarterly for CY19 and CY20, which included the CY19 base data period. In developing non-benefit cost assumptions, consideration was given to economies of scale associated with the disenrollment freeze, as well as fixed and variable costs, resulting in variation between final non-benefit cost projections across populations. The level of non-benefit costs necessary varies between populations to effectively manage care. The statewide non-medical load varies by rate cell and is applied consistently to both MCOs for all rate cells. This load is approximately 7.8% in aggregate, using the CY19 base membership mix, which is 0.1% higher than the SFY21b rate development.

ii. Cost Categories

The non-medical cost load includes administrative costs and an allocation for profit, risk, and contingency which is 1.75% of premium for all rate cells. This amount is consistent with that of the SFY20 and SFY21 capitation rates.

iii. Historical Non-Benefit Cost Data

As described in the sections above, the historical non-benefit cost data provided by the IA Health Link MCOs was relied upon when developing the non-medical load assumptions within the SFY22 capitation rates. The MCOs provided financial information for the CY19 and CY20 rating periods. **Optumas** reviewed both years for consistency but relied on the CY20 time period for developing the non-medical load assumptions for rate development since CY20 contained a complete year of experience for Iowa Total Care who entered the market July 1, 2019. **Optumas** and IME will continue to monitor the IA Health Link program non-benefit cost data provided by the MCOs in future rate development cycles.

iv. Health Insurance Providers Fee

As noted in Section I.5.A.iv, no allowance has been made for the HIPF as a result of the fee being repealed for calendar years beginning after December 31, 2020.

6. Risk Adjustment and Acuity Adjustments

A. Risk Development Standards

i. Risk Adjustment

Optumas accounted for the relative risk in the health status of enrollees in each MCO through various methods designed to best match payment to risk for each cohort within the IA Health Link rate development process. For the SFY19 rates **Optumas** relied on a combination of health-based 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 was primarily due to the MCO transitions 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 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 and the use of CDPS+Rx would be reevaluated again in future rate development cycles.

As part of the SFY21b rate development, **Optumas** reviewed the risk adjustment methodology, assumptions, and possibility of using CDPS+Rx risk scores to develop rates that reflect the relative risk differences between MCOs for the IA Health Link program. The member-choice period ended in October 2019 within the SFY20 contract period. **Optumas** reviewed the distribution of members between the MCOs after the member-choice period ended and observed that the enrollment between the MCOs has stabilized, even with the ongoing disenrollment freeze associated with the COVID-19 pandemic. This program stabilization and consistency between the MCO enrollment over time reduces the concerns around the potential for one MCO having a significantly disproportionate share of more acute, high-cost members resulting in inadequate prospective risk scores.

Additionally, **Optumas** analyzed the impact of the attribution process and compared the inherent relativities of PMPMs pre- and post-MCO attribution to the concurrent risk scores for members pre- and post-MCO attribution and saw directionally consistent results. This consistency indicates that risk scores do not lose their predictive power as a result of the MCO-attribution changes that have occurred within the IA Health Link program to-date. Thus, **Optumas** transitioned back to using CDPS+Rx to develop the risk adjustment for the standard Medicaid populations for the SFY21b rate development and has continued to this approach for the SFY22 rate development.

Optumas developed and applied risk scores or relativity factors for most populations within the IA Health Link program. The populations that were adjusted within the SFY22 rates are consistent with the populations that were adjusted within the SFY21b rate development. The methodology and risk scores have remained unchanged from SFY21b since there is limited emerging data available in addition to what was used within the SFY21b rate development. A description of the methodology is included below for completeness.

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.

iii. Acuity Adjustment

Please see Section I.3.B.iii for a description of the acuity adjustment that was calculated in response to the disenrollment suspension associated with the COVID-19 pandemic. The acuity adjustment was applied to the statewide SFY22 projected medical PMPMs, prior to the application of risk adjustment for the Children, TANF Adult, and Wellness Plan populations.

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 CY19 enrollment and encounter base data as the experience period for capturing the relevant diagnoses and pharmacy information for calculating member risk scores and developing the relativity factors at the rate cell level. IME provided **Optumas** with the member-level MCO capitation file from July 2020 that was used to attribute the members within the CY19 base data period to Amerigroup and Iowa Total Care. The July 2020 capitation file contains detailed member-level demographic information for members enrolled within the two MCOs during the month and was used in the development of the plan-specific relativity factors. In response to the COVID-19 pandemic, IME implemented a disenrollment freeze across the entire Medicaid program, with few exceptions in line with federal guidance. **Optumas** reviewed the distribution of membership between the MCOs during a pre-COVID (February 2020) and a COVID-impacted (July 2020) month and saw relative consistency between the MCOs for each snapshot. **Optumas** relied on the July 2020 snapshot month to assign members and their associated risk scores to each MCO, for purposes of prospective application in the SFY22 capitation rate development.

Model

Optumas developed and applied risk scores or relativity factors for most populations within the IA Health Link program. The populations that were adjusted for SFY22 are consistent with the populations that were adjusted within the SFY21b rate development.

Optumas applied health-status based risk scores to most non-LTSS populations. Risk scores were developed using UCSD's CDPS+Rx V6.4 tool, with national prospective weights and a July 2020 enrollment snapshot. The modeling was developed with a 6-month eligibility duration requirement,

such that members had to have at least 6 months of enrollment within the CY19 study period to be scored. Members who were unscored received the MCO-specific average disease weight of scored members for each rate cell, along with their member-specific demographic weight.

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

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

Populations that are relativity adjusted, rather than risk adjusted, are Dual populations and cohorts that have significant LTSS utilization and expenditures. CDPS+Rx risk adjustment does not adequately capture the differences in risk profiles since typical Medicaid risk adjustment tools rely mainly on acute care services and the majority of costs for these populations are either covered by Medicare or are LTSS. Instead, relativity factors were developed by comparing the total PMPM of each rate cell, by MCO, to the statewide PMPM for the rate cell in the CY19 base data period. The July 2020 capitation data was used to identify member months and costs associated with members enrolled with Amerigroup and Iowa Total Care since the CY19 base data reflected a combination of Amerigroup, United, and Iowa Total Care experience. 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 CY19, but not present in July 2020 per the capitation data. The experience for these members was incorporated into the relativity factor calculation at each rate cell by distributing the unattributed members and costs between the MCOs in a manner consistent with the enrollment distribution inherent in the July 2020 capitation file. In general, about 60% of each rate cell is enrolled with Amerigroup and 40% is enrolled with Iowa Total Care as of July 2020. This distribution is expected to continue within the SFY22 contract period and splitting these members approximately 60/40 (with variations by rate cell) between the two MCOs results in a slight adjustment to the initial MCO relativity factors described above.

Optumas reviewed the prevalence of members with $100k+ claims in the CY19 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 not a compelling reason to make an explicit adjustment for members with high-cost claims as part of the relativity factor development.

Similarly, **Optumas** reviewed the average CY19 enrollment duration for members assigned to Amerigroup and Iowa Total Care to understand the differences and consider whether significant differences in duration played a role in the relativity factor development. Upon 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 durational differences.

Relativity factors were used for Dual and LTSS populations that have sufficient membership volume even when split between the MCOs:

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

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

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

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

Methodology

The risk adjustment and relativity factors were applied to the statewide rates in a budget neutral manner consistent with the SFY20 and SFY21 rate developments. The risk and relativity adjustment methodologies follow the use of generally accepted actuarial principles and practices that surround standard risk adjustment. Appendix II.E demonstrates the budget neutrality of the risk adjustments made to split the statewide rates into MCO-specific rates for each applicable rate cell. Consistent with how rates were developed, same-demographic Children and CHIP rate cells were combined for credibility in developing the risk adjustment factors.

Magnitude

A proxy CY19 membership mix for each MCO was developed using the distribution of members between Amerigroup and Iowa Total Care for each rate cell within the July 2020 capitation file. The CY19 base data membership was distributed between the MCOs using the enrollment for each rate cell within the July 2020 capitation file. This proxy CY19 MCO enrollment is used when aggregating the totals within the certification appendices. The magnitude of the relativity adjustment is an increase of 0.6% for Amerigroup and a decrease of 0.8% for Iowa Total Care, based on each MCO’s respective CY19 proxy membership. The impact by rate cell and in total for each MCO is shown in Appendix II.F.

Assessment of Predictive Value

Optumas reviewed the raw risk scores by rate cell developed for the SFY22 IA Health Link rates to the raw risk scores within the SFY19 rate development and compared the MCO-specific normalized risk scores to the relativity factors used within the SFY20 rate development. In general, the raw risk scores by rate cell showed consistency in magnitude and the normalized risk scores showed directional

consistency with the cost-based relativity adjustment used within the SFY20 rates. The SFY22 MCO relativity factors were compared to those used within the SFY20 rates for the applicable populations. 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** does not have concerns with the predictive value of the risk and relativity adjustment methodology used within SFY22 for predicting the relative risk differences between MCOs.

ii. Retrospective Risk Adjustment

No retrospective risk adjustment has been made in the development of the SFY22 rates.

iii. Changes to Risk Adjustment Model and Budget Neutrality

As noted in Section I.6.B.i, **Optumas** has transitioned from the use of cost-based relativity factors for most non-LTSS and non-Dual cohorts in SFY20, to the use of UCSD's CDPS+Rx V6.4 health-status based risk adjustment tool for the SFY21b and SFY22 rates. Consistent with historical rate developments, Dual eligible and certain LTSS populations continue to be risk adjusted using relativity factors by plan compared to statewide PMPMs. All risk/relativity adjustments are applied in a budget neutral fashion in accordance with 42 CFR §438.5(g). Appendix II.E demonstrates the budget neutrality of the risk adjustments made to split the statewide rates into MCO-specific rates for each applicable rate cell.

iv. Acuity Adjustment

Please see Section I.3.B.iii for a description of the acuity adjustment that was calculated in response to the disenrollment freeze associated with the COVID-19 pandemic. The acuity adjustment was applied to the statewide SFY22 projected medical PMPMs, prior to the application of risk adjustment for the Children, TANF Adult, and Wellness Plan populations.

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 SFY22 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 rate cells. Beneficiaries in these rate cells include elderly and disabled individuals, including all home and community-based waiver enrollees. A significant portion of services provided to these members are LTSS benefits including nursing facility, home care, and 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 SFY22 rates were developed for all services incurred by LTSS members, with the exception of dental services. These services are carved out of the IA Health Link capitation rates since dental services are covered by a separate Iowa Medicaid dental managed care program.

B. Rate Development Standards

i. Rate Blending

Optumas developed the LTSS capitation rates by blending the individual rate cells for each LTSS rating group. The rating groups are consistent with those used within the SFY19 through SFY21 rate developments and include the following rate groups:

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

C. Appropriate Documentation

i. Payment Structures

Capitation payments for LTSS benefits are paid as a single capitation rate to the MCOs for each LTSS rating group outlined above. The MCO payments vary based on actual MCO enrollment. **Optumas** used the July 2020 capitation file as the basis for the LTSS blend for each MCO. This file provides the actual mix of Institutional and Waiver members that each MCO has enrolled with their organization as of July 2020.

The individual LTSS rate cells are blended using the rating groups mentioned in Section II.1.B. above. A summary of the rate blending methodology is shown in Appendix II.G.

The capitation payments made to the MCOs are reflective of the rates (net withhold) shown within Appendix I.A based on the members enrolled within the Health Link MCO for each month of the contract period. There is no reconciliation of actual enrollment experience with the underlying LTSS blend assumption used within the rates, as the blend is set on a prospective basis.

The rates within Appendix I.A reflect the blended LTSS rates shown within Appendix II.G, with the additional directed payments included for each rate cell to show the final rate paid to the MCOs. A summary of the additional payments that are added after the LTSS rate blending are shown in Appendix I.B. The GME, GEMT, and NF CRR additional payments vary by individual rate cell based on service utilization and since providers are not eligible to receive enhanced payments for all populations (e.g., dual eligible members). The UIHC Physician and Hospital ACR directed payments are operationalized via a separate payment term arrangement that is reimbursement outside of the capitation rates, but an initial PMPM estimate for these arrangements for the LTSS rate cells has been included in Appendix I.C.

ii. Non-Benefit Costs

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

iii. Sources

The LTSS capitation rates were developed using CY19 encounter data. 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.G.

Section III. New Adult Group Capitation Rates

1. Data

A. New Adult Group Data

The same data sources used to set the SFY22 rates for the traditional Medicaid populations were used to develop rates for the new adult group. IA Health Link encounter data for the Wellness Plan (WP) new adult group, as described in Section I.2, was primarily used to develop SFY22 rates.

B. Previous Rating Periods

i. New Data

Optumas used IA Health Link experience from CY19 as the basis for SFY22 rate development since this was the most recent complete year of data, prior to COVID-19, available for the IA Health Link program. The CY19 base data time period is consistent with that used for the SFY21b rate development.

ii. Monitor Costs

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

iii. Actual Experience Compared with Expectations

Optumas believes that the use of CY19 IA Health Link experience as the basis for rate development should better align payment to risk for the SFY22 contract period as compared with the pre-IA Health Link data used in the early years of IA Health Link rate development.

iv. Adjustment for Differences

Optumas has used CY19 encounter data as the base data for the SFY22 rates, which incorporates the most recent pre-COVID WP population's actual experience under the IA Health Link program. Therefore, no adjustment has been made for any differences between actual experience compared with expectations. It is expected that the use of CY19 IA Health Link experience will better align payment to risk for the SFY22 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 CY19 IA Health Link encounter data as the base for the SFY22 capitation rates. This is consistent with the source of base data used within the development of the SFY19 and SFY20 rates but represents a more recent time period. The CY19 IA Health Link encounters were also used as the base data for the recently developed SFY21b capitation rates.

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

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

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

The Acuity Adjustment described in Section I.3.B.iii applies to all Wellness Plan rate cells, with the exception of WP 50+ M&F (Medically Exempt) and WP 50+ M&F (Non-Medically Exempt).

ii. New Adult Groups Not Covered in Previous Rating Periods

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

iii. Key Assumptions

Acuity Adjustments

Please see Section I.3.B.iii for further details on the acuity adjustment associated with the COVID-19 disenrollment freeze. The impact of this adjustment for the applicable Wellness Plan population rate cells is shown in Appendix I.B.

Pent-up Demand

The WP population has had several years of experience within the Iowa Medicaid program at the time of the CY19 base data period, so no adjustment for pent-up demand was deemed necessary.

Adverse Selection

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

Demographics

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

Provider Reimbursement and Networks

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

Other Adjustments

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

3. Projected Non-Benefit Costs

A. Required Components

i. Changes in Methodology

Projected non-benefit costs for the WP populations were developed using the same data, methodology, and assumptions as the traditional Medicaid populations, described in Section I.5. No other methodology changes have been made to the projected non-benefit costs between the SFY21b and SFY22 Health Link rate development for the WP population.

ii. Changes in Assumptions

Projected non-benefit costs for the WP population were developed using the same data, methodology, and assumptions as the traditional Medicaid populations, described in Section I.5. No other changes in assumptions for the following items have been made to the projected non-benefit costs between the SFY21b and SFY22 Health Link rate development outside of what has already been described in Section I.5:

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

B. Key Assumptions

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

4. Final Certified Rates

A. Required Components

i. Comparison to Previous Rates

Consistent with CMS' request under 42 CFR §438.7(d), Appendix II.A contains a comparison of the final certified SFY22 rates to the final rates from the previous SFY21b rate certification. This appendix contains the comparison for all rate cells, including the Wellness Plan populations.

ii. Other Material Changes

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

5. Risk Mitigation Strategies

A. Description of Strategy

As discussed in Section I.4, the SFY22 IA Health Link capitation rates have been developed as full risk rates. There is a program-wide risk corridor in place for the SFY22 contract period, but there are no risk mitigation strategies that are specific to only the Wellness Plan population. Both the risk corridor and minimum MLR requirement apply to the overall IA Health Link program, across all populations.

B. Comparison to Previous Period

i. Changes in Strategy

There have been no changes in risk mitigation strategy for SFY22 compared to the SFY21b IA Health Link rates specific to the Wellness Plan population.

ii. Rationale for Change

There has been no change from the SFY21b rates in use of a risk corridor specific to the WP population. There is a program-wide risk corridor across all populations, due to the ongoing uncertainties associated with the COVID-19 pandemic.

iii. Experience and Results

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

Actuarial Certification Letter

We, Barry Jordan, Consulting Actuary at **Optumas** and Member of the American Academy of Actuaries (MAAA) and a Fellow of the Society of Actuaries (FSA), and Elrycc Berkman, 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:

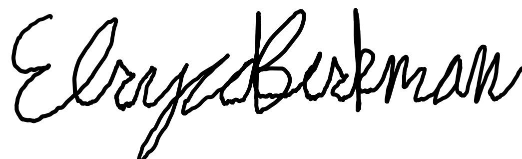
- The capitation rates have been developed in accordance with generally accepted actuarial principles and practices;
- The capitation rates are appropriate for the populations to be covered, and the services to be furnished under the contract; and
- The capitation rates meet the requirements of 42 CFR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

The actuarially sound rates that are associated with this certification are effective July 1, 2021 through June 30, 2022 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 Barry at 480.588.2492 or Elrycc at 480.247.2890 for any additional information.

Sincerely,



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

Elrycc Berkman, ASA, MAAA
Consulting Actuary, **Optumas**

Appendices

The appendices are contained in the following accompanying Excel workbooks:

IA Health Link SFY22 Rate Certification Appendix I 2021.04.29.xlsx
IA Health Link SFY22 Rate Certification Appendix II 2021.04.29.xlsx